DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

This historical compilation on the Social Security Act and Amendments is provided specifically for the position of:

Director, BHI

These volumes are not to be considered personal possessions of the incumbent and remain the property of the United States Government.

BACKGROUND ON MEDICARE

1957-62

Volumes 1-2

85th-87th CONGRESS

REPORTS, STUDIES AND CONGRESSIONAL CONSIDERATIONS ON HEALTH LEGISLATION

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TABLE OF CONTENTS

VOLUME 1

TABLE OF CONTENTS *(Continued)*

TABLE OF CONTENTS *(Continued)*

VOLUME 2

HEALTH INSURANCE FOR THE AGED UNDER SOCIAL SECURITY

Statement
by
Abraham Ribicoff
Secretary of Health, Education, and Welfare
Before the Committee on Ways and Means
U. S. House of Representatives
Monday, July 24, 1961
10:00 a.m., EDT

I appreciate the opportunity to appear before this Committee in support of health insurance for the aged under the social security program--H.R. 4222, introduced by Representative Cecil R. King. It is my firm belief that this bill, if enacted, is destined to become as significant as any piece of domestic legislation produced by the 87th Congress.

You have the opportunity to equal the landmark action taken by the 74th Congress, which passed the Social Security Act in 1935. They sought to promote freedom from fear--the fear of economic insecurity. To a large extent they succeeded.

Today the later years of millions of Americans are plagued anew by fear. With lifespan lengthened, with medical science breaking into undreamed realms of discovery, the Nation's aged now face another aspect of insecurity--how to meet the mounting costs of medical care.

Gentlemen, let me set forth my position clearly:

1. The high costs of medical care for the aged are going to be paid for in this country. The issue is not whether to pay these costs. The only issue is how to pay them.

2. The alternatives to health insurance that have been suggested are not adequate, not fair to the elderly who need the care and not fair to the public which pays for it.

Private insurance plus public assistance cannot do the complete job. If the medical assistance for the aged program, enacted by Congress last year, is expanded to cover a major share of the costs, the drain on State treasuries will be fantastic. If the issue is left to collective bargaining, the pressures on employers to absorb the total costs will be overwhelming. If hospitals have to collect from those who can pay the costs for those who cannot, the burden on middle-income hospital patients will be unconscionable.

3. The facts will show that paying for hospital costs under the social security system is the conservative answer, the practical answer, the fair answer.

Let me begin by discussing the need.

The Need For Action

In his Special Message to the Congress on Health and Hospital Care, the President described the need of the aged for insurance against health care costs. You may recall that he said: "Those among us who are over 65--16 million today in the United States--go to the hospital more often and stay longer than their younger neighbors. Their physical activity is limited by six times as much disability as the rest of the population. Their annual medical bill is twice that of persons under 65--but their annual income is only half as high."

The President went on to say: "Twenty-six years ago this Nation adopted the principle that every member of the labor force and his family should be insured against the haunting fear of loss of income caused by retirement, death, or unemployment. To that we have added insurance against the economic loss caused by disability. But there remains a significant gap that denies to all but those with the highest incomes a full measure of security--the high cost of ill health in old age."

The statistics to demonstrate the need are legion, and I want the Committee to have them. I am submitting, in addition to my statement, two supplementary documents for the information of the Committee. One of these, a report entitled "Health Insurance for Aged Persons," contains a comprehensive discussion of the financial circumstances and the health status of the aged and the need for a program of health insurance and also presents in detail the specifications for the provisions of the President's proposal and the reasons underlying the specifications. The second document, an actuarial report prepared by the Chief Actuary of the Social Security Administration,

presents detailed estimates of both the short-range and long-range costs of the proposal, the assumptions underlying the estimates, and other pertinent actuarial material.

But before talking statistics let me say a few words about people--some of the many men and women who have taken pen in hand to tell the President of the United States what it means to face sky-high medical costs.

The President recently received a letter from a man in North Carolina who said: "I am writing you for some information about medical bills for the old aged. I don't know whether any of them has been passed yet. Mr. Kennedy, my wife is 72 years old and I am 74. We only get $51.00 a month social security between us both. I own a small house of my own so we don't get any old aged pension. My wife had to have an operation the other day and bill is so big we just can't pay it. The welfare doesn't want to help. So, I just don't know what to do."

A woman in Georgia has written to the President: "I went to the hospital last February. Stayed a week and one day. It cost me $172. I have no hospital insurance and do not get enough money from Social Security to pay on insurance."

A man in Oklahoma wrote to me: "I am past 70 years old and am retired and drawing social security. It costs my wife and me $275.00 a year to carry hospital insurance and what we fear most is that the policies might be cancelled if we have to use them. Something should be done about this. I am in favor of the social security plan which you advocated on TV a few days ago."

These and many other letters bring out very clearly, I think, how older people live in fear of the costs that illness brings. This threat is very real for most of the aged; it is not only the very poor or those with very expensive illnesses who can suffer financial disaster as a result of health care costs.

Let me describe the case of a couple in Connecticut, who were among those interviewed in a survey of old-age and survivors insurance beneficiaries made in 1957, at the time I was Governor. This couple--let's call them Mr. and Mrs. Day--were getting along pretty well in their later years. Mr. Day had retired from his job as a general laborer in a factory in 1952 at the age of 74. He had worked hard, and he and his wife had saved what they could and had a small house paid for. The house needed some repairs, but they didn't feel that they could spend the money to put it in good condition.

Mr. Day's social security benefit was about $80 a month, and his wife's benefit was $40. They rented part of their house, bringing their total income to about $2,300 a year. We all know that a couple, even when they own their own home, can't splurge much on $2,300 a year, but this couple was getting along. The financial picture of this retired couple, incidentally, is just about the average.

Then Mr. Day had a stroke and had to go to the hospital for 11 days. The hospital bill was $405--not at all unusual as cases of hospitalization go. Out-of-hospital costs were $26.

This couple didn't have any health insurance. They had had health insurance when Mr. Day was working, but their protection ended when he retired. By the time they finished paying the hospital bill and the $26 for the doctor, their savings were pretty well wiped out by this one illness. They now have practically nothing to meet future emergencies with. What happens if Mr. Day has another stroke or Mrs. Day gets sick?

Here is the case of another elderly couple who was questioned in the 1957 survey. This couple was living in New York. They were receiving $113.90 a month in social security benefits for the husband and wife. The man was also getting a pension of $65 a month from his employer, making their total annual income about $2,150. They had about $1,000 in savings at the beginning of the survey year. They were living in modest circumstances, but they were getting along.

Then the man had to have a serious operation. His care cost $1,263, including a hospital bill of $738. In addition, the wife had health-care expenses amounting to $330. They managed to meet all their medical and hospital bills, but it took all their savings. At the end of the year they had no assets left, and the man was still in poor health. A couple like this probably will have to seek assistance to get future medical care.

The fear of future illness is something that people in this situation live with every day, and what they fear happens to many of them time and again.

Now a few facts that show the general situation of the aged.

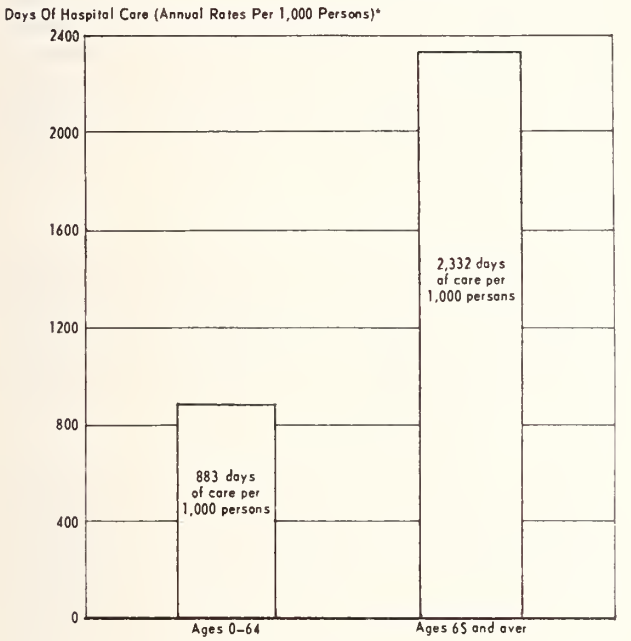
Nine out of 10 of the people who live to be 65 go to the hospital at least once between age 65 and death.

Among couples, in about half of the cases the husband and the wife will each have at least two

hospital stays between age 65 and death--at least four hospital stays for half of the couples after age 65.

When an aged person goes to the hospital he is likely to stay longer than a younger person because he is more likely to have serious and long-lasting disease. People over 65 are in hospitals, on the average, over 2-1/2 times as much as younger people. I have here a chart that illustrates this point.

DAYS OF HOSPITAL CARE

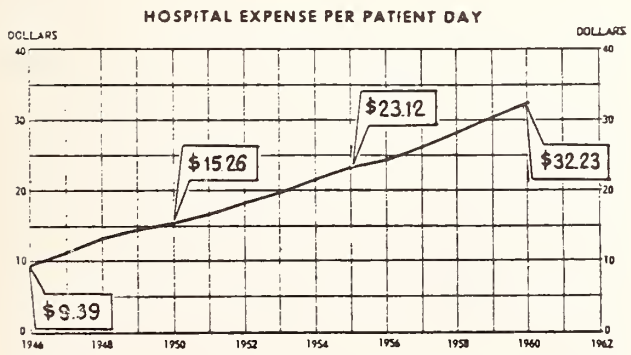


* Data are for the Middle Atlantic States, 1957.

SOURCE: Public Health Service, U S National Health Survey

In recent years these problems have been aggravated by rising hospital costs. The costs have more than tripled in the last 15 years as shown on the second chart.

HOSPITAL EXPENSE PER PATIENT DAY



SOURCE: American Hospital Association

The financial impact of repeated hospital stays becomes apparent when we consider that the median yearly income for a widow is about $1,000, and for an aged couple is less than $2,500. About 1/3 of the aged have no assets that can readily be turned into cash, and about half have less than $500. Much of the health insurance available to the aged provides very limited protection and that only at high cost to them, and less than half of the aged have any hospitalization insurance at all. This is not surprising, since it is impossible for most retired people to pay currently the high premiums that, considering the high incidence of illness among older people, would be necessary to provide adequate coverage.

Is it not true, though, as some people are asking, that whether people can pay for it or not everyone in this country gets the hospital care he ought to have? I doubt very much that this is true. I believe it is true that very few, if any, who are absolutely in need of urgent care are turned away from our hospitals because of inability to pay. But what about those who are too proud to accept what they look on as charity or going on relief, who will dangerously postpone seeking care because they fear cancellation of their insurance or do not want to dip into their small savings or to burden the limited resources of their children? Who can say with confidence that needed hospital care has not been foregone, that terminal illness and premature death have not been caused by the unwillingness of our older people to seek the care they need?

We know that hospital use by older people goes up when an assured source of financing is provided on terms that older people find acceptable. Insured older people do use more hospital care than the uninsured. Financial barriers do stand in the way of adequate care.

The Present Role of Government

The need must be met. But by whom? In proposing that the Federal Government play a part, we are not suggesting anything new. The Government is already involved in meeting the cost of personal medical care, for the aged as well as for other groups, and on a large scale. We are simply proposing a more logical, a more equitable, a more efficient, and a more fiscally responsible approach to medical-care problems with which the Government is already involved and has been for quite some time.

In 1959, total expenditures for personal health and medical care in this country amounted to $22.5 billion. Almost 22 percent of this total--about $4.9 billion--was paid from public funds. Federal expenditures amounted to almost $2 bil-

lion, or about 40 percent of the total public spending for personal health and medical care.

The 1960 legislation providing for increased Federal grants for direct payments to providers of medical care under old-age assistance and for medical assistance for the aged will, of course, increase public expenditures for health care. If all States were to put into effect medical assistance programs for the aged comparable with the average program now in effect or under study in the States, and if health insurance for the aged is not provided under social security, the annual cost, Federal and State, for this category alone would be more than $650 million. If the State programs were to provide better benefits in the future than the average now provided, the cost of medical assistance for the aged, in the absence of a health insurance program for the aged under social security, could run to as much as $1 billion a year or even more, with the Federal Government paying somewhat more than half a billion dollars. Make no mistake about it; the Federal Government is already in medical care, and on a large scale.

It is in this medical-care business because there were problems that had to be met. Action had to be taken. The program of medical assistance for the aged was and is urgently needed. In fact, we believe that still further action is needed: use of the social security approach to insure against the costs of hospital care for older people.

The Social Insurance Method

Provisions for health insurance benefits for the aged are a necessary part of income protection in retirement. Without such benefits the social security program cannot adequately provide basic security for the aged. For most older people old-age, survivors, and disability insurance cash benefits are barely large enough to keep them housed, clothed, and fed, and half of the beneficiaries do not have any significant additional regular income. The benefits are not large enough to meet the costs of expensive illnesses or to pay large health insurance premiums during retirement. The only way to remove the threat to the financial independence of older people posed by the high cost of illness is through providing the aged with basic health insurance protection in addition to their monthly cash benefits. And this can be assured only through the social insurance method.

Basically the problem is that the larger medical-care needs of the aged as a group result in higher average costs than those incurred by younger people. To cover these costs higher premiums must be charged, and this at a time when, because they have retired, people's incomes are lower than in earlier years, and there is no employer to share the cost. We cannot expect them to finance the higher-than-average medical costs that they have at this time of their lives out of their lower-than-average financial resources. The best solution for a problem of this sort is an arrangement, like that for present social security benefits, under which people pay while they are working toward the cost of the protection that they will need to have in retirement, so that no further payment after retirement is required.

The method of providing paid-up health insurance protection for retirement has not been followed on any large scale in private insurance, nor is it likely that it will be. The social insurance method, then, is the only practical way of enabling most people to pay during their working years toward meeting the health costs they will face in old age.

Moreover, the social insurance approach affords the best assurance of keeping program costs under control, for there is a direct and known relationship between increases in benefits and increases in taxes, and the State and Federal Governments are relieved of a considerable burden on general revenues.

I have mentioned that if we do not have health insurance for the aged under social security and if the State assistance programs were to provide better medical benefits than the ones in effect in the present initial programs, the cost of medical assistance for the aged could run as high as $1 billion a year or even more. With almost one-half of this coming from the States, the States would have to spend something like 3 times the $146 million they paid toward vendor payments for medical care under old-age assistance in 1960. Such a volume of expenditure, by some of the States, is almost impossible to envisage, but the need is there, and pressures to meet it will be great. Far better, surely, to look to meeting the major part of the costs through health insurance for the aged.

The social insurance approach, on a national basis, makes possible provision of basic protection for the aged regardless of where they may happen to live. As you know, the State programs of medical assistance for the aged can, depending on State action, be very narrow, both in eligibility, and in benefits, or on the other hand can provide virtually comprehensive medical care to a substantial portion of the aged. New York, for example, has enacted a comprehensive program, providing a broad range of medical services and a relatively liberal definition of medical indigence. Unmarried aged people with annual incomes of

$1,800 or less and couples with incomes totaling $2,600 or less are eligible. Kentucky's program, on the other hand, is limited to individuals with an annual income of $1,200 or less and couples with annual incomes of $1,800 or less, and it provides payments only for 6 days of hospital care for acute emergency and life-endangering illness.

Variations such as these and the fact that most States have no program at all raise the very serious question of whether this country can long tolerate a situation in which health care is available to many of its aged citizens in New York and Massachusetts but not to people similarly situated in Kentucky or North Carolina. There is nothing fair or equitable in a situation of this sort. The problem is nationwide, and it should be dealt with nationally.

The social insurance approach would provide health insurance protection for the aged without limiting the patient's choice of doctor or hospital. In fact it makes possible greater freedom of choice than now exists, since the most important limitation for those who have not been able to pay--the financial barrier--would be removed. The only limitations on the patient's choice, for any beneficiary, would be what they are today for those who are able to pay: namely, that a hospital may be unable or unwilling to accept a patient and that one's physician may not happen to have hospital privileges at the hospital of one's choice. Thus, contrary to the argument of those who say that the plan would limit the patient's freedom of choice of doctor or hospital, it would in fact broaden freedom of choice for many and limit it for none.

Finally, the social insurance approach means that those who qualify under it can be protected without having to undergo a means test. Requiring older people who have always been financially independent to undergo a means test, with its investigation of their personal circumstances, when serious illness strikes, denies them dignity and self-respect in their days of retirement.

We have, then, in the social insurance approach these advantages: It is the only way in which people generally can pay during their working years toward meeting their health costs in retirement; it is sound and fiscally responsible; it makes possible provision of basic protection for the aged regardless of where they live; it preserves and increases freedom of choice of doctor and hospital; and it does all this in a way that is consistent with the dignity of the individual.

The Cost of the President's Proposal

When the administration bill was introduced in February, it provided for full financing of the estimated long-range cost of the program--0.60 percent of taxable payroll. This cost would have been met by an increase in the tax rate of 1/4 of 1 percent each for employers and employees and by 3/8 of 1 percent for self-employed persons, effective in 1963, together with the net gain to the program from an increase in the taxable earnings base from $4,800 to $5,000 a year effective in 1962.

Since the introduction of the bill, the Chief Actuary of the Social Security Administration, in accordance with his usual procedure, has reevaluated the cost estimates. The estimate of the cost of the hospital services has been fully confirmed in this reevaluation. There is a great deal of information on hospital use under insurance programs, and our assumptions on use of hospitals under the President's proposal seem very safe.

For nursing-home and home health-care services, the Chief Actuary is now using assumptions that are more conservative than those he originally used. In the original estimates a moderate increase in the use of these services had been assumed. In the course of his reevaluation, he decided to allow for a substantial increase in the use of the kinds of nursing-home and home health services that would be covered under the bill. A change of this magnitude may not occur, but we propose to provide sufficient funds to make possible payment for increased use of the services, if the change does occur, without further increases in the contribution rate.

Based on the new assumptions on use of services, the long-range cost of the program is now estimated by the Chief Actuary at 0.66 percent of payroll rather than 0.60 percent. In accordance with the long-established practice of fully covering the cost of any new benefits that are added to the program, I am recommending that the financing provisions of the proposal be changed so as to keep the program on a sound financial basis.

Specifically, I recommend that the taxable earnings base be increased to $5,200 instead of to $5,000 in order to fully meet the cost of the benefits provided in the bill. Although our most recent estimates indicate that, even with the previously recommended financing provisions, the income earmarked for health insurance benefits would have exceeded the outgo in every year until after 1980, we believe the prudent and advisable course is to make provision now for the additional income that would be required over the very long run.

Incidentally, an increase to $5,200 would not only be desirable to provide the necessary financing but at the same time, since raising the maximum wage base also raises the benefit amount payable at the maximum, it would improve the benefit structure of the social insurance program. As was brought out in this Committee when the recent social security amendments were under consideration, the maximum wage base is now out of date in view of the increase in wages since 1958, the last time the maximum was raised. And the recent increase in the minimum benefit amount from $33 to $40 is an additional reason for raising the earnings base.

It is important, as this Committee has always recognized, in a program in which benefits are related to prior earnings, to maintain a reasonable spread between the minimum and the maximum benefit. If the minimum benefit becomes too high in relation to the maximum benefit the wage-related character of the program is weakened. The increase in the minimum benefit to $40 reduced the spread of benefits from $94 to $87. Since the maximum benefit amount payable under the $5,200 earnings base would be $134, the spread between the minimum and the maximum benefit would be restored to $94.

How Would the President's Plan Work?

President Kennedy proposes a fiscally responsible method of financing hospital care and certain related health services for the aged in a way that protects the dignity of the individual. There are differences in the method of collecting the funds and in the population groups affected, but what the plan would do would be very much like what Blue Cross plans have been doing for many years: it would pay hospital bills without interfering with hospital operations.

The People Who Would Be Protected

About 95 percent of today's workers will have this protection when they reach age 65. Only 5 percent of all present workers would not be protected under the plan, and they would be largely Federal employees, who will be protected under their own system, self-employed physicians, and those State and local government employees who are not brought under social security. At a given point in time there are always also some irregularly employed farm and household workers and low-income self-employed who are excluded from coverage, but most of these people will acquire protection over a working lifetime.

Even among those already retired, the great majority will be protected immediately under the plan. At the beginning of 1963, the first full calendar year in which the plan would be in operation, of the 17-3/4 million people who will then be age 65 and over, 14-1/4 million would have health insurance protection--13-3/4 million as old-age, survivors, and disability insurance beneficiaries and 1/2 million as railroad retirement annuitants. Among those not protected immediately by the new plan are people who have protection under other programs--retired Federal employees, veterans eligible for care under the special program for that group, and people in institutions.

This pattern of immediate protection for those who had worked under the program in the past, with growth in the proportion protected in the future until ultimately practically all are protected, is the tradition that has been followed from the beginning of the program. When cash benefits for the aged were first payable in 1940, benefits were made immediately available for those who, though already old, had demonstrated attachment to covered work after the program started in 1937.

When cash disability benefits were first paid in 1957 to people age 50 and over, those already disabled who were between the ages of 50 and 64 and who previously had worked substantial periods in covered jobs were made eligible for benefits. In this way the work-related character of the benefits was established and maintained, while at the same time the provisions were given immediate effect to the extent that it seemed practical to do so within the framework of a work-related program. At the same time, both at the very beginning of the program and with its extension to the additional risk of disability, assistance programs, put into operation before the insurance provisions, have been relied on to meet the needs of those who had not earned eligibility under social insurance.

We propose that this time-tested pattern be followed for health insurance benefits, with 80 percent of the aged protected immediately, with 95 percent or better to be protected in the long run, and with medical assistance for the aged becoming increasingly available to those not protected by social insurance.

The Benefits Provided

The proposed legislation would provide for the payment, through the social security program, of certain health costs for people who are aged 65 or older and entitled to old-age, survivors, and disability insurance or railroad retirement benefits. A person would have the health insurance protection at age 65 even though his monthly cash

benefits are being withheld because of earnings from work. In general, the following health services would be paid for under the proposed program:

(1) Inpatient hospital services, including bed, board, drugs, and other supplies and services of the kind customarily furnished by the hospital.

(2) Followup skilled nursing-home services provided to a patient after his transfer from a hospital, including bed, board, nursing services, drugs, and other services and supplies which are customarily provided by skilled nursing homes.

(3) Home health services furnished by or through a public or nonprofit agency under a plan prescribed by a physician, including nursing care, physical, occupational, and speech therapy, medical supplies (other than drugs) and appliances for temporary use, and certain part-time or intermittent homemaker services.

(4) Outpatient hospital diagnostic services of the kind customarily furnished by or through the hospital to its outpatients for diagnostic study.

Hospital and home health services that are furnished on and after October 1, 1962, and skilled nursing-home services furnished on and after July 1, 1963, could be paid for under the program.

In essence what this program adds up to is payment of the cost of hospital care and of economical substitutes for hospital care.

There are two reasons why the proposal focuses on hospital services. First, the hospital is the center of modern medical care, and hospitalization is required in a large proportion of major illnesses. Second, hospital care is very expensive; people who need hospital services generally face a heavy financial burden. Medical expenses for older people who are hospitalized are about 5 times as great as the medical bills of older people who are not hospitalized.

The chief reason why certain services other than hospital inpatient services are covered is to promote economical use of the latter. Thus, the efforts of the health professions to reserve hospital beds for the care of the acutely ill who need the intensive care that only a hospital can furnish would be reinforced by the proposal. The provision for payment of the cost of skilled nursing-home care after a hospital stay, for example, would relieve the hospitals of the problem of caring for patients in the post-acute stage of illness. Pressure for hospital care of such patients could be expected to develop if only hospital care were covered by the proposal. Similarly, because the plan would pay the costs of outpatient hospital diagnostic tests, there would be no incentive to get inpatient care where not required for diagnosis. In addition, of course, payment of the costs of out patient diagnostic services would promote early detection of disease. Payment of the cost of home health services, too, would encourage the use of these less expensive services, where medically appropriate, rather than those of a hospital.

We recognize that there is a great need for an increase in the number of physicians, medical schools, community health facilities, and skilled nursing homes to fully meet the health needs of our growing population. The administration has recommended to the Congress legislative proposals to accomplish these objectives. The proposed Health Professions Educational Act of 1961 (H.R. 4999) and the proposed Community Health Services and Facilities Act of 1961 (H.R. 4998) are part of a total program to improve the health and well-being of the American people. Enactment of these programs is of great importance to the success of the proposed insurance program. On the other hand, passage of the insurance program will do much, in and of itself, to encourage the development of new facilities and services and thus to assure the success of these Federal-State programs. This is because adequate operating funds from patient income must be reasonably assured before a building project can be undertaken, before standards can be raised, or before new service programs can be put into effect. Social insurance financing would help to furnish these operating funds by its payment of the full reasonable costs of the covered services they will provide.

In short, these several programs would work in a coordinated way to increase the availability to the aged of the health services and facilities they need.

The bill would not cover all health services. Much would be left for coverage under private insurance contracts and other voluntary arrangements. As is true of the basic protection provided by the cash benefits, the health insurance protection could be supplemented by the individual as he saw the need to do so and could afford it.

Physicians' services would not be covered except for services in the fields of pathology, radiology, physical medicine, anesthesiology, and ser-

vices rendered by interns and residents-in-training, and those services would be covered only when they are provided as part of the hospital's services. Hospitals enter into various kinds of arrangements with doctors specializing in pathology, radiology, physical medicine, and anesthesiology. Some hospitals employ these specialists as salaried staff members; others arrange for these services by contracting with individuals or partnerships. In order to provide payments for these services for beneficiaries wherever provided by the hospitals, the administration proposal would provide payments to a hospital for the services in question whether the specialist is on salary or provides services for the hospital under some other kind of arrangement. Service provided by the patient's private doctor would not be covered, nor would services furnished by mental, tuberculosis, and, in general, Federal hospitals.

For both inpatient hospital service and nursing-home services, there is a limitation on the number of days of care that could be paid for in a period of illness--a maximum of 90 days for hospital care and a maximum of 180 days for skilled nursing-home care. (This "two-for-one" provision is designed to provide an incentive to use nursing-home facilities, where medically appropriate, rather than hospitals.) In addition there is an overall limitation of 150 "units of service" which may be paid for in a single period of illness. A "unit of service" is defined as 1 day of inpatient hospital care or 2 days of skilled nursing-home care--again a two-for-one ratio. If someone eligible for benefits under the plan should go into the hospital and stay for 70 days, for example, and then require followup skilled nursing-home care, he would be eligible for payment for the cost of up to 160 days of such care.

A period of illness is so defined in the bill that a new period could not begin unless there had been a lapse of 90 days during which the individual was neither an inpatient in a hospital nor a patient in a skilled nursing home.

For home health services an annual maximum of 240 visits is provided. Home health services involve periodic visits to the patient's home by therapists, nurses, and other professional personnel. The limitation placed on the payment of the costs of home health services is written in terms of "visits" rather than "days" so that the amount of home health services covered would be unaffected by whether a variety of services is offered on the same day or different days. A larger amount of service is covered in this area than in hospital and nursing-home care because home health services are far lower in cost than are hospital and nursing-home services.

The proposed health insurance program would not provide "first-dollar" coverage. There is no coverage of a "deductible" amount of $10 for each of the first 9 days of inpatient hospital care in a benefit period, and the minimum deductible amount is $20. Also, there is a deductible amount of $20 for each hospital outpatient diagnostic study.

The inclusion of the various deductible provisions in the proposal results in a substantial reduction (about 0.2 percent of payroll) in benefit costs, thus making it possible to provide a broader range of benefits and greater protection against the cost of catastrophic illness. It is expected that most aged beneficiaries would be able to budget for, or have modest resources available to meet, these small costs to which the deductibles apply.

Administration of the Program

Overall responsibility for administration of the program for social security beneficiaries would rest with the Secretary of Health, Education, and Welfare. State agencies would be used, however, to carry out those services they are best equipped to perform. The bill, for example, authorizes the Secretary to enter into agreements with the States to have them conduct any activities that may be needed to determine whether a provider meets the conditions for participation in the plan. The States could also be reimbursed under such agreements for making available consultative services to help providers to meet these conditions. This help would be in the nature of technical advice on request and would make available to institutions desiring assistance the benefit of State and community professional experience.

Conditions of participation could, of course, be readily met by institutions that fulfill the standards established by accreditation bodies. The Secretary could accept accreditation of a hospital or other facility by a recognized national organization as prima facie evidence that the institution had met some or all of the conditions for participation in the program. The help of State agencies would be used for the most part to determine whether unaccredited hospitals and nursing homes are eligible to participate.

Provision would be made for the establishment of an Advisory Council, which would advise the Secretary on matters of general policy in connection with administration. The Council would also advise the Secretary in the formulation of of regulations. There would be 14 members of the Council, none of whom could otherwise be in the employ of the U.S. Government and at least 4 of whom would have to be persons who are out-

standing in fields pertaining to hospitals and health activities.

The proposal would be carried out through the use of the administrative machinery now used for the old-age, survivors, and disability insurance provisions. This would make it possible to administer the plan with operating costs of about 3 percent of benefit costs, because the administrative machinery for collecting taxes, keeping records, processing claims, and many of the other functions that would have to be performed is already in existence and operating smoothly in the administration of the present program.

Summary and Conclusion

To summarize: Older people have low incomes and high health costs. We believe that many refrain from seeking care they need because they cannot pay for it or are unwilling to ask for help. Others, who do seek care, are made destitute by the cost of the care they get.

With the cost of health care rising and the number of older persons increasing rapidly, the need for protection against the cost of health care for the aged is an urgent and pressing one. The only satisfactory way of providing the aged with adequate health insurance protection is through a system under which the cost of the health insurance will be paid by people during their working years, together with their employers. The social security program is the only practical mechanism which follows this approach and through which in the future practically everyone in every State in the United States can secure basic protection.

Gentlemen, I have given you only a few statistics today. Many more facts and figures could be cited. But statistics cannot measure the anxiety and suffering of elderly people who see their small savings, their homes. their security about to be swept away by the near certainty of expensive illness.

Behind the facts and figures are human beings--average Americans--facing retirement on low income, knowing that in the days ahead there are almost certain to be large hospital bills. Many can just make it day by day on social security supplemented by minimum income from other sources, barely meeting the costs of rent and food and shelter. What they worry about is what happens if they get sick? Will their children be able to help? Will they have to sell their homes, draw the last dollar from the bank, for the first time in their lives apply for relief and go through the humiliation of a test of need, ask help from friends?

Even if medical care on a means-test basis were adequate and available for all needy, it would not be the answer. They, just as you and I, want protection before disaster strikes--not relief after they have lost everything. Growing old has its inevitable sadness; must we add the cruelty of fear and insecurity?

A quarter of a century ago we faced a problem much like the one we face now. We chose, as our basic solution then, a system of social insurance, under which the people, with their employers, would build their own old-age security while working by paying social security contributions into special funds from which payments would be made to them when they were no longer working. Now, after 25 years, few would question the wisdom of that decision.

I hope we will choose the social security approach again today as the Nation's primary answer to the problem of how to meet the costs of medical care for the aged.

HEALTH INSURANCE FOR AGED PERSONS

REPORT

Submitted To The

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

By The

SECRETARY OF HEALTH, EDUCATION, AND WELFARE

July 24, 1961

C O N T E N T S

Appendix. Medical assistance for the aged: Selected characteristics of State plans.

HEALTH INSURANCE FOR AGED PERSONS

INTRODUCTION

Rapid growth in our aged population has been accompanied by increasing concern about their problems. One of these is the problem of medical care: How can higher-than-average needs be financed for a group with lower-than-average financial resources?

Medical care has become a matter of national concern in the United States--not because sickness and disease are more prevalent but because of the very successes of modern medicine. Modern medical services are not only more effective, they are also very much more costly than the best services available as recently as the early decades of this century. The medical profession will have to work out the future pattern of medical practice. Society as a whole, however, has a proper concern with the methods of paying for medical services. The method of paying for care is of particular consequence for the aged. And the problem is by no means limited to low-income groups: Many middle-income families with too much money to expect free care may find themselves with too little to pay for what they need.

Because no one knows when he will be taken seriously ill, the cost of medical care is a threat to the security and independence of the aged. Every aged person knows--and fears--that some day before he dies he will face serious illness. Most have too little set aside to finance an expensive illness. And it is understandable that those who have savings hesitate to use them all up; they know only too well how likely it is that they will have further illness. Aged persons, like others, dislike turning to public assistance; many old persons go without care rather than subject themselves to a means test.

With medical service a basic necessity, and an individual's need for it highly variable and unpredictable, some socially organized method of paying for services is indicated. One method is that of insurance, which permits individuals to budget ahead for at least some medical expenditures.

Aged persons now find it difficult to obtain adequate health insurance protection. As a group they have more need of medical services than younger persons. Because they use more than others, the average medical cost and hence the current insurance premium needed for aged persons is between two and three times as high as for younger persons.

Up until quite recently, most persons over 65 could not buy health insurance. At present, less than half of all persons aged 65 and over have some type of health insurance. While the extent of insurance protection has increased in recent years, voluntary action alone cannot meet the full need. Some who need the insurance most, because they already have expensive health problems, will find they are not accepted as insurable risks. Others, who would be considered good risks, will find the premium cost more than can be spared out of an income already stretched thin by everyday necessities.

How, in terms acceptable to our social goals and political organization, should medical care for the aged be financed? Much care for the aged and for other low-income groups is already supported out of public funds, that is, from taxes paid largely by the working population. If the aged are to have adequate medical care, society as a whole must continue to help carry the costs of this group in our population. Society does have a choice as to the terms on which the care should be available and how the tax funds should be collected. This problem cannot be met satisfactorily through sole reliance on a program of assistance varying from State to State and with the funds coming from general revenues. What is required is a national program, financed through social insurance contributions, with the same benefits available throughout the Nation.

* * *

This report first summarizes the evidences of the problem of medical care for the aged. It describes the means now available to deal with the problem--primarily voluntary insurance and public assistance programs. It then takes up in some detail the Administration's proposal to provide protection against the costs of hospital and skilled nursing home services, home health services, and outpatient hospital diagnostic services through social insurance. It describes the provisions as to coverage and benefits, the costs and the financing, and how the program might be administered.

PART I

MEDICAL CARE FOR THE AGED:
THE NEED AND PRESENT PROVISIONS FOR MEETING THAT NEED

The growth of the aged population of the United States, both in absolute numbers and in relation to the total population, has led to increasing concern about their special problems. In the 10 years from 1950 to 1960 the number aged 65 and over in the United States increased more than 4 million, or 35 percent, nearly twice the rate of increase in the total population. The total number of persons in this age group in the United States, Puerto Rico, and the Virgin Islands now exceeds 17 million, and by 1970 will probably exceed 20 million.

The sharp drop in income associated with withdrawal from the labor market has been of first concern. Monthly benefits under the old-age, survivors, and disability insurance system provide substantial protection against loss of earnings, making it possible for the great majority of beneficiaries to meet day-to-day living expenses, at least at a minimal level. Heavy medical costs are now the most serious impediment to security in old age. For this reason, increasing attention has been directed toward methods of financing the medical services needed by older persons.

THE NEED FOR FINANCING MEDICAL CARE

HEALTH CHARACTERISTICS 1/

Millions of older persons are reasonably healthy, but many more millions suffer from disease and disability. Health of course affects every aspect of a person's life--his participation in society and his financial status--and is in turn largely dependent on his ability to obtain appropriate care.

1/ Unless otherwise indicated, the data in this section are drawn from U.S. Public Health Service Publication No. 584-C4, Older Persons, Selected Health Characteristics, United States, July 1957-June 1959, and other National Health Survey reports.

Persons 65 and over are twice as likely as younger persons to have one or more chronic conditions, six times as likely to have their activity restricted and thirteen times as likely to be limited in their mobility. Specifically, according to the National Health Survey, 77 percent of all persons 65 and over not in insitutions had one or more chronic conditions or impairments and 42 percent were limited in their activity (table 1). Indeed, one in seven of the aged was completely unable to engage in his usual activities of working or keeping house and another two in seven were partially restricted in their activity. Some persons can get around by themselves even though chronic conditions limit their ability to work or keep house. Nevertheless, 18 percent of those 65 or older reported their mobility was limited: More than 4 percent were confined to the house and 14 percent were limited or needed help in getting around outside the house.

The older the individual, the greater the likelihood of chronic conditions. Thus, of all persons 75 and over not in institutions 55 percent had some chronic limitation of activity, with nearly one-fourth unable to work or keep house, and almost one-third restricted in their activity. Some 30 percent were confined to the house or limited in getting around outdoors.

The fact that the National Health Survey does not include persons in nursing homes, homes for the aged and long-stay hospitals and other institutions--now estimated to number more than half a million--means that the health situation of older persons is actually more unfavorable than data from that survey indicate, particularly in comparison with younger persons.

Older persons tend to maintain their independent living arrangements as long as possible. These may have to be adjusted to their physical conditions, however. The National Health Survey shows that among aged persons who are not married, those whose mobility is limited are much more likely than others to live with children or other relatives--about two-thirds as compared with half of those with no restriction on mobility.

Days of Disability

Reported limitations on activity and mobility give a qualitative measure of the extent of chronic disability in the population. Information is also available from the National Health Survey on the number of days of disability resulting from both acute and chronic conditions.

Persons 65 and over reported an average of 43 days during the year when their usual activities were restricted because of illness or injury--$2\frac{1}{2}$ times as many as younger persons (table 2). On 14 of these days they were confined to bed for all or most of the day. Persons under 65 years of age were confined to bed only half as often.

Table 1.--Percentage distribution according to chronic limitation of mobility and activity, for persons 65 and older by age, sex, family status, family income, and for younger persons by age, July 1957-June 1959

(Noninstitutional population of the United States)

Age, sex, family status, and family income	Total	With 1 or more chronic conditions 3/						With no chronic condition
		Total	Mobility		Activity			
			Limited	Not limited	Unable to work or keep house	Partially limited	Not limited	
Total 65 and over.....	100.0	77.3	18.1	59.2	14.3	28.0	35.0	22.7
65-74.....	100.0	74.2	11.8	62.4	9.4	26.2	38.6	25.8
75 and over.....	100.0	83.3	30.5	52.8	23.9	31.3	28.1	16.7
Male.....	100.0	75.2	15.1	60.2	19.4	24.5	31.3	24.8
Female.....	100.0	79.0	20.7	58.3	10.0	30.9	38.1	20.9
Married, spouse present..	100.0	75.1	14.6	60.5	12.5	27.7	34.8	24.9
Nonmarried 1/								
Alone or with nonrelatives	100.0	81.7	15.9	65.7	11.3	28.5	41.9	18.3
With relatives.....	100.0	77.8	27.0	50.8	20.5	27.9	29.3	22.2
Under $2,000.....	100.0	82.1	20.7	61.4	16.1	32.0	34.0	17.9
$2,000-3,999.....	100.0	76.1	15.1	61.1	12.2	26.9	37.0	23.9
4,000-6,999.....	100.0	74.0	17.3	56.6	14.1	24.9	35.0	26.0
7,000 and over.....	100.0	73.8	17.0	56.7	12.7	24.7	36.4	26.2
Total under 65 2/.....	100.0	37.9	1.4	36.5	1.0	6.0	30.9	62.1
55-64.....	100.0	64.4	5.8	58.6	4.3	17.1	43.0	35.6
45-54.....	100.0	56.5	2.2	54.3	1.6	11.1	43.8	43.5
Under 45 2/.....	100.0	31.4	.6	30.7	1.5	3.7	27.2	68.6

1/ Widowed, divorced, separated, single.

2/ Data relate to period July 1957-June 1958.

3/ Generally a condition that had been present for more than 3 months.

SOURCE: U.S. Public Health Service Publications No. 584-C4, Older Persons, Selected Health Characteristics, July 1957-June 1959; No. 584-B11, Limitation of Activity and Mobility, July 1957-June 1958.

The lower the family income, the more likely were the aged to be restricted in their activity and to be confined to bed.

Table 2.--Number of restricted-activity and bed-disability days per person per year for persons 65 and older by age, sex, and family income, and for young persons by age, July 1957-June 1959

Age, sex, and family income	Restricted-activity days--number per person	Bed-disability days per year
Total 65 and over.....	42.6	14.2
65-74.....	38.3	11.6
75 and over.....	51.1	19.4
Men.....	40.5	13.3
Women.....	44.3	15.0
Under $2,000.....	52.4	16.5
$2,000-3,999.....	38.9	13.4
4,000-6,999.....	33.5	12.1
7,000 and over.....	31.7	10.8
Total under 65 1/.....	17.4	7.0
55-64.....	27.7	9.3
45-54.....	19.0	6.4
Under 45 1/.....	15.1	6.4

1/ Data relate to period July 1957-June 1958.

SOURCE: U.S. Public Health Service Publication No. 584-C4, Older Persons, Selected Health Characteristics, United States, July 1957-June 1959, and No. 584-B10, Disability Days, United States, July 1957-June 1958.

Prevalence of Chronic Conditions

As already indicated, 77 percent of the persons 65 and over in the noninstitutional population had one or more chronic conditions, compared to 38 percent among younger persons. Twenty-six percent of the 65 and over group reported one chronic condition, 20 percent had two, and 31 percent had three or more such conditions.

Arthritis, rheumatism, heart disease, and high blood pressure cause much of the disability in later life. The prevalence of these and other selected chronic diseases and impairments among persons 65 and over not in institutions is shown in table 3 in rank order, together with the proportion medically attended.

The percentage of cases that had never been seen by a physician was negligible or small in most diagnostic categories. However, a substantial proportion of those with chronic conditions were reported as not under care at the time of interview.

Table 3.--Prevalence of selected chronic conditions among persons 65 and older and percent medically attended, June 1957-June 1959

Selected conditions	Rate per 1,000 persons	Medically attended		Never medically attended
		Under care	Not under care	
		Percent		
Arthritis and rheumatism.....	266	42.7	38.3	19.0
Hearing impairments.....	172	14.1	44.2	41.7
Heart conditions.....	149	83.1	15.6	1.3
High blood pressure.....	129	75.8	22.9	1.4
Visual impairments.....	103	40.8	51.9	7.3
Hernia.....	55	42.4	42.9	14.6
Asthma-hay fever.....	54	45.8	32.8	21.4
Diabetes.....	40	92.2	7.6	*
Paralysis of major extremities and/or trunk.....	22	53.4	43.6	*
Peptic ulcer.....	22	75.2	23.9	*
Chronic bronchitis.....	19	39.4	51.3	9.4

*Less than 0.05 percent.

SOURCE: U.S. Public Health Service Publication No. 584-C4, Older Persons, Selected Health Characteristics, United States, July 1957-June 1959.

Incidence of Acute Conditions

With the increased emphasis on chronic conditions among older persons during recent years, there has been a tendency to underestimate the importance for this age group of illness and disability due to acute conditions--that is, which had lasted less than three months but involved either medical attention or one or more days of restricted activity. While the annual rate of incidence of acute conditions among persons 65 years and older is slightly lower than for other adults in the population, according to National Health Survey data it is by no means negligible.

Roughly three-fifths of the acute conditions reported by persons 65 and over for the July 1957-June 1959 period involved the respiratory system. Nearly half the others were a result of injuries. This constituted a rate of 228 older persons injured annually per 1,000 aged population. About two-thirds of the older persons were injured in accidents occurring in the home. About 85 percent of the bed-disability days reported were associated with fractures, dislocations, sprains, strains, contusions, and superficial injuries.

Use of Medical Services

Aged persons require and utilize many health services. They consult a physician about 6.8 times per year, on the average, compared to a rate of 4.8 for persons under 65. The rate for older persons would probably be considerably greater if all sought and received as much care as they need. The fact that they do not is suggested by the fact that those living as members of families whose income was less than $2,000 had on the average 6.5 physician visits per year, while persons in this age group in families with income of $7,000 or more consulted a physician on the average 8.7 times per year. This difference is in contrast to the fact that persons with family incomes of less than $2,000 were more likely to have chronic conditions and limitations on their activities. Within each of the activity limitation categories, the rate of physician visits was higher as the amount of family income increased.

There is little change with age (comparing 10-year age groups from 45 to 75 and over) in the use of physicians' services by persons with no limitation of activity or mobility. For persons with limitations, however, there was a decrease with age. For those with major limitation of mobility, the average annual number of physician visits dropped sharply, from 35 per person for the 45 to 54 age group to 18 for the 75 and over.

Older persons visited a dentist 0.8 times per person per year, compared with 1.5 visits per person per year in the total population. (Approximately one-third of all visits made by persons 65 years and older were for denture work.) Similar to the pattern for physician visits, the rate of dental visits for persons 65 years and older was progressively higher the larger the family income.

Hospital Utilization

Summary data on use of general hospitals.--Aged people go to the hospital more often and stay longer than younger persons. According to National Health Survey data for the period July 1958-June 1960, there

are 14.6 discharges per year per 100 persons 65 and older living at the time of interview and not in institutions. 2/

Hospital stays of persons 65 and over averaged 14.9 days (compared to 14.7 days shown by the 1957-58 survey). The stays and the total days of hospitalization during the year for aged persons living at time of interview were distributed as follows by length of stay:

Length of stay	Number of discharges	Number of days
Total	100.0	100.0
1 day	4.1	0.3
2-5 days	22.6	5.3
6-14 days	44.1	28.3
15-30 days	19.4	28.2
31 days or more	8.8	37.9
Unknown	1.1	----

Some persons are of course hospitalized more than once during a year, so that the number of discharges per person is larger than the number hospitalized.

The National Health Survey found the following differences for persons over and under 65 discharged from short-stay general hospitals in 1958-60:

	Persons 65 and over	Persons under 65
Discharges per 100 persons	14.6	11.2
Average length of stay in days	14.9	7.6
Aggregate days per 100 persons	218.0	85.0

2/ This is substantially more than the 12.1 discharges per 100 aged persons shown by the first National Health Survey report on use of short-term general hospitals in the period July 1957-June 1958. Most of the difference is attributable to improved methods of data collection, the remainder to the fact that the data relate to a later period when utilization was somewhat higher. The July 1958-June 1960 reports are not yet published. The earlier figures are from U.S. Public Health Service Publication No. 584-B7, Hospitalization: Patients Discharged from Short-Stay Hospitals, July 1957-June 1958. See also U.S. Public Health Service Publication No. 584-D4, Reporting of Hospitalization in the Health Interview Survey (May 1961).

A national survey of old-age and survivors insurance beneficiaries conducted in late 1957 found somewhat more days of general hospital care per year than the National Health Survey for persons 65 and over--236 as compared with 218 per 100 aged persons. The difference stems in part from the fact that the National Health Survey includes aged persons in the labor force, who are less likely than the retired to be hospitalized, and in part from the fact that it is restricted to the noninstitutional population, whereas the beneficiary survey includes time spent in a general hospital by persons who were otherwise in an institution.

One in nine of all aged beneficiaries was hospitalized during the course of a year. They are distributed as follows by number of days spent in a short-stay general hospital (regardless of number of hospital episodes within the year):

Days in hospital during year	Percent of beneficiaries hospitalized
Total	100.0
1-30 days	81.9
31-60 days	12.4
61-90 days	3.2
91 days and over	2.5

About every fifth aged beneficiary who spent any time in a general hospital during the year had more than one hospital stay. In other words, there were 14 stays per 100 beneficiaries; and there were 21.2 days of care per hospitalized beneficiary.

Corresponding data from other surveys conducted in 1956 and 1957 appear in the Report Submitted to the Committee on Ways and Means on April 3, 1959, Hospitalization Insurance for OASDI Beneficiaries.

Factors affecting time spent in short-stay hospitals.--Age and sex affect the amount of time spent in hospitals. Household surveys show that aged men are usually admitted more frequently and stay longer in hospitals than aged women. The differences found are much greater in some surveys than in others and, perhaps because of sampling variations, are not consistent for all age and other subgroups. In general, the amount of time spent in the hospital for every 100 persons in the population increases with age. The latest data from the National Health Survey are summarized in table 4.

Table 4.--Number of patients discharged per 100 persons and average length of stay for persons 65 and over, by sex and age, July 1958-June 1960
(Noninstitutional population of the United States)

Sex and age	Discharges per 100 aged persons per year	Average length of stay in days
Total 65 and over...	14.6	14.9
Men.....	16.5	15.9
Women.....	13.0	14.0
65-74.....	14.1	14.4
75 and over.....	15.4	15.8

SOURCE: National Health Survey, unpublished data.

The earlier data from the National Health Survey show some correlation between hospital utilization and amount of family income, but it is not clear to what extent this reflects the fact that aged persons needing hospitalization are more likely to share a home with relatives. The Bureau of Old-Age and Survivors Insurance survey data indicate that the probability of a beneficiary entering a hospital during the year bears no systematic relationship to his income (or, in the case of married beneficiaries, to the income of the couple). At each income level, however, those beneficiaries with some health insurance tend to have a higher hospital admission rate than beneficiaries with no insurance.

Persons who have health insurance enter hospitals more frequently, but have shorter average stays than those who are uninsured. The following data from the National Health Survey for July-December 1959 show that regardless of sex or age older persons with health insurance are much more likely than other aged persons to have one or more short-stay hospital episodes in a year: 3/

Sex and age	Percent with one or more hospital episodes	
	Insured	Not insured
Total 65 and over	13.7	8.3
Men 65-74	13.3	9.7
75 and over	15.5	9.1
Women 65-74	12.5	7.8
75 and over	17.0	6.5

3/ U.S. Public Health Service Publication No. 584-B25, Interim Report on Health Insurance, United States, July-December 1959.

Matching information on length of stay, while not available from the National Health Survey, is provided by the 1957 survey of OASI beneficiaries. The frequency of hospital visits among the insured and uninsured OASI beneficiaries covered in that survey is in line with that found in the National Health Survey, as shown by the following figures:

	Insured	Not insured
Persons hospitalized during year per 100 persons	14.2	8.8
Average days of care per person hospitalized	17.4	25.7
Total days hospital care per 100 persons	248.0	226.0

The average stay is less for the insured because persons with insurance are more likely to go to the hospital early in the course of an illness or for essentially diagnostic purposes and thus stay a relatively short time. The uninsured group includes a larger proportion of "impaired risks" who cannot purchase insurance, of older persons with more serious medical needs, and probably of persons who--because of fear of the costs--postpone getting medical and hospital care until the need is overwhelming.

Utilization in last year of life.--Household surveys considerably understate the hospital utilization of aged persons because they generally exclude the hospitalization experience during the survey year of persons who had died prior to the interview. The mortality rate of the 65 and over group is of course high.

A special National Health Survey report, Hospital Utilization in the Last Year of Life,[4/] based on data from surveys in the Middle Atlantic States, shows that the inclusion of hospitalization received by decedents during the survey year results in a substantial increase in the total volume of hospitalization reported, especially for persons 65 and over.

In this region the days of care used by persons who died during 1957 would increase by about 40 percent the total estimated hospital days used by all the aged in the year, computed solely on the basis of the reported experience of persons alive at date of interview. However, inasmuch as the current statistics on hospital utilization by the population alive at date of interview are higher than formerly reported--as a consequence of the improved collection procedures now followed by the National Health Survey--the days used by decedents would raise the estimated days used by all the aged (derived from the experience of survivors) by no more than a third and possibly by as little as a fourth.

4/ U.S. Public Health Service Publication No. 584-D3 (January 1961).

The 1957 survey of OASI beneficiaries also gives some indication of the heavy volume of hospitalization which may characterize a person's last illness. Although no data were obtained for nonmarried beneficiaries dying during the survey year, data were obtained for the small number of persons in the sample who died leaving a spouse drawing a retired worker's benefit. Among the couples where a spouse (usually the wife) had died, three times as many had one or both members hospitalized during the year as among those where both partners survived the year. (The average known medical cost for the year was 2 1/3 times as high for the couples with one member dying as when both lived through the entire year.)

Long-stay institutions.--In addition to their high rate of general hospital use, aged persons are heavy users of nursing homes and other long-stay institutions. But relatively little is known about admission rates and length of stay in the chronic-care facilities because most household surveys exclude persons in institutions, as did the National Health Survey.

The 1957 survey of OASI beneficiaries, however, did include beneficiaries in institutions. It found that only one-fifth as many spent time in a long-stay institution during the year as in a general hospital, but the average stay in such facilities was much longer. In the aggregate, for aged beneficiaries there were close to two days in a long-stay institution for every one day in a general hospital.

Kind of institution	Number in institution per 1,000 beneficiaries	Aggregate days per 1,000 beneficiaries
General hospital	111	2,360
Long-stay institution	23	4,480
Nursing home	13	2,760
Other	10	1,720

It is not known for how many of the beneficiaries in nursing homes the care was primarily residential and custodial, and for how many it was skilled nursing and medical care. But it is known that nearly a third of those reporting nursing home care also spent some time in a general hospital--outside the nursing home--during the year.

FINANCIAL RESOURCES

Money Income

As earnings decline or cease altogether, most persons 65 and over must get along on reduced resources. Just exactly how many have low incomes varies not only with the definition of "low" but also with the system of measurement, that is, the definition of the income unit and

the method of its allocation among family members. One cause of confusion is that income statistics for the aged population are seldom available in the form that would be most useful, that is, separately for couples who keep house by themselves, for persons widowed, divorced or never married who live alone, and for the aged individuals and couples who live with relatives. But no matter what study is cited or how it treats income, it is likely to show that at least half of all persons 65 and over have less than $1,000 cash income for a year.

Income statistics from the Bureau of the Census for aged persons, and for families with an aged head, are collected annually and are the most comprehensive. Data which have just become available for 1960 show 52 percent of the persons 65 and over not in institutions had cash incomes below $1,000 in that year (table 5).

Income data for persons have the limitation that they do not indicate how many persons depend on the income. In the case of the married, some of the income attributed to the husband may go for support of his wife, who may be under 65. Similarly, wives dependent on their husbands will be shown as having little or no income. However, less than one-fifth of all persons 65 and over are married women, and many older married couples have less than $2,000 between them. Therefore, even if the reported income data were adjusted to reflect an equal sharing by husband and wife, the proportion of persons 65 and over having less than $1,000 would be very little less than the 52 percent shown.

Data for older families are likewise not favorable: in 1959 (when 55 percent of the aged persons had less than $1,000), half the families with head 65 and over had less than $2,830 and one-fourth had less than $1,620, according to the Census Bureau. These incomes were for the support of 2.6 members, on the average--about two-fifths of them under 65. Often, a younger relative contributes a substantial share of the family's income.

Of the aged persons living alone or with nonrelatives (3.6 million in 1959), half had less than $1,010 and four-fifths had less than $2,000.

There were in addition 2.3 million aged persons living in the home of a younger relative who are counted in the figures for "persons," but who are not identified in the family income analysis. The typical aged person in this group is very likely not financially independent, and has a lower income than a person who lives in his own household as the head of the household or the spouse.

Data collected in a special survey for the Health Information Foundation by the National Opinion Research Council illustrate this point. 5/

5/ Ethel Shanas, Meeting Medical Care Costs Among the Aging, Health Information Foundation, Research Series 17 (1960); see table 6 in section on "Medical Care Expenditures" for summary.

Table 5.--Percentage distribution of persons aged 65 and over, by total money income, and by sex, 1960
(Noninstitutional population of the United States)

Money income class	Total 1/	Men	Women
Total	100.0	100.0	100.0
Less than $1,000	52.7	27.1	73.9
Zero	14.5	3.6	23.6
$ 1-499	11.7	5.5	16.8
500-999	26.5	18.0	33.5
$1,000-1,999	23.7	32.0	16.8
$1,000-1,499	15.3	20.1	11.2
1,500-1,999	8.4	11.9	5.6
$2,000-2,999	10.2	17.3	4.5
$3,000-4,999	7.2	11.8	3.4
$5,000-or more	6.3	11.8	1.7
Median income for:			
All persons	$ 950	$1,620	$ 640
Income recipients	1,150	1,690	820
Year-round, full-time workers	NA	4,120	2,840

1/ The distributions for men and women were combined using population figures estimated in the Division of Program Research by updating the Decennial Census counts after adjustment to exclude institutional inmates (estimated at 540,000). The Census Bureau has not yet released estimates for aged persons in the noninstitutional population as of spring 1961, when the income data were collected.

SOURCE: Distributions of men and women with income from U.S. Bureau of the Census, Current Population Report, Consumer Income, Series P-60, No. 36 (June 9, 1961); percent with zero income made available in advance of publication.

They show that among nonmarried persons 65 and over median money incomes in 1956 were about $200 higher for persons living alone or with nonrelatives than for those sharing a home with relatives.

	Median income	
	Men	Women
Living with relatives	$1,139	$750
Living alone or with nonrelatives	1,339	972

The differential might well be greater were it not for a slight underrepresentation in the study of those in the oldest age groups. It would certainly be greater if aged persons in institutions were included with those sharing a home with relatives.

It is especially important to take into account the number of persons supported by the family income when comparisons are made between families at different stages in the life cycle. When median family income as reported by the Census for 1958, for example, was divided by mean family size in that year, the income of families with head 65 and over was only 58 percent as much as that of families with head 55 to 64 and 81 percent as much as that for very young families (head 25 to 34 years). When account is taken also of the large number of children in younger families (treating those under 13 as equivalent in need to half an adult and older children as adults) the relative position of the aged is even more unfavorable, as shown by the following figures:

	Median income per family in 1958		
Age of head	Total	Per capita	Per equivalent adult
65 and over	$2,666	$1,030	$1,070
55-64	5,153	1,780	1,840
45-54	5,738	1,550	1,740
35-44	5,704	1,300	1,630
25-34	5,207	1,270	1,680

Other Financial Resources

Older persons are more likely than younger persons to have some savings, but in general those with the smallest incomes are the least likely to have other resources to fall back on. Moreover, most of the savings of the aged are tied up in their homes or in life insurance, rather than in a form readily convertible to cash.

According to the 1960 Survey of Consumer Finances, "spending units" in the oldest age group (head 65 and over) were distributed as follows in early 1960 by amount of liquid assets in bank accounts or savings bonds: 6/

Liquid asset holdings	Percent
Total	100
Zero	30
$ 1- 199	6
200- 999	14
1,000-1,999	10
2,000 or more	40

Relatively few of the aged hold any marketable securities, and they usually are the ones who have other liquid assets also. Only one in fourteen of the aged spending units reported owning corporate stock. Three years earlier, when this question was last studied by the Federal Reserve Board, only one in nine had corporate stocks or bonds and virtually all of these stockholders were among the group that had over $2,000 in other liquid assets.

Having savings, as one might expect, is related to income. The 1959 survey for the Federal Reserve Board, in relating assets to current income, found that when money income of the aged spending units was less than $3,000, 47 percent had less than $200 in liquid assets and 44 percent had assets of $500 or more. By contrast, when income was $3,000 to $5,000, 21 percent of the units had less than $200 in liquid assets and 70 percent had assets of $500 or more.

The 1960 Survey of Consumer Finances shows explicitly that relatively few of the aged have more than one type of asset other than equity in a home. The distribution by number and pattern of their holdings was as follows for spending units with head 65 and over. (See chart on following page.)

6/ Survey Research Center, Institute for Social Research, University of Michigan, 1961. These and subsequent data for aged spending units exclude about one-fourth of all aged persons--those who were members of units headed by younger persons, who are not in general financially independent, and those in large lodging houses and institutions.

Pattern of holding	Percent
None	13
One only	30
Liquid assets	15
Equity in home or farm	13
One other	1
Two only	34
Liquid assets and equity	26
Two others	8
Three only	19
Liquid assets, equity and stock	7
Liquid assets, equity and other real estate	11
Three others	1
Four or five	4
Total	100

This is important because, aside from their own utility as a resource to fall back on, some assets can be income-producing and thus in themselves raise total money income. When beneficiary couples were classified by the amount of their OASI benefit, among those at the minimum, only one in four had as much as $75 in income from assets during the year. Among those near the maximum, on the other hand, more than one in two had at least $75 in asset income for the year.

Life insurance is a fairly common form of saving, although less so among the aged than among younger families. The policies of the aged have a relatively low face value, however, and some of them have no cash surrender value. The proceeds are therefore more likely to go toward burial costs or some of the bills outstanding after a terminal illness, than to meet costs of current medical care.

Among OASI beneficiaries studied in the fall of 1957, 71 percent of the married couples and half of the other aged beneficiaries carried some life insurance. The median face value was $1,850 for the policies carried by couples and less than half as much for nonmarried beneficiaries. More than two-thirds of all the beneficiaries held policies with a face value of less than $1,000 per person ($2,000 for a couple) or had no insurance at all.

Homeownership

Equity in a home is the most common "saving" of the aged and represents the major portion of their net worth. Like other forms of

saving, the advantage of homeownership is more common among those with higher incomes.

In early 1959, 62 percent of the nonfarm "spending units" headed by a person 65 and over owned their homes. Of these homes, 83 percent were clear of mortgage debt.

Among aged spending units with liquid assets of less than $200 half lived in rented quarters or with relatives. Among aged spending units with liquid assets of $200 or more on the other hand, more than two-thirds owned their home.

Among OASI beneficiaries just about two out of three of those married and one out of three of the nonmarried studied in 1957 owned a nonfarm home. Most of these homes were mortgage free, but the equity was relatively modest: the median amount about $8,000 for couples and widows and about $6,000 for single retired workers. Nearly eight out of ten of the beneficiary couples with income of $5,000 or more, but fewer than two out of three with less than $1,200, owned their homes.

While homeownership can mean lower out-of-pocket costs, it does not mean living without significant housing costs. Data from the 1957 beneficiary survey indicate that urban couples keeping house alone in a paid-up home averaged only about 30 percent less for taxes, upkeep and utilities than the average outlay for rent, heat and other utilities by couples renting their living quarters.

Noncash Income

Many aged persons have noncash resources which enable them to enjoy better living than their money resources alone could make possible. Such "nonmoney" income, however, does not necessarily release an equivalent number of dollars for purchasing goods and services, such as health care.

According to the 1957 survey of OASI beneficiaries, four out of five couples and three out of five nonmarried beneficiaries had noncash income of one or more of the following types: an owned home or rent-free housing, food home-grown or obtained without cost, or medical care for which the beneficiary did not pay.7/ Others received some support from the children or relatives with whom they lived.

7/ This assumes that homeownership yields noncash income in the long run, although about one-fifth of the homeowners reported current housing expenses for the survey year that exceeded the estimated rental value of the home. Roughly every third homeowner reported noncash income from another source, usually food, because homeowners are more likely than renters to have garden space.

A fourth of all beneficiary couples and a tenth of all other aged beneficiaries raised some food. Such food makes for a better and more interesting diet, but the net saving in family food expenditures is likely to be considerably less than dollar for dollar.

Measures of Need

When it is said that the aged as a group have relatively low incomes, this implies some standard of how much they really need. Certainly for many, with the children grown and the home paid for, wants in many aspects of daily living are lessened. "Need" is admittedly a relative term: It will vary with considerations such as homeownership, the state of health, and perhaps the extent to which children and other relatives can be counted on for help in an emergency. The needs as well as the financial resources of the aged are in some measure a function of where they live. Those in cities, for example, have higher income on the average and are more likely to be drawing OASI benefits than those who spent their lives on farms or at other work only recently brought under the program. On the other hand, in large cities people are less likely to have the advantage of an owned home and home-grown food which can help make a small income go farther, and often must pay higher prices, particularly for housing.

One measure of need might be the recent Bureau of Labor Statistics budget for a retired couple, in reasonably good health, keeping house alone in a rented dwelling in one of 20 large cities. The cost in late 1959 ranges from $2,390 to $3,110 or from $2,640 to $3,370, depending on whether one adheres to a concept adopted earlier by the Social Security Administration, or applies the somewhat higher food and transportation standard conforming to that used for a city worker's family budget. Only a minority of the aged live in the circumstances to which this "modest but adequate" budget applies, however: Just over half of all persons aged 65 and over are currently married and living with a spouse; less than two-thirds live in a community classified as urban, and most elderly couples own their own homes, usually mortgage-free; and not all of them keep house by themselves.

Currently, income data from the Bureau of the Census are available only for families with an aged head and not for aged couples living alone. Such families include an average of 2.6 persons. On the basis, however, of a special Census income tabulation for 1956 for both types of families, the median income of all elderly couples living alone in urban areas might be estimated at roughly $2,600-$2,800 in 1959. Thus the cost of maintaining an elderly couple, in reasonably good health for their age and living alone in a rented dwelling in a large city--ranging from $2,390 in Houston to $3,110 in Chicago in autumn 1959--may have been beyond the reach of more than half of them. Lowering the budget to a range of $2,200 to

$2,800 to allow for the estimated amount of housing costs that many of the couples would save as homeowners would reduce the number for whom the budget standard would be more than income could provide, but this number would still be considerable. Furthermore relatively few with incomes below the budget level would have sufficient cash savings or assets readily convertible to cash to make up the deficit.

An important but difficult task is adapting the budget-for-two to represent the needs of one elderly person. While there is no generally accepted procedure, there is likely to be agreement that the least suitable estimate is a simple division by two. For housing, the cost for a single individual is probably little less than for two. If keeping house is impractical, as may be true for an elderly man living alone, the budget will have to allow for eating most meals out and sending out the laundry.

The Bureau of Labor Statistics has developed a scale based on the relation between food expenditures and income throughout the entire range of income which suggests that one person 65 or over would need 59 percent as much income as an elderly couple living at the same standard. Further study will most likely show that when incomes are low and consumption is already close to the marginal level, this ratio is too low. However, even the 59 percent ratio brings estimated costs for an elderly individual considerably above average means. On this basis, a "modest but adequate" standard for an elderly person living alone would take from $1,410 to $1,835 in the 20 cities studied. The median income for individuals aged 65 or over living alone (or with nonrelatives) in cities was $1,140 in 1959.

MEDICAL CARE EXPENDITURES

Although opinions differ as to the standard against which to measure resources of the aged, it is generally agreed that their lower-than-average income is accompanied by higher-than-average medical care needs. It is well-known also that the aged, like other predominantly low-income groups, are likely to find the financing of their medical needs a heavy burden. Sometimes they forego necessary medical care entirely or defer it much longer than is desirable. In other instances they get the care they need, but must rely on others to help pay for it.

Total Medical Care Expenditures Per Capita

Personal expenditures.--According to a study conducted for the Health Information Foundation, per capita gross private medical care expenditures by (or for) persons aged 65 and over are at least twice as large as those by (or for) persons under 65 (table 6). This leaves out the heavy costs for terminal illness of persons who had lived alone, and

the cost of care in nursing homes, mental or tuberculosis hospitals and other institutions (much of which is publicly financed) which are particularly important for the aged, and also the value of care provided at no charge to those individuals who cannot pay.

Table 6.--Private expenditures for medical care per person, by age, 1957-58

	Persons 65 and over	Persons under 65
Total	$177	$86
Physicians	55	29
Hospitals	49	19
Drugs	42	18
Dentists	10	14
Other	21	6

SOURCE: Odin Anderson, et al., Family Expenditure Patterns for Personal Health Services, Health Information Foundation Research Series 14 (1960).

If allowance were made for the amounts spent by private individuals for medical care of the aged in nursing homes and other institutions, and for medical expenses incurred in their last illness by the aged living alone, the private medical care expenditures for persons 65 and over would probably have averaged $187 instead of $177 in 1957-58.

Public and private expenditures.--Aggregate annual public expenditures in the fiscal year 1958 for medical care for the aged are estimated at about $650 million exclusive of care in tuberculosis and mental hospitals, and at about $940 million inclusive of such care. Philanthropic expenditures for medical care for the aged are estimated at $150 million. The total medical care expenditures for persons 65 and over in 1957-58 would therefore have been about $240 per capita, omitting care in tuberculosis and mental hospitals, or $260 including such institutional care for aged persons. At present prices the per capita average for all care probably exceeds $290, or a total of almost $5 billion.

Hospital care is estimated to account for about two-fifths of the total.

Wide variation in expenditures.--The erratic incidence of illness is one of the factors that aggravates the medical burden. Average medical cost figures conceal wide variations in expenditures and give no indication of the very heavy burden that may come to the individual whose illness requires hospitalization. A hospital stay usually means total medical bills for the year are relatively high. No one can foresee whether or just when he will have to enter a hospital, which makes individual budgeting unsuitable as a means for meeting the cost of hospitalization.

Hospital Stays and Medical Bills

The impact of hospitalization on aged persons is well illustrated by data from the 1957 survey of OASI beneficiaries. They are presented for married couples and for other aged beneficiaries separately, rather than for individuals as in the case of disability and utilization data, because for married persons medical costs should be related to the resources of the couple.

At least one member in every fifth aged couple entitled to benefits spent some time in a hospital during the year, according to the 1957 survey of beneficiaries. For half the couples with a hospitalized illness (excluding those reporting free service or other unknown costs), the total medical bills incurred amounted to over $700, more than the cost of a modest food budget for the year, compared with $150 for couples with neither member hospitalized (table 7).

Table 7.--Percentage distribution of aged OASI beneficiaries, hospitalized and not hospitalized by amount of medical costs incurred during year, 1957

Medical costs incurred in year	OASI couples		Nonmarried beneficiaries	
	Hospitalized 1/	Not hospitalized	Hospitalized 1/	Not hospitalized
Under $100.....	1	39	2	60
$ 100-199.....	4	21	9	18
200-399.....	13	23	15	12
400-599.....	17	7	10	2
600-999.....	16	3	14	1
1000 or more.....	28	1	22	1
Unknown 2/.....	20	5	28	6
Median.....	$700	$150	$600	$80

1/ Includes persons who received care in nursing homes or chronic care institutions as well as in short-stay general hospitals, because their medical-cost experience tends to be similar.

2/ In most cases, includes some "free" care, i.e., no bills rendered to anyone, or vendor paid directly by public assistance or other agency.

SOURCE: 1957 Survey of OASI Beneficiaries.

Nonmarried beneficiaries, who tend to be older, use more hospital and other institutional care than the married. One in seven of those interviewed in late 1957 spent some time in a hospital, nursing home or other institution during the previous 12 months. Median medical costs amounted to $600 for all such beneficiaries, to $500 counting only those who spent some time in a short-term general hospital.

The effect of hospitalization on the size of the total medical bill can be demonstrated more directly in another way. Among those couples with one or both the members hospitalized and able to report their total medical costs, the costs associated with such episodes averaged 64 percent of their total medical bills for the year--41 percent representing charges made by a general hospital, 4 percent charges of chronic care institutions, and 19 percent the fees for the surgeon and inhospital doctor's care. For nonmarried beneficiaries the costs associated with hospital and nursing home care made up 77 percent of total medical costs, an even greater portion than for beneficiary couples.

Means of Meeting Medical Bills

Persons who are hospitalized--and therefore have relatively large medical costs--naturally have more difficulty than others in meeting their total medical bills for the year.

According to the 1957 beneficiary survey, more than two-fifths of the couples and roughly three-fifths of the nonmarried beneficiaries who spent some time in a general hospital did not meet the year's medical costs out of their own income, assets and health insurance. The longer the hospital stay, the larger the proportion that could not stretch their resources.

Medical debts were incurred--or increased--by 21 percent of the couples and 12 percent of the nonmarried beneficiaries with a hospital episode during the year. (For all the aged, whether or not hospitalized, the proportions were very much smaller--6 percent and 3 percent, respectively.) And this does not count the cases where a doctor, for example, may reduce his fees because he knows that the patient cannot pay. Moreover, a considerable number of the beneficiaries who had more unpaid medical bills at the end than at the beginning of the year got help from outside as well.

Fifteen percent of the couples and 29 percent of the nonmarried beneficiaries relied for at least part of their medical care on public assistance agencies, hospitals, or other public and private health and welfare agencies. Less than half as many of the nonhospitalized beneficiaries had to turn to welfare agencies.

The number receiving help from relatives in one form or another was at least as large. When beneficiaries were asked how they met their medical bills, 15 percent of the couples and 26 percent of the nonmarried with one or more hospital episodes reported that relatives helped pay for them. (Less than half as many of the other beneficiaries had to turn to relatives.) Some additional beneficiaries with hospital bills in effect received as much or more help with their medical costs from relatives who helped support them either sharing their home or by paying other regular living expenses.

The Role of Hospital Insurance

Were it not for health insurance--despite the limitations discussed below of many policies held by the aged--many more would have had to turn to relatives or welfare agencies, or both, to meet their pressing medical needs.

Data just becoming available from the National Health Survey reveal that for half the hospital stays of aged persons, health insurance paid no part of the bill. On the other hand, insurance paid some part of the hospital costs for three-fourths of the stays of younger persons.

Even when insurance is available, it is of course less effective for long than for short stays (table 8). Thus, three-fourths or more of the hospital bill was paid by insurance for three-fifths of the episodes lasting less than a month, but for less than half the episodes of a month or longer.

The actual proportion of hospital bills paid in some part by insurance is probably smaller than shown, because terminal illness cases are excluded, and those at the older ages, who are most likely to die, are least likely to have any insurance. It is not feasible, however, to try to quantify the effect of this exclusion on the findings as they relate to length of stay.

Table 8.--Percentage distribution of short-stay hospital discharges according to proportion of bill paid by insurance, by length of stay, July 1958-June 1960 (Civilian noninstitutional population of the United States)

Age and length of stay	Total discharges	Proportion of bill paid by insurance			
		None of bill	Any part of bill		
			Less than 1/2	1/2 to 3/4	3/4 or more
65 and over	100.0	48.8	9.0	11.9	30.3
1-5 days	100.0	48.9	10.1	11.5	29.4
6-14 days	100.0	46.4	8.6	11.9	33.1
15-30 days	100.0	49.8	9.2	11.0	30.0
31 days or more	100.0	54.7	8.1	15.8	21.4
Under 65	100.0	30.0	4.9	11.2	53.8
1-5 days	100.0	31.6	4.6	11.1	52.7
6-14 days	100.0	25.1	5.3	11.7	57.9
15-30 days	100.0	28.2	5.2	12.3	54.4
31 days or more	100.0	49.1	7.2	8.7	34.7

SOURCE: National Health Survey, unpublished data.

PRESENT PROVISIONS FOR FINANCING MEDICAL CARE FOR THE AGED

VOLUNTARY HEALTH INSURANCE

During the past few years the private insurance industry has made an intensive and commendable effort to develop health insurance policies for older persons. Until quite recently persons aged 65 and over who were not still at work and members of an employed group, had limited opportunity to purchase health insurance. An increasing proportion of the persons now reaching age 65 are able to carry over into retirement health insurance coverage which they obtained in their younger years, although frequently with more limited protection or higher premiums or

both. Blue Cross, Blue Shield and many commercial insurance companies have developed special "Senior Citizen Certificates" or group policies that can be purchased by persons aged 65 and over in most circumstances, although coverage of pre-existing conditions may be limited.

There has now been enough experience with private health insurance for the aged to indicate that it can provide useful supplementary protection but also to demonstrate why private insurance alone cannot and should not be expected to meet the basic health care costs of the aged. The essential factors have already been discussed. The larger medical care needs of the aged as a group must result in higher average costs--in insurance terms, higher premiums. These costs are beyond the ability to pay of large numbers of older persons. The younger members of society must in one way or another pay part of these costs if older people are to have adequate medical care.

Private insurance has been able to effectuate some cost-sharing. The community-rated premiums of Blue Cross plans average hospital costs for all participants. Coverage of many persons past age 65 has been achieved, however, only by the development of special policies with their own (higher) premium rates. Perhaps three-fourths of all private health insurance coverage is written under employee benefit plans. In many such plans, the employer carries or shares in the cost. For those retired employees who are continued under a group plan with no change in premiums or benefits or with the employer paying a substantial part of the cost of their benefits, the aged person's health costs are shared by other age groups. But the number of pensioners in this situation is very small and such arrangements cannot be expected to apply to the great majority of retired persons, because of worker mobility, limited vesting, and the fact that in general it is only the larger firms that have such plans.

A compulsory social insurance program offers the only feasible basis for a broad spreading of the costs of health protection for the great majority of older persons.

Aged Persons Having Some Kind of Health Insurance

No more than half of all persons aged 65 and over have any kind of health insurance. The National Health Survey found that in the last half of 1959, 46 percent of those 65 and over, as compared with 67 percent in the population as a whole, had some form of health insurance.8/ Other estimates confirm these general magnitudes.

8/ U.S. Public Health Service Publication No. 584-B26, Health Statistics: Interim Report on Health Insurance, United States, July-December 1959, (December 1960).

Estimates prepared by the Health Insurance Council on total health insurance enrollment are somewhat higher than those derived from household surveys. For January 1960, the Health Insurance Council estimated that 73 percent of the total population (rather than 67 percent) were covered. The Council's estimates are built up from reports from individual companies' plans and may well make too little allowance for multiple policy holding. On the other hand, household interview surveys may miss some individuals. Special studies are now under way that will provide a better basis for estimating the extent of multiple policy holding. In any event, information for separate age groups is available only from household interview surveys.

Perhaps as important as the numbers of aged persons with health insurance are the characteristics of those having and those not having such protection. In general, health insurance is much more likely to be owned by aged persons still in the labor force, by those closest to age 65, by those with relatively higher incomes and by those in the best health. These factors are, of course, closely related to one another.

Income and coverage.--According to the National Health Survey, when the total family income of the person 65 or over (including both his own income and that of all other family members) was under $2,000 only 33 percent of the aged had hospitalization insurance. When the family income was $4,000 or more, 59 percent had hospitalization insurance.

The survey of OASI beneficiaries in 1957 showed a similar relationship. The median income of OASI beneficiaries with no hospitalization insurance was 30 percent lower than that of those with insurance.

Age and coverage.--According to the National Health Survey, among persons aged 65 to 74, 53 percent had protection against hospital costs; among persons aged 75 or over, 32 percent had protection against hospital costs.

Work status and coverage.--Aged persons still in the labor force are more likely than those fully retired to have some health insurance because employment means higher income, the less expensive group coverage is more likely to be available to those employed, and part of the premium is frequently paid by the employer. Among the relatively few aged reporting themselves as usually working, nearly two out of three (64 percent) had some hospital insurance; but among those not usually working, less than half (42 percent) had hospital insurance in the latter part of 1959.

Health status and coverage.--Aged persons in relatively poorer health--at least by their own designation--are less likely to have hospital insurance.

Of those reporting themselves in the National Health Survey as having no chronic conditions, or only conditions that did not curtail activity, 53 percent had hospital insurance; of those reporting themselves unable to carry on their major activity, only 30 percent had hospital insurance.

Reasons for not having insurance.--A study conducted by the National Opinion Research Center for the Health Information Foundation found that in 1957 about half the aged persons without health insurance would have liked to be covered, just over one-quarter had not thought about it, and just under a quarter didn't want it.9/ Among those who wanted coverage, 68 percent couldn't afford it and 32 percent had been refused insurance or had it canceled.

About one-sixth (16 percent) of the aged surveyed in the HIF-NORC study had formerly been covered by health insurance but were not covered at the time of the survey. Among the reasons given for not continuing health insurance were:

Could no longer afford it (31 percent)
Retired or gave up working (26 percent)
Dissatisfied with policy's coverage (24 percent)
Other reasons:
- Company discontinued plan
- Did not feel need
- Job change without the policy's carrying over

A similar picture emerges from the responses of OASI beneficiaries to the question as to why they do not have health insurance. According to the 1957 beneficiary survey, 68 percent of the aged beneficiaries who did not have hospitalization insurance had never had such insurance. Thirty percent had been insured at one time, but the policy was dropped before the survey year. For 2 percent the insurance status before the survey year was unknown.

9/ "Voluntary Health Insurance Among the Aged," Progress in Health Services, Health Information Foundation (January 1959).

The reasons given for not having insurance were as follows:

	Percent
Aged beneficiaries never insured	100
Could not afford	41
Never thought about it	30
Not interested	18
Refused by insurance company	9
Other reason	2
Insured at one time, policy dropped	100
Could not afford	39
Group policy could not be converted at retirement	29
Not interested	14
Canceled by insurance company or terminated at death of husband	13
Other reason	5

Characteristics and Costs of Health Insurance

Of the aged who have hospitalization insurance, according to the National Health Survey,

43 percent are covered by Blue Cross or Blue Shield,
7 percent have a "Blue" plan and some other insurance,
49 percent are insured through a commercial insurer or an independent plan,
1 percent are of unknown type

At present, there are some 1,200 insuring organizations actively in the health field in the United States, including 737 insurance companies, 78 Blue Cross plans, 68 Blue Shield plans, and over 300 other plans. Most of these provide benefits for the aged through some means, if only through carrying persons past the age of 65 within groups primarily composed of younger persons.

Many aged persons, however, are not able to buy health insurance even if they could afford it. Persons in poor health or with a record of substantial need of care may either be unable to purchase insurance or have their policies canceled. As of early 1961, only about half the Blue Cross plans accepted initial nongroup enrollment from persons over 65, either through nongroup certificates with no age limit or through senior certificates (table 9).

Table 9.--Age limits on initial nongroup enrollment in Blue Cross hospitalization plans, early 1961

Age limits	Blue Cross plans	
	Number	Percent
Total 1/	78	100.0
"Senior" certificates offered.....	21	26.9
No age limit.....	16	20.5
70 years.....	2	2.6
66 years.....	2	2.6
65 years.....	24	30.8
65/60 years 2/.....	1	1.3
60 years.....	10	12.8
No nongroup enrollment.....	2	2.6

1/ Does not include Puerto Rican Blue Cross Plan.

2/ Two certificates offered, one with a 60-year limit, one with a 65-year limit.

Insurance policies generally available to the aged tend to provide more limited protection as well as to have higher premiums than policies for younger persons. Seventeen of the 21 Blue Cross Senior Certificates provide for no more than 30 or 31 days of benefits and many provide limited allowances ($7 to $10 a day) toward the cost of room and board, or provide for a deductible or coinsurance. All but four of these plans require that a health statement be completed by the individual applying for coverage. Coverage of hospitalization for pre-existing conditions varies from immediate coverage in six plans to exclusion for life in four; other plans provide benefits after waiting periods of six to twenty-four months. The annual premium cost of the Senior Certificates ranges from about $40 to about $66 per person. The most usual Blue Shield Senior Certificates with maximum surgical fee schedules of $200 to $300 and reimbursement for inhospital physician visits at $3 to $8 a day for 21 to 60 days cost from about $20 to $40 a year for an individual and $24 to $64 for a couple.

Commercial health insurance policies sold to aged persons include wide variations in benefits and premium costs. One of the most widely advertised and widely available plans is the 65 Plus Plan of the Continental Casualty Company. This plan is open for membership on a Statewide basis in 48 States during periodic enrollment periods. It has a 6-months waiting period for pre-existing conditions, but no limitations because of physical conditions. The policies can be canceled and premiums adjusted only on a Statewide basis. The policy provides up to $10 a day for room and board costs for a maximum of 31 days, up to $100 for miscellaneous hospital extras, and the cost of surgery up to a maximum of $200. The annual premium is $78.

Aged persons in normal health can purchase individual health insurance policies that are guaranteed renewable for life. Policies providing room and board payments of $10 a day for 30 to 60 days, up to $50 or $100 for hospital extras and surgical expenses with a maximum of $200 to $300, were available in early 1961 at premiums for a man aged 65 ranging from $80 to $92 a year.

Paid-up-at-retirement policies.--There has been considerable discussion of paid-up-at-retirement policies. Such a policy guarantees that a specified set of health insurance benefits will be available to the policyholder during the remainder of his life. The benefits are on a cash indemnity basis (a specified number of dollars for up to a specified number of days of care, plus an allowance for hospital extras). It would be very difficult for an insurance company to estimate the future cost of a service benefit (guaranteeing up to a specified number of days of care). This is a very new approach and very little of this type of coverage has been sold. If the policy is not purchased until the date of retirement, the initial costs are high ($700 to $1,300 per individual). Similarly, even if purchased prior to retirement, the annual payments required for persons already approaching retirement would be substantial.

If the costs were spread over the full working life of the individual, the annual payments would be small, and might be coupled with current health insurance premium payments throughout his working life. However, assuming the insurance were acquired through the place of employment, there is a practical barrier to this approach in that few persons spend their entire working life with one employer. Aside from the uncertainty as to whether they will still be with the same employer when they retire, there are other factors that could make workers reluctant to participate in purchasing this form of insurance. They may anticipate that their existing health insurance coverage will continue after retirement or they may fear that a specified set of cash indemnity health benefits may prove inadequate if the trend of rising medical costs continues.

Extent of Protection for Those Having Insurance

It will be evident from this description of generally available hospital insurance policies that even those aged persons who have health insurance may have to pay directly a considerable share of any hospital bill they incur.

The National Health Survey, as noted above, found that in half of all hospital stays by aged persons none of the hospital bill was met by insurance. Where insurance paid part of the bill, it covered less than half the total in 18 percent of those cases, between one-half and three-quarters of the bill in 23 percent and three-fourths or more in 59 percent of those cases.

For persons under 65, on the other hand, in only 30 percent of the cases did insurance meet no part of the bill. And it covered three-fourths or more of the total bill for 77 percent of those cases in which there were any insurance payments.

There are no comparable figures on the proportion of all medical expenditures covered by insurance for different age groups. For the population as a whole, insurance payments in 1959 covered 25 percent of all private medical care expenditures and 58 percent of private expenditures for hospital care.

PUBLIC PROGRAMS

Publicly administered general hospitals in many localities provide care at no charge, or at charges related to income, for persons who cannot afford to pay in full. Some medical care programs--notably those under public assistance and those for veterans' nonservice-connected disabilities--are open only to the needy. Others--notably those for veterans' service-connected disabilities, or for military personnel and their families--provide for all in special population groups without regard to income or ability to pay.

Traditionally, nongovernmental hospitals also provide some free medical care to the needy. Increasingly, these hospitals are being paid for their services to the needy through public programs and public grants. But in many of our poorer States, much of the burden of the care of the aged rests on the hospitals themselves. Such care may be financed from endowment income and philanthropic sources. Often the cost of free or part-pay care is defrayed by higher charges to paying patients.

In privately-controlled general hospitals, about a fifth of all patients are aged 65 or over. But in general hospitals of State and local governments, which more often than private institutions provide care free or at reduced charges to those not able to pay in full, every fourth patient is at least 65 years of age. In Veterans Administration general hospitals, one out of five patients is at least aged 65.

The most important source of public funds for medical care of aged persons is now the public assistance programs.

Public Assistance Medical Care

From the beginning of the Federal-State old-age assistance program established under the 1935 Social Security Act, costs of medical care could be included in monthly cash payments of old-age assistance recipients. The payments were subject to Federal and State maximums, however, which very much limited the care made available in most States.

In 1950, the Social Security Act was amended to permit Federal matching of payments for medical care made directly to suppliers. However, these vendor payments had to be within existing maximums on Federal participation in individual cash payments. In 1956, old-age assistance was again broadened by establishing separate Federal matching for medical care payments over and above the cash assistance payment. In 1958, the effective ceiling on Federal matching was increased.

The 1960 amendments to the Social Security Act provided two extensions of medical care for the aged under the public assistance program: (1) increased Federal matching of medical care payments under old-age assistance, and (2) a new program of medical assistance for the aged, designed to provide help with medical bills for the so-called medically indigent. The 1961 amendments, signed by the President on June 30, included a slight additional liberalization of the Federal matching provisions for vendor medical payments under old-age assistance.

Public Assistance Medical Care: Old-Age Assistance

Fifty-four jurisdictions administer old-age assistance (OAA) programs, including the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. Forty-three of the States 10/ provided some medical care to old-age assistance recipients through vendor payments in September 1960. But these States varied widely in the content of their medical care provisions. Some State programs included a wide range of medical services, covering virtually the entire gamut of needed types of medical care, while in other State programs medical care provisions were extremely limited in scope. However, there was undoubtedly some room for improvement of medical care content and coverage in nearly all State old-age assistance programs.

10/ The word "State" in Part I of this document applies equally to the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

Changes in medical care under old-age assistance since September 1960.--The 1960 amendments have resulted in increases in the medical care provided through vendor payments under old-age assistance in a substantial number of States. According to information received by the Bureau of Public Assistance by May 31, 1961, of the 43 States providing vendor payments in September 1960, 23 11/ had taken steps by that time to improve the content or coverage of their medical care provisions through old-age assistance vendor payments.

During this period, three States reduced medical services provided through old-age assistance vendor payments. Two, Massachusetts and New York, moved many cases formerly receiving medical care under old-age assistance to the new medical assistance for the aged program, under which the recipients will continue to receive the same care as formerly. The third State, Colorado, has been forced, by a State constitutional limitation on funds expended for the purpose, to reduce medical care paid for through old-age assistance vendor payments.

Of the 11 States which made no vendor payments for costs of medical care in old-age assistance before October 1960, five 12/ have either begun to make vendor payments or are planning to do so sometime in 1961.

Changes in vendor payments: September 1960 - April 1961.--The above information is based on the States' descriptions of medical care provided through vendor payments under State old-age assistance plans. Their expansion of medical care services may involve the addition of a great deal, a moderate amount, or very little in the way of an actual increase in services rendered. In some States, expansion is only in the planning stage and may not actually materialize. In some States, the additional provision represents only a change in payment method, as when States have begun making vendor payments for services that were previously provided through money payments to recipients (the change in payment method being made because it brings increased Federal participation in the assistance payments). However, this change of method may mean a great deal to the

---

11/

California	Maryland	Tennessee
District of Columbia	Michigan	Utah
Florida	Missouri	Vermont
Idaho	Nevada	Virginia
Indiana	New Mexico	Virgin Islands
Iowa	North Carolina	Washington
Louisiana	Ohio	West Virginia
Maine	Oklahoma	

12/ Alabama, Kentucky, Mississippi, Puerto Rico, and South Dakota.

recipient because it may affect his money payment and the kind and quality of medical care provided. Since many States have maximums or other provisions limiting the money payment, the removal of the special cost of medical care from the money payment permits more leeway in meeting the recipient's subsistence needs, insofar as State or local funds are available. In addition, the cost of a particular medical service paid in the recipient's behalf frequently is greater than could be allowed in the State's money payment.

A much more definite indication of the impact of the 1960 legislation on old-age assistance vendor payments may be obtained by comparing average vendor payments for States in September 1960 with the averages for April 1961, the latest month for which data are available, and by comparing average money payments for the same months.

In September 1960, the average vendor payment under old-age assistance for all States combined was $10.75 per recipient. In April 1961, it was $11.06 (table 10). Specific program changes in Massachusetts and New York partly explain the fact that the national average did not rise more than 31 cents. In Massachusetts, more than 15,000 old-age assistance nursing home and other institutional cases were transferred to the State's new program, medical assistance for the aged, between September and April. This resulted in a reduction in the average old-age assistance vendor payment in the State from $45.86 in September to $17.10 in April (the only very large drop occurring in any State during the period). In New York, 16,000 cases were transferred from old-age assistance to medical assistance for the aged in March and April, and the average old-age assistance vendor payment dropped from $33.45 in September to $28.95 in April. Excluding Massachusetts and New York, the remaining 52 States had average vendor payments of $8.66 in September and $10.34 in April, or an increase of $1.68 in the average vendor payment over the 7-month period.

The number of States with changes in average vendor payments of specified amounts is shown in table 11. It is possible that some of the changes in State averages represent random month-to-month fluctuation; however, this is certainly not true for the States whose average vendor payments increased by a sizeable amount over the 7-month period.

Increases in average vendor payments have come to some extent at the expense of decreases in average money payments. Under the revised formula for Federal participation in old-age assistance, it was to the advantage of some States that formerly had low average vendor payments to begin paying for additional types of medical care through vendor payments rather than through money payments to recipients. For example, in some States nursing home care was formerly paid for through money payments. It is now covered through vendor payments, and the shift in payment method has brought a drop in average old-age assistance money payments together with the increase in average vendor payments. Among the 27 States in which the vendor payment averages had increased more than $1.00 by April, 9 States decreased their money payment averages by more than $1.00, while in 7 the money payment average increased by more than $1.00 (table 11).

Table 10.--Old-age assistance: Average payment per recipient for all assistance, for money payments to recipients, and for vendor payments for medical care, September 1960 and April 1961, and changes in averages from September to April, by State
(corrected to June 22, 1961)

State	September 1960			April 1961			Change, Sept. 1960 - April 1961		
	All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care
Total, all States	$68.75	$58.00	$10.75	$68.45	$57.39	$11.06	-$0.30	-$0.61	$0.31
Total, without Massachusetts and New York	65.94	57.28	8.66	67.13	56.79	10.34	1.19	- 0.49	1.68
Alabama	52.88	52.87	.01	53.25	50.85	2.41	.37	-2.02	2.40
Alaska	64.34	64.34	---	66.31	66.31	---	1.97	1.97	---
Arizona	61.41	61.41	---	61.00	61.00	---	-.41	-.41	---
Arkansas	52.63	45.95	6.68	52.31	45.14	7.17	- .32	- .81	.49
California	90.19	80.43	9.76	90.43	79.10	11.33	.24	-1.33	1.57
Colorado	100.55	83.53	17.02	100.96	82.63	18.33	.41	- .90	1.31
Connecticut	109.42	90.56	18.86	110.91	93.13	17.77	1.49	2.57	-1.09
Delaware	50.48	50.48	---	49.85	49.85	---	- .63	- .63	---
District of Columbia	64.92	56.52	8.40	66.01	56.57	9.44	1.09	.05	1.04
Florida	56.24	50.21	6.02	60.01	48.06	11.95	3.77	-2.15	5.93
Georgia	47.26	47.26	---	47.07	47.07	---	- .19	- .19	---
Guam	29.24	29.24	---	25.20	25.20	---	-4.04	-4.04	---
Hawaii	63.42	57.68	5.74	70.26	61.81	8.45	6.84	4.13	2.71
Idaho	69.61	60.19	9.42	84.75	56.71	28.04	15.14	-3.48	18.62
Illinois	77.98	43.83	34.15	78.10	43.93	34.16	.12	.10	.01
Indiana	64.90	44.15	20.75	64.33	44.44	19.90	- .57	.29	- .85
Iowa	82.05	74.03	8.02	87.69	62.46	25.23	5.64	-11.57	17.21
Kansas	80.24	68.11	12.13	82.42	68.95	13.47	2.18	.84	1.34
Kentucky	50.34	50.34	---	50.28	49.98	.30	- .06	- .36	.30
Louisiana	71.19	69.14	2.05	71.07	68.70	2.37	- .12	- .44	.32
Maine	66.39	53.39	13.00	67.92	46.92	21.00	1.53	-6.47	8.00
Maryland	62.41	56.88	5.53	63.74	57.49	6.25	1.33	.61	.72
Massachusetts	106.89	61.03	45.86	86.81	69.71	17.10	-20.08	8.68	-28.76
Michigan	76.59	65.93	10.66	78.95	66.23	12.73	2.36	.30	2.07
Minnesota	89.46	52.40	37.06	93.58	52.23	41.35	4.12	- .17	4.29
Mississippi	34.61	34.61	---	34.49	34.49	---	- .12	- .12	---
Missouri	60.12	59.74	.39	61.43	59.77	1.66	1.31	.03	1.27
Montana	64.00	63.74	.27	63.62	63.44	.18	- .38	- .30	- .09
Nebraska	71.99	47.04	24.95	75.88	49.55	26.33	3.89	2.51	1.38
Nevada	74.96	68.98	5.97	78.69	71.07	7.62	3.73	2.09	1.65
New Hampshire	79.21	62.11	17.10	85.39	68.01	17.38	6.18	5.90	.28
New Jersey	90.11	55.05	35.06	92.51	55.07	37.44	2.40	.02	2.38
New Mexico	68.17	59.64	8.54	67.55	56.89	10.66	-.62	-2.75	2.12
New York	107.87	74.42	33.45	94.03	65.08	28.95	-13.84	-9.34	-4.50
North Carolina	44.00	41.72	2.28	44.94	42.66	2.28	.94	.94	---
North Dakota	90.18	55.41	34.76	92.40	56.03	36.37	2.22	.62	1.61
Ohio	75.80	65.01	10.79	76.58	64.89	11.68	.78	- .12	.89
Oklahoma	79.14	67.16	11.99	87.58	69.66	17.92	8.44	2.50	5.93
Oregon	80.21	51.56	28.65	86.57	52.86	33.71	6.36	1.30	5.06
Pennsylvania	68.54	64.69	3.85	67.42	64.34	3.08	-1.12	- .35	- .77
Puerto Rico	8.24	8.24	---	8.28	8.28	---	.04	.04	---
Rhode Island	80.77	65.77	15.00	81.11	66.11	15.00	.34	.34	---
South Carolina	40.94	38.05	2.88	41.75	38.38	3.37	.81	.33	.49
South Dakota	62.51	62.51	---	63.68	63.68	---	1.17	1.17	---
Tennessee	41.86	41.26	.60	43.94	40.54	3.40	2.08	- .72	2.80
Texas	52.90	52.90	---	52.73	52.73	---	- .17	- .17	---
Utah	72.19	67.20	4.99	71.14	51.20	19.95	-1.05	-16.00	14.96
Vermont	64.98	51.48	13.50	70.87	49.59	21.28	5.89	-1.89	7.78
Virgin Islands	26.86	26.36	.50	26.44	26.44	---	- .42	.08	- .50
Virginia	46.58	37.52	9.06	53.56	41.46	12.10	6.98	3.94	3.04
Washington	87.83	57.30	30.53	87.27	56.98	30.29	- .56	- .32	- .24
West Virginia	39.07	34.13	4.93	40.98	34.05	6.93	1.91	- .08	2.00
Wisconsin	84.01	38.62	45.39	86.70	37.90	48.80	2.69	- .72	3.41
Wyoming	71.06	61.87	9.19	76.11	64.94	11.17	5.05	3.07	1.98

Table 11.--Old-age assistance: Distribution of States by amounts of increase or decrease in average money payment and average vendor payment per recipient from September 1960 to April 1961 (corrected to June 27, 1961)

Change in average vendor payment	Total	Change in average money payment: Decrease of: More than $1	Decrease of: $.20 to $1	Change of less than $.20	Increase of: $.20 to $1	Increase of: More than $1
Total	54	11	11	12	8	12
Decrease of more than $1	3	1				2
$.20 to $1	4		2	1	1	
Change of less than $.20	4		1	1	2	
Increase of $.20 to $1	7		3	1	2	1
More than $1	27	9	3	5	3	7
No vendor payment, September or April	9	1	2	4		2

States with relatively high average vendor payments do not necessarily provide comprehensive and high-quality medical care for old-age assistance recipients, nor do all States with low averages have inadequate medical care programs. There are a number of variables other than the scope and quality of care received by recipients which influence the level of average vendor payments--variations in costs of medical care, availability of medical personnel and facilities, access of recipients to other medical care programs, provision of medical care through money payments to recipients, etc. But,

for most States, the amount of the average vendor payment does tend to reflect the relative adequacy of medical care available to old-age assistance recipients; the increases in average vendor payments since October 1, 1960, perhaps furnish a rough gauge of the improvements in medical care for the recipients since that date; and the large number of States still remaining with relatively low average vendor payments may roughly indicate the improvements still needed in medical care provisions for recipients of old-age assistance.

Public Assistance Medical Care: Medical Assistance for the Aged

The 1960 amendments provided for a new program of medical assistance to aged people who do not qualify for old-age assistance but who cannot meet the cost of needed medical care. The program must be administered by the same State agency that administers old-age assistance.

The States have considerable latitude in deciding the scope of medical assistance for the aged with regard to both the definition of persons eligible and the kind and extent of services provided. However, if a State decides to have such a program, it may not set an age limit of more than 65 years, a citizenship requirement which excludes any citizen of the United States, or a durational residence requirement. Nor may it impose a lien against the property of any individual prior to his death on account of medical assistance properly paid in his behalf nor require recovery from his estate until after the death of the surviving spouse, if any.

In addition, there must be a provision that no enrollment fee, premium, or similar charge will be imposed as a condition of eligibility by the agency which administers medical assistance for the aged. There is specific provision in the statute for Federal financial participation in State expenditures "for insurance premiums for medical or any other type of remedial care or the cost thereof" paid as medical assistance in behalf of eligible individuals.

In defining the content of medical care to be provided by a State for medical assistance for the aged, the Federal Act requires that there be some institutional and some noninstitutional care. The Federal Government participates, according to a specified formula, in amounts paid in behalf of eligible recipients, that is, payments to suppliers of medical or remedial care. The program does not include amounts paid directly to recipients.

Program development.--The medical assistance for the aged program was in operation in 10 States 13/ by the end of June 1961. An additional nine States 14/ have adopted legislation and expect to have a program in operation by November 1, 1961; while four others 15/ have legislation with later effective dates. As of mid-July legislation was in process in seven States.16/ It appears unlikely that the remaining 24 States will implement the legislation in 1961 or early 1962.

The major provisions of the medical assistance for the aged programs in effect or enacted in each of the 17 States for which such information was available as of the end of June 1961 are shown in the Appendix. A summary analysis of the provisions in the 10 State programs that were in operation prior to July 1 is presented in the material which follows.

Financial eligibility: income.--In determining the group who will be eligible, some States have set a maximum on the income and assets medical assistance for the aged recipients may hold, and a person who possesses more than these value amounts is ineligible. Other States say, in effect, "A certain level of income and resources is necessary for subsistence; any amount beyond this level will be evaluated to determine its availability to meet medical need. If the amount available is still not enough to pay for the person's necessary medical care, he is eligible for medical assistance for the aged."

Among the seven States using the system of maximums on income and assets, the lowest maximum on income for a single recipient with no dependents is $1,080; the highest is $1,500. Varying allowances are made for dependents.

Financial eligibility: assets.--All 10 States with a medical assistance for the aged program in operation before July 1961 exempt the real property used as a home in determining eligibility. They take into account the resource value of other real estate, although most States do not require its liquidation. Most of the States exempt a life-insurance policy with a small cash-surrender value. Medical insurance policies and similar resources designed to meet medical need are also considered as assets to be taken into account in determining the amount to be paid from medical assistance for the aged funds.

13/ Kentucky, Maryland, Massachusetts, Michigan, New York, Oklahoma, Washington, West Virginia, Puerto Rico, and Virgin Islands.

14/ Arkansas, Idaho, Maine, New Hampshire, North Dakota, Oregon, South Carolina, Tennessee, and Utah.

15/ California, Connecticut, Hawaii, and Louisiana.

16/ Bills had passed both houses of the legislature in Illinois and Vermont, and one house in Alabama and Wisconsin; bills had been introduced but not passed in New Jersey, Ohio, and Pennsylvania.

A small reserve of cash or "resources convertible to cash" is specifically permitted in 8 of the 10 States. The amount permitted a single person ranged from $300 in one State (Maryland) to $5,000 in another (West Virginia). However, the State with the $300 limit permits "liquid resources" reserve of $2,500 if it "represents the only resource for regular living expenses."

Types of medical care covered.--All 10 States operating medical assistance for the aged prior to July 1961 provide for inpatient hospital care. The length of the hospital stay to be paid for ranges from 6 days (Kentucky) to as many as are necessary, as determined by the physician's statement and a review by the staff giving medical supervision to the State's program. Several States limit hospital care to acute, life-endangering, or traumatic conditions requiring hospital care; all others provide it as recommended by the physician. Nursing home care is provided by 6 of the 10 States. In West Virginia such care is restricted to posthospital care.

Physicians' services in home and office is the type of noninstitutional care most frequently specified. Nine of the 10 States provide for such services. Some States limit the services to acute conditions or treatment necessary to prevent the recipient's need for hospital care. Among the States that do not provide for a full range of noninstitutional services, the most frequently covered services, in addition to those of the physician, are dental services to relieve pain or treat acute infections, and prescribed drugs. In some States, the latter are limited to those drugs needed for the treatment of acute or life-endangering conditions.

Of the 10 jurisdictions now operating medical assistance for the aged, 5 (Massachusetts, New York, Puerto Rico, Washington, and West Virginia) provide medical care services covering the basic types of medical care needs (hospital, nursing home care, physicians' services, prescribed drugs). In the other 5 States, one or more of these services is not included.

Persons receiving care.--Payments of almost $6 million were made on behalf of 28,000 recipients of medical assistance for the aged in April 1961, in seven States (table 12). Of the remaining States with programs in operation prior to July, Puerto Rico and the Virgin Islands have not reported and the Maryland program did not begin until June.

The term "recipients" means the number of persons for whom bills from suppliers of medical care were paid in the reporting month. The bills generally represent services provided in a preceding month. The count of recipients, therefore, does not necessarily reflect the number of persons actually receiving medical care services during the month covered by the report.

Table 12.--Medical assistance for the aged: recipients and payments for recipients, by State, April 1961 1/

State	Number of recipients	Payments for recipients	
		Total amount	Average
Total.....	27,998	$5,890,726	$210.40
Kentucky.....	14	508	(2/)
Massachusetts.....	14,722	3,024,301 3/	205.43
Michigan.....	3,585	1,113,873	310.70
New York.....	5,589 1/	1,418,463 1/	253.80 1/
Oklahoma.....	190	42,302	222.64
Washington.....	281	56,276	200.27
West Virginia.....	3,617	235,003	64.97

1/ Figures underlined represent program under State plan not yet approved by the Social Security Administration. All data subject to revision.

2/ Average payment not computed on base of fewer than 50 recipients.

3/ Excludes $93,740 in money payments not subject to Federal participation.

Persons whose cases were opened for medical assistance for the aged, October 1960-April 1961.--Practices in opening cases vary among the 10 States. In three (Kentucky, Virgin Islands, and West Virginia) persons may apply in advance of their need for medical care. When their eligibility is established, they are given identification cards for use when medical care becomes necessary. At the time medical care is needed, their eligibility is reviewed. When a year has elapsed, continuing eligibility for medical care assistance is redetermined for all opened cases.

The general practice in the other seven States is to determine eligibility at the time the need for medical care is made known. Financial eligibility is directly related to the kind and cost of the medical care needed.

These variations in practice are reflected in reports on the number of cases opened. Also reflected in these reports are the practices of the States with respect to the transfer of cases from other assistance programs to medical assistance for the aged.

Reports on the number of cases opened have been received from 8 of the 10 States (table 13). Of the 62,414 persons whose cases had been opened in these 8 States since the initiation of the program, 96 percent were in Massachusetts, Michigan, New York, and West Virginia. In New York and Massachusetts, almost all the cases were transfers from old-age assistance; in Michigan, about one-fourth of the cases formerly received old-age assistance. In contrast, none of the West Virginia cases represented transfers from any public assistance program.

Program costs for medical assistance for the aged.--Program costs for medical assistance for the aged have been increasing rapidly, as would be expected with a new program. For the month of May 1961, they were $8 million, an increase of $2 million over April, and $4 million over March expenditures. The average monthly expenditures per recipient since the program's inception have ranged around $200.

As with any new and growing program, estimating future costs or costs under a fully developed program are difficult. The President's budget for fiscal year 1962 includes $60 million for the Federal cost of benefits under the program, based upon an estimated total program cost of $116 million. These estimates appear low in the light of data developed by a recent survey of State action to implement medical programs for the aged, conducted by the Senate Special Committee on Aging. Twenty States and two territories estimated their costs for a year's operation of a medical assistance for the aged program, based on the situation as of March 31, 1961. The 22 jurisdictions include all those with programs in operation, all except 3 of those which anticipate programs by early 1962, and 3 which do not anticipate an operating program by that time. The expected total cost for 1 year's services, as estimated by the 22 jurisdictions, is $331 million. Of this $172.3 million would be Federal funds, $98.5 million State funds, and $60.2 million local funds.

There is no satisfactory way to project from these data costs for the program of medical assistance for the aged if all States were to participate. However, assuming similar benefit levels and eligibility requirements in the remaining States, the cost might be about $650 to $700 million, of which about $360 to $390 million would probably be required from Federal funds. This assumes medical care prices at the present level. With the probable increase in these prices and with a general expansion of the program toward comprehensive benefits and lowered eligibility requirements, the cost would become substantially greater.

Table 13.--Cases opened for MAA by type of previous assistance, discontinued or continued, October 1960-April 1961

State	Total cases opened	Specified type of assistance									Other or no assistance
		Discontinued					Continued				
		OAA	ADC	AB	APTD	GA	ADC	AB	APTD	GA	
Total	62,414	33,372	0	218	262	239	0	114	7	31	28,171
Kentucky	572	0	0	0	0	55	0	0	0	3	514
Massachusetts	18,959	15,221	0	0	189	38	0	0	0	0	3,511
Michigan	8,260	2,057	0	18	34	140	0	5	7	28	5,971
New York	17,068	16,084	0	200	39	6	0	109	0	0	630
Oklahoma	604	0	0	0	0	0	0	0	0	0	604
Virgin Islands	99	0	0	0	0	0	0	0	0	0	99
Washington	1,302	10	0	0	0	0	0	0	0	0	1,292
West Virginia	15,550	0	0	0	0	0	0	0	0	0	15,550

PART II

THE ADMINISTRATION PLAN OF HEALTH INSURANCE FOR THE AGED

THE ESSENCE OF THE PLAN

The social security benefits to which 95 percent of the aged will, in the long run, be entitled cannot offer an adequate basis for their security so long as they must continue to fear that the costs of serious illness in old age may reduce them to destitution. Normal budgeting from cash benefits and other income resources cannot remove this threat to the independence of those who will become old in the future, as well as those who are already aged. The only way to remove this threat is through providing the aged with, in addition to a basic monthly cash benefit, basic insurance protection against large health costs.

Adequate health insurance protection can be paid for by the aged only if they make contributions during their working years for their protection in old age. Such a spreading of cost over a long period of time for this purpose is not feasible under private insurance except on a very limited basis. A requirement that private insurance premiums be paid over a working lifetime means that no one could obtain protection until several decades have gone by and, when the lifetime of payments have been made, the best plans for adequate paid-up health benefits may be insufficient if medical costs have risen greatly. Another system for helping the aged acquire insurance is through community rating. However, community rating has weakened the competitive position of plans using it and experience rating is increasingly replacing community rates.

Social security contributions are paid during entire working lifetimes, vary with earnings levels and are shared by employers and employees. Such an arrangement for prepaying the costs of health insurance is not available under private programs. Under private programs low income groups have considerable difficulty in prepaying the cost of their old-age protection and employer practices in sharing costs differ widely.

The social insurance mechanism offers a truly conservative approach to meeting basic costs of illness in old age. The scope of the health insurance protection provided would be clearly defined and limited by law, the long-run cost of making health insurance payments would be actuarially calculated, and revenue sufficient to finance these benefit payments would be provided. Through such means the States, whose finances are already hard pressed, would be spared a burden on their general revenues. Furthermore, use of the existing OASDI administrative machinery would make it possible to carry out the Administration's plan with operating costs of about 3 percent of benefit costs because the necessary tax-gathering, record-keeping, claims-processing and much of the other administrative machinery is already in existence and operating smoothly in carrying out the existing OASDI program.

THE ROLES OF OTHER PROGRAMS

Neither private insurance nor public assistance can serve as the primary means of protecting the aged against the expenses of a costly illness. However, both would play an important role in complementing the basic health insurance protection that would be afforded the aged under the Administration plan. Many of the aged who now have some insurance against the cost of health care would no doubt carry supplemental protection. Also, some aged people who are now without any protection because they know they cannot safeguard themselves against financial catastrophe resulting from illness would obtain additional coverage from private sources when real security becomes a possibility. As the basic cash benefits under social insurance have been so successfully complemented by pensions and annuities under private plans, so we would expect basic social security health insurance to be complemented by private health insurance.

If the proposed program is enacted public assistance would serve as a backstop--filling in for the smaller and smaller group of aged persons who cannot qualify for social insurance protection or whose benefits do not fit their needs. This of course is the accepted role of public assistance in the area of income maintenance. In fact, enactment of the proposal would enable the States, without taking on too great a burden, to move in the direction of more meaningful and effective medical assistance programs for the persons who would still need State help in meeting their health costs. Just as during the last decade improvements in the OASDI program have enabled the public assistance programs to do a better job in supplementing the basic social insurance program, it is expected that enactment of the health insurance program would relieve the States of part of their present financial burden and enable them to provide more adequate programs of medical assistance for the aged.

THE RELATION OF SOCIAL INSURANCE TO MEDICAL PRACTICE

The main premise behind the proposal that health insurance for the aged be provided as a basic part of the social insurance system is that the aged require an improvement in the method through which they pay for their health care. The only way of providing this improvement involves the use of payment over the working lifetime for basic protection in old age and such payment is feasible for the great majority of the population only under social insurance.

No part of the plan proposes to interfere with the practice of medicine. The Administration's plan has been drawn with care to avoid Federal interference. What is proposed is a means of financing hospital care and certain related or alternative services. Aside from the difference in the method of collecting contributions and the population group affected, what is proposed is very much like what Blue Cross plans have been doing for many years, paying hospital bills without interfering in hospital operation.

The proposal would not limit the patient's freedom of choice of doctor or hospital but, on the contrary, would remove economic barriers that can restrict the exercise of that freedom.

THE SPECIFICATIONS OF THE PLAN

On February 9, 1961, the President sent to the Congress a Special Message on Health and Hospital Care which contained a proposal to provide persons aged 65 and over with health insurance protection through the OASDI program and the railroad retirement system. Two bills (H.R. 4222, King, California, and S. 909, Anderson, New Mexico) to carry out the President's recommendation were subsequently introduced on behalf of the Administration. 1/

1/ Cosponsors of S. 909 are Senators Douglas (Illinois), Hartke (Indiana), McCarthy (Minnesota), Humphrey (Minnesota), Jackson (Washington), Long (Hawaii), Randolph (West Virginia), Engle (California), Magnuson (Washington), Pell (Rhode Island), Burdick (North Dakota), Mrs. Neuberger (Oregon), Morse (Oregon), Long (Missouri), Moss (Utah), and Pastore (Rhode Island). Eight bills identical to H.R. 4222 have been sponsored by Congressmen Dingell (Michigan), Karsten (Missouri), Machrowicz (Michigan), Green (Pennsylvania), Ullman (Oregon), McFall (California), Pucinski (Illinois), O'Neill (Massachusetts), and Santangelo (New York). Twelve additional bills which would use the old-age and survivors insurance approach have been introduced in the Congress.

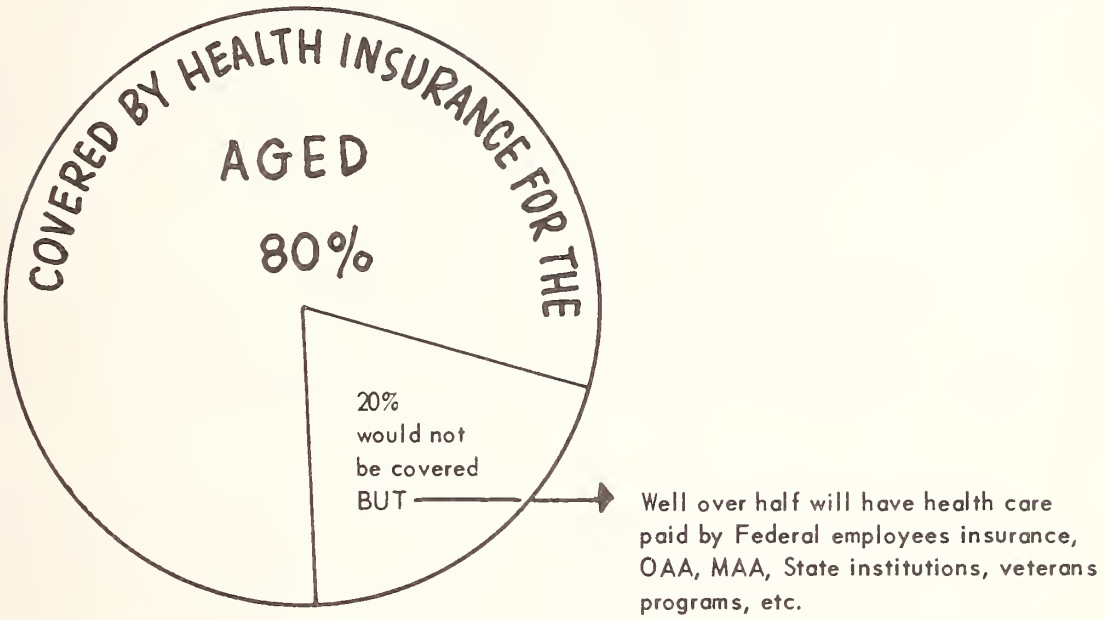
ELIGIBILITY

Under the Administration plan, health insurance protection would be provided under the OASDI program for all persons who are aged 65 and over and entitled to monthly old-age or survivors insurance benefits. The same health insurance protection as that provided for old-age and survivors insurance beneficiaries would be provided at age 65 for persons entitled to an annuity under the Railroad Retirement Act. Under the proposal, an individual would be eligible for health insurance protection at age 65 even though his monthly cash benefits are being withheld because of earnings from work.

Part I of this report spells out in detail the fact that after age 65 serious illness is more frequent, health care costs are higher, and income is lower. Furthermore, age 65 is generally the point at which persons begin experiencing the greatest difficulty in obtaining adequate health insurance.

Since eligibility for health insurance benefits would be based on entitlement to old-age and survivors insurance or railroad retirement benefits as well as age, persons who have not worked in covered employment and self-employment long enough to be insured would not qualify. In 1963, the first full calendar year in which the proposed program would be in effect, the total population aged 65 and over is expected to be about 17 3/4 million. Of these, 14 1/4 million--about 80 percent of the aged--would be eligible for benefits under the proposed legislation as a result of their entitlement to old-age and survivors insurance benefits (13 3/4 million) or to an annuity under the Railroad Retirement Act (1/2 million). Furthermore, a high proportion of those aged persons who could not qualify for health insurance benefits will be recipients under other public programs which provide help in meeting the costs of health care. One-quarter million aged persons will be beneficiaries under Federal Government staff retirement systems and will be eligible for health benefits under special plans. More than half of the remaining 3 1/4 million aged would be eligible for care in Veterans Administration hospitals or for such payment of medical costs as the public assistance programs provide. Others will be receiving care in State and local mental or tuberculosis hospitals and in other public institutions.

IN 1963, 14-1/4 OUT OF THE APPROXIMATELY 17-3/4 MILLION AGED WOULD HAVE HEALTH INSURANCE UNDER THE PROPOSAL



With about nine out of ten persons in paid employment covered by OASDI since the mid-1950's, the percentage of persons protected at retirement age will increase as the program grows to maturity. The percentage of the people in the aged population who would have health insurance protection will be 80 percent in 1963 and will eventually reach 95 percent.

This pattern of immediate protection for those who had worked under the program in the past, with growth in the proportion protected in the future until ultimately practically all are protected, is the tradition that has been followed from the beginning of the program. When cash benefits for the aged were first payable in 1940, benefits were made immediately available for those who, though already old, had

demonstrated attachment to covered work after the program started in 1937. When disability insurance benefits were first paid in 1957 to people aged 50 and over, those already disabled who were between the ages of 50 and 64 and who previously had worked substantial periods in covered employment and self-employment were made eligible for benefits. In this way the work-related character of the benefits was established and maintained while at the same time the provisions were given immediate effect to the extent that it seemed practical to do so within the framework of a work-related program. At the same time, both at the very beginning of the program and with its extension to the additional risk of disability, public assistance programs have been relied on to meet the needs of those who had not earned eligibility under social insurance. Under the Administration plan, this pattern would be followed.

SCOPE OF PROTECTION

The Administration plan would provide payments for inpatient hospital services, follow-up skilled nursing home services, certain organized home health care services and hospital outpatient diagnostic services. The chart on the next page lists the specific kinds of health care for which payments could be made and those which would not be covered.

Under the plan, health insurance payments would generally cover any hospital services and supplies of the kind ordinarily furnished by the hospital and which are necessary in the care and treatment of its patients. Thus, as hospitals acquire new plant and equipment, adopt new health practices and improve their services and techniques, the additional operating costs resulting from such changes would be included in the proportionate share of hospital costs that would be covered under the present proposal.

Inpatient hospital services are appropriate for coverage under the proposed health insurance program because of the great financial strain placed on persons who must go to the hospital. Medical expenses for aged persons who are hospitalized are about five times greater than the medical bills of aged people who are not hospitalized. Also, of course, hospitalization is a common occurrence among the aged. It is estimated that nine out of every ten persons who reach age 65 will be hospitalized at least once before they die; two out of three will be hospitalized two or more times. As Part I of this report shows, hospital costs contribute greatly to the size of the inordinately high health bills the aged hospital patient must face.

The Administration plan would provide payments for skilled nursing home care in cases where a hospital inpatient is transferred to a skilled nursing home to receive skilled nursing care needed in connection with

HEALTH SERVICES AND SUPPLIES THAT COULD BE PAID FOR UNDER THE ADMINISTRATION PLAN FOR HEALTH INSURANCE FOR THE AGED (H.R. 4222 AND S. 909)

	Inpatient hospital benefits	Skilled nursing home benefits	Outpatient hospital diagnostic benefits	Home health benefits
Room and board	Coverage limited to bed and board in a 2-4 bed room or in more expensive accommodations where medically required		Not applicable	Not covered
General duty nursing services	Covered (Benefits would not cover private duty nursing)			Coverage limited to part-time or intermittent nursing care
Physicians' services	Not covered except where furnished by an intern or resident-in-training in the course of an approved teaching program, or where the services are in the field of pathology, radiology, anesthesiology, and physical medicine and are rendered through the hospital. Part or all of the services of physicians included under hospital services may be covered if generally furnished by nursing homes.			Not covered
Physical, occupational, and speech therapy	Covered		Not applicable	Covered
Medical social services	Covered		Not applicable	Covered
Drugs	Covered		Not applicable	Not covered
Other services and supplies necessary to the health of the patient	Covered if the hospital customarily furnishes them to its patients	Covered if generally provided by skilled nursing homes	Covered if customarily furnished by the hospital to outpatients for the purpose of diagnostic study	To the extent permitted by regulations, part-time or intermittent homemaker services and such other services which are not specifically excluded as may be permitted by regulation

a condition for which he was hospitalized. The requirement that the nursing home patient have been transferred from a hospital would tend to restrict nursing home benefits to persons who are in the post-acute stage of an illness which nevertheless requires skilled, although less intensive, care than that provided by hospitals. In addition to the kinds of services specifically listed in the bill, payment could also be made for such other services as are generally provided by skilled nursing facilities.

Health insurance payments would be made for visiting nurse services and for other related home health services only when furnished by a public or nonprofit agency in accordance with a plan for the patient's care that is established and periodically reviewed by a physician. Since the nature and extent of the care a patient would receive would be planned by a physician, medical supervision and control over the utilization of home health services would be assured.

In the case of outpatient hospital diagnostic services, payment could generally be made for tests and related services which are customarily furnished by a hospital to its outpatients for the purpose of diagnostic study.

The Administration plan provides payments for the specified combination of services in order to promote the economical use of hospital inpatient services. In doing so, the proposed legislation would support the efforts of the health professions to use hospital beds for the care of the acutely ill who need the intensive care that only a hospital can furnish. For example, the availability of protection against the costs of outpatient hospital diagnostic tests would avoid providing an incentive to use inpatient hospital services in order to obtain coverage of the cost of diagnostic services. The availability of this protection would also give support to preventive medicine by meeting part of the costs of procedures that are essential in the early detection of disease. Similarly, the availability of health insurance payments for skilled nursing home care and home health services would encourage the use of these less expensive services rather than hospital care where the alternatives are medically appropriate.

While the plan would by no means provide protection against all of a beneficiary's health costs, it can be expected that once what might be described as the basic health insurance needs are met under OASDI, many beneficiaries could afford to make their coverage more nearly complete by purchasing supplemental protection (against the costs of physicians' services, drugs, etc.) from nonprofit and commercial insurance carriers.

INCLUDED AND EXCLUDED SERVICES

Under the Administration plan, payment for health services would be limited to those which are essential elements of services provided by hospitals. Since the primary purpose of the proposal is to provide health insurance protection against hospital expenses, and a major reason for the coverage of other services is to provide economical substitutes for hospitalization, the proposed legislation is framed to permit payment for skilled nursing home, home health, or outpatient diagnostic services only to the extent that they could be paid for if furnished to a hospital inpatient. Thus the outer limits on what the proposed program would pay for are set by the general scope of inpatient hospital services for which payment could be made. Generally, services covered outside the hospital are more limited than those in the hospital. Following is a description of the various health services for which payment would be made under the proposal:

Room and Board

Payments would be made for room and board in hospital and skilled nursing home accommodations. Generally speaking, accomodations for which payment would be made would consist of rooms containing from two to four beds. Payments could also be made for more expensive accommodations where their use is medically required. Where private accommodations are furnished at the patient's request, health insurance benefits would cover the semiprivate room rate and the hospital would bill the patient for the difference between the private and the semiprivate rate.

Nursing Services

Payments would cover all hospital nursing costs, but not private duty nursing. The nursing services provided by hospitals and skilled nursing homes which would participate in the program should almost always adequately meet the nursing needs of their patients.

Payments for home health services would only cover part-time or intermittent nursing care such as that provided by visiting nurses. Where more or less continuing skilled nursing care is needed, an institutional setting is more economical and generally more suitable.

Physicians' Services

The cost of a physician's services would not be paid for under the proposal except for the services of hospital interns and residents-in-training, and for the professional component of ancillary hospital services described below under "Other Health Services."

The Administration plan would cover the cost of the services that interns and residents furnish while they are participants in teaching programs that are approved by the American Medical Association's Council on Medical Education and Hospitals (or any equivalent organization). This policy is in agreement with the generally accepted principle of hospital payment that third parties should contribute a fair share toward the hospital costs--in large part consisting of educational costs--of interns and residents.

Drugs

Under the proposal, payment could be made for drugs furnished to hospital and skilled nursing home patients for their use while inpatients. The Administration plan follows the practice of most Blue Cross plans and other insurers by providing payment for drugs which are listed in the United States Pharmacopoeia, National Formulary, and New and Non-Official Drugs. A hospital's drugs must meet the standards established by these drug listings in order for the hospital to be accredited by the Joint Commission on Accreditation.

The drugs prescribed for a patient as part of his home health care would not be paid for by health insurance benefits. The decision to exclude the cost of drugs from home health service payments is part of the more basic decision not to provide coverage of drug and other outpatient therapeutic costs under the program. Also, the coverage of all drugs would add greatly to the cost of the program and would present exceedingly difficult problems in preventing abuses. The payment for drugs for home health patients only might have the effect of providing drug payments for the aged generally and expose physicians to demands that they prescribe home health services for patients needing expensive drugs.

Supplies and Appliances

Under the proposal, payment would be made for supplies and appliances which are provided as part of the treatment provided in connection with covered health services. For example, the cost of the use of a wheelchair, crutches or prosthetic appliances could be paid for as part of hospital, nursing home or home health services but payments would not be provided for the patient's use of these items upon discharge from the institution or upon completion of the home health plan.

Medical Social Services

Health insurance payments would cover the cost of the medical social services customarily furnished in a hospital, as well as such services in a nursing home, or as part of a home health plan.

Other Health Services

Payment would be made for the various ancillary services customarily furnished as a part of hospital care, including various laboratory services and X-ray services and use of hospital equipment and personnel. Among the covered services also would be physical, occupational, and speech therapy. While these services are rendered in large part by laymen, payments for ancillary services would include the costs of services rendered by physicians in four specialty fields--anesthesiology, radiology, pathology and physiatry (physical medicine)--where the physician furnishes his services to an inpatient as an employee of the hospital or where he furnishes them under an arrangement with the hospital which governs the provisions of the services.

All hospitals must have at least minimal laboratory and X-ray services readily available, and the larger hospitals generally provide a wide range of services. The head of each of these departments is a physician, and except in some very small hospitals is ordinarily a specialist in the appropriate field. The pathologist or radiologist assumes over-all responsibility, performs personally some of the most difficult procedures and makes needed medical interpretations, but the greater volume of the work is done by nonmedical personnel who typically are salaried employees of the hospital. Arrangements between the hospitals and the specialists who head the departments vary widely. Sometimes the specialist is on salary from the hospital; more frequently, the hospital and the specialist have agreed on a percentage division of gross or net receipts for the services, with the hospital hiring and paying the nonmedical personnel, and the parties dividing in various ways the responsibility for equipment, supplies and other items. In some instances the specialist may operate the department as a concession, hiring and paying his lay assistants, with the hospital's percentage of gross or net representing little more than rental. Sometimes a firm of radiologists or pathologists assumes the responsibility of service to a hospital, the members of the firm rotating among several hospitals or between a hospital and a private clinic or office. Under all these percentage arrangements the charges to the patients are usually fixed by agreement between the hospital and the specialist. The billing is ordinarily done by the hospital; under percentage arrangements the hospital sometimes bills in the name of the specialist.

The Administration proposal provides for reimbursing hospitals for X-ray and laboratory services to inpatient beneficiaries and for diagnostic tests furnished to outpatient beneficiaries, whether these services are furnished directly by the hospital or under arrangements made by the hospital. This provision is intended to make available, and to pay the hospital for, the same radiology and pathology services that are regularly furnished to all other patients (under whatever the local arrangement may be) in the particular hospital, provided that the billing and collection are handled by the hospital.

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

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

In addition, health services, including physical therapy, furnished by a skilled nursing home would be covered if they are of a type generally provided by such homes. Payment for home health services which are not specifically covered or excluded could only be made if specifically permitted by regulations prescribed by the Secretary of Health, Education, and Welfare.

LIMITATIONS ON PAYMENT

As the chart on the next page shows, the Administration's plan would place a number of limitations on the payment of health insurance benefits, primarily because of considerations of cost and priorities of need.

Duration of Benefits

The maximum number of days of inpatient hospital care for which payment could be made--90 days per benefit period--would cover the entire hospital stay of 95 percent or more of aged beneficiaries. Since some persons need an extended period of skilled nursing care after a period of the more intensive hospital treatment, a maximum of 180 days of skilled nursing home care is provided for each spell of illness. The proposal also places an over-all limitation of "150 units" on the duration of services covered during a benefit period: one "unit" is equal to a day of inpatient hospital services or two days of inpatient nursing home services. This "two-for-one" provision is designed to provide an incentive to use nursing home facilities rather than hospitals where medically appropriate. If the transfer from a hospital to a nursing home is as early as possible (and before he has used or received 90 days of hospital care), the patient would, of course, be eligible for hospital treatment (within the limits for a benefit period) while an inpatient in the nursing home or after his discharge.

The deductible provision and the other limitations on inpatient hospital and skilled nursing home payments are applied on a "benefit period" basis. In general, the "benefit period" would coincide with the beneficiary's episode of illness; that is, it would begin with the first day in which the patient receives inpatient hospital services for which health insurance payments could be made and would end after the close of a 90-day period during which he was neither an inpatient in a hospital nor a skilled nursing home. Blue Cross plans and commercial insurers generally relate their "benefit period" to an episode of illness in this manner.

Unlike the institutionalized patient, people receiving home health services do not receive health care on a full-time basis. Home health services involve periodic visits to the patient's home by therapists, nurses, and other professional personnel. The limitations placed on the payment of home health benefits is written in terms of "visits" rather than "days" so that the amount of home health service which is covered would be unaffected by whether a variety of services is offered on the same day or different days.

Under the proposal, as many as 240 home health visits could be paid for in a calendar year. The larger amount of service which may be covered is related to the fact that home health services are

LIMITATIONS ON HEALTH INSURANCE PAYMENT UNDER THE ADMINISTRATION PLAN

	Inpatient hospital services*	Skilled nursing home services*	Outpatient hospital diagnostic services	Home health services
Deductible	$10 per day for each of the first 9 days of hospitalization during a benefit period, with a minimum deductible amount of $20	None (but is covered only after hospitalization to which the deductible applies)	$20 per diagnostic study	None
Maximum duration of benefits	90 days per benefit period	180 days per benefit period	None	240 home health visits per calendar year
Over-all limitation on duration of benefits	150 units per benefit period: One "unit" is equal to (a) one day of inpatient hospital services, or (b) two days of skilled nursing home services		None	None

*The limitations on hospital and skilled nursing home payments are applied on a "benefit period" basis. An individual's benefit period would begin with the first day he receives covered inpatient hospital services and would end with the last day of the first 90-day period during which he was neither an inpatient in a hospital or a skilled nursing home. A new benefit period would begin when the individual next receives covered inpatient hospital services.

far lower in cost than is hospital and nursing home care. The over-all limitation of 150 units does not apply to home health services because that limit has no significant effect on the cost of those services and because of the difficulty beneficiaries would have in understanding how the over-all limitation applied to three kinds of health care in combination.

Deductible

Under the proposal, health insurance payments for inpatient hospital services would be subject to a deductible amount of $10 a day for each of the first nine days of a person's stay in a benefit period, with a minimum deductible amount of $20. The inclusion of a deductible provision in the proposal, which would apply only to inpatient and outpatient hospital services, results in a substantial reduction (about 0.2 percent of payroll) in benefit costs, thus making it possible to provide greater protection against the cost of catastrophic illness and a broader range of benefits. It is expected that most aged beneficiaries would be able to budget for, or have modest resources available to meet these small "first dollar" costs to which the deductibles apply. There is also a point of view which holds that the deductible might tend to discourage unnecessary hospital utilization.

A deductible amount of $20 is also applied against health insurance payments for outpatient diagnostic studies--primarily to reduce costs and to avoid processing a large volume of small claims. Thus the program provides protection against the cost of the more expensive procedures--not only the single expensive test but the series of tests whose costs add up to large amounts. Since the deductible amount applicable to outpatient diagnostic services is equal to the minimum deductible on inpatient care, there would be no financial incentive to use the hospital's more expensive inpatient facilities in cases where the required diagnostic study could be performed on an outpatient basis.

CONDITIONS FOR PARTICIPATION FOR PROVIDERS OF HEALTH SERVICES

One of the keys to determining the nature of the health services which would be paid for under the proposal is the type of institution which may participate in the health insurance program. Therefore, the question as to what, for purposes of the proposed program, is a hospital, a skilled nursing facility, or a home health agency is of considerable significance. There are no universally accepted definitions of the various health facilities. The type of institution providing health services on which there is closest agreement on definition is, of course,

the hospital. Even in the case of hospitals there is considerable variance in definition. For example, where the States count 8,000 institutions as meeting their various definitions of hospital, the American Hospital Association counts only 6,000 institutions as meeting the definition it applies. The definition of a health institution includes within it elements related to the quality and adequacy of the services which the institution provides. For example, one of the conditions an institution must meet to satisfy the American Hospital Association requirements for listing as a hospital--the same condition would have to be met before an institution could participate under the program--is provision of 24-hour nursing service rendered or supervised by registered professional nurses. This is one of the characteristics that differentiates a hospital from other institutions; in addition, of course, an institution which does not meet this condition cannot offer adequate services as a hospital.

The Administration bill therefore lists the conditions that an institution must meet in order to participate in the program. These conditions offer some assurance that participating institutions have the facilities necessary for the provision of adequate care. Also, the inclusion of these conditions is a precautionary measure designed to prevent the program from having the effect of undercutting the efforts of the various professional accrediting organizations sponsored by the medical and hospital professions, Blue Cross plans, and State agencies to improve the quality of care in hospitals and nursing homes. To provide payments to institutions for services of quality lower than are now generally acceptable might provide an incentive to create low quality institutions as well as an inducement for existing facilities to strive less hard to meet the requirements of other programs.

Under the bill, the Secretary would have authority to prescribe, in the case of any one type, or in the case of all types of participating providers of services, conditions in addition to those specifically listed where such additional conditions are found to be necessary in the interest of the health and safety of beneficiaries. This authority is proposed to be given to the Secretary because it would be inappropriate and unnecessary to include in a Federal law all of the precautions against fire hazards, contagion, etc., which should be required of institutions to make them safe. According to reports of State agencies, about 10 percent of the hospital beds and about 40 percent of the skilled nursing home beds are unacceptable because of "fire and health hazards." Payment for services in such institutions could seriously undermine the efforts of State health departments and professional groups to eliminate dangerous conditions in health care institutions.

The conditions could also be varied for different areas and classes of institutions and could, at the request of a State, be higher for institutions in that State than for those in other States. There would be uniform national minimum requirements. But in addition, in States where requirements are higher than the prescribed minimum, the program would at the request of a State follow the higher State requirements. If a State decided, for example, that all nursing homes within its jurisdiction should provide high health and safety standards and requested that the requirements under the program with respect to institutions within its boundaries conform to this level, the Secretary could cooperate to the full extent of his authority. This flexibility in the Federal program would give further support to the various States in their efforts to improve conditions in institutions. Furthermore, the States would apply either uniform requirements or the higher ones which they might recommend. In this way, the States would not only be responsible for areas of the program in which local conditions must be taken into account but also would have opportunity to coordinate their present efforts in the broad field of health care with their functions under the proposal.

The conditions in the Administration bill are framed so that medically supervised rehabilitation facilities can qualify as providers of services. Some rehabilitation facilities are for all intents and purposes hospitals, and in fact some are licensed as hospitals. Others are more like skilled nursing homes in the extent of their medical supervision, staffing, and scope of service. An institution of either type, which conducts a program of rehabilitating disabled people, could participate in the program by meeting the conditions specified in the bill for hospitals or nursing homes.

Under the bill, institutions providing care primarily for mental or tuberculosis patients are excluded from participation. The primary reason for this exclusion is that these institutions are, for the most part, supported by public funds. A similar exclusion exists in most other prepayment health insurance programs and in the program of medical assistance for the aged enacted last year.

Conditions for Hospitals

In addition to the health and safety requirements to be established by the Secretary, an institution, to meet the definition of a hospital, must (a) be primarily engaged in providing diagnostic and therapeutic services or rehabilitation services, (b) maintain adequate medical records, (c) have by-laws in effect for its medical staff,

(d) provide 24-hour nursing service rendered or supervised by registered professional nurses, (e) have a hospital utilization committee or meet alternative requirements to be provided in regulations, and (f) be licensed under the applicable local law.

These specified conditions provide a basic definition of a hospital and embody minimum requirements of safety, sanitation, and quality. As such, they are fully in accord with the established principles and objectives of professional hospital organizations. The requirement that there be by-laws for an organized medical staff--included at the specific suggestion of representatives of the American Hospital Association--is intended to assure that the hospital's staff of physicians be organized in a manner usual in most hospitals and required for accredited hospitals. Such a requirement will encourage the fullest contribution by medical staff to the operation of the hospital and to the quality of medical services by the individual staff members. One of the responsibilities which the health insurance proposal would place upon the medical staff, through the requirement that the hospital have a utilization committee, would be to consider the appropriateness of the utilization of hospital services.

The hospital utilization committee would review the admissions of patients to the hospital, the durations of stay therein and the medical services furnished to the patients. Provision for such a committee, as a self-governing unit of a hospital, has been recommended in many studies of health insurance in the United States. It is better, as is provided under the plan, to take precautions against over-utilization of services through self-screening and evaluation of practices by the professional staff of the hospital than through investigations by outside organizations. The idea of a utilization committee originated with hospitals and has received widespread recognition as a promising technique for encouraging the most efficient use of hospital services. It has been urged upon hospitals by State insurance commissioners, advocated by private study groups in New York and Indiana, and recommended by a State medical society which has actively participated in the formulation of such committees in hospitals within its State.

Conditions for Nursing Homes

To meet the definition of a "skilled nursing facility" an institution (or a distinct part of an institution) must (a) primarily provide skilled nursing care for patients requiring planned medical or nursing care, or rehabilitation services, (b) have medical policies established by a professional group (including

physicians) with a requirement that each patient be under a physician's care, (c) be under a physician's or registered professional nurse's supervision, (d) maintain adequate medical records, (e) provide 24-hour nursing service, (f) operate under a nursing facility utilization plan, and (g) be licensed under applicable local law. Nursing facilities must also meet such conditions essential to health and safety as may be prescribed by the Secretary. Some nursing homes are not engaged primarily in the furnishing of skilled nursing care for patients who require planned medical or nursing care. However, if a nursing or infirmary section were a "distinct" part of such a home and were primarily engaged in providing skilled nursing care, and met the other conditions for participation, this section of the home would be treated as a "skilled nursing facility."

As in the case of hospitals, these conditions describe the essential elements necessary for an institutional setting in which adequate skilled nursing services are provided. Generally institutions which provide skilled nursing services to patients who require continuing planned nursing care would be able to meet these conditions. While many existing nursing homes could not meet these conditions because they generally provide, exclusively or primarily, domiciliary or custodial care and not skilled nursing care, the provisions of the bill would encourage such homes to take the necessary steps to qualify.

Like the hospital utilization committee, a nursing facility utilization plan, required under the Administration's bill, is one which provides for review of need for admission, length of stay, and services furnished. The plan may be developed by the facility itself, or it may be developed through consultation between the facility or a group of such facilities, community agencies and the appropriate State agency. For example, a nursing home affiliated with a hospital might use the hospital's utilization committee to evaluate the nursing home's practices, or it might use a community-based utilization plan developed by a State health department for skilled nursing facilities. The nursing facility utilization plan would have to be approved by the public health authorities of the State in which the facility is located, but the Secretary could provide this approval if the State does not accept the responsibility. This approval procedure is required in the case of nursing homes because usually they do not have professional medical staffs which can take full responsibility for such activities. In many nursing homes full direction of operation is in the hands of the owner-operator who may not be professionally qualified.

The requirement that a nursing facility have a utilization plan would, as in the case of hospitals, help to safeguard against the unnecessary use of covered services. The additional requirement that payment cannot be made for nursing home services unless the patient is transferred from a hospital would, of course, provide an added safeguard.

Conditions for Home Health Agencies

To meet the definition of a home health agency an organization must (a) be a public agency or nonprofit organization exempt from Federal taxation under Section 501 of the Internal Revenue Code of 1954, (b) be primarily engaged in providing skilled nursing or other therapeutic services, (c) have medical policies established by a professional group (including physicians), (d) maintain adequate medical records, and (e) be licensed under applicable local law. As in the case of hospitals and nursing homes, home health agencies would also have to meet any further conditions that the Secretary may find necessary in the interest of the health and safety of the patients.

The conditions for home health agencies are designed primarily to provide assurance that agencies participating in the program are basically suppliers of health services. The plan would cover agencies specifically established to provide a wide range of organized home health services. The provision of services under such agencies is now only in the initial stage of development. The services covered are based on the practices of the pioneer agencies now in existence. These agencies, while few and generally of recent origin, have established excellent records of operation so that it seems appropriate to expect that new providers of these services will adopt the pattern of organization found successful thus far. Home health service agencies which may participate include in addition approximately 1,000 agencies which now provide a more limited range of home health services, which include nursing or therapeutic services. These home health service agencies primarily provide visiting nurse services. More than half of the cities of 25,000 or more population have such care available at the present time.

CONDITIONS FOR PARTICIPATION

Hospital	Skilled nursing facility	Home health agency
1. Is primarily engaged in providing diagnostic and therapeutic services or rehabilitation services, by or under supervision of physicians or surgeons.	1. Is primarily engaged in providing skilled nursing care and related services or rehabilitation services.	1. Is a public agency or a private non-profit organization.
2. Maintains adequate medical records.	2. Has medical policies established by professional personnel including one or more physicians; policy must include requirement that every patient be under care of a physician.	2. Is primarily engaged in providing skilled nursing services or other therapeutic services.
3. Has medical staff by-laws.	3. Is under supervision of a physician or registered professional nurse who is responsible for execution of medical policies.	3. Has medical policies established by professional personnel including one or more physicians.
4. Provides 24-hour nursing services by or under supervision of registered professional nurses.	4. Maintains adequate medical records.	4. Maintains adequate medical records of services rendered.
5. Has a hospital utilization committee or (if such a committee is impractical) meets other requirements prescribed in regulations to accomplish similar purposes.	5. Provides 24-hour nursing services by or under supervision of registered professional nurses or licensed practical nurses.	5. Is licensed (if State or local law provides for licensing) or is a public institution (if licensing law does not apply to a public institution).
6. Is licensed (if State or local law provides for licensing) or is a public institution (if licensing law does not apply to a public institution).	6. Operates under a nursing facility utilization plan.	6. Meets other conditions the Secretary may find necessary in the interest of health and safety.
7. Meets other conditions the Secretary may find necessary in the interest of health and safety.	7. Is licensed (if State or local law provides for licensing) or is a public institution (if licensing law does not apply to a public institution).	7. Is not primarily for the care and treatment of tuberculosis or mentally ill patients.
8. Is not primarily for the care and treatment of tuberculosis or mentally ill patients.	8. Meets other conditions the Secretary may find necessary in the interest of health and safety.	
	9. Is not primarily for the care and treatment of tuberculosis or mentally ill patients.	

PAYMENT TO PROVIDERS

Under the bill, payments to providers of service would be made on the basis of the reasonable cost of services furnished. The bill authorizes the Secretary to develop a method or methods of determining costs and to provide for payment on a per diem, per unit, per capita, or other basis, as most appropriate under the circumstances. In the case of hospital services, the principles for reimbursing hospitals developed by the American Hospital Association provide a basis for determining how costs would be computed. However since the elements of cost are, to some extent, different for different types of providers of health services, a number of alternative methods of computing costs are permitted so that variations in practices may be taken into account. In computing reimbursement on a "reasonable cost" basis, the program would be following practices already well established and accepted by hospitals in their dealings with other Federal programs.

If a person gets services at his own request for which full payment cannot be made because the services are more expensive than those usually offered to other patients, the person would bear the additional cost involved. The purpose of this limitation is to exclude payment for luxury items.

No payment would be made to a Federal hospital, except for emergency services, unless it is providing services to the public generally as a community hospital--a rare situation but its exclusion would be a hardship to beneficiaries in the localities involved. Also, payment would not be made to any provider for services it is obligated to render at public expense under Federal law or contract. The purpose of this exclusion is to provide assurance that Federal hospitals would not be used to furnish care under the program as well as to avoid payment for services which are furnished under other Government programs to veterans, military personnel, etc.

Payment could be made to nonparticipating hospitals for emergency inpatient hospital services if the hospital agrees, with respect to the emergency services for which payment is provided, not to make any charges to the beneficiary for these services.

AGREEMENTS BY PROVIDERS

Any eligible provider may participate in the proposed program if it files an agreement not to charge any beneficiary for covered services and to make adequate provision for refund of erroneous charges. Of course, a provider could bill a beneficiary for the amount of the deductible, and for the portion of the charge for expensive accommodations or services supplied at the patient's request and not paid for under the proposal.

An agreement may be terminated by either the provider of service or the Secretary. The Secretary may terminate an agreement only if the provider (a) does not comply with the provisions of law or the agreement, (b) is no longer eligible to participate, or (c) fails to provide data to determine benefit eligibility or costs of services, or refuses access to records for verification.

A provider may be represented by an agent in negotiations with the Federal Government about the terms of participation. In developing this provision it was contemplated that providers of service might wish to use their associations--for example, Blue Cross or hospital associations--for this purpose.

STATES, PRIVATE ORGANIZATIONS AND HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

The bill provides for considerable participation by professional experts outside the Federal Government in establishing administrative policy and in carrying out some of the administrative steps, where this is appropriate. The bill provides for an Advisory Council consisting of a chairman and 13 members appointed by the Secretary who are not otherwise employees of the Federal Government. The Advisory Council would advise the Secretary on matters of general policy in connection with administration of the plan. To assure representation of the health professions, four or more members of the Advisory Council would be persons outstanding in hospital or other health activities.

The bill also provides for use, by the Secretary, of State agencies to perform the important administrative function of determining which providers of services are eligible to participate in the program and to render consultative services to the providers to assist them in becoming eligible to participate. As indicated previously, the proposal also authorizes providers to use private organizations as agents to represent them in their dealings with the Government. More detailed discussion of the functions that these various State and private organizations would perform is included in a following section of this report.

FEDERAL SOCIAL INSURANCE TRUST FUND

The bill creates a Federal Social Insurance Trust Fund under title II of the Social Security Act, and establishes three accounts in the new trust fund--an OASI account, disability insurance account,

and a health insurance account. Thus, the financing of the social security program would be carried on through one fund with three separate accounts rather than two funds, as now, plus a provision for health insurance. Each account will be credited with its portion of the taxes collected and will be charged with the costs of the benefits payable from the account. Through this modified provision, all the safety involved in separation of the cost and income experience of the three parts of the program would be preserved but at the same time the funds could be invested--all in Government bonds--in combination.

RAILROAD RETIREMENT COORDINATION

Under the bill, beneficiaries of the railroad retirement system would be entitled to the same health insurance benefits as beneficiaries under the old-age and survivors insurance program. At age 65, annuitants and pensioners (and certain dependents of railroad workers who are not beneficiaries under the railroad program but who would be beneficiaries under the OASDI program if the worker's employment had been covered under the OASDI program instead of under the railroad program) would be eligible for health insurance benefits.

The bill provides a slightly different definition of providers of services to whom payment may be made in the case of the railroad retirement provisions from those for old-age and survivors insurance beneficiaries. In the case of old-age and survivors insurance beneficiaries services provided outside the United States would not be covered but for railroad retirement annuitants payments would be permitted for the costs of services furnished in Canadian hospitals. This provision takes into account the fact that some employment in Canada (in connection with railroads that have operations on both sides of the border) is covered under the Railroad Retirement Act. The other difference in railroad retirement cases is that services provided to railroad retirement annuitants by railroad hospitals having an agreement with the Railroad Retirement Board would be covered even though these hospitals might not have an agreement with the Secretary of Health, Education, and Welfare.

The bill prohibits duplication of payments for health services in cases where an eligible individual is covered under both the railroad retirement and OASDI programs; that is, one or the other program would make payment, but not both.

As part of the present coordination of the railroad retirement and OASDI programs, the Railroad Retirement Act provides for cost adjustments to place the social security trust funds in the position they would have been in if railroad employment had been covered under OASDI since 1937. The OASDI system in effect receives from the railroad retirement system the OASDI contributions with respect to railroad services and pays the additional OASDI benefits resulting from such service.

These same financial arrangements would apply to health insurance benefits. The railroad contributions for health insurance benefits would be transferred to the Federal Social Insurance Trust Fund. In some cases, payment of these benefits would be made directly by the OASDI system. In cases where the Railroad Retirement Board made payment of health insurance benefits, there would be a transfer from the Federal Social Insurance Trust Fund to the Railroad Retirement Account equal to the amount of the benefits. However, these arrangements would not apply to health insurance benefits provided in Canadian hospitals. The cost of such benefits would be borne by the Railroad Retirement Account.

THE COST AND FINANCING OF THE PLAN

In order to provide the same assurance as for other elements of the OASDI program that contributions provided for will meet the benefit costs, careful study has been given to estimating the costs of the proposed health insurance benefits.

The kind of extensive operating experience derived from the OASDI portion of the program is, of course, not available in the case of health insurance. Also, it is recognized that there is the possibility of variation in costs of health benefits as medical practices change in the future. The approach taken in estimating the costs of health benefits allows for the possibility of future changes which will result in considerably increased use of hospital and auxiliary facilities above that of the present aged population.

When the Administration bill was introduced in February 1961 the long-term level-premium cost had been estimated at 0.60 percent of payroll. The estimated cost of the program would have been met by the proposed increase in the tax rate of 1/4 of one percent each for employers and employees and by 3/8 of one percent for self-employed persons, effective in 1963, together with the net gain to the system resulting from the proposed increase in the taxable earnings base from $4,800 to $5,000 a year.

Since the introduction of the bill there has been opportunity to do a full re-evaluation of the cost estimates. The original estimates of the short-run costs generally and of the short-run as well as long-run cost of the hospital services for which payment would be made have been confirmed. Previous long-term estimates have been slightly revised as a result of a re-examination. The estimates for nursing home and home health services allow for a substantial increase in the use of these services that would be covered under the bill. A change of this magnitude may not occur but sufficient funds will be available to make payment for increased use of the services, if this change does occur, without further increases in the contribution rate.

Since the major cost of the proposal involves payment for hospital services, generally the revision is not of large magnitude. Furthermore, the upward revisions of nursing home and home health service costs are partially offset by a reduction in hospital utilization as the use of other services increases and by a slight reduction in costs associated with outpatient diagnostic services. The current estimates take into account the enactment of the Social Security Amendments of 1961 which make about 100,000 persons aged 65 and over eligible for benefits in 1962 as a result of the liberalization of the insured status requirements. This change has a slight effect on the short-term estimates, but no change on the long-term estimates because it will not affect significantly the size of the beneficiary rolls over the long run.

Shown below are the original and revised estimates of the level-premium costs on an intermediate cost basis of the various types of benefits (plus administrative expenses):

Type of benefit	Original estimate	Revised estimate
Hospitalization	.56%	.52%
Skilled nursing home	.01	.08
Home health	.01	.05
Outpatient hospital diagnostic	.02	.01
Total	.60	.66

The outgo for benefit payments and accompanying administrative expenses in the first 12 months of operation for each of the four types of benefits, taking into account the actual price and earnings-level situation (rather than the long-range assumptions in these respects), is shown in the following table for the revised cost estimates:

Type of benefit	Amount (millions)	Percent of payroll
Hospitalization	$1,015	.44%
Skilled nursing home	25	.01
Home health	10	.004
Outpatient hospital diagnostic	10	.004
Total	$1,060	.46%

As shown above, with a $5,000 earnings base, the cost of the health benefits is estimated at 0.66 percent of taxable payroll. Of this cost, .10 percent would be met by the net additional revenue to the entire system resulting from the increase in the earnings base from $4,800 to $5,000; the remaining cost of .56 percent would be only partially met by the increase of 0.5 percent in the contribution rate, leaving a deficit of 0.06 percent.

If the earnings base is increased to $5,200, the cost of the health benefits in terms of dollars is unchanged, but in relation to the larger taxable payroll it is decreased--from .66 percent to .65 percent. Of this .65 percent cost, .16 is met by the net additional revenue to the entire system resulting from the increase in the base from $4,800 to $5,200; the remaining cost of .49 percent is met fully by the 1/2 percent contribution rate increase (with .01 percent left over).

The figures below show the estimated progress of the Health Insurance Account by calendar years, according to the intermediate-cost estimate, into the long-range future. The cost of the health insurance proposal under the revised estimates could be fully financed by increasing the earnings base to $5,200, rather than $5,000 as in H.R. 4222, and retaining the same increase in contribution rate as provided for in the bill. It will be noted that even under the financing provisions in the original proposal and under the revised cost estimates the health insurance account would not be exhausted for almost 60 years--until the year 2017.

Estimated progress of Health Insurance Account under H.R. 4222
Revised intermediate cost estimate
(in millions)

Calendar year	Contributions allocated 1/	Benefit payments and administrative expenses	Interest on account 2/	Account at end of year
1962	$ 180	$ 152	--	$ 28
1963	1,150	1,062	$ 2	118
1964	1,365	1,098	8	393
1965	1,395	1,134	17	671
1970	1,548	1,361	61	1,974
1975	1,677	1,557	89	3,102
1980	1,805	1,803	113	3,872
1990	2,096	2,308	117	3,898
2000	2,436	2,640	77	2,515 3/

1/ Based on allocations of 0.60 percent of payroll derived from an increase in contributions of 0.5 percent of payroll and the net additional revenue from an increase in the earnings base to $5,000.

2/ Based on varying interest rate estimated to be earned by OASDI trust funds, ultimately leveling off at 3.02 percent on total assets (3.10 percent on invested assets).

3/ Fund exhausted in year 2017.

A full statement of the assumptions and methods used in estimating the cost of the Administration's proposal is included in "Actuarial Cost Estimates for Health Insurance Bill," Actuarial Study No. 52.

PROPOSED PLAN OF ADMINISTRATION

Basically, the benefits provided by the Administration health insurance proposal are service benefits to be secured by the individual from a provider of his choice and paid for through a third party payment mechanism. The essential pattern for administering such benefits is well established through a variety of third party payment programs--private, nonprofit, and governmental. The procedures that are required flow quite naturally from the basic relationships established--i.e., eligible individuals are provided with identification, qualified providers who wish to participate are identified, an agreed-upon basis of reimbursement is arrived at to cover the cost of services, and records of utilization are kept.

This section describes a proposed plan for carrying out the various functions involved in the health insurance proposal. This plan is, of course, tentative. It could readily accommodate modifications and procedural alternatives, as may be suggested by providers of service and interested groups and associations.

Administration of the health insurance proposal for old-age and survivors insurance beneficiaries would involve:

--assigning, to existing Federal and State organizations, responsibility for managing the program;
--providing information and explanations to providers of service on particulars in the health insurance bill;
--identifying providers of services meeting conditions of participation;
--developing policies and formulas for reimbursing providers;
--formulating systems and procedures for prompt payment of providers' bills;
--operating procedures for identifying beneficiaries and for keeping records of utilization.

MANAGEMENT OF THE HEALTH INSURANCE BENEFITS PROGRAM

Over-All Responsibility

As in the case of other benefits to which persons under the social security system can become entitled, over-all responsibility for administration of the health benefits would rest with the Secretary of Health, Education, and Welfare. Similar responsibility for railroad retirement annuitants rests with the Railroad Retirement Board. Agreements by hospitals and other providers with the Secretary would be made on behalf of both the Secretary and the Board.

An Advisory Council would be established to advise the Secretary on policy matters in connection with administration. The Secretary would also consult with appropriate State agencies, national and State associations of providers of services, and recognized national accrediting bodies. These efforts would be especially oriented to the development of policies, operational procedures and administrative arrangements of mutual satisfaction to all parties interested in the program. This consultation at the local and national level would also provide additional assurance that varying conditions and impacts of local and national significance are taken into account.

There are other programs, not directly related to the administration or financing of the proposed health insurance program for old-age and survivors insurance beneficiaries, in which the Secretary has major responsibilities for providing both financial and technical assistance to States, for example, in the construction and improvement of health facilities. Through coordinated consultative activities with State agencies, the Secretary would be able to exercise leadership in encouraging States to correlate their own activities in relation to providers of services under the health insurance program with activities related to planning for the development of community health facilities and services. This approach would provide an orderly way of seeing that new facilities and services are developed where most needed to assure a progressively more equitable availability of health insurance benefits for all eligible beneficiaries. Accordingly, certain important aspects of medical policy, including those pertinent to the direction and planning of activities carried out by State health agencies, would be handled by the Surgeon General, thus providing a focal point for medical policy and for professional advice in the Public Health Service.

Operating Responsibilities of the Bureau of Old-Age and Survivors Insurance

Within the framework of Social Security Administration responsibility for the health insurance program, administrative responsibility over systems, procedures, and the day-by-day execution of policies relating to beneficiaries and providers of services would be delegated to the Bureau of Old-Age and Survivors Insurance (BOASI). This Bureau has had extensive experience with large-scale claims operations applying to a general insured population and with State-Federal administration on a contractual basis. Additionally, it provides a reservoir of trained manpower and the facilities that can be readily used in and adapted to the needs of the health insurance program.

BOASI can make available for the operations of the health insurance program the facilities and manpower of a nation-wide network of approximately 600 district offices, 3,600 contact stations and a trained field staff of 15,000 claims and administrative personnel engaged in direct service to the public, readily accessible in all population centers. District offices and other Bureau offices are now being linked by a high-speed nation-wide telecommunications network to improve service in processing

old-age, survivors, and disability claims; this network will be fully operational by July 1962. Advance-type electronic computer operations have been installed in the seven BOASI payment centers which service claims on a nation-wide basis, to speed up the processing of claims information and to expedite payments. Thus, in terms of trained personnel, experience, facilities available to the public, automatic data processing equipment, and the high-speed communications network, the BOASI is well prepared to carry out the additional operating responsibilities of the magnitude inherent in the health insurance proposal.

The telecommunications network and the computer operations would be available and utilized fully in the health insurance operations. These facilities can readily be adapted to assure speedy and accurate processing of health insurance actions, issuance of identification cards to beneficiaries to be shown to providers of services as notice of the beneficiary's eligibility to health insurance benefits, and payment of provider bills.

The establishment and maintenance by BOASI of necessary records for the health insurance program offers major advantages. BOASI would keep controls on beneficiary eligibility and on utilization of health insurance benefits, despite interstate movement of beneficiaries--whether the movement results from change of residence, election to secure medical services away from home, or emergency circumstances while visiting or traveling in another State. The mobility of the beneficiary population is significant in that it affects recordkeeping, identification, and service to providers. Also, BOASI beneficiary rolls contain accounts for many beneficiaries who are not yet aged 65, and hence would not be immediately eligible for health insurance benefits; the Bureau's computers would identify these beneficiaries as they attain age 65 and become eligible for health insurance benefits, and would enable the Bureau to notify those beneficiaries promptly of their eligibility.

The operations of the health insurance program would follow the pattern established for title II claims. This decentralized configuration of operations would assure the ready availability and accessibility of Bureau staff to State agencies, to providers and their representatives, and to health insurance beneficiaries. Trained personnel knowledgeable in the health insurance program--like experts in other aspects of OASDI programs--would be available at selected field installations to deal with providers and beneficiaries on a face-to-face basis.

To assure effective administration, the local operations of the health insurance program would be integrated to the fullest extent feasible within the present framework, resources and facilities of BOASI. This would include:

--the taking of claims and the development of evidence to support entitlement to health insurance benefits would be handled in the 584 BOASI district offices as an added function to their regular claim activities under title II of the Social Security Act;
--similarly, the review of these claims and the certification of the claimant's entitlement to health insurance benefits would be handled in the Bureau's present payment centers;
--the establishment and maintenance of the beneficiary's record of entitlement to health insurance benefits and of the status of his entitlement to health benefits during a period of hospitalization (or other use of provider services) would be processed as part of the payment centers' data processing system, utilizing computer facilities;
--the national telecommunications network now being installed for regular Bureau claims operations would accommodate and accelerate the transmission of appropriate traffic relating to the health insurance benefits program.

Participating Roles, States and Private Organizations

Significant participating roles in the program are provided in the bill for State agencies and private organizations. These are over and beyond the consultative roles to the Federal Government, as mentioned above. These organizations would be utilized to the fullest extent consistent with the roles assigned to them by the legislation.

Role of States.--Under the Administration proposal the Secretary is authorized to use State agencies to perform certain administrative functions. The Secretary would expect to exercise this authority fully, and it is believed that all States would be willing and able to assume these responsibilities. State agencies would be used in:

a. determining whether and certifying to the Secretary that a provider meets conditions for participation in the health insurance program; and

b. rendering consultative services to providers to assist them in meeting the conditions for participation, in establishing and maintaining necessary fiscal records and in providing information necessary to derive operating costs so as to determine amounts to be paid for the provider's services.

In varying degrees, States have established standards for the types of providers of service described in the bill. These standards are based on the State's authority to license or supervise health facilities. Under the Administration proposal, licensure under applicable State (or local) law is a prerequisite for participation in the program by a provider of service. Some States, through programs or standards-setting authority that is additional to licensing authority, have established or may plan to make improvements in their standards for medical institutions. Although the proposed Federal program does not govern the question of what services a provider may offer to the general public, it should not, through its conditions of participation, detract from efforts on the part of a State to set higher requirements for health or safety, consistent with local experience and needs. Accordingly, State standard-setting activities are safeguarded by a provision that a State could recommend higher conditions of participation for providers of health insurance benefits within that State than in other States.

State agencies would be reimbursed for the costs of activities they perform in the health insurance benefits program. As in the cooperative arrangements with State agencies in the BOASI disability program, reimbursement to State agencies for health insurance benefits activities would meet the agency's related costs of administrative overhead as well as of staff.

What is contemplated is a Federal-State relationship under which each governmental entity performs those functions for which it is best equipped and most appropriately suited. State governments license health facilities and State public health authorities generally supervise these facilities. In addition, State programs purchase care from providers of health services. On the basis of experience and function, State agencies should assist the Federal Government in determining which providers of health services conform to prescribed conditions. Furthermore, where an institution or organization that has not yet qualified needs consultative services in order to determine what steps may be appropriately taken to permit qualification, such consultative services should be furnished by the State health or other appropriate State agency. Other types of consultative services closely related to conditions of the health benefits program or similarly related to State programs and requirements should logically be provided for or coordinated in the State agency. There may, of course, be situations where a State is unwilling or unable to perform some or all of these certifications and consultative services. In any such situation, the Secretary will have to make other provisions for these activities.

Role of Private Organizations.--Upon enactment of a health program of this type it is expected that organizations of providers would cooperate in facilitating the administration of the program. For example, State and national associations of providers would make known to the Secretary the needs and viewpoints of their members, and would

impart information on the program to their members. Moreover, the Secretary could secure existing data and information from these organizations or contract with them to produce necessary data which would facilitate program operations. For example, it is anticipated that accreditation bodies would provide data that would greatly simplify the identification of qualified providers of services and periodic information that would permit maintenance of up-to-date lists of eligible providers, thus reducing the need for inspection activities by State agencies. Similarly, for purposes of audit and cost analysis, it is expected that nonprofit--mainly Blue Cross--or other organizations regularly in this business, could make available cost information that would avoid duplication of Federal, State, and nongovernmental activity in the collection and analysis of fiscal information from providers.

It is also expected that some providers or groups of providers would elect to use an agent in their dealings with the Secretary. Such an arrangement is authorized in the Administration proposal. If a provider elects to use a private organization, such as a State or national hospital association, or Blue Cross, or similar nonprofit organizations, as its agent, the agent could represent the provider in negotiation of terms of participation. Also, where the agent has high-speed communication links with the providers, the possibility exists and needs to be explored whether the agent would serve as the focal point for transmitting and receiving messages as to a patient's eligibility for and utilization of health insurance benefits. Additionally, to the extent necessary, the agent could assist providers in completing the health insurance form for payment of provider bills. The provider's request for payment would be prepared on a standard health insurance form, tailored to the needs of the program and to the operating practices prevailing generally in participating institutions.

Selection of an agent would not bar the provider from a direct contact with the Secretary, when the provider so desires. Nor would the provider-agent relationship preclude direct contact by the Secretary when necessary for the audit of provider records or for other essential program purposes.

To some extent, the use of agents by providers might increase the total costs of the health insurance program in that they might result in additional operating costs for the provider. However, under some arrangements these added costs could be offset by: a smoother transmission of data between the Secretary and providers, easier communications between providers and the Secretary, accelerated agreements with providers, and adding the least possible administrative and operational burden on the providers of service.

Lead Time to Have Health Insurance Benefits Program Fully Operational

The effective dates in the Administration proposal are designed to provide a lead period of at least one year between enactment of the statute and the first month for which benefits would be payable. This one-year period would be sufficient for the "tooling up" necessary to get the program into effective operation.

"Tooling up" includes the development and implementation of policies and procedures for administering the program; arranging for operational participation of State agencies and private organizations; creation of and discussions with advisory boards; orientation of State and Federal employees in present jobs to new duties generated by the health insurance program; and recruitment, training, and housing of new personnel.

Additionally, this lead period would enable the BOASI to identify and register all persons eligible for benefits under the new program. This would be a two-pronged effort of:

--obtaining claims from all aged persons eligible for health insurance benefits who had not yet filed a claim for old-age and survivors insurance benefits, and
--preparing, recording, and issuing on or shortly before the effective date to each person then entitled to health insurance benefits (estimated at 14,000,000 beneficiaries) an identification card to serve as notice to providers of service of the entitlement of the card-holder.

IDENTIFYING PROVIDERS MEETING CONDITIONS OF PARTICIPATION

To assure a common understanding throughout the country of what hospitals, skilled nursing facilities and home health agencies are, for the purpose of this program, definitions are provided. These are broad in nature and reflect what is the current, generally-accepted understanding of the essential features that characterize each kind of institution.

Conditions of participation by hospitals can readily be met by institutions that fulfill the standards established by accreditation bodies. No special administrative problems are anticipated, therefore, in obtaining agreements by providers of service who are both accredited and licensed. The Secretary would have authority to find that accreditation by a recognized national accreditation body provides reasonable assurance that some or all of the conditions for participation in the program are met, and accreditation could accordingly be accepted as evidence of such qualification.

There are, however, some hospitals that lack accreditation--because of small size or for other reasons. There are also hospitals and nursing homes that may be exempt from licensure or be licensed under circumstances where it is not clear that the standards of licensure provide adequate assurance that the institution qualifies under the defined concepts of the program. Moreover, there is not yet a functioning national accreditation program in the nursing home field, and in many localities such homes may be licensed without meeting the conditions necessary for operation of a skilled nursing facility. For these reasons the program would operate under the general requirement that institutions or organizations wishing to participate must meet such additional conditions (beyond those specified by law) as the Secretary may find necessary in the interest of the health and safety of beneficiaries.

In establishing any such additional conditions the Secretary would be required to consult the Health Insurance Benefits Advisory Council, appropriate State agencies, and recognized national listing or accreditation bodies. Moreover, the Secretary would also be authorized in this regard to specify higher requirements for participation at the request of a State for a given area or a class of institution within the State. This feature of the program would make it possible for the Secretary to cooperate with the programs of national accrediting bodies and State licensing agencies by establishing more specific requirements as, with the passage of time, technical changes or other developments indicate a need in any area or with respect to any class of institutions.

Certifying Eligibility of Providers to Participate

In determining and certifying the eligibility of providers to participate in the program, State health agencies would be utilized and they would be paid for the cost of services they rendered to the Federal program. The Secretary would enter into agreements with appropriate agencies in those States willing to assume the responsibility of applying the conditions for provider participation and to provide the consultative services necessary to assist institutions to qualify. While, from a legal point of view, the Secretary would retain review authority and final decision-making responsibility, he would be authorized by law to accept as conclusive the findings of the contracting State agency.

This inspection and certification workload would be reduced greatly by the accrediting activities of the Joint Commission on Accreditation of Hospitals.

For unaccredited hospitals and nursing homes wishing to participate in the program, the actual amount of inspection in each State would depend upon the extent to which State licensure requirements are already as high as, or higher than, the conditions for participation in the health benefits program, and on the scope and extent of inspections that have been conducted by the State as prerequisites to licensing. In the case of skilled nursing homes other considerations could apply, for example, the extent to which the particular home has affiliation or receives medical supervision from an accredited hospital. Subject to these considerations, each participating State agency would inspect institutions or would certify to the Secretary those that meet the requirements for entering into an agreement to receive reimbursement for services rendered.

There may be some situations in which a provider meets substantially all of the conditions of participation. Depending on the nature and degree of the unsatisfied conditions (but not with respect to conditions specified by the law), the Secretary could authorize a certification valid only for a limited period, for example, one year, within which time the provider would be expected to upgrade services and facilities so as to satisfy completely all the required conditions. Failure to so comply would preclude renewal of the certification.

As part of a continuing operation, contracting State agencies would inspect new providers and nonparticipating institutions as they register a desire to participate. Also, State agencies would re-examine and re-evaluate the status of institutions previously denied certification, at the request of any such institution. Periodically, these contracting State agencies would, as necessary, reinspect and recertify to the Secretary the status of an institution previously certified.

REIMBURSEMENT POLICIES AND FORMULAS

Reimbursement formulas would not be developed until there has been full opportunity for consultation with experts in financial accounting and administration of hospitals, nursing homes and home health care services. In this effort, the Secretary would have the counsel of the Health Insurance Benefits Advisory Council and would also consult with other nationally representative professional organizations. Groups having direct experience with reimbursement practices and formulas include hospital associations, Blue Cross and other prepayment plans, State agencies and other Federal agencies administering similar programs. The Secretary would draw upon this considerable experience in applying standard cost-accounting principles to develop equitable reimbursement formulas.

Providers of services would be paid on the basis of reasonable cost incurred in furnishing health services to old-age and survivors insurance beneficiaries. The formula of payment, based on standard cost-accounting principles, would be established for specific application to particular types of service. The amount and method of

payment to all providers of services should be such as to reimburse them fairly and adequately for the services rendered. Adequate payment is necessary to permit them to maintain essential services, to support good patient care, and to encourage the development of the kind of service required to meet the needs of the community. The "reasonable cost" basis of reimbursement contemplates that the providers of services would be reimbursed the full cost incurred by them in providing quality care. On the other hand, "reasonable cost" would not require reimbursement for luxury services or for costs unreasonably out of line on account of factors unrelated to hospital care.

The reimbursement formula for inpatient hospital services could be expected to follow the general principles that have been formulated and published by the American Hospital Association in the Association's manual, "Principles of Payment for Hospital Care." Under this approach, reasonable variations of per diem costs will exist as between hospitals in the same city, between various sections of the country, and for providers offering various levels of service.

After the formulas have been developed and approved, a standard form (with implementing instructions) would be made available to each qualified provider of services wishing to participate in the program. For hospitals, for example, one possibility is that the form and procedure could be patterned, with appropriate modifications, after the governmental Joint Hospital Form 1 (Hospital Statement of Reimbursable Cost). This form is used by Children's Bureau, Office of Vocational Rehabilitation, Division of Indian Health (PHS), and the Veterans Administration in purchasing hospital care. Larger hospitals should not have any difficulty in executing such a form since practically all have had experience in completing Joint Hospital Form 1. Smaller hospitals would not necessarily be experienced with this form, but hospitals in many areas are familiar with this type of reimbursement pattern through Blue Cross and State program requirements. For outpatient diagnostic services, more information, or a different approach, may be required than is currently reflected by the principles of Joint Hospital Form 1.

For skilled nursing home facilities and home health agencies, separate procedures would be devised, perhaps quite different from those developed for hospitals. Experience in applying reimbursable cost formulas to nursing homes in general is rather limited. As a result, greater difficulty can be expected both in the formulation of reimbursement formulas and in the application of reimbursement principles to these homes than to hospitals. Quite extensive audit operations or consultative services on accounting and cost records may be needed for some nursing homes. This difficulty might be

offset by the availability of a longer lead time as proposed in the bill for nursing homes, i.e., nine months after the effective date for hospital benefits. However, the well organized nursing homes with established cost accounting systems (e.g., the larger nonprofit or the hospital-based nursing homes which more generally provide the kind of skilled nursing services encompassed in the bill) should not have difficulty in developing and furnishing cost data. Likewise, organized home health agencies, whether they be public agencies or private nonprofit organizations, should be able to furnish necessary cost data.

AGREEMENTS BY QUALIFIED PROVIDERS

As soon as possible in the lead period--i.e., the time between enactment and effective date--arrangements would be made for the distribution through private as well as governmental channels of the detailed information that hospitals and other providers would need to have. By utilizing the services of agents of providers, and the cooperative efforts of provider associations (e.g., American Hospital Association, local hospital councils), the initial contacts would be facilitated. Providers could also obtain assistance and information from participating State agencies.

The lead period in the bill should be adequate to permit timely consummation of agreements with qualified providers of services that want to participate in the program. The signing of agreements by providers is expected to be accelerated to the extent that groups of providers have previously arranged for a hospital association or other agent to represent them in establishing the terms for participation.

The agreements to be signed by the qualified provider and filed with the Secretary would indicate that in participating in the program, the provider will not charge any individual for services covered under the program and will make adequate provision for the refund of charges incorrectly collected from such individual. This agreement would permit the provider to bill a beneficiary for the amount of the deductible, and for the applicable part of the charge for expensive accommodations supplied at the beneficiary's request and not payable under the program.

ADMINISTRATIVE AND OPERATING PROCEDURES

Identification of Individuals Entitled to Health Insurance Benefits

Each person entitled to health insurance benefits would be issued an identification card by BOASI. Persons entitled under the Railroad Retirement Act would be issued their cards by the Railroad Retirement Board. These cards would be presented to hospitals and

other providers of services as evidence that the individual is entitled to health insurance benefits, just as hospitals now accept Blue Cross and other prepayment plan identification cards.

To identify eligible persons already on the benefit rolls, BOASI would screen, by electronic computer, the records of all of its beneficiaries to locate those meeting the age requirements. Each beneficiary would receive his identification card and informational literature before the effective date of the program. No action would need to be taken by these beneficiaries to establish entitlement to health insurance benefits and they would be so informed.

Beneficiaries who first file claims after the program's effective date would receive their identification card from the BOASI payment center simultaneously with their notification that their claim for benefits has been approved. Positive steps would be undertaken during the lead period to reach all eligible individuals who have not filed applications to establish their entitlement to old-age and survivors insurance benefits. These would number about 13 percent of the total number of persons eligible for protection under the health insurance proposal. BOASI offices would be staffed to accommodate this additional workload and to process these claims expeditiously so that each claimant's entitlement to health benefits could be established before he might need to use the benefits of the program. On a continuing basis after the effective date for benefits, BOASI would use its electronic computers to identify those OASDI beneficiaries under age 65, as they attain age 65, so as to issue cards promptly to this group also.

Establishing and Maintaining Beneficiary Records

In addition to establishing an initial record for each person entitled to health insurance benefits who has received his identification card, all data affecting status and utilization would be maintained by BOASI on a current basis. Any event affecting the beneficiary's continued right to benefits or change of address processed in regular computer updating operations for old-age and survivors insurance purposes would automatically also be used to update the health insurance benefit record.

When requests for verification of eligibility were received from a hospital or other providers of services, the current status could automatically be certified from a magnetic tape record. At the same time, the record would be updated to show the date of admission, hospital code, and other required identification or status information. Thereafter, when the provider's bill was subsequently processed for payment, the necessary utilization information would also be recorded on magnetic tape. That tape would then be used to update the master health insurance record, from which it would always be possible to tell promptly the status of an individual's account.

The maintenance and updating of utilization data on BOASI electronic equipment would make it possible to obtain by-product information for a variety of important statistical and administrative purposes.

The records would reflect not only health service utilization but also other data offering valuable information for analysis of program operations as well as for more general health studies by the Public Health Service, State agencies, and professional organizations.

Admission Procedures for Providers of Services

Methods could be worked out to the satisfaction of hospitals and other providers for notifying them of a patient's entitlement to health insurance benefits. Such procedures could closely parallel current Blue Cross and commercial insurance practices.

BOASI would explore the feasibility of supplying to each beneficiary, following each use of services, a statement of the service for which the program has made payment. If this system is adopted, then when a beneficiary requests health services from a hospital, skilled nursing home, or home health agency, he would present to the provider his identification card and the BOASI notice of prior services received. Otherwise, the identification card in itself would serve as notice of the beneficiary's eligibility. The provider of service would use the information from these documents and from the questions routinely asked during the admission interviews to complete a request that payment be made to the provider for the health services. The patient would sign a portion of the form unless, of course, he is incapable of doing so, and the provider would retain the form until it is time to submit a bill.

Upon admission to a hospital as an inpatient, a recommended procedure would be for the hospital to request BOASI to certify the inpatient's eligibility for payment for service. This request would be handled through the BOASI local district office and transmitted to the appropriate Bureau records office via the BOASI nationwide telecommunications network which will link all district offices with records centers. The reply, as previously noted, would be generated in a computer process and delivered promptly through the telecommunications network to the hospital. This BOASI certification would cover the number of days of care for which payment may be made as well as the amount of deductibles already paid in the benefit period. Where groups of hospitals and a Blue Cross organization wished to explore the possibilities,

it might be advantageous to them and to the Government, to link a local Blue Cross wire network into the BOASI telecommunications system. Several large Blue Cross plans have already installed, or have plans to install, wire communications between member hospitals and the Blue Cross offices. By tying in the Blue Cross office to the BOASI network, a hospital request for certification of a beneficiary's health insurance entitlement could be electronically handled from initiation of the request to receipt of the certification at the hospital.

In the case of outpatient diagnostic services, the hospital could generally rely on the beneficiary's identification card as evidence of entitlement without requesting certification of entitlement from BOASI. This difference in procedure between inpatient and outpatient cases would seem to be warranted by these considerations arising from the provisions of the proposed program:

--the diagnostic study would usually be completed before a certification could be transmitted to the hospital;
--there is no statutory limitation on the number of diagnostic studies;
--the cost per outpatient diagnostic study, especially with a $20 deductible, is comparatively small in contrast to inpatient costs;
--the deductible amount is fixed, being pegged to each study, rather than to a specified number of days, as in inpatient cases; and
--entitlement would be affected only by an event that terminated the individual's entitlement to monthly benefits under title II, such as divorce, or remarriage of widow to a nonbeneficiary, both rare occurrences for people over age 65.

Since transfer from a hospital to a skilled nursing home is a condition of skilled nursing home service benefits, the home would often know in advance when a patient is to be admitted. While these transfer arrangements are being made, the home could ask BOASI for information on the patient's eligibility and the number of days of skilled nursing home care available to the beneficiary. This request from the home would, as for hospital inpatient admissions, be handled through the BOASI local office, transmitted to the appropriate BOASI records office via the BOASI telecommunications network and the reply from BOASI would be transmitted promptly to the nursing home.

A home health agency could accept the beneficiary's health insurance benefits identification card as evidence of his entitlement to home health services. The agency could then obtain through the BOASI local office, a current record of the number of home health visits for which payment could be made in the current year.

Payment of Provider Bills

On the basis of consultation with representatives of hospitals and other interested parties, methods could readily be established for presentation, review and payment of provider bills, patterned on similar practices and procedures now followed by hospitals and prepayment plans. Procedures would assure prompt payment of bills and the least possible burden of paperwork on the provider.

Upon discharge of an eligible patient, or, at appropriate times in conjunction with its normal billing cycle, providers participating in the program, or their agents, would submit bills to the appropriate office for review and payment. After review to assure that the supporting documentation is complete and that there are no inconsistencies in the bills which need to be reconciled before payment can be made, the payment office would apply the appropriate reimbursement formula and deductible provisions to compute the amount due to the particular provider, and authorize the Treasury Disbursing Office to issue a check. If feasible, notice of payment of the bill, including a summary statement of the current status of his health benefits record, would be sent to the beneficiary; he would be asked to present this notice together with his identification card to a provider if he again required additional health services.

In an emergency admission to a nonparticipating hospital, the hospital would submit a bill, evidence of the emergency, and documentation establishing the identity and entitlement of the patient. Since generally no cost data would have been collected for nonparticipating hospitals, this bill which would be required to be on a cost basis would have to be examined and reviewed for general conformance to the level of reimbursement to similar hospitals in the same locality. In some instances, cost data used by Blue Cross or by a State program may be available for comparison purposes. Where the amount billed is beyond a reasonable tolerance limit, the nonparticipating hospital could be requested to supply sufficient information to support a finding that the amount billed is the reasonable cost for the services rendered.

Audit of Provider Records

At the time of agreement and periodically thereafter, accounting data would be obtained from providers in sufficient detail to permit a computation of average cost per unit--patient day, or other unit as required under the applicable reimbursement formula. Reimbursement on a cost basis requires assurance of

proper audits of the records of hospitals and other providers. Such audits would assure equity to both the purchaser of care and the providers of service and in general would contribute to sound management of the program. Audit data would also be used to determine the need for adjustment of reimbursement formulas and rates and would contribute to appraisal of reimbursement policies and procedures.

Many hospitals have their books audited annually by independent accounting firms. To a much lesser degree this auditing practice may be followed by some other types of providers. In some cases, audits of the records of providers of health services are being performed by nonprofit organizations (such as the Hospital Cost Analysis Service, Inc., in Maryland) and by State agencies.

Where independent auditing staffs perform an effective audit or cost analysis of provider records, the Secretary could contract to use the results in connection with the health benefits program. For providers having inadequate accounting systems or lacking outside audits, the Federal program would make arrangements to have audits performed.

Review and Reconsideration of Unfavorable Decisions

Applicants for health benefit services would be entitled to appeal unfavorable determinations in the same manner as now provided under the OASDI program. The applicant could, if found not entitled to benefits, obtain reconsideration by BOASI, hearing and appeal by the Office of Hearings and Appeals, and Federal court review. Beneficiary complaints concerning the content or quality of service, however, would not be subject to such review, but would be directed to the appropriate State agency, medical and hospital groups for their attention.

The procedures for resolving beneficiary appeals are statutorily provided for, as a concomitant to the beneficiary's statutory right to benefits. The rights of a provider under the program would be of an entirely different nature, and the procedures provided for beneficiaries would not be appropriate for providers. Instead, provisions for administrative review and resolution of provider complaints would be established.

Safeguards Against Overutilization of Services

Utilization of hospital and other health benefits would be safeguarded by the admission procedures of the providers of services, by the self-governing utilization mechanisms established by hospitals (and in the case of nursing homes, established by or for a nursing home and approved by public health authorities of the State) and by the opportunities afforded to State agencies and professional organizations for analysis and study of by-product statistical data reflecting utilization practices.

With respect to each kind of health services provided, arrangements could be made for certification by a physician that the service was required for defined reasons of medical treatment. The primary assurance of proper utilization, therefore, rests with the admitting physician as it does generally in other cases where third-party payment is involved in meeting the costs of a medical service. A great deal of reliance would be placed upon effective utilization reviews by appropriate utilization review groups which are essentially self-governing. In addition to the review of cases from the standpoint of admission, duration of stays and services furnished, there would become available with the passage of time statistical utilization data which could be made available to these utilization committees. Under the proposed legislation, the utilization committees would not be required to review all cases or to submit reports of individual cases to either the State agencies or to the Federal Government but they rather would be expected to have such organization and to maintain such evidence of self-review of the services they provide as to give assurance that determinations have been made by them with respect to the need for the services rendered by the institution. In the case of inpatient hospital services and skilled nursing home services involving extended stays there would be a further requirement that a determination has been made by the appropriate utilization mechanism that there is or was a need for such utilization in excess of a 30-day period.

While the proposed legislation does not specify what a "nursing facility utilization plan" shall encompass, recommended specifications would be provided after consultation with State agencies, appropriate advisory boards and representative associations of these providers. The broad definition in the bill includes the requirement that the plan be approved by the public health authorities of the State in which the facility is located, thus making it possible for States to establish plans based on community-wide professional consultation and in coordination with local health authorities.

Coordination with Railroad Retirement Board

The bill covers railroad retirement beneficiaries as well as old-age and survivors insurance beneficiaries. It provides that agreements by the providers of services or their agents will be entered into also on behalf of the Railroad Retirement Board. Coverage for railroad beneficiaries would include services secured in railroad hospitals which, otherwise, may not be participating under the program, and services in Canadian

hospitals, which for old-age and survivors insurance beneficiaries are excluded from the program. In the case of individuals who may be entitled to monthly benefits under both programs the limitations on number of days, units of care and the deductible provisions would be applied as if the individuals were covered under a single program.

The administration of present law requires close coordination between the Railroad Retirement Board and the BOASI in recordkeeping and claims processes. There has been continuing and extensive experience between these agencies in the kinds of coordination that would be required under a health benefits program. Where individuals are entitled under both programs, agreement would be reached on which organization will issue the identification card. Railroad hospitals and Canadian hospitals would send their requests for verification of eligibility direct to the Railroad Retirement Board. Hospitals in the United States, other than railroad hospitals which do not have an agreement with the Secretary, would accept either card and a common procedure would be established for requesting verification of eligibility. The Railroad Retirement Board could be linked with the BOASI wire communications system. Bills could be paid under uniform policies and procedures, and the trust funds of the two programs could be adjusted periodically through the financial interchange provisions of the Railroad Retirement Act.

APPENDIX

MEDICAL ASSISTANCE FOR THE AGED
Selected Characteristics of State Plans

Plans in effect prior to July 1, 1961:

Kentucky
Maryland
Massachusetts
Michigan
New York
Oklahoma
Puerto Rico
Virgin Islands
Washington
West Virginia

Plans (for which information is available) as proposed to go into effect before end of 1961:

Arkansas
Idaho
North Dakota
Oregon
South Carolina
Tennessee
Utah

Medical assistance for the aged: selected characteristics

Effective: January 1, 1961
(Revisions effective June 1, 1961)

Department of Economic Security

I. Financial eligibility

A. Income: Maximum annual gross income for single person, $1,200; for applicant and spouse, $1,800. (Special procedure for determining income from self-employment or farming operations.)

B. Assets:
1. Real property - homestead is exempt. Nonincome-producing real property other than the home is limited to $5,000. Real property which is producing income is taken into consideration from the standpoint of income derived.

2. Personal property - (defined as "cash on hand, money in the bank, stocks, bonds, and other resources that can be converted into liquid assets", excluding cash surrender value of life insurance) limited to $750 for single person, $1,000 for applicant and spouse. Cash surrender value of life insurance is limited to $3,000. Excluded from consideration as personal property is tangible personal property not listed above.

   Availability of health insurance is to be determined.

C. Financial eligibility: Exists for a 12-month period, subject to reinvestigation. Person is issued an identification card, which is to be reissued periodically.

II. Medical care provided

A. Institutional:

Hospitalization - for "acute, emergency, and life-endangering illness, ... requiring admission to the hospital;" available in hospitals licensed under the laws of the State which elect to participate in the plan, signifying such election by a written agreement. Limited to 6 days.

B. Noninstitutional:

1. Physicians' services - home and office calls limited to 2 visits per month per patient. ($3 office; $5 home.)

2. Dental services - for relief of pain and treatment of acute infections - up to a maximum of $16 per recipient per calendar month and limited to $48 per recipient per annum.

3. Drugs - according to established list and fee schedules.

Medical assistance for the aged: selected characteristics

Effective: June 1, 1961

Department of Public Welfare

I. Financial eligibility

A. Income: Regular income not to exceed
1. in 6 larger counties - single person, $1,140; applicant with 1 dependent, $1,560;
2. in 18 other counties - single person, $1,080; applicant with 1 dependent, $1,500. Income scale rises with number of persons dependent upon applicant. Income includes that of spouse living with applicant and of any other person claimed as a dependent. Scale for value of income-in-kind is provided.

B. Assets:
1. Real property - home is exempt; real property other than the home is included with the other resources convertible to cash.

2. Personal property - resources convertible to cash (savings, insurance, real property other than the home, etc.) may not exceed (1) $300 if it is in addition to the regular monthly income or (2) $2,500 cash value if it "represents the only resource for regular living expenses."

A person is ineligible who has any insurance or other benefit, the terms of which provide for payment for the medical care items included in the plan.

C. Financial eligibility: Determined on the basis of the certificate of the Department of Public Welfare, the Health Department issues a medical care card valid for one year. Reinvestigation and recertification are then made.

II. Medical care provided

A. Institutional:

Hospitalization - general hospital care.

B. Noninstitutional:

1. Physicians' services - in home, office, or clinic.

2. Special medical care clinics

3. Laboratory services

4. X-rays

5. Minor surgery - in private office facility or accident room.

6. Drugs and limited medical supplies - when prescribed by a physician.

7. Restorative dental care

8. Prescribed eyeglasses - for patients who have had a cataract operation.

Medical assistance for the aged:
selected characteristics

Effective: October 1, 1960

Department of Public Welfare

I. Financial eligibility

Group One: "For persons in licensed nursing homes, licensed chronic hospitals, and public medical institutions...or persons needing such care", with defined exceptions.

A. Income:

1. For persons having need of a place of residence apart from a licensed chronic hospital, nursing home, etc., there shall be excluded from consideration--
   a. $150 a month if unmarried, or if married and the applicant is the husband;
   b. $225 a month combined income of husband and wife, if married and the applicant is the wife.

   All other income is taken into consideration in determining need for medical assistance for the aged.

2. For person having no need of a place of residence apart from a licensed chronic hospital, nursing home, etc., the amount of income and resources...shall be determined by rule and regulation of the Department. The first $15 of any monthly income shall be retained by the recipient for personal needs.

B. Assets:

1. Real property - real estate used as a home does not disqualify; ownership of any interest in other real estate disqualifies.

2. Personal property - (includes bank deposits, securities, cash on hand, and similar assets; excludes cash surrender value of insurance) maximums are:

-continued-

II. Medical care provided

A. Institutional:

1. Hospitalization - in-patient hospital services.
2. Skilled nursing home services

B. Noninstitutional:

1. Physicians' services
2. Outpatient hospital or clinic services
3. Home health care services
4. Private duty nursing services
5. Physical therapy and related services
6. Dental services
7. Laboratory and X-ray services
8. Prescribed drugs
9. Eyeglasses, dentures, and prosthetic devices - as prescribed.
10. Diagnostic screening and preventive services
11. Any other medical or remedial care recognized under the law of the Commonwealth and in accordance with the Department medical plan

I. Financial eligibility	
a. $2,000 if person is unmarried, or is married and applicant is the husband; b. $3,000 if married and the applicant is the wife, includes the combined ownership of husband and wife. Group Two: The eligibility of other persons "whose income and resources are insufficient to meet the costs, of necessary medical services" shall be determined by the rules and regulations of the Department of Public Welfare.	

Medical assistance for the aged: selected characteristics

Effective: October 1, 1960

Department of Social Welfare

I. Financial eligibility

A. Income: Maximum annual income for single person (unmarried or not living with spouse) is $1,500; if married and living with spouse, not more than $2,000, including the annual income of the spouse. "Income" must include contributions which son, daughter, or estranged spouse should be making to applicant, according to agency standards or court determination, except that such contributions are not included in computing income during first 30 days of each separate period recipient is hospitalized.

B. Assets:

1. Real property - value of property used as a home is excluded. Value of other real property must be included in limits on marketable assets specified below.

2. Personal property, i.e., "liquid or marketable assets" - may be held with value of not more than $1,500 for single person, $2,000 for married applicant and spouse. Excluded in making this determination are: clothing and household effects; cash surrender value (not value of matured policies) of life insurance; and not to exceed $1,000 of fair market value of personal property used in earning income. All other property, real and personal, must be evaluated in determining eligibility under the $1,500 or $2,000 limitation specified.

II. Medical care provided

A. Institutional:

Hospitalization - inpatient care not to exceed services furnished under Blue Cross (M-75) as of September 1, 1960.

B. Noninstitutional:

Physicians' services - not to exceed those services furnished by Michigan Medical Service under Blue Shield plan as of September 1, 1960; may be in office, medical care facility, or in outpatient clinic of approved hospital (no home calls); limited to emergency treatment and specified tests.

Medical assistance for the aged:
selected characteristics

Effective: April 1, 1961

Department of Social Welfare

I. Financial eligibility

All income and resources shall be deemed available to meet costs of medical care except as indicated below:

A. Income:

1. In medical or nursing institutions for chronic care - up to $10 a month for personal care items; annual premiums for health insurance policy up to $150 for single recipient or $250 for married recipient if policy covers spouse; if married, up to $1800 a year for support of spouse, including any income of spouse.
2. Not in facility for chronic care - $1800 for single applicant; $2600 for married applicant living with spouse; health insurance policy premiums up to $150 per year for single recipient or $250 if married and policy includes spouse. (See reserves, below.)

B. Assets:

1. Real property - home is exempt; other real property not used as home must be utilized to apply to costs of care.
2. Personal property - clothing and household effects are exempt; may have life insurance with cash surrender value of not more than $500 for single person or for couple. Insurance in excess of this amount and nonessential personal property must be utilized.
3. Cash reserve for person not living in a medical facility may be permitted up to $900 for single person or $1300 for married couple. If value of non-home real estate, nonessential personal property, and excess insurance together with cash or liquid assets does not exceed this reserve limit, such resources need not be utilized to be applied to costs of care.

II. Medical care provided

A. Institutional:

1. Hospitalization - inpatient services.
2. Nursing home services

B. Noninstitutional: (not as extensive as provided for OAA)

1. Physicians' services - M.D. and doctors of osteopathy only; services of dentists, podiatrists, and optometrists are not included in the MAA program.
2. Nursing services
3. Outpatient hospital or clinical services
4. Drugs
5. Home health care
6. Prosthetic appliances
7. Physical therapy

Medical assistance for the aged: selected characteristics

Effective: October 1, 1960

Department of Public Welfare

I. Financial eligibility

A. Income: (as amended April 18, 1961) Maximum for single person, $1,500 annual income; for man and wife, $2,000 annual income.

B. Assets:

1. Real property - may have equity of $8,000 in home owned and occupied as home; equity above this amount is considered among "other resources". Home not occupied as such, or to which recipient or spouse has no feasible plans to return is no longer "considered an exemption".

2. Personal property -

   a. Insurance -- single person, cash value of first $1,000 face value; married, cash value of first $2,000 face value; married, living together and have separate policies, cash value of first $1,000 face value for each.

   b. Equity in tools with which he earns a living, up to $1,500.

   c. Equity in small business which he operates, up to $2,500, including building, ground, equipment, and invoice of stock.

   d. "Other resources" (cash, stocks, bonds, notes, mortgages, automobiles, excess of value of items listed in (a) and (b) above, excess equity of home, or property of any kind which can be made available for the use of recipient or spouse) limited to $700 for single person, $1,000 for married couple.

II. Medical care provided

A. Institutional:

1. Hospitalization - general hospital care for life-endangering or sight-endangering conditions as determined by the attending physician; not to exceed 21 days per single admission; provision for readmission for defined conditions within 10 days after date of discharge.

2. Nursing care in nursing home - up to 6 months in a 12-month period.

B. Noninstitutional:

1. Physicians' services - in home of patient approved for nursing care in own home; 2 visits per month.

2. Nursing care - in own home for "bedfast or chair fast patients...".

3. Diagnostic services - to determine need of nursing care and physician's services in patient's home.

4. Outpatient therapeutic radiology - prescribed while patient was in the hospital.

5. Ambulance - under defined conditions.

6. Blood banks - use of under specified limitations.

7. Services of dentists or oral surgeons - "for services performed in a licensed general hospital when a patient is admitted for life-endangering conditions involving fractures, infections, or tumors of the mouth."

Medical assistance for the aged: selected characteristics

Effective: October 1, 1960

Division of Public Welfare
Department of Health

I. Financial eligibility

A. Income: Individual annual income and available resources may not exceed maximum of $1,500.

B. Assets: (as amended April 5, 1961)

1. Real property - home where applicant resides is excluded from consideration. Value of other real property is taken into account.

2. Personal property - loan value of life insurance and any other available resources will be taken into account.

An applicant's "membership in such organizations as Blue Cross, Blue Shield, ... State retirement or compensation systems, purchase of health insurance of any appropriate type, his right to veterans' benefits, etc., shall make him ineligible for participation in this plan."

C. Financial eligibility: Certified to by the Division of Public Welfare upon evaluation of the applicant's statement concerning his "annual income and available resources and his status with regard to health insurance or membership in organizations which provide medical care or the payment thereof." Certification is for period of 1 year, subject to renewal on the basis of a new statement from the applicant. Identification card good for 1 year is issued.

II. Medical care provided

Care and services are provided through the Commonwealth and Municipal Government systems of medical care and hospital facilities, several private nonprofit medical institutions under contract. The content of medical care is the same as for old-age assistance.

A. Institutional:

1. Hospitalization - total hospital care, including physician's services and drugs and appliances as prescribed.

2. Nursing home services - where available.

B. Noninstitutional:

1. Outpatient hospital and dispensary services - including physician's and ancillary services, prescribed drugs and appliances.

2. Physical therapy and related services, dental care, laboratory and X-ray services, and preventive medical care services.

3. Diagnosis and treatment of tuberculosis and psychosis in medical institutions - with Federal matching claimed for 42 days after such diagnosis.

Medical assistance for the aged: selected characteristics

Effective: January 1, 1961

Insular Department of Social Welfare

I. Financial eligibility

A. Income: Current continuing gross income of $1,200 a year or less for individual; twice this amount for married couple living together.

B. Assets:

1. Real property - property owned and occupied as a home not considered.

2. Personal property - liquid assets which can be easily convertible are limited to not more than $1,200; including savings, government bonds, health insurance, government entitlement such as Veterans Medical Services, etc.

C. Financial eligibility: Determined by the Department of Social Welfare which certifies to the Department of Health that applicant is eligible for medical care. Applicant receives identification card which remains in effect as long as he is eligible, subject to annual or earlier reinvestigation.

II. Medical care provided

Medical care must be prescribed by a physician or dentist of the Department of Health. All care except home visits of physician will be given at facilities of the Department of Health.

A. Institutional:

Hospitalization - inpatient hospital care, surgical and laboratory services, private duty nursing when prescribed as "critically necessary".

B. Noninstitutional:

1. Home care - including home visits by private physicians.

2. Drugs

3. Prosthetic appliances - except glasses.

Medical assistance for the aged: selected characteristics

Effective: October 1, 1960

Department of Public Assistance

I. Financial eligibility

A. Income (of applicant and spouse): sufficient to meet maintenance requirements of applicant and his legal dependents but not sufficient to meet his medical expenses, wholly or in part. Such requirements are determined by old-age assistance standards (maximum on money payment per case, $275 a month, unless exception is made) and by considering certain pressing obligations of applicant and his legal dependents.

B. Assets:

1. Real property - home used by the applicant or his legal dependents, together with a reasonable amount of property surrounding and contiguous thereto is exempt from consideration as an available asset.

2. Personal property - all other resources and liquid assets (with exceptions listed below), including any combination, are considered to determine the extent to which they may be utilized for planning for payment of required medical care. Medical insurance in force and effect at the time of application and any potential compensation for injury must be utilized to the fullest extent.

   Exempt from consideration as personal property are: household furnishings and personal clothing, cash surrender value of life insurance not to exceed $500, one automobile owned by applicant or spouse "which is used and useful", and personal property "which is used and useful or...has great sentimental value."

II. Medical care provided

All medical care is limited to conditions currently endangering life or a medical condition which, if not immediately treated, would necessitate extended hospitalization and/or surgery. In specified emergencies exceptions to these limitations are permitted. The following services may be given, when authorized, by vendors participating in the program:

A. Institutional:

1. Hospitalization and related medical services - all needed while so hospitalized. Outpatient clinic care available at county hospitals or at others if "emergency presently endangering life."

2. Nursing home care

B. Noninstitutional:

1. Physicians' services - in home or office, for conditions such as heart, diabetes, and others which are subject to the general limitation given above.

2. Dental care - for relief of pain only.

3. Drugs and pharmaceutical supplies - subject to general limitation given above.

4. Ambulance - if other transportation cannot be used without hardship to the patient.

Medical assistance for the aged: selected characteristics

Effective: October 1, 1960

Department of Public Assistance

I. Financial eligibility

A. Income: For single individual, $1,500 or less per year; person married and living with spouse, combined income of both is $3,000 or less. Income includes contributions received from relatives.

B. Assets: (as amended January 30, 1961)

1. Real property - homestead or property on which applicant resides and other real property is excluded from liquid or marketable assets.

2. Personal property - or other liquid or marketable assets limited to value of $5,000 for single person or $7,500 for combined assets of husband and wife. Excluded are clothing, jewelry, and household effects; livestock, farm machinery, and other vehicles; and cash surrender value of life insurance (limit to be set).

   Membership in insurance plan and eligibility for payment of medical services from other agencies and organizations such as Veterans' Administration, Workmen's Compensation, United Mine Workers of America must be taken into account in determining whether MAA will assume all or part of the cost of medical services needed or received.

C. Financial eligibility: May be determined at a point before applicant needs medical services; continues in effect for maximum period of 1 year, subject to reinvestigation.

II. Medical care provided

Includes all the medical services available to recipients of old-age assistance as of October 5, 1960, including payment for drugs for specified chronic illnesses (such as diabetes, heart conditions, terminal cancer).

A. Institutional:

1. Hospitalization - for acute illnesses, immediate surgery, and diagnostic services; may be more extensive if medical service for other conditions will increase person's capacity for self-care or self-support. Limited to 30 days annually.

2. Nursing home care - after hospitalization or if such care would prevent need for hospital care; limited to acute conditions and must be prescribed by physician as part of the treatment for that condition.

B. Noninstitutional:

1. Physicians' services - for acute illnesses.

2. Drugs - for acute illnesses and specified chronic illnesses.

3. Ambulance services

4. Dental services - for emergency extractions and treatment.

Plans (for which information is available) as proposed to go into effect before end of 1961

Proposed plan for medical assistance for the aged: selected characteristics

To be effective July 1, 1961 — Not yet approved

I. Financial eligibility

A. Income: Cash income for single person, $1,200; for family $1,500.

B. Assets:

Real property - may have home or an equity in home not to exceed $7,500. Value of other real property must come under the maximum on all resources. All other real and personal property other than the home and household furnishings, may not exceed $2,500, including value of nonhome real estate, livestock, motor vehicle, tools, equipment, and cash surrender value of life insurance.

In addition to these, the applicant may hold as a cash reserve up to $300 for himself and an additional $300 for dependents; with a family maximum of $600.

II. Medical care to be provided

The same services are to be available to persons receiving MAA as for persons eligible for medical care under the other categories.

A. Institutional:

1. Hospitalization - including laboratory and full range of services and supplies considered to be necessary for hospital treatment limited to 30 days per year except for specified types of cases requiring longer hospital care.

2. Nursing home care - including physicians' services, 2 per month per patient, and prescribed drugs up to $5 per month per patient.

B. Noninstitutional:

1. Outpatient clinic services - including drugs and appliances prescribed by physicians giving the service; generally not to exceed 2 visits per month with certain exceptions.

2. Remedial eye care services - in office or in hospital.

3. Dental care

4. Transportation to receive medical care and domicilary care - for patients requiring such care - while receiving outpatient care and treatment at an approved clinic.

Medical assistance for the aged: selected characteristics

Effective: July 1, 1961 — Not yet approved

I. Financial eligibility

A. Income: From the applicant's figures, his ordinary expenses and obligations, including contractual payments, are deducted from available cash income; any excess is applied to the cost of needed medical care, plus each month, 1/12 of any savings and cash resources above the amount of $2,000 and less than $10,000.

B. Assets:

1. Real property - home property is exempt from consideration as a resource.

2. Personal property - a "popular priced" car, personal possessions, and cash value of life insurance not to exceed $1,000.

All other savings and cash assets may not exceed $10,000; with a designated proportion of any such assets in excess of $2,000 being considered available for application to the cost of needed medical care.

II. Medical care provided

A. Institutional:

1. Hospitalization - limited to 14 days for each admission for acute medical conditions, acute complications of chronic diseases, nonelective surgery, contagious diseases, or acute emergencies that are a threat to life. Diagnostic tests in the hospital are provided for up to $50 and necessary physicians' and surgeons' services.

2. Nursing home care - in approved and licensed nursing homes (service is removed from OAA medical services and placed in MAA, provisions made for amounts for personal needs of recipients without income to meet such needs).

B. Noninstitutional:

Practitioners' services - home or office calls limited to 2 per month; visit to patient in nursing home limited to 1 a month; includes M.D., D.O., chiropractors, podiatrists.

Proposed plan for medical assistance for the aged: selected characteristics

To be effective July 1, 1961 — Not yet formally submitted

I. Financial eligibility

Income and property limitations are expressed in terms of resources to be disregarded as available to meet the costs of medical care. Amounts in excess of the limitations are to be applied to medical expenses.

A. Income: For a single person, $1,200 per year; for a married couple, $1,800. Amounts in excess are considered available to meet medical expenses.

B. Assets:

1. Real property - home not considered available as a resource.
2. Personal property - not to exceed $2,500 for a single individual or for a married couple; and of this amount, not more than $500 for a single individual or $1,000 for a couple shall be in the form of cash or other liquid assets. Household goods and personal effects are exempt from consideration as resources.

   To be eligible for payment of medical costs, the individual shall have paid or obligated himself to pay $50 for medical services received in the 12 months prior to application.

   The applicant shall not have a child or other legally responsible relative of sufficient ability to provide support to the individual.

II. Medical care to be provided

"The scope of services to be provided ...is to be as broad as the Federal act permits." State has a comprehensive scope of services now in the categorical programs:

A. Institutional:

1. Hospitalization - all recommended by physician.
2. Nursing home care - as needed by the recipient up to negotiated rates based on type of care needed and provided.

B. Noninstitutional:

1. Physicians' services - home, office, nursing home; all licensed practitioners.
2. Prescribed drugs
3. Nursing care in own home, dental services, X-ray, laboratory, and many other services - as needed or as prescribed by licensed practitioner.

Proposed plan for medical assistance for the aged: selected characteristics

To be effective November 1, 1961 Not yet approved

I. Financial eligibility	II. Medical care to be provided
A. Income: Annual cash income for single recipient, less than $1,500; for married applicant, combined income of husband and wife is less than $2,000. Where it is not possible to determine the income of an absent spouse, the applicant is treated as a single person. B. Assets: 1. Real property - home used by applicant or legal dependents is exempt (real property other than the home is not mentioned). 2. Personal property - not to be considered as resources are: 1 automobile, household furnishings, personal property holdings used in earning a living, such as clothing, tools, machinery, and other goods and equipment necessary to the continuance of earning a livelihood. Also exempt is cash surrender value of life insurance held by the applicant, not to exceed $1,000. All other liquid assets shall be less than $1,500 for a single person or less than $2,000 for married couple. Private medical insurance policies may be utilized in payment of the "deductibles" and must be utilized to the fullest extent possible as an "offset" before MAA benefits are payable. MAA and partial benefits supplement each other.	A. Institutional: 1. Hospitalization - up to 9 days per year to be paid at the hospital's all-inclusive per diem rate; patient pays first $65 of hospital expense incurred during the nine days. 2. Nursing home care - posthospital cases, after at least 1 day of hospital care; up to 32 additional days of care. B. Noninstitutional: 1. Physicians' services - in office, home, or outpatient hospital, 8 visits per year after first 2 paid by patient. 2. X-ray and laboratory services - in physician's office or hospital outpatient facility, 8 "units of service" per year.

Proposed plan for medical assistance for the aged:
selected characteristics

To be effective July 1, 1961 — Not yet formally submitted

I. Financial eligibility	II. Medical care to be provided
Not yet reported.	A. Institutional: Hospitalization - for acute illness or injury, limited to 40 days hospital care per fiscal year. B. Noninstitutional: Outpatient care - limited to specified diagnostic tests. (State's present medical vendor payment provisions for OAA consist of hospital care with the same limitations as above and nursing home care following a period of hospitalization and limited to 90 days unless necessary to extend it for situations such as terminal cancer or severe burns.)

Proposed plan for medical assistance for the aged:
selected characteristics

To be effective July 1, 1961 — Not yet formally submitted

I. Financial eligibility	II. Medical care to be provided
A. Income: Annual income not to exceed $1,000 for single person, or $2,000 for a couple. B. Assets: 1. Real property - equity in all real property owned by applicant cannot exceed $5,000 and total real value of such property cannot exceed $7,000. 2. Personal property - not to exceed $1,000 for single person or $1,500 for a couple.	A. Institutional: Hospitalization - for acute illness or injury, limited to 10 days per year. B. Noninstitutional: Drugs - essential life-saving drugs for treatment of diabetes and cardiac conditions.

Medical assistance for the aged: selected characteristics

Effective: July 1, 1961 — Not yet approved

I. Financial eligibility	II. Medical care provided
A. Income: For 1 person, not to exceed $110 per month; for 2 persons, $170 per month; for 3 persons, $210 per month. B. Assets: 1. Real property - home not to be considered among resources. 2. Personal property - cash or liquid assets for 1 person not to exceed $1,000; for couple or family, $2,000; excluded from consideration are household goods and 1 automobile. Total of all real and personal property is not to exceed $10,000 in value.	A. Institutional: Hospitalization - not to exceed 30 days for any single admission; the recipient is to pay the first $50 of cost on each admission. B. Noninstitutional: Physicians' services - home, office, or hospital; no limit on the number of visits, but recipient must be responsible for first $20 of such services within each 90 day period; deductible applies to physicians' services or to outpatient care in hospital clinic.

ctuarial Cost Estimates for Health Insurance Benefits Bill

by ROBERT J. MYERS

Department of Health, Education, and Welfare

Social Security Administration · · · · Division of the Actuary

ACTUARIAL STUDY NO. 52

JULY 1961

TABLE OF CONTENTS

LIST OF TABLES

This study has been issued by the Division of the Actuary, under authority delegated by the Commissioner of Social Security. It is designed for the use of the staff of the Social Security Administration and for limited circulation to other persons in administration, insurance, and research concerned with the subject treated.

FOREWORD

Proposals to add health benefits for beneficiaries aged 65 and over to the OASDI program have created an interest in the data and methods used to develop actuarial cost estimates in this new area.

It is the policy of the Division of the Actuary to make its methods and procedures available to those interested. It is our hope that this Study will provide, in a condensed form, the information not readily available in other published reports.

Robert J. Myers
Chief Actuary
Social Security Administration

A. Introduction

This Study presents the long-range actuarial cost estimates for the Health Insurance Benefits Bill, H.R. 4222, introduced by Congressman King on February 13 (an identical bill, S. 909, was introduced by Senator Anderson on the same date). H.R. 4222 contains the recommendations for a health insurance program under the Old-Age, Survivors, and Disability Insurance system made by President Kennedy as part of his Message Transmitting Recommendations Relating to a Health Program (H. Doc. No. 85, 87th Cong., February 9, 1961).

This bill would provide a limited program of health benefits for all persons who are (1) aged 65 and over, and (2) "entitled" to monthly benefits under the OASDI system. The term "entitled" means that the individual meets all the statutory provisions governing eligibility for monthly benefits (old-age, dependent, or survivor) and has filed an application therefor (which may be concurrent with application for health benefits). The term thus includes not only beneficiaries in current-payment status, but also those who are not drawing monthly benefits because they are continuing their employment. The following health benefits would be provided:

(a) 90 days of semi-private hospital care within a "benefit period", with a deductible of $10 per day for the first 9 days (minimum deductible of $20).

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

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

(d) Outpatient-hospital-diagnostic services in excess of a $20 deductible, for each diagnostic study.

There is an overall limit on hospitalization and nursing-home benefits in that during any "benefit period" only 150 "units of service" can be used, where such a "unit" consists of 1 day of hospitalization benefits or 2 days of nursing-home benefits. The term "benefit period" means the period beginning with the first day that an individual receives hospitalization benefits and ending with the last day of the first 90-day period thereafter during which he has not been a patient in a hospital or a skilled nursing home. The health benefits would first be available in October 1962, except for nursing-home benefits, which would first be available in July 1963.

These benefits (and the accompanying administrative expenses) would be financed, on a long-range basis, by (1) an increase in the combined employer-employee contribution rate of ½% (effective in 1963), with a corresponding increase of 3/8% in the rate for the self-employed, and (2) the

"gain" to the OASDI system resulting from increasing the maximum earnings base from $4800 to $5000 (effective in 1962). The gain from increasing the earnings base is estimated to be equivalent to the effect of a rise in the combined employer-employee contribution rate of .1% of payroll. This income would be channelled into the Health Insurance Account of the Federal Social Insurance Trust Fund, which would also include the existing OASI and DI Trust Funds as two separate accounts.

This Study sets forth in Section B the basic data utilized, the assumptions made, and the computation procedure. In Section C, the cost estimates are presented, along with discussion of changes made in them in the past year. Finally, Section D outlines the problems involved in making actuarial cost estimates for the proposal.

B. Data, Assumptions, and Procedures

The various cost factors involved for each of the types of benefits have been developed by the Division of the Actuary in collaboration with the Division of Program Research. These factors have been applied to the estimated numbers of OASDI eligibles, which are available from the long-range actuarial cost estimates for the system. The latter are summarized in the 21st Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, pages 27-32 and 37-44 (H.Doc. No. 60, 87th Congress, January 18, 1961). The general assumptions and procedures for these estimates are described in Actuarial Study No. 49.

Factors Affecting Hospitalization-Benefit Costs

The elements affecting costs in each year may be itemized as follows:

(1) Number of eligible beneficiaries and their age-sex composition;

(2) Rates of hospital admission;

(3) Average duration of hospitalization;

(4) Average daily per capita hospital charges; and

(5) Effect of maximum-duration and deductible provisions.

Hospitalization-benefit costs for various future years are obtained by multiplying the estimated number of eligibles by a factor representing the average annual per capita cost of hospitalization (after taking into account any maximum-duration and deductible provisions). This is done separately by sex and by age groups (65-69, 70-74, and 75 and over, in connection with the cost estimates for H.R. 4222) since duration of hospitalization varies significantly by age and sex. Likewise, the age-sex composition of the eligible group will vary over the years. The per capita hospitalization-cost factor is derived in relation to all eligibles in the age-sex group, including those who are not hospitalized.

The per capita hospitalization-cost factor consists of two elements, the average length (in days) of compensable hospitalization (considering all eligibles, and including the effect of any deductible, as well as any maximum-duration provisions) and the average daily cost of hospitalization (including both room and board, and all other hospital services, averaged out on a daily basis).

Average Length of Hospitalization

First, considering the element of average length of hospitalization, the basic procedure is to make the detailed calculations for a 60-day maximum provision and then to modify the overall results for differences in the provisions of the particular proposal. The basic data are presented in Table 1, which shows hospital utilization rates on both low-cost and high-cost bases. The "hospital utilization rate" is defined as the average number of hospital days experienced per person exposed to risk. In other words, they are the result obtained by multiplying the proportion of persons experiencing hospitalization by the average duration of hospitalization for those hospitalized.

The basic data are from the BOASI Survey of Beneficiaries, but with modifications to recognize that the availability of benefits will result in greater utilization than that reported in the Survey. In addition, the basic data have been corrected to allow for hospitalization of persons who died during the year, who of course would not be reported in the Survey.

The corrections for the availability of hospitalization benefits were made in the following manner (described in more detail on pages 77-78 of the Department's 1959 Hospitalization Report). For the high-cost estimate, the admission rate was assumed to be the same as the rate reported in the Survey for those with insurance (approximately 60% higher than the reported rate for those without insurance). The average duration of hospitalization was taken to be the same as that reported in the Survey for those with insurance and those without insurance combined (the average duration for the latter category was about 50% higher than for the former); this assumption is, of course, a "conservative" one.

For the low-cost estimate, the hospital utilization rate was obtained by weighting such rate for insured persons in the Survey by the proportion of insured persons and by weighting such rate for those in the Survey without insurance by the average hospital utilization rate for all persons in the Survey (about 5% higher than the actual experience for the uninsured group). Also, an adjustment of the hospital utilization rate was made for men aged 65-69 to reflect the fact that utilization is substantially lower among employed persons than among retired persons. In connection with the latter point, it should be noted that the beneficiary group surveyed consisted of retired persons; thus, making no such downward adjustment in the high-cost estimate added an element of conservatism. Operating in the other direction, however, is the factor that utilization of the proposed health benefits by persons with insurance in the past may be somewhat increased because of the greater protection available in many instances (where the deductible does not have an offsetting effect).

Table 1

HOSPITALIZATION UTILIZATION RATES FOR PERSONS AGED 65 AND OVER, 60-DAY MAXIMUM, AVERAGE DAYS PER PERSON PER YEAR

Age Group	Low-Cost Estimate			High-Cost Estimate		
	Before Correction for Decedents	Correction for Decedents	Corrected Rate	Before Correction for Decedents	Correction for Decedents	Corrected Rate
			Men			
65-69	1.59	.34	1.93	2.18	.43	2.61
70-74	1.66	.48	2.14	2.01	.60	2.61
75 & over	2.44	.93	3.37	3.46	1.17	4.63
			Women			
65-69	1.59	.20	1.79	1.73	.25	1.98
70-74	2.42	.31	2.73	2.65	.38	3.03
75 & over	2.53	.78	3.31	3.11	.97	4.08
			Total Persons			
Total[a/]	1.99	.47	2.46	2.43	.58	3.01

a/ Obtained by weighting the rates by age and sex by the estimated OASDI "eligible" population as of the beginning of 1960.

Note: The figures shown above for "corrected rates" are the same (except for one correction) as those in the table on page 101 of the Hospitalization Report of April 3, 1959, published by the House Ways and Means Committee.

The assumptions in the low-cost estimate produce costs only slightly above the Beneficiary Survey experience. This seems plausible for the near-future. For the long-range future, this low-cost assumption may be said to give recognition to the probable success of current efforts for progressive patient care, for reductions in hospitalization costs resulting from development of outpatient-hospital-diagnostic facilities, and for progressive cost-reducing trends in medical practice.

As yet unpublished hospital utilization data from the National Health Survey, for July 1958 to June 1960, have been used to develop utilization rates comparable with those obtained from the Beneficiary Survey data. In the aggregate, the hospital utilization rates derived from the NHS data confirm those developed from the Beneficiary Survey (used for the purposes of this Actuarial Study), being in fact somewhat lower.

The hospital utilization rates derived from the Beneficiary Survey, modified as described above to allow for the effect of benefits being available as a right, must be corrected in respect to hospitalization used by persons dying during the survey year, who would not have been included in the Survey. For both cost estimates, this correction was obtained for each age-sex group by applying to the estimated proportion dying in a year an assumed average number of days of hospitalization for decedents (8 days for the low-cost estimate and 10 days for the high-cost estimate). As indicated by Table 1, the relative size of this correction naturally varies considerably by age and sex. For both cost estimates, the correction amounts to about 24% of the rate derived from the Beneficiary Survey for all ages combined, but it is as little as about 15% for women aged 65-69 and as much as 35% for men aged 75 and over. The absolute amount of the correction for decedents averages .53 days for a cost estimate intermediate between the low-cost and high-cost ones.

Since the basic work was completed on these cost estimates, there has appeared a more extensive study on the general subject of correcting hospital utilization rates derived from surveys so as to allow for decedents ("Hospital Utilization in the Last Year of Life," Health Statistics from the U.S. National Health Survey, Series D, No. 3, January 1961). This report presented a preliminary study using data for the Middle Atlantic states (New Jersey, New York, and Pennsylvania) for 1957. On the whole, after modifications to obtain comparability, the results of this survey agreed reasonably well with the adjustments made in the cost estimates for the effect of the exclusion of decedents from the Beneficiary Survey.

The NHS report showed that for persons aged 65 and over, the unadjusted utilization rate was 1.67 days per person per year and that

the rate adjusted for decedents was 2.33 days[1/]. This is a difference of .66 days, or a relative increase of 39%. The absolute correction for decedents in the NHS report is somewhat higher than used in these cost estimates (.53 days on the basis of the current age-sex distribution of the eligibles). The correction based on NHS data, however, did not include the effect of a 60-day maximum, which of course would have the effect of reducing the absolute correction (in days) and also the unadjusted utilization rate. Furthermore, it was derived from a population that is somewhat older on the average than the present OASDI "entitled" population which includes those who are not current beneficiaries because of the retirement test).

The percentage increase due to this correction factor was higher in the NHS report than in these cost estimates (39% vs. 24%) both because of the foregoing two elements and because the increase was measured against a lower unadjusted rate, computed solely on the basis of reported experience of persons alive at date of interview (namely, 1.67 days in the NHS report as compared with our 2.21 days). Current NHS statistics on hospital utilization by the population alive at date of interview are higher than formerly reported--as a consequence of the improved data-collection procedures now followed. Accordingly, when measured against this higher base, the days used by decedents would raise the estimated days used by all the aged (derived from the experience of survivors) by a significantly lower amount than 39%, especially after further adjustment for a 60-day limit and for age distribution.

As a further point of comparison between the NHS data and the assumptions in these cost estimates, the average number of days of hospitalization for decedents was 9.57 for the former, as against the assumption here of 8 days for the low-cost estimate and 10 days for the high-cost estimate.

A growing body of additional data on hospitalization experience of persons aged 65 and over, subdivided by health-insurance ownership and other relevant characteristics, is becoming available from the National Health Survey. In some respects these findings are at variance with those from the Beneficiary Survey, partly because of the later time period and differing population groups represented, and partly because of differences in survey techniques. Preliminary investigation indicates, however, that on balance the present cost estimates would be little changed if NHS data were substituted for corresponding Beneficiary Survey data.

1/ In Table 8 on page 11 of this report, the adjusted rate for persons aged 65 and over is shown as 2,373 per 1,000 persons. Actually, it should be 2,332 since it is derived by dividing the 5,021,000 nights of hospital care used by those alive (Table 6) plus the 1,976,000 nights used by those who died (Table 7) by the 3,000,000 persons in the exposure (Table 6).

The foregoing discussion has related to the derivation of hospital utilization rates on the basis of a 60-day maximum provision. It is assumed that such rates apply with equal accuracy whether the maximum relates to a calendar year, a benefit year, or a benefit period as defined in the proposal. Proceeding from those basic cost factors, modifications have been made for proposals considered from time to time in the past that have had different maximum-duration periods or that introduced deductible periods (whether expressed in terms of the first "n" days of hospitalization, a flat dollar deductible regardless of length of hospitalization, or a uniform dollar deductible for the first "n" days of hospitalization).

The relative effect on cost factors of increasing the maximum duration of benefits from 60 days to various other durations is as follows: 90 days - 9%; 120 days - 10½%; 180 days - 12%; and 360 days - 15%. Conversely, if the maximum duration is reduced from 60 days to 21 days, the cost will be lowered by 15%. These factors have been derived from consideration of data from the National Health Survey and from private insurance experiences.

In considering the effect of a deductible provision on hospitalization-cost factors, it is necessary to have what is termed a hospitalization continuance table applicable to the particular beneficiary group involved. Such a table was derived from data in the National Health Survey (Health Statistics, Series B, No. 7) and is shown in Table 2.

Average Daily Cost of Hospitalization

The second element in hospitalization-benefit cost factors is the average daily cost (including both room and board and other hospital costs). The Hospitalization Report derived a figure of $21 a day for persons aged 65 and over in 1956 (see pp. 79-80). This figure was used as the basis for the long-range actuarial cost estimates made for that Report, since all the actuarial cost estimates for the OASDI system made at that time used the 1956 general earnings level. The figure, however, was adjusted upward by 14% (to $24) to take into account the fact that, as of 1956, hospital charges had been increasing more rapidly than the general wage level and would probably do so for at least a few more years. The basis of this 14% increase was the assumption that over the next 4 or 5 years after 1956, hospital charges might increase at an average rate of about 6% (perhaps 7-8% in the beginning and lessening amounts thereafter) before an assumed leveling-off so as to have the same rate of increase as the general wage level. Thus, during this period, the "real increase" of hospital costs in relation to the general wage level might begin at 3-4% a year and then decline, so that a cumulative relative increase of 14% would precede the leveling-off at the end of the 4-5 year period.

Table 2

HOSPITALIZATION CONTINUANCE TABLE FOR AGED PERSONS FOR 60-DAY MAXIMUM BENEFIT

Waiting Period (days)	Proportion Hospitalized for		Days of Hospitalization for Those With		Hospitalization Excluded by Waiting Period	
	Exactly the Length of the Waiting Period	Length of the Waiting Period or a Shorter Time	Exactly the Length of the Waiting Period	Length of the Waiting Period or a Shorter Time	Days	Proportion
1	3.8%	3.8%	3.8	3.8	100.0	7.2%
3	6.6	17.5	19.8	37.8	285.3	20.6
5	6.0	29.8	30.0	93.0	444.0	32.0
7	5.6	41.2	39.2	167.0	578.6	41.7
10	4.5	56.0	45.0	299.4	739.4	53.3
14	3.1	70.9	43.4	483.8	891.2	64.3
20	1.2	81.5	24.0	664.3	1034.3	74.6
30	.6	89.6	18.0	866.4[a]	1178.4	85.0
60	.1	95.0	306.0[a]	1386.1[a]	[b]	[b]

[a] Including 60 days of hospitalization for the 5.0% who are hospitalized more than 60 days.
[b] Not meaningful (to have waiting period coincide with maximum benefit-period covered).

Source: Based on data from the National Health Survey (Health Statistics, Series B-7, December 1958, Table 14).

The actuarial cost estimates for the 1960 legislative proposals in regard to health benefits were modified to reflect the 1959 earnings level, but the hospitalization-benefit costs relative to payroll were left unchanged. Thus, in essence, the assumption was made that, from 1956 to 1959, hospitalization costs increased more rapidly than the change in covered earnings and would shortly "level off" (with equal relative increases thereafter).

The average hospital-per-diem cost of $21 for 1956, used in the Hospitalization Report, represented .851% of the average annual taxable wage of $2467 in that year (on a $4200 base). This ratio is important to consider when analysis is made of the current and projected future relationships.

The current cost estimates for monthly benefits of the OASDI system are based on the 1959 earnings level. The average hospital-per-diem cost for persons aged 65 and over in 1959 was about $26, which was .932% of the average annual taxable wage of $2790 in that year (on a $4800 base). This ratio is 10% higher than the 1956 ratio.

The preceding analysis indicates that during 1956-59, hospital costs rose 10% more than the general wage level. This is almost as much as the 14% "leveling off" factor previously assumed. Since this "leveling off" has not actually been achieved and apparently will not be achieved in the next few years, on the basis of current trends, it seems advisable to begin the cost-projection of hospitalization charges from the 1959 base. Accordingly, the procedure has been adopted in the present estimates for hospitalization benefits of providing for a 14% increase in the current (1959) average hospital-per-diem cost for persons aged 65 and over of $26--yielding a figure of $29.60--to allow for future "leveling off" of the ratio of hospitalization costs to the general wage level.

In other words, the adjustment factor used in the previous estimates has been applied to reflect the assumption that the "leveling off" period will be transferred and postponed until some time after the mid-1960's. If this were the only change made, the hospitalization-benefit costs as a percentage of payroll would remain unaffected. However, the costs have been adjusted upward by an additional 10% to reflect the experience during 1956-59, when the expected trend toward a "leveling off" did not occur.

Although the average hospital-per-diem cost for persons aged 65 and over for 1962 is estimated at about $32, this is not inconsistent with the lower long-range assumption because the per-diem cost figure used in the long-range estimates is relative to a lower general earnings level (1959) than that estimated to prevail in 1962.

An analytical study was made as to the reasonableness of assuming that after this 14% relative increase, there would be a leveling-off as between hospitalization costs and the general wage level. The data seemed

to indicate that in the years since World War II, hospital daily costs have been increasing in a linear manner (at a rate of about $1.60 per year), and that wage rates have been increasing geometrically. Accordingly, although in the recent past the difference between these two trends series has been about 3-4% per year, this seems to be declining somewhat, and in about 5-10 years (after 1959) there might be a "leveling-off," with the aggregate relative difference being from perhaps 10% to 14%.

Intermediate-Cost Estimates for Hospitalization Benefits

As indicated previously, low-cost and high-cost factors were developed for hospital utilization rates. An intermediate-cost estimate is necessary for purposes of determining the financing basis of this portion of the program. In order to arrive at such an estimate, the low-cost and high-cost factors were averaged and applied to the intermediate estimate of persons aged 65 and over who are entitled (or could become entitled upon application) to monthly cash benefits under the OASDI system. In considering the figures actually presented for the intermediate-cost estimate, it should be kept in mind that a considerable range of variation is possible. The spread from the intermediate-cost estimate to the high-cost estimate (or to the low-cost estimate) is approximately 15% due to the hospitalization element alone, and perhaps another 15% due to the range of variation inherent in the basic OASDI cost estimates.

Cost Estimates for Skilled-Nursing-Home Benefits

It is very difficult to make estimates for skilled-nursing-home benefits because currently such facilities are not uniformly available in adequate amount in all sections of the country, and even more so because there are a number of different concepts under which these benefits might be operative or be utilized by the medical profession. At the one extreme, such a benefit might be utilized almost entirely for very limited convalescent care and be applicable to only a relatively few cases. At the other extreme, the benefit might be utilized so broadly as to provide care that emphasizes the long-term domiciliary element far more than nursing care (naturally, both elements must be present, but much importance hinges on the relative predominance of one feature or the other). In fact, there is the question of whether hospitalization will occur that, under present circumstances, would not be considered necessary and proper, and whether nursing-home benefits will be provided following these hospital stays.

The bill provides that skilled-nursing-home benefits shall be available only upon transfer from a hospital and for further treatment of the condition that resulted in the hospitalization. It is not possible to know from this written definition exactly what the actual admitting and transferring practices may be. In the early years of operation, one limitation on the costs for this benefit will, of course, be the limited availability of qualifying facilities. In the long run, however, this cannot reasonably be regarded as a cost-control factor.

In the Department's 1959 Hospitalization Report, cost estimates were made for a strictly administered "recuperative care only" skilled-nursing-home benefit (and also for much broader provisions)--see pages 83-84. The original cost estimates for this very limited benefit were based on the experience of a few Blue Cross plans having such a benefit. The available data suggested that there might be annual utilization of 10 days of such care per 100 beneficiaries protected by this type of benefit. Since the average daily cost would be about $10, this would mean an aggregate average cost of $1 per year per person aged 65 and over entitled to monthly OASDI cash benefits.

Subsequent staff consideration of the skilled-nursing-home benefits under the proposal have led to a reconsideration of the cost of this benefit. Analysis has been made of the various elements involved in the cost of this type of benefit, namely:

(1) Present number of skilled nursing home beds;

(2) Number of such beds that are acceptable according to reasonable standards;

(3) Estimated needed beds;

(4) Proportion of beds occupied;

(5) Proportion of occupied beds used by aged persons;

(6) Proportion of the aged occupants of beds that consists of OASDI beneficiaries;

(7) Proportion of occupants with duration less than 6 months;

(8) Proportion of occupants who entered the nursing home by transfer from a hospital; and

(9) Average daily cost.

Use of the above data and analysis can produce a wide spread in the cost estimates--both short-range and long-range. In the first full year of operation, the cost would be relatively low because of lack of facilities (since many of the existing beds would not be improved sufficiently to meet the standards, and in many cases new facilities would not yet be constructed) and because of lack of knowledge of the benefits available. Accordingly, assuming generally wider coverage, the revised estimate of the cost in the first full year of operation is $25 million (as compared to the previous estimate of about $10 million). In the next few years of operation, the cost would rise steadily as existing facilities are improved and as new facilities are built to meet the demand (and in recognition of the money available from the benefits).

The long-range cost of these nursing-home benefits would be higher than the early-year costs for a number of reasons--an increase in the number of available beds to meet the demands, OASDI beneficiaries being a larger proportion of the total population aged 65 and over, and a greater utilization of the benefits available.

Consideration has been given to the various possibilities as to nursing-home benefit costs, and a new intermediate estimate has been developed. In making this higher estimate, it is recognized that part of the cost arising for the skilled-nursing-home benefits, when more widely utilized, will be an offset to the cost for hospitalization benefits. In the present estimates, it is assumed that this offset represents 25% of the cost of the skilled-nursing-home benefits.

Cost Estimates for Home-Health-Service Benefits

The original estimates for home-health-service benefits were based on an assumed annual cost of $1 per eligible beneficiary. This assumption was based on such limited experience with this benefit as was available, taking into account also the limited general availability of such services at present. For the foregoing reason, it is likely that this is the cost that will develop in the early years of operation of the program. In later years, however, it seems reasonable to assume that this type of service will become generally available throughout the country, since there will be the money to pay for it.

A recent study made by the Kansas Blue Cross and Blue Shield indicates that for persons aged 65 and over, the annual per capita cost was almost $6. Over the long-range for the country as a whole, it seems that this is a much better figure to use than the previous figure of $1.

If there are significant expenditures for home-health-service benefits, this should mean somewhat lower hospitalization and skilled-nursing-home benefit costs. In fact, in cases where a person would otherwise be in the hospital but is instead receiving the much less expensive home-health services, there would actually be a net savings in cost to the program, or in other words the program would cost less because of the inclusion of this type of benefit. It is believed, however, that any such savings will be more than offset by the home-health services being made available to people who would not otherwise be in hospitals or skilled nursing homes. Nonetheless, with the availability of these home-health services on an expanded national basis, there should be some offset taken against the hospitalization-benefit costs that would otherwise occur if there were no home-health-service benefits. This adjustment has been taken as 40% of the estimated cost for home-health-service benefits.

Cost Estimates for Outpatient-Hospital-Diagnostic-Services Benefits

The cost estimate for the outpatient-hospital-diagnostic-services benefits was first made on the basis that there would be no deductible.

Relatively little experience is available in regard to the cost of this benefit for a group consisting of persons aged 65 and over. Such Blue Cross and insurance company experience as there is seems to indicate that the annual cost per capita will be about $7.50 (spread over the total protected population and not merely among those who will use this benefit).

From a cost standpoint, the effect of a $20 deductible for each diagnostic study (note that it is not an annual deductible) will be significant. This deductible provision will reduce the aggregate cost by an estimated 80%, since most of the charges for these services will be relatively small amounts, such as $10 for an X-ray. The number of claims will also be reduced by about 80% by the deductible provision, and thus a considerable amount of the administrative costs otherwise involved in paying a large number of small claims will be eliminated. The relative magnitude of the reduction arising from a deductible tends to be verified by a study of the actual charges of hospital outpatients covered under group insurance policies (see "A Reinvestigation of Group Hospital Expense Experience" by S. W. Gingery in Transactions, Society of Actuaries, Vol. XII, 1961, which gives data on such claims by size intervals).

Estimated Administrative Expenses

It is assumed that the administrative expenses that will be chargeable to the Health Insurance Account for processing the health-benefit claims and for a pro-rata share of the cost of maintaining the earnings records and collecting the contributions will represent 5% of the benefit disbursements. This figure is comparable with the relative administrative costs of the most efficiently-run Blue Cross plans. The latter frequently have substantial administrative costs that would not arise in connection with health benefits under OASDI--such as those for selling individual enrollments, collection of health insurance contributions alone, and maintenance of the rolls of insured persons solely for purposes of health insurance. The administrative expenses for the proposed health benefits that are chargeable to the Health Insurance Account do not, of course, include the administrative expenses of the hospitals and other health agencies supplying the benefits, which are included as part of the benefit disbursements. Also not included are the record-keeping and tax-payment expenses incurred by employers in connection with the OASDI program.

C. Results of Cost Estimates

Long-range actuarial cost estimates made at about the time the bill was introduced indicated that the benefits provided (and the accompanying administrative expenses) would be exactly financed, on a long-range basis, by the two sources of revenue to the Health Insurance Account. These two sources are an increase of ½% in the combined employer-employee contribution rate (and a corresponding increase of 3/8% for the self-employed), effective in 1963, and the net "gain" to the OASDI system resulting from increasing the maximum annual earnings base from $4800 to $5000, effective in 1962. The latter "gain" is estimated to be equivalent, over the long run, to the effect of a rise in the combined employer-employee contribution rate of .1%. The bill provides that the equivalent of this level contribution rate is to be continuously appropriated to the Health Insurance Account.

As indicated in the previous section, the original estimates have been revised somewhat, as a result of the continuous process of study and investigation of all factors involved in the actuarial cost estimates. In particular, this reexamination was focused on the three "subsidiary" benefits (i.e., other than hospitalization benefits), which are less important cost-wise. The revised estimates for these benefits also include certain partially offsetting reductions in hospitalization-benefit costs, as discussed previously.

Furthermore, the estimates presented here take into account the enactment of the Social Security Amendments of 1961 (P.L. 87-64), which affect the health-benefits proposal because of the liberalization in the fully-insured status provisions of the OASDI system. This change makes about 100,000 additional beneficiaries aged 65 and over eligible in the first year of operation, and somewhat larger numbers in the next few years. Ultimately, however, there is no effect (because the maximum requirement of 40 quarters of coverage continues to apply in the same way that it did before the enactment of that legislation). Accordingly, the 1961 Amendments have a slight effect on estimated outgo for health benefits in the early years of operation, but no effect on costs in later years so that the effect on the level-premium cost is negligible.

The following table shows the original and revised estimates of the level-premium costs [2/] of the various types of benefits (plus administrative expenses):

Type of Benefit	Original Estimate	Revised Estimate
Hospitalization	.56%	.52%*
Skilled-Nursing-Home	.01	.08
Home-Health	.01	.05
Outpatient-Hospital-Diagnostic	.02	.01
Total	.60	.66

*After offset for reduced cost because of availability and use of skilled-nursing-home and home-health benefits.

As will be seen from these figures, the income of .60% of payroll on a level-premium basis would be just sufficient to finance the benefits on a long-range basis according to the original intermediate cost estimate, but would fall about 10% short relatively according to the revised figures.

The outgo for benefit payments and accompanying administrative expenses in the first 12 months of operation for each of the four types of benefits, taking into account the actual price and earnings-level situation (rather than the long-range assumptions in these respects), are shown in the following table for the revised cost estimates:

Type of Benefit	Amount (millions)	Percent of Payroll
Hospitalization	$1,015	.44%
Skilled-Nursing-Home	25	.01
Home-Health	10	.004
Outpatient-Hospital-Diagnostic	10	.004
Total	$1,060	.46%

2/ The level-premium cost is the average long-range cost, based on discounting at 3.02% interest, relative to effective taxable payroll (which is the total earnings of all covered workers reduced to take into account both the maximum taxable earnings base and the lower contribution rate for the self-employed as compared with the combined employer-employee rate so that, in effect, only 3/4 of the earnings of the self-employed within the maximum base are counted). For more details on this concept, see Section E of Actuarial Study No. 49. In this Study, the term "payroll" is used to denote the effective taxable payroll.

Next, there may be considered the additional income and outgo picture, by fiscal years, for the entire OASDI system, including the proposed health-benefits program. The following table gives these data for the next four fiscal years (in millions):

Fiscal Year	Additional Income to System: From ½% Rise in Tax Rate	Additional Income to System: From Earnings Base Change*	Additional Outgo of System
1962	--	$40	--
1963	$414	325	$660
1964	1,125	410	1,065
1965	1,156	420	1,100

* Includes additional income from change in earnings base applicable to the ½% rise in combined employer-employee rate.

In considering the above figures, it should be noted that the additional income from the earnings-base change is the total of such income and not merely that portion of it which is assigned to the Health Insurance Account as being the quivalent of an increase of .1% in the combined employer-employee contribution rate. Also, it should be noted that the outgo includes the relatively small amount of additional cash benefits that will arise from increasing the earnings base--practically nothing in 1962, about $2 million in 1963, about $5 million in 1964, and about $10 million in 1965 (in the future such amounts will grow steadily).

The estimated income and outgo of the Health Insurance Account for the next four fiscal years is as follows (in millions):

Fiscal Year	Allocation to Health Insurance Account: From ½% Rise in Tax Rate	Allocation to Health Insurance Account: From Earnings Base Change*	Allocation to Health Insurance Account: Total	Outgo from Health Insurance Account
1962	———	$40	$40	———
1963	$414	221	635	$658
1964	1,125	225	1,350	1,060
1965	1,156	231	1,387	1,090

*Includes additional income from change in earnings base applicable to the ½% rise in combined employer-employee rate.

Table 3 presents the estimated progress of the Health Insurance Account by calendar years, according to the intermediate-cost estimate, carried out into the long-range future. The early-year figures (1962-65) represent what is actually anticipated on the basis of expected future earnings levels and medical-care costs; by 1970 these are merged with the long-range cost estimates, which assume 1959 price and wage conditions.

Table 3

ESTIMATED PROGRESS OF HEALTH INSURANCE ACCOUNT UNDER H.R. 4222,
INTERMEDIATE-COST ESTIMATE
(in millions)

Calendar Year	Contributions Allocated	Benefit Payments and Administrative Expenses	Interest on Account[a]	Account at End of Year
1962	$180	$152	--	$28
1963	1,150	1,062	$2	118
1964	1,365	1,098	8	393
1965	1,395	1,134	17	671
1970	1,548	1,361	61	1,974
1975	1,677	1,557	89	3,102
1980	1,805	1,803	113	3,872
1990	2,096	2,308	117	3,898
2000	2,436	2,640	77	2,515[b]

a/ Based on varying interest rate estimated to be earned by OASDI Trust Funds, ultimately leveling off at 3.02% on total assets (3.10% on invested assets).

b/ Fund exhausted in year 2017.

The benefit cost in the early years (including also administrative expenses) is significantly lower than the level-premium cost and, conversely, higher eventually. This is the result of the relatively more rapid rise in the number of persons aged 65 and over entitled to monthly cash benefits than is the case for the covered-worker population. In the first full calendar year of operations, 1963, the cost is estimated at .46% of payroll, and by 1970 it is .53%. The average cost for the first 10 full calendar years of operation, 1963-72, is .50% of payroll. The cost as a percentage of payroll gradually rises after 1970; by 1980 it is .60%, and ultimately it rises to somewhat more than 3/4%.

The Account builds up slowly in the first few years because the benefits are made effective so rapidly and because the income has a certain lag due to the delay in collecting tax payments resulting from general legislative provisions. Thus, in both 1962 and 1963, income and outgo are virtually in balance--in fact, the former exceeds the latter by only about 10% relatively.

In the next few years after 1963, however, income to the Account is some 25% in excess of outgo so that a moderate fund builds up, and by 1965 it is almost $700 million. Income continues to exceed outgo in the following years since the covered population increases almost as rapidly as the beneficiary roll. In fact, it is not until about 20 years from now that outgo for benefits and administrative expenses is estimated to exceed the contributions allocated to this Account. It will, of course, be remembered that this is the intermediate-cost estimate and, accordingly, that high-cost experience would not show such favorable developments, while low-cost experience would show more favorable developments.

The Account is estimated to reach $2.0 billion by the end of 1970 and $3.9 billion in 1980. Thereafter, interest earnings continue to augment the growth of the Account so that it reaches a level of about $4.1 billion in 1985, but declines slowly thereafter (because the beneficiary roll eventually grows more rapidly than the covered population).

D. Problems Involved in Cost Estimates for Health Benefits

Long-range actuarial cost estimates, by their very nature, can present the general range of costs but cannot be a precise forecast of future experience. This fact has been taken into consideration in the cost estimates for the Old-Age, Survivors, and Disability Insurance program over the quarter century of its operation. From time to time the assumptions underlying the actuarial cost estimates have been revised to take into account later available data and indications of trends. The cost estimates for the proposed health benefits program are subject to similar revisions.

There is a somewhat greater relative range of probable costs for the proposed health benefits than for the OASDI monthly cash benefits portion of the program, which has been functioning for more than 20 years. Not only is there incomplete data available on some of the various cost aspects and factors underlying the proposed health benefits as they would be provided under a social insurance system, but also service benefits quite obviously do not have costs as readily determinable as cash benefits that are directly related to covered earnings. But it should be recognized that, similarly, when the present OASDI cash benefits program was inaugurated in 1935, little was known about many of the factors entering into the actuarial cost estimates. Then, as now, assumptions had to be made on the basis of the data available, using the best possible actuarial judgment.

From a cost standpoint, the major benefit in the bill is the provision of hospital care. A great amount of data is available in regard to hospitalization experience of aged persons. Principal sources include the 1957 Beneficiary Survey made by the Bureau of Old-Age and Survivors Insurance, the continuing investigations made by the National Health Survey of the Public Health Service, and the experience of various insuring organizations such as the Blue Cross and private insurance companies. Much of this information has previously been summarized in "Hospitalization Insurance for OASDI Beneficiaries," a Report Submitted to the Committee on Ways and Means of the House of Representatives by the Secretary of Health, Education, and Welfare on April 3, 1959. Nonetheless, precise estimates are not possible because of such unknowns as the extent of hospital utilization by persons who have not had insurance in the past, but who would have benefit coverage under the provisions of the bill.

Another major difficulty in making cost estimates for hospitalization benefits is the extent to which hospital costs will rise in the future. The long-range actuarial cost estimates for the OASDI system have always assumed that earnings would be level in the future--for reasons that are described in detail elsewhere (see Actuarial Study No. 49, page 8, and the Report of the Committee on Ways and Means of the House of Representatives on the Social Security Amendments of 1961, H.Rept. No. 216, 87th Cong., April 7, 1961, pp. 14-16). This assumption

means that benefit costs relative to payroll will not be affected by any rising-earnings trend that may develop, because the benefit structure (including the maximum earnings base that is creditable toward benefits and that is subject to contributions) is assumed to be adjusted to keep pace with the rising earnings.

When earnings levels have increased in the past (increasing both benefit outgo and tax income--the latter more than the former, because of the weighted benefit formula), this factor has been recognized in subsequent cost estimates. Any resulting net reduction in cost has been made available for the financing of the program, including proposed benefit liberalizations. Liberalizations financed entirely in this manner merely keep the system up to date.

In considering the hospitalization-benefit costs in conjunction with a level-earnings assumption for the future, it is sufficient for the purposes of long-range cost estimates merely to analyze possible future trends in hospitalization costs relative to earnings. Accordingly, any study of past experience of hospitalization costs should be made on this relative basis. The actual experience in recent years has indicated, in general, that hospitalization costs have risen much more rapidly than earnings, with the differential being in the neighborhood of 3% or 4% per year.

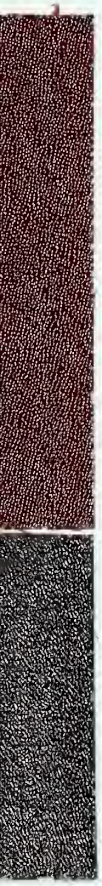
One of the uncertainties in cost estimates for hospitalization benefits, then, is how long and to what extent this tendency will continue in the future. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly "catching up" with the general level of wages and obviously may be expected to "catch up" at some future date, rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased expense. In connection with the latter factor, there are possible counterbalancing items in that the higher costs involved for more refined and extensive treatments may be offset by better general health conditions, the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures.

The other three benefits provided by the bill would have a far lower relative cost than the hospitalization benefit (assuming that the types of services provided by the different facilities remain approximately the same as at present). Accordingly, even relatively large variations in the cost estimates for these benefits would have much less effect on the overall costs of the proposal. Although these services (skilled-nursing-home care following hospitalization, outpatient-hospital-diagnosis, and home-health-visits) are now being extensively provided in a number of areas, comparatively little data is available in regard to their cost for aged persons, when provided in the manner set out by the bill.

In many instances, these three types of benefits are not currently available because of lack of facilities (or inadequate or insufficient facilities). This is especially true in regard to home-health services and outpatient-hospital-diagnostic services, and is to some extent the case as to skilled-nursing-home benefits. Accordingly, the early-year costs for these benefits will be relatively low. The long-range costs, however, are determined on the assumption that sufficient, adequate facilities will be available to supply the benefits provided.

Another important factor in connection with the actuarial analysis of proposals for various types of health benefits is their cost-inter-relationship. For example, if hospitalization benefits were provided, but skilled-nursing-home care were not, there would tend to be more utilization of the hospitalization benefits because an individual would be more likely to stay longer in a hospital (at little or no cost to him) rather than to enter a skilled-nursing home operating at lower cost, but with the full amount to be paid by him. Similarly, if there were no outpatient-hospital-diagnostic benefits provided in the bill, and if there were no deductible in the hospitalization benefits, there would be a financial incentive for an individual to enter a hospital (with resulting higher cost) to obtain these services without cost to him.

Likewise, the availability of home-health services can reduce hospitalization-benefit costs in certain cases. Otherwise, an individual might enter a hospital or stay in it longer if in doing so there were less cost to him personally than in obtaining home-health services. On the other hand, the home-health services when available will also undoubtedly be utilized by many persons who would not otherwise have been in hospitals. In the same way, the presence (or absence) of a deductible provision for one benefit can influence not only total cost, but also the costs of other types of benefit.



87TH CONGRESS } HOUSE OF REPRESENTATIVES { DOCUMENT
2d Session } { No. 347

HEALTH PROGRAM

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

RELATIVE TO

A HEALTH PROGRAM

FEBRUARY 27, 1962.—Referred to the Committee of the Whole House on the State of the Union and ordered to be printed

To the Congress of the United States:

The basic resource of a nation is its people. Its strength can be no greater than the health and vitality of its population. Preventable sickness, disability, and physical or mental incapacity are matters of both individual and national concern.

We can take justifiable pride in our achievements in the field of medicine. We stand among the select company of nations for whom fear of the great epidemic plagues is long past; our life expectancy has already reached the Biblical 3 score and 10; and, unlike so many less fortunate peoples of the world, we need not struggle for mere survival. But measured against our capacity and capability in the fields of health and medical care, measured against the scope of the problems that remain and the opportunities to be seized, this Nation still falls far short of its responsibility.

Many thousands needlessly suffer from infectious diseases for which preventive measures are available. We are still 10th among the nations of the world in our infant mortality rate. Prolonged and costly illness in later years robs too many of our older citizens of pride, purpose, and savings. In many communities the treatment of the mentally ill and the mentally retarded is totally inadequate. And there are increasingly severe shortages of skilled personnel in all the vital health professions.

Basically, health care is a responsibility of individuals and families, of communities and voluntary agencies, of local and State governments. But the Federal Government shares this responsibility by

providing leadership, guidance, and support in areas of national concern. And the Congress last year recognized this responsibility in important ways.

PROGRESS DURING 1961

Our States and communities have responded quickly and with impressive vigor to the invitation to cooperative action extended by the Community Health Services and Facilities Act passed by the Congress and signed into law only 4 months ago. As a result, better care for the chronically ill and the aged will soon be available in many parts of the Nation, both inside and outside the hospitals and other institutions in this program.

There is also visible progress in the effort to control water pollution, resulting from the expanded legislation passed by the Congress in 1961. Last year construction was begun on more waste treatment plants than ever before in our history—30 percent above the calendar year 1960 level.

There were, in addition, other important forward thrusts taken, with Federal help, in the protection of our Nation's health. Medical research advanced at an accelerated pace. We are now better equipped than ever before to evaluate and deal with radiation perils. The incidence of polio has been reduced to the lowest levels ever recorded. We have engaged our most talented doctors and scientists in an intensified search for the cause and cure of cancer, heart disease, mental illness, mental retardation, environmental health problems, and other serious health hazards.

But, of the four basic improvements in the Federal health program I recommended to the Congress last year, two urgent needs—health insurance for the aged and assistance to education for the health professions—have not yet been met. The passage of time has only served to increase their urgency; and I repeat those requests today, along with other needed improvements.

I. HEALTH INSURANCE FOR THE AGED

Our social insurance system today guards against nearly every major financial setback: retirement, death, disability, and unemployment. But it does not protect our older citizens against the hardships of prolonged and expensive illness. Under our social security system, a retired person receives cash benefits to help meet the basic cost of food, shelter, and clothing—benefits to which he is entitled by reason of the contributions he made during his working years. They permit him to live in dignity and with independence, but only if a serious illness does not overtake him.

For, compared to the rest of us, our older citizens go to the hospital more often, they have more days of illness, and their stays in the hospital are thus more costly. But both their income and the proportion of their hospital bill covered by private insurance are, in most cases, substantially lower than those of younger persons.

Private health insurance has made notable advances in recent years. But older people, who need it most but can afford it least, are still unable to pay the high premiums made necessary by their disproportionately heavy use of health care services and facilities, if eligibility requirements are to be low and the scope of benefits broad. Today,

only about half of our aged population has any health insurance of any kind, and most of these have insufficient coverage.

To be sure, welfare assistance, and Federal legislation to help the needy or "medically indigent," will provide health services in some instances, but this kind of help is not only less appealing, coupled as it is with a means test, it reaches very few of those who are not eligible for public assistance but are still not able to afford the care they need.

I therefore recommend again the enactment of a health insurance program for the elderly under the social security system. By this means the cost of health services in later years can be spread over the working years, and every worker can face the future with pride and confidence. This program, of course, would not interfere in any way with the freedom of choice of doctor, hospital, or nurse. It would not specify in any way the kind of medical or health care or treatment to be provided. But it would establish a means to pay for the following minimum levels of protection:

First. Inpatient hospital expenses for up to 90 days, in excess of $10 per day for the first 9 days (with a minimum payment by each person of $20), and full costs for the remaining 81 days.

Second. The cost of nursing home services up to 180 days immediately after discharge from a hospital. By providing nursing home care for twice as long as that in the hospital, the patient is encouraged to use the less expensive facilities when these will satisfy his requirements.

Third. The cost of hospital outpatient clinic diagnostic services in excess of $20. These benefits will reduce the need for hospital admissions and encourage early diagnosis.

Fourth. The cost of community visiting nurse services, and related home health services, for a limited number of visits. These will enable many older people to receive proper health care in their own homes.

It should be emphasized that we are discussing a gap in our self-financed, contributory social insurance system. These are all insurance benefits which will be available to everyone over 65 who is eligible for social security or railroad retirement benefits. They would be entirely self-financed by an increase in social security contributions of one-quarter of 1 percent each on employers and employees, and by an increase in the maximum earnings base from $4,800 a year to $5,200 a year. No burden on the general revenues is involved. I am not unmindful of the fact, however, that none of our social insurance systems is universal in its coverage, and that direct payments may be necessary to provide help to those not covered for health insurance by social security. But the two problems should not be confused—and those who have never made any contribution toward the system should not be regarded as in the same category as those who have—and because a minority lacks the protection of social security is no reason to deny additional self-financed benefits to the great majority which it covers.

II. HEALTH PROFESSIONS PERSONNEL

The Nation's health depends on the availability and efficient use of highly trained and skilled professional people. These people are in very short supply. Unless we take steps to train more physicians

and more dentists, the promise of modern medicine cannot be fully realized.

In an earlier message this year, I repeated my recommendation for Federal aid for the construction and expansion of schools of medicine, osteopathy, dentistry, and public health, and for helping talented but needy students pursue their professional education. I recommended: (1) A 10-year program of grants to plan and construct such professional schools in order to increase the Nation's training capacity; and (2) a program of Federal scholarship aid for talented students in need of financial assistance, plus cost-of-education payments to the schools.

The urgency of this proposal cannot be repeated too often. It takes time to construct new facilities and many years for doctors to be trained. A young man entering college this fall will not be ready to start his practice until 1972—and even later if he plans to enter a speciality. The costs of construction and operation are mounting. Only six schools of medicine have been opened in the last decade; and the number of graduates has risen only 15 percent. Over the same period, student applications to medical schools have declined sharply. Our ratio of active physicians to population is less today than it was 10 years ago, and growing worse, and in the next 10 years we shall need to expand existing medical and dental school facilities, and to construct 20 new medical and 20 new dental schools.

We must also provide financial help to talented but needy students. I have previously expressed concern over the fact that medicine is increasingly attracting only the sons and daughters of high income families—43 percent of the students in our Nation's medical schools in 1959 came from the 12 percent of the U.S. families with an annual income of $10,000 or more.

A survey has shown that 4 years in medical school cost each student of the 1959 graduating class an average of $11,600. More than half of them had to borrow substantial sums to complete their education, and one-third of the group had an average debt of $5,000. Many of these students still have from 1 to 7 years of additional professional training, at low stipends, still facing them. Obviously further loans and further debts are not the answer.

Also, modern health care is extremely complex. It demands the services of a skilled and diversified team of specialists and technical personnel.

But there are shortages in almost every category, and the shortages are particularly severe in nursing. Last year I authorized the Surgeon General of the Public Health Service to set up a consultant group on nursing, and a comprehensive study of this field is well underway. I expect to receive their report in the near future.

III. IMMUNIZATION

There is no longer any reason why American children should suffer from polio, diphtheria, whooping cough, or tetanus—diseases which can cause death or serious consequences throughout a lifetime, which can be prevented, but which still prevail in too many cases.

I am asking the American people to join in a nationwide vaccination program to stamp out these four diseases, encouraging all communities to immunize both children and adults, keep them immunized, and

plan for the routine immunization of children yet to be born. To assist the States and local communities in this effort over the next 3 years, I am proposing legislation authorizing a program of Federal assistance. This program would cover the full cost of vaccines for all children under 5 years of age. It would also assist in meeting the cost of organizing the vaccination drives begun during this period, and the cost of extra personnel needed for certain special tasks.

In addition, the legislation provides continuing authority to permit a similar attack on other infectious diseases which may become susceptible of practical eradication as a result of new vaccines or other preventive agents. Success in this effort will require the wholehearted assistance of the medical and public health professions, and a sustained nationwide health education effort.

IV. HEALTH RESEARCH

The development of these immunization techniques was made possible by medical research, just as it has made possible the new drugs, surgical techniques, and other treatments which have virtually conquered many of the leading killers of a generation ago—tuberculosis, pneumonia, rheumatic fever, and many others.

But conquest of the infectious diseases, by increasing our lifespan, has made us more vulnerable to cancer, heart disease, and other long-term illnesses. Today, two persons die from heart disease and cancer in the United States every minute. Last year, more than 1 million Americans fell victim to these merciless diseases.

They are not merely diseases of old age. Cancer leads all other diseases as the cause of death in children under age 15. Of the 10 million Americans who suffer from heart disease, more than half of them are in their most productive years, between 25 and 64.

Fortunately, medical research, supported to an increasing degree over the past 15 years by the Federal Government, is achieving exciting breakthroughs against both cancer and heart disease as well as on many other fronts. We can now save one out of every three victims of cancer, compared to only one out of four saved less than a decade ago. Our nationwide cancer chemotherapy program is saving many children and adults who would have been considered hopeless cases only a few years ago. And advances in heart surgery have restored to productive lives many thousands, while full prevention of many forms of heart disease seems increasingly within our reach.

We must, therefore, continue to stimulate this flow of inventive ideas by supporting medical research along a very broad front. I have proposed substantially increased funds for the National Institutes of Health for 1963, particularly for research project grants, and the training of specialists in mental health. Expenditures by the Institutes in 1963 are estimated to exceed $740 million, an increase of more than $100 million from the current year and a fourfold increase in the last 5 years. I am also renewing my recommendation that the current limitation on payment of indirect costs by the National Institutes of Health in connection with research grants to universities and other institutions be removed.

In keeping with the broadening horizons of medical research, I again recommend the establishment of a new Institute for Child Health and Human Development within the National Institutes of

Health. Legislation to create this new Institute was introduced in the last session of Congress.

We look to such an Institute for a full-scale attack on the unsolved afflictions of childhood. It would explore prenatal influences, mental retardation, the effect of nutrition on growth, and other basic facts needed to equip a child for a healthy, happy life. It would, in addition, stimulate imaginative research into the health problems of the whole person throughout his entire lifespan—from infancy to the health problems of aging.

As a parallel action I am requesting authorization for contracts and cooperative arrangements for research related to maternal and child health and crippled children's services. This legislation, introduced in the last session of Congress, would strengthen the programs of the Children's Bureau in these areas, and foster effective coordination between the research activities of this Bureau and those of the proposed new Institute.

I also recommend that the present Division of General Medical Sciences at the National Institutes of Health be given the status and title of an institute. This program supports fundamental research in biology and other sciences, and strengthens the research capabilities of universities and other institutions.

Last year, Congress enacted legislation temporarily extending and expanding the program of Federal matching grants for the construction of health research facilities. This program has been very successful and it should be further extended.

In these and other endeavors, including our new National Library of Medicine, we must take steps to accelerate the flow of scientific communication. The accumulation of knowledge is of little avail if it is not brought within reach of those who can use it. Faster and more complete communication from scientist to scientist is needed, so that their research efforts reinforce and complement each other; from researcher to practicing physician, so that new knowledge can save lives as swiftly as possible: and from the health professions to the public, so that people may act to protect their own health.

V. MENTAL HEALTH

While we have treated the physically ill with sympathy, our society has all too often rejected the mentally ill, consigning them to huge custodial institutions away from the heart of the medical community. But more recently, the signs of progress toward enlightened treatment have been increasing. The discovery and widespread use of tranquilizing drugs over the past 6 years has resulted in an unprecedented reduction of 32,000 patients in the census of our State mental hospitals. But one-half of our hospital beds are still occupied by the mentally ill; and hundreds of thousands of sufferers and their families are still virtually without hope for progress.

I want to take this opportunity to express my approval, and offer Federal cooperation, for the action of the Governors of the 50 States at a special national Governors' conference called last November. In accepting the challenge of the report of the Joint Commission on Mental Illness and Health, they pledged a greater State effort, both to transfer treatment of the majority of mental patients from isolated institutions to modern psychiatric facilities in the heart of the com-

munity, and to provide more intensive treatment for hospitalized patients in State institutions.

But this problem cuts across State lines. Since the enactment in 1946 of the National Mental Health Act, the Federal Government has provided substantial assistance for the support of psychiatric research, training of personnel, and community mental health programs. The Government is currently spending over $1 billion annually for mental health activities and benefits. The National Institute of Mental Health alone will use approximately $100 million this year. Approximately $350 million is budgeted by Federal agencies for the care of the mentally ill; over $500 million is spent annually in the form of pensions and compensation for veterans with neuropsychiatric disorders; and additional sums for similar benefits are paid by the social security and other Federal disability programs.

But far more needs to be done. Adequate care requires a supply of well-trained personnel, working both in and out of mental hospitals. In 1946, there were only 500 psychiatric outpatient clinics in the Nation. Today, there are more than 1,500. More than 500,000 people received treatment in these clinics last year. We are making progress, but the total effort is still far short of the need. It will require still further Federal, State, and local cooperation and assistance.

I have directed the Secretary of Health, Education, and Welfare, the Secretary of Labor, and the Administrator of Veterans' Affairs, with the assistance of the Council of Economic Advisers and the Bureau of the Budget, to review the recommendations of the Joint Commission on Mental Illness and Health and to develop appropriate courses of action for the Federal Government. They have been instructed to consider such questions as the desirable alinement of responsibility among Federal, State, and local agencies and private groups; the channels through which Federal activities should be directed; the rate of expansion possible in the light of trained manpower availabilities; and the balance which should be maintained between institutional and noninstitutional programs.

Meanwhile, we must continue our vigorous support of research to learn more about the causes and treatment of mental illness. We must train many more mental health personnel. We must continue to strengthen treatment programs for Federal beneficiaries through our many existing Federal institutions, including St. Elizabeths Hospital. And I have recommended added funds for the National Institute of Mental Health to increase its program for the training of professional mental health workers and physicians.

VI. MENTAL RETARDATION

The nature and extent of mental retardation is often misunderstood. It is frequently confused with mental illness. While mental illness disables after a period of normal development, mental retardation is usually either present at birth or underway during childhood. It is not a disease but a symptom of a disease, an injury, or some obscure failure of development. It refers to a lack of intellectual ability, resulting from arrested mental development, and manifesting itself in poor learning, inadequate social adjustment, and delayed achievement. Its causes are many and obscure. We are encouraged with each new discovery, but present knowledge of this condition is still so frag-

mentary that its prevention and cure will require continued and persistent research over an extended period of time. The present limitations of knowledge make diagnosis extremely difficult, particularly since it involves the very young. And a major obstacle to progress is the lack of personnel trained in the special skills required to work effectively with the mentally retarded.

Thus, in spite of the progress made in recent years, mental retardation remains one of our most serious health and education problems. Approximately 5 million people in the United States are mentally retarded; and each year more than 126,000 more babies are born who will suffer from this tragic affliction.

I have asked the Panel on Mental Retardation which I appointed last year to appraise the adequacies of existing programs and the possibilities for greater utilization of current knowledge. It will review and make recommendations with regard to (1) the personnel necessary to develop and apply new knowledge; (2) promising avenues of investigation, and the means to support and encourage research along these lines; and (3) improvement and extension of present programs of treatment, education, and rehabilitation.

I expect the Panel's report before the end of this year; and we should then be ready for the next phase of the attack upon this problem. I am confident that the work of this Panel will help us chart the path toward our ultimate goal of preventing this tragic condition.

VII. TOWARD A MORE HEALTHY ENVIRONMENT

There is an increasing gap in our knowledge of the impact upon our health of the many new chemical compounds and physical and biological factors introduced daily into our environment. Every year 400 to 500 new chemicals come into use. Many of them will improve the public health. Others, regardless of every safeguard, present potential hazards. Each year there are 2 million new cases of intestinal disease. Hepatitis is at an alltime high. We need to apply additional protection against every new hazard resulting from contamination of the air we breathe or the water we drink.

As I already mentioned, the water pollution control legislation passed by the Congress last year has permitted us to step up our efforts to purify our water. We should make a similarly accelerated effort in parallel fields. I am therefore recommending:

1. Legislation to strengthen the Federal effort to prevent air pollution, a growing and serious problem in many areas. Fresh air cannot be piped into the cities, nor can it be stored for future use. Our only protection is to prevent pollution.

Under the existing Air Pollution Act, the Federal Government is conducting badly needed research on the biological effects of air pollution; developing improved methods for identifying, measuring, analyzing, and controlling pollution; and working with State and local officials to accelerate necessary control programs.

I recommend that the Congress enact legislation to provide—

(a) authority for an adequate research program on the causes, effects, and control of air pollution,

(b) project grants and technical assistance to State and local air pollution control agencies to assist in the development and initiation or improvement of programs to safeguard the quality of air, and

(c) authority to conduct studies and hold public conferences concerning any air pollution problem of interstate nature or of significance to communities in different parts of the Nation.

Legislation along these lines has already passed the Senate, and I urge final favorable action in this Congress.

2. In order to provide a central focal point for nationwide activities in the control of air pollution, water pollution, radiation hazards, and occupational hazards, I recommend the establishment of a National Environmental Health Center. This center will serve as the base laboratory for research and training activities, and as headquarters for Public Health Service personnel concerned with health hazards in the environment. It will facilitate regular and frequent collaboration between Public Health Service scientists and those with whom they should consult in other Federal agencies. The center will serve also to encourage closer cooperation with industrial research and control groups, with universities and private foundations, and with State and local agencies.

3. Finally, I have recommended an increase in the appropriations for the study and control of water and air pollution and for research into protection against radiation peril.

VIII. ENCOURAGEMENT OF GROUP PRACTICE

Akin to the problem of increasing our overall supply of professional and technical health personnel is the problem of making more effective use of the personnel we already have. Experience in many communities has proven the value of group medical and dental practice, where general practitioners and medical specialists voluntarily join to pool their professional skills, to use common facilities and personnel, and to offer comprehensive health services to their patients. Group practice offers great promise of improving the quality of medical care, of achieving significant economies and conveniences to physician and patient alike, and of facilitating a wider and better distribution of the available supply of scarce personnel.

A major obstacle to the development of group practice, however, particularly in our smaller communities, is a lack of the specialized facilities needed. I therefore recommend legislation which will authorize a 5-year program of Federal loans for construction and equipment of group practice medical and dental facilities, with priority being given to facilities in smaller communities and to those sponsored by nonprofit or cooperative organizations.

IX. HEALTH OF DOMESTIC AGRICULTURAL MIGRANT WORKERS

Domestic agricultural migrants and their families, numbering almost 1 million persons, have unmet health needs far greater than those of the general population. Their poor health not only affects their own lives and opportunities, but it is a threat to the members of the permanent communities through which they migrate. The poverty of these migrants, their lack of health knowledge, and their physical isolation and mobility, all tend to limit their access to community health services. To help improve their health conditions, I recommend, in addition to expanding the special Public Health Service activities directed to them, the enactment of legislation to encourage the States to provide facilities and services for migrant workers.

X. PUBLIC HEALTH SERVICE REORGANIZATION

Changes in recent years have greatly increased the responsibilities of the Public Health Service. Some major organizational changes are necessary in order to help this agency carry out its vital tasks more effectively. I will shortly forward to the Congress a proposal which will make these reorganizational changes possible. It will permit more effective administration of community health programs and those dealing with the health hazards of the environment.

Other Health Goals

The struggle for improved health is never ending. While we are pressing new attacks in sectors of past neglect and present urgency, we must continue to advance along the entire front.

Health facilities construction.—I have asked the Secretary of Health, Education, and Welfare to review the program of federally aided medical facility construction, to evaluate its accomplishments and future course. Through the Federal support provided by this very successful program, general medical care facilities have been constructed in most of the areas of greatest need. There are, however, large and urgent unmet requirements for facilities to provide long-term care, especially for the elderly, and short-term mental care at the community level. In addition, a growing number of existing urban hospitals require modernization so that they may continue to serve the needs of the people dependent upon them.

Health of merchant seamen.—Over the past several years funds for the operation of the Public Health Service hospitals have been substantially increased to improve the quality of medical care for merchant seamen and other beneficiaries. A start has also been made on enabling these hospitals to conduct medical research. I have directed the Secretary of Health, Education, and Welfare to develop a plan for providing more readily accessible hospital care for seamen and for improving the physical facilities of those Public Health Service hospitals which are needed to provide such care.

Physical fitness.—The foundation of good health is laid in early life. Yet large numbers do not receive necessary health care as infants and schoolchildren. The alarming rate of correctible health defects among selective service registrants highlights the problem. In all 50 States there has been a gratifying response to my call of last year for vigorous programs for the physical development of our youth. Pilot projects stimulated by the President's Council on Youth Fitness proved that basic programs, within the reach of every school, can produce dramatic results. Our children must have an opportunity for physical development as well as for intellectual growth. Our increased national emphasis on physical fitness, based on daily vigorous activity and sound nutritional and health practices, should and will be continued.

International health.—Finally, it is imperative that we help fufill the health needs and expectations of less-developed nations, who look to us as a source of hope and strength in fighting their staggering problems of disease and hunger. Mutual efforts toward attaining better health will help create mutual understanding. Our foreign assistance program must make maximum use of the medical and other health resources, skills, and experience of our Nation in helping these

nations advance their own knowledge and skill. We should, in addition, explore every possibility for scientific exchange and collaboration between our medical scientists and those of other nations—programs which are of benefit to all who participate and to all mankind.

Conclusion

Good health is a prerequisite to the enjoyment of "pursuit of happiness." Whenever the miracles of modern medicine are beyond the reach of any group of Americans, for whatever reason—economic, geographic, occupational, or other—we must find a way to meet their needs and fulfill their hopes. For one true measure of a nation is its success in fulfilling the promise of a better life for each of its members. Let this be the measure of our Nation.

John F. Kennedy.

The White House, *February 27, 1962.*

○

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 87th CONGRESS, SECOND SESSION

Response of Cecil R. King to Testimony of American Medical Association

SPEECH
OF
HON. CECIL R. KING
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Monday, March 5, 1962

Mr. KING of California. Mr. Speaker, no one is more aware than a Member of the Congress of the right enjoyed by all Americans to oppose legislation they believe will be disadvantageous to their own interests or the best interests of our country; however, I believe we would also agree that opposition to any proposal should be based on fact or at least on reasonable assumption.

I am submitting today for inclusion in the RECORD my response to the American Medical Association's testimony before the Committee on Ways and Means on my bill, H.R. 4222, to provide health insurance for the aged under the social security insurance system. But first I would like to place the AMA's criticisms of the proposal in proper perspective—in the perspective of some of the many other humanitarian programs the AMA has bitterly criticized and vigorously opposed through the years, in order that each Member may determine for himself just how unenlightened and incompatible with the obvious need of the people of our country the AMA's opposition continues to be.

It is a revealing anomaly that the hierarchy of the American Medical Association, after having, through their powerfully effective tactics over the years, deprived the members they represent and their dependents of the privilege of being covered under social security, despite the desires of many, if not the majority, of their members for coverage, still has the effrontery to dictate from the sidelines the rules of the game for all others, and especially when one realizes that traditionally doctors and their families enjoy the professional courtesy of free medical services.

In opposing the health-insurance-for-the-aged bill, the AMA emphasizes its support of voluntary methods and grant-in-aid programs for the indigent and medically indigent. The AMA has in the past, however, strongly opposed such programs. It seems that the AMA supports voluntary and grant-in-aid programs only since these have become so widely accepted that opposition is obviously futile, and only when they can be offered as alternatives to a current proposal that the AMA opposes.

The American Medical Association has a long history of opposition to Government programs that advance public welfare, and it is apparent that it has not raised the level of its tactics in opposing the King-Anderson bill in spite of its resounding lack of success in opposing a number of such forward-looking measures over the years, such as:

First. The social security program: In 1939 it was denounced by the AMA as "a definite step toward either communism or totalitarianism," and in 1949 they continued to express their opposition stating "so-called social security is in fact a compulsory socialistic tax which has not provided satisfactory insurance protection for individuals where it has been tried but, instead, has served as the entering wedge for establishment of a socialistic form of government control over the lives and fortunes of the people."

Second. Opposition to extension of social security benefits to the permanently and totally disabled at age 50. The American Medical Association testified "To initiate a Federal disability program would represent another step toward wholesale nationalization of medical care and the socialization of the practice of medicine" and cited this program, which is in its sixth year of successful operation, as constituting "a serious threat to American medicine" and at "incalculable cost to the public." The incalculable cost to the public which the AMA foresaw has been so moderate that the Congress in 1960 found it possible to eliminate the eligibility limitation at age 50 and provide for those eligible at any age without an increase in social security taxes.

Third. Opposition to elimination of the means test in the crippled children's program, declaring it to be "a socialistic regulation."

Fourth. Early opposition to voluntary health insurance. In December 1949 the Journal of the American Hospital Association commented editorially that "it is a sad fact that through the 1930's and early 1940's, the American Medical Association did not believe in voluntary sickness insurance, did almost everything possible to prevent its development."

Fifth. Labeling of old-age and unemployment insurance as representing "a weakening of national caliber, a definite step toward either communism or totalitarianism."

Sixth. Opposition to Federal grants for maternal and child welfare programs.

There were even medical opponents to the Red Cross blood bank plan, stating:

> The allotment of blood and its products by the American Red Cross should ultimately lead to the effect of having the Red Cross practice medicine. The transition from this arrangement to State medicine could become an imminent danger

The AMA now enthusiastically endorses Kerr-Mills legislation which authorizes Federal-State programs of medical assistance for the aged financed through grants-in-aid. However, it opposed Federal grants-in-aid in the health field when they were first established. The House of Delegates of the AMA on more than one occasion adopted resolutions which disapproved the Sheppard-Towner Act, the original grants-in-aid program granting Federal funds to State health agencies to reduce the death rate among mothers and children. AMA opposition was not against this act alone but against any such grant program. A 1930 resolution said in part:

> The House of Delegates of the American Medical Association condemns as unsound in policy, wasteful and extravagant, unproductive of results and tending to promote Communism, the Federal subsidy system established by the Sheppard-Towner Maternity and Infancy Act and protests against the revival of that system in any form (Digest of Official Actions, 1846–1958, American Medical Association, p. 92).

The house of delegates also denounced the Sheppard-Towner Act as:

> A form of bureaucratic interference with the sacred rights of the American home (96 CONGRESSIONAL RECORD 13914).

In like manner, the AMA, which now sings the praises of voluntary health insurance, adopted a resolution in 1933 condemning voluntary and compulsory insurance or tax supported programs as

equally bad. Their resolution said in part:

The organization of groups around hospitals or otherwise, supported by a voluntary or compulsory insurance or taxation, as recommended by the majority report of the Committee on the Costs of Medical Care would be inimical to the best interests of all concerned. (Digest of Official Actions, p. 314.)

Moreover, the AMA has not only opposed voluntary prepaid health insurance plans, but has disciplined physicians who participated in now well-accepted plans it did not approve. An authoritative Yale Law Journal article published in 1954 carefully documents disciplinary measures that have been used against such physicians—including the withholding or withdrawing of medical society membership and the denial of hospital staff privileges—63 Yale Law Journal, 988–996, May 1934. Such actions have not ceased.

In 1934 the house of delegates of the AMA adopted a principle intended to prevent the public from organizing voluntary plans for health insurance. To be approved the voluntary plan—not just the practice of medical care under the plan—had to be controlled by the medical profession, and restraints were imposed on physicians affiliating with nonapproved plans. Such physicians were faced with expulsion from medical societies and with exclusion from hospital privileges. Group Health Association, a nonprofit prepaid medical plan in Washington, D.C., had to fight its case in the courts for 6 years before the U.S. Supreme Court unanimously upheld a lower court conviction of the AMA and its local medical society for violation of the antitrust laws because of such actions against physicians—317 U.S. 519. AMA opposition to voluntary prepaid medical plans also resulted in State legislation which barred the establishment of medical service prepayment plans except when approved by medical associations. In many States this has made the establishment of new group-practice prepayment arrangements impossible.

Mr. Speaker, while I am referring to the States, I would like to remind the House that a resolution was adopted by the Governors' conference on June 29, 1960, urging the enactment of legislation providing a health insurance plan for the aged under the framework of the old-age and survivors and disability insurance system. This resolution was endorsed by the Governors of 30 States—Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Washington, and Wisconsin. Hearings before the Committee on Finance, U.S. Senate, on H.R. 12580, 86th Congress, 2d session, page 161. The Governors of two additional States—Illinois and Indiana—indicated their support of this approach in 1961. See hearings before the Committee on Ways and Means, House of Representatives, on H.R. 4222, 87th Congress, 1st session, volume 4, page 1795.

The AMA's history of past opposition to voluntary health insurance and to grants-in-aid for health purposes is the proper setting in which to consider the association's present opposition to health insurance for the aged.

On August 2, 1961, representatives of the AMA testified before the Committee on Ways and Means in opposition to H.R. 4222, the bill which would provide health insurance for aged beneficiaries under the social security and railroad retirement programs. At that time the committee had no opportunity before the oral testimony was presented to examine the more than 100 pages of testimony that the AMA submitted for the record. I have since explored the contents of the material submitted for the record. Closer examination has borne out my earlier reaction to the AMA testimony—it is filled with gross misrepresentations. It is difficult to believe these documents are advanced in the name of American medicine. They substitute debating tricks for a serious discussion of serious issues. They are the exact opposite of what one has the right to expect of a scientifically oriented profession. And all of this is even more shocking when we realize that it is done in an effort to malign a proposal which would have virtually no effect on physicians or medical practices. I am impelled to reply in detail.

It is not my purpose in this response to detract in any way from the great achievements of American medicine in the area of health care. I have the greatest respect for the individual doctor who practices his great profession for the relief of human suffering. My purpose is to show that the AMA's interpretations of legislative language, statistics, the nature of social insurance, and many other aspects of the problem of financing health care for the aged are completely erroneous and designed to mislead. My purpose is to show that the AMA has not been objective or honest in its presentation. I am sure that the ordinary doctor who will follow this testimony and my comments through will turn with revulsion from this performance of the association which speaks in his name.

For these reasons I have prepared a section-by-section rebuttal of the statement submitted on behalf of the AMA by Dr. Leonard W. Larson, president. References are to pages in the original statement—in the printed hearings this statement appears on pages 1315–1404, with the original page numbers below the text.

COMMENTS ON THE STATEMENT SUBMITTED FOR THE RECORD BY THE AMERICAN MEDICAL ASSOCIATION

COMMENTS ON SECTION I—DESCRIPTION OF AMA AND ITS POSITION ON H.R. 4222, 87TH CONGRESS

The specific points mentioned by the AMA in this general presentation of its position are expanded in other sections of the statement and I will deal with each point in commenting on the following sections. The only item I will discuss here is the AMA's objection to levying social security taxes for health insurance for the aged on the ground that the aged, with few exceptions—Federal employees, wards of the governments, members of the uniformed services, and veterans disabled in service—have no special claim on the Federal Government unless they have satisfied a means test. (Page 2.)

This single statement presents a striking illustration of the basic difference between the AMA and most of the rest of us, for this statement indicates that in the view of the AMA old-age, survivors, and disability insurance is undesirable. The AMA takes the position that Government should not act to promote the general welfare of the people of this country except in cases where the individual is subjected to a means test and can prove that he can no longer pay his own way. Following this theory, the AMA would oppose not only the old-age, survivors, and disability insurance program but virtually all other Government-established benefit programs that assist the people in this country without first subjecting them to a means test. Thus, such programs as unemployment compensation and workmen's compensation would be unjustifiable if the AMA theory of Government were followed. Similarly, the FHA home loan program, the Federal deposit insurance program, and many more would have to be abandoned, or modified beyond recognition. Our Nation would indeed be in a sorry plight if we were to accept the pronouncement of Dr. Annis, at the beginning of his testimony, that the AMA's position is representative of what Americans want, and if we were to wipe such legislation off the statute books.

COMMENTS ON SECTION II—SPECIFIC OBJECTIONS TO H.R. 4222

In section II of the statement, the American Medical Association alleges that the bill provides "blanket authorization for the Federal Government to control the providers of services." (Page 5.) The "proof" of the allegation is that the Secretary would be permitted to do what is "specifically provided" in the law. This exercise in logic—in which a statutory limitation to do only what is "specifically provided" becomes a "blanket authorization" to exercise power without limit—illustrates clearly the AMA's approach to the problem: the approach of a calculated attempt to distort the meaning of the bill. In an effort to support this distortion, reference is made to the provision in H.R. 4222 which states that the Secretary of Health, Education, and Welfare would be empowered to set "such other conditions of participation—as the Secretary may find necessary in the interest of health and safety of individuals who are furnished services by or in such institution." (Page 5.) This provision, the AMA says, "provides the means by which Federal officials can regiment and control all providers of the services covered." (Page 5.)

How strange this argument. I cannot believe that the individual doctors this association claims to represent have the same feelings about the conditions in the bill—the conditions that preclude participation by institutions that are

firetraps or present other serious hazards to the safety or health of their patients. I cannot believe that the witnesses who testified here representing the American Medical Association are unfamiliar with the valuable and fully accepted activities of the Government in regard to the Food and Drug Act, water pollution safeguards, and the many other areas in which the health of our citizens is safeguarded. These witnesses do not cite a single instance of regimentation, or even an attempt at regimentation, of the health professions, in all of the Government's protection of the public health. What reason is there to assume that the Government would now quite suddenly adopt arbitrary methods? In attacking the eligibility conditions in the bill, I can only believe that the AMA is deliberately trying to frighten the uninitiated and the uninformed. My conviction is borne out by the testimony presented to this committee by the representatives of the American Hospital Association—the association of the very same providers of service about which the AMA expresses such grave concern.

Dr. Frank S. Groner, the president of the American Hospital Association, was questioned by me about this very same provision in the bill. My question, and Mr. Groner's response, is part of the record of these hearings. Because the AMA chooses to ignore facts and play on fears in order to gain its ends, I want to repeat that question and answer. I asked Mr. Groner the following: "Your organization in previous testimony before this committee has stated that reasonable criteria are necessary to determine the eligibility of hospitals to participate. Are the criteria in this bill reasonable?"

Mr. Groner's response—the response of the Amercan Hospital Association—was a clear and unequivocal "Yes, sir." Later, when I asked Mr. Groner if there were any changes that he would suggest in any of the provisions in the bill, he did not suggest one single change in the conditions that providers must meet in order to participate. This demonstrates beyond a shadow of a doubt what the conditions of eligibility really constitute, namely, a description of those components of institutional and home health care which are essential to the safety and well-being of our older people. These conditions have not only been thoroughly reviewed and approved by distinguished representatives of the American Hospital Association, but the association stands squarely behind the inclusion of these eligibility conditions in any legislation that may be enacted The hospitals, which, unlike the doctors, are major providers of service under the bill, would hardly encourage the retention of these standards if, in fact, the standards could be used—as the AMA charges—as the means by which Federal officials can regiment and control all providers of the services covered.

Let me say where these conditions came from and why they are so easily accepted by the American Hospital Association. Every condition save two is part of the requirements an institution must meet even to be considered a hospital by the American Hospital Association. The remaining two are: First, the health and safety requirement, which must be met for accreditation according to standards set jointly by representatives of the American Hospital Association, American Medical Association, American College of Surgeons, and the American College of Physicians; and second, the utilization committee requirement, which the American Hospital Association has proposed for inclusion as part of these accreditation requirements.

The AMA asserts that, "it is axiomatic that the Federal Government tends to control what it subsidizes." (Page 5.) It subsidizes the building of hospitals and nursing homes under the Hill-Burton program. Does it already control hospitals and nursing homes? Perhaps the AMA should have fought harder than it did against the Hill-Burton and similar programs if the axiom is an axiom, not a conundrum to test how many are smart enough to find the error of logic.

The AMA also bases its allegations that the program would result in regimentation and Federal control on the fact that payment for services would be on the basis of reasonable costs. (Page 9.) Yet, this is the basis which the American Hospital Association, in its "Principles of Reimbursement for Hospital Care," proposes and which has proved successful in application by Blue Cross and a multitude of State and Federal Government programs. Provision for reimbursement by Government on the basis of reasonable cost has never had any such effects as the AMA says it would have in this instance.

The AMA also attaches implications of Government control to the requirements that hospitals maintain "adequate medical records" and establish bylaws for their medical staff. (Page 10.) The AMA implies that the Secretary might misuse authority by requiring medical records to be too "adequate." The AMA knows that medical records are required for accreditation because a medical history is essential for proper treatment of the patient. The AMA also knows that clearcut guides have been developed for purposes of accreditation as to what constitute adequate medical records. The AMA knows that the Secretary would have authority under the bill to accept accreditation of an institution as evidence that the requirements are met and that Secretary Ribicoff has said, in his testimony before this committee, that he would do so. Instead of recognizing these facts, the AMA analogizes medical records to business records. (Page 11.) Either its experts are feigning ignorance in this matter to mislead, or the experts on medical care did not participate in writing this statement but some other kind of expert in some field foreign to medicine was employed for the purpose.

The existence of bylaws for the medical staff is a requirement the American Hospital Association uses to determine whether an institution is a hospital—it must have a medical staff which is organized under bylaws so that there is some expectation that the medical staff will participate in running the hospital. I presume that objection to this provision must have resulted from the fact that this section of the paper was written by someone ignorant of the background—not by a competent physician or hospital expert.

The AMA further suggests that it is wrong to require nursing homes to provide 24-hour nursing service because some nursing homes would be excluded from participation under the bill. (Page 12.) But this can hardly be regarded as a reasonable suggestion. After all, the point of the bill is protection against health costs and it is the provision of nursing services that distinguished nursing homes from domiciliary care. Housing is intended to be taken care of by the cash benefit. If every institution—including a hotel—could be considered a nursing home, the H.R. 4222 costs might be as high as the AMA says. The intention is to cover only health care costs when the care is provided by facilities able to render health care services. In some places such institutions are in short supply, but paying boarding home bills instead will not remedy the scarcity. Other administration proposals such as H.R. 4999, Health Professions Educational Act of 1961, and H.R. 4998, Community Health Services Act of 1961, will help to remedy this scarcity as will the payments under H.R. 4222 towards the operating costs of the needed facilities. The AMA by its very description of the scarcity of proper health facilities rebuts its own allegations that without this bill the aged are getting the care they need.

All this talk of arbitrary control by Government is just scare technique. The Government needs the willing agreement and cooperation of the hospitals in the plan. The Government is prepared to deal responsibly and fairly with them. It is nonsense to think that the Government could deal arbitrarily with the providers of services, ignore their just demands, and ignore the advice of the statutory advisory council provided in the bill.

Section II of the AMA statement also criticizes the assertion that only a relatively few physicians would be affected by the bill. To support their contention that this assertion is not correct, the AMA says that the bill "involves the services, and the provision of services of at least 50,000 physicians." (Page 6.)

This figure is grossly misleading. The AMA statement itself recognizes that the vast majority—almost 38,000—of the 50,000 "physicians" referred to are interns, few of whom are licensed as physicians, and residents-in-training. Interns are salaried employees of hospitals completing a necessary part of their professional education without which they are not fully prepared to assume the responsibilities of a physician. Residents-in-training are also salaried employees who are training for the practice of specialties and subspecialties, including general practice.

The practice that would be followed under the administration bill would be to pay the hospital, in which the intern

632084—83231

is finishing his education, the reasonable cost of the services which the hospital undertakes to provide, including the services of the intern. This is fully in accord with the "Principles of Payment for Hospital Care," developed and approved by the American Hospital Association as a guide to hospitals and to agencies which contract to purchase hospital care. The pertinent principle reads as follows:

In determining "full cost," a reasonable amount for medical, nursing and other education not reimbursed through tuition, scholarships, grants, or other community contributions is a legitimate inclusion in the interest of continuing to upgrade quality of service to the community. The community should assist ultimately in the support of such educational programs.

Under the bill, the cost incurred in providing services to aged beneficiaries would also include the cost of ancillary services such as diagnostic X-ray, laboratory tests and anesthesia, which to an extent involve the services of licensed physicians. These services are covered only if furnished through hospitals as part of the hospital services.

The AMA claims to be apprehensive about the consequences that might ensue if hospitals are paid on a "reasonable cost" basis. (Page 9.) Is it not strange, however, that the AMA is more worried than the organization representing those whose pocketbooks are affected by the method of payment? It is true that the American Hospital Association has expressed mild reservations about the shades of interpretation which might be placed on the word "reasonable." Unlike the AMA, however, in the course of testimony before this committee, they said they believe that this is something which can be worked out without difficulty to the mutual satisfaction of hospitals and Government.

This section of the AMA statement also indulges in an extraordinary exhibition of self-contradiction—all on the same page. It says in one paragraph that the provision in the bill which limits nursing home benefits to conditions for which people have been hospitalized and provides the benefits only after admission from a hospital "will result in a vastly increased demand for—hospital facilities. This portion of the bill is not a deterrent to overuse of hospitals, but an engraved invitation to overuse them. It is an invitation that would be accepted by large numbers of people whose health care does not require hospitalization." (Page 8.) Only six paragraphs later, in criticizing the requirement that hospitals and nursing homes have the utilization committees which would provide a group review of experience by physicians in a given hospital in order to prevent overutilization, the statement says:

The physician is best qualified to judge how ill his patient is, what treatment should be prescribed, whether or not he should be admitted to a hospital, when he is well enough to go home. Is it wise to subject his judgment to the critical review of a group? (Page 8.)

Thus, on the one hand, they say that physicians—who are the only ones who can get an individual into a hospital—would be unable to prevent unnecessary hospital admissions in order to qualify for nursing home benefits, and, on the other hand, they say there would be no need to review the physician's decision when he does admit patients to the hospital. I leave it to the AMA to choose the horn of the dilemma it prefers. If the AMA expects an increase in unnecessary hospital utilization it must subscribe to the view that physicians are either collaborating with their patients in unethical practices or are unable to make proper medical judgments. The AMA cannot gainsay the fact that hospital admissions are controlled by physicians. Indeed, the AMA insists that the right to admit patients remains, the prerogative of the physician. If, however, the AMA rejects the thesis that physicians are responsible for unnecessary utilization, on the grounds that physicians are subjected to pressure from their patients, it cannot reasonably object to a professional and impartial group of physicians established by the hospital, reviewing cases in order to determine whether patients are—for whatever reason—overutilizing services.

The AMA's criticism of hospital utilization committees—which, incidentally, have been recommended by two State medical associations and are operating without appearance of difficulty in many hospitals—appears at this time after we have been informed by the American Hospital Association that it has recommended the Joint Commission on Accreditation of Hospitals require a hospital to have a utilization committee in order to be accredited. (Page 8.) The AMA objects to the requirement of a utilization committee because it does not consider it wise to subject a doctor's judgment on use of services to the review of his peers; this, despite the fact that many services are already subject to review. The AMA seems to forget for the moment that it has long subscribed to the view that it is desirable for hospitals to have committees, such as medical records committees and tissue committees, to review the medical practices of physicians. In fact, as a member organization of the Joint Commission of Accreditation, the AMA supports the requirements for accreditation, one of which is that hospitals carry on, through medical staff committees, "constant analysis and review of the clinical work done in hospitals."

A similar illogic is applied to the deductible. The AMA considers the deductible as it applies, first, to the wealthy, and second, to the indigent—as though all the aged were in these two groups. (Page 7.) They forget that the great majority of the aged fall in neither group. The wealthy, who incidentally are very few in number, get tremendous help with hospital bills by reason of income tax treatment—favored by the AMA—of medical expenses. The indigent—a group continuously growing smaller in size, I hope—will get help from old-age assistance and medical assistance for the aged. It is the great middle group, that can afford to pay a $90 bill out of their limited resources but cannot afford hundreds or thousands of dollars to pay on huge hospital bills, for whom this bill is primarily intended. The bill would provide protection for these people against the possibility of having their savings wiped out and becoming dependent. The AMA keeps saying it wishes to help those who need help, but until the recent past the legislative provisions it has favored were aimed to help most the wealthiest through tax savings. For example, the AMA has endorsed proposals to allow tax exemption for all drugs and medicines purchased by persons aged 65 and over, and proposals to provide additional exemptions for aged persons who pay medical care expenses amounting to 25 percent or more of their gross income. Since, however, more than 80 percent of the aged do not now pay income tax, these proposals would benefit only those persons with considerably higher income than the average aged person. Are the wealthy the ones the AMA thinks need help?

The AMA seems very fond of the false dilemma. On the one hand you have this, on the other hand, that, and both are bad. Since they do not talk of other alternatives, the listener is supposed to feel that all paths lead to ruin. I have already said how they refer on the one hand to the wealthy and on the other to the indigent and ignore the great mass of ordinary persons in between. Another example is their statement that the Government has two choices: First, it will either be so budget conscious it will lower the quality of care; or second, the program will be faced with runaway costs. (Page 9.) They wish to avoid consideration of the possibility that the program will operate well—with an eye for assuring that high quality of care is encouraged and at the same time that money is not wasted. Utilization committees and payment made on a cost basis, as H.R. 4222 provides, will mean that costs are in keeping with the necessary services provided. Apparently the AMA can imagine no instance in which people—nonphysicians, that is, merely do what is reasonable; everything must be extreme.

COMMENTS ON SECTION III—PROPOSED LEGISLATION BASED ON FIVE FALSE PREMISES

The "five false premises" stated by the American Medical Association as the basis for the proposal for health insurance benefits for the aged under social security are indeed misstatements, but they are the AMA's misstatements. This is the old debating trick of the straw man—define your opponents' position falsely and then prove it is wrong. The first three premises in the American Medical Association's statement actually are false; but they have never been offered as either factual or philosophical reasons supporting the proposal for health insurance benefits. The last two premises which the AMA label false, I believe to be true. They actually reflect—although somewhat less than precisely—considerations in favor of the proposal. I shall give specific comments on each of the so-called

"false premises" and on the discussion presented by the AMA on them.

The AMA statement offers as false premise No. 1: "The sociological problems of older people can be solved through legislation." (Page 14.)

I am not aware of suggestions by any proponents of my bill that the sociological problems of older people can in general be solved through legislation nor that the health insurance proposal is in any way intended to solve all problems of aged persons. The AMA discussion seems to argue that since it is not possible to solve all sociological problems of the aged through legislation, no legislation to relieve problems of aged persons is justified. Such an argument leads to no realistic conclusion; if its efficacy in solving all problems were a test of soundness of any specific course of action, one could not, of course, find any course of action that would meet the test of soundness. Such a test would even make a case against the practice of modern medicine, since it does not appear that, with all its almost miraculous advances, medical science has been able to solve all sociological problems of the aged. The proposed health insurance benefits under OASI have not been proposed as a total solution for even the financing of medical care of aged persons but have been advanced rather as a part of the solution to the problem of providing a method of financing needed health care of the aged. Many other problems will of course remain. This way of debating is hardly to be taken seriously. It is sheer demagoguery, and unworthy of the association which claims to speak for American medicine.

The AMA statement offers as false premise No. 2: "Most, if not all of the aged, are in poor health." (Page 16.)

Here again, the premise as stated by the AMA is of course not a valid statement of the position of the bill's proponents. There is no contention that all, or most, aged persons are in poor health. If that were the case, the costs of health care would hardly be insurable. Just as the need for fire insurance does not rest on the premise that all or most owners of properties experience fires, so does the need for protection against the costs of hospitalization not depend on universal and continued experience of hospitalized illness. Rather, it is based on the fact, accepted by the AMA, that "the aged receive approximately twice as much hospitalization as those under 65" (page 18), together with the contrast in incomes of younger and aged persons; these are what demonstrate a special need for such coverage as is provided under H.R. 4222.

Furthermore, the prevalence of all kinds of chronic illness is not a fact that one would use to demonstrate the need for the health insurance benefits. The bill is directed toward meeting the costs of only those chronic conditions which require the specific types of health care outlined in the bill. Statements that the aged are generally in good health or are "a great deal healthier than they are frequently pictured to be" (page 18) would seem to support the official cost estimates and the feasibility of financing health insurance benefits as proposed in my bill rather than the statements of others, including the AMA, that costs will be many times the estimates of the Department of Health, Education, and Welfare and that utilization of hospitals and nursing homes will increase astronomically if the proposal is enacted.

On the other hand, even assuming that the overwhelming proportion of the aged were in excellent health, the inevitability of death at some age obviously suggests the likelihood of terminal illness unless aged persons were in all cases to die suddenly in the midst of good health. The high rate of hospitalization in the year of death, coupled with the overall high hospitalization rates for aged people—twice the rates of younger persons—seems adequate evidence that the great majority of the aged are not so fortunate as to escape serious illness and sizable health care costs during all of their later years. What kind of nonsense is this the AMA is trying to foist off on people?

The statement offers as the third false premise: Most, if not all of the aged, are verging on bankruptcy.

Contrary to the AMA's allegation, proponents of my bill have made no such statement, and the health insurance proposal does not rest on any such premise. It rests, rather, on the well-established fact that most of the aged are not in a position financially to meet the heavy costs that a long period of hospitalization usually entails. The AMA attempts to cover up this fact with vague statements that "some" of the aged are "comfortable" or "well-to-do" or "wealthy." (Page 19.) Of course, some of them are. The great majority, however, are in very modest circumstances and quite unable to meet a large hospital bill.

In attempting to cast doubt on the validity of data from the U.S. Bureau of the Census showing the low incomes of most aged people, the AMA argues that it is not meaningful to say that "60 percent of our aged have incomes of $1,000 a year or less" (page 19) because this 60 percent includes dependents, many of whom have no individual income of their own. This argument will not bear analysis. Let me note, by the way, that the AMA figure is an erroneous one; current data show 52 percent with incomes of $1,000 or less.

I agree with the AMA that "facts are of little significance until they are examined and interpreted by reason" (page 19) and I would therefore like to quote the analysis and interpretation of these income data from the report on "Health Insurance for Aged Persons," submitted to the Committee by the Department of Health, Education, and Welfare:

> Income statistics from the Bureau of the Census for aged persons, and for families with an aged head, are collected annually and are the most comprehensive. Data which have just become available for 1960 show 52 percent of the persons 65 and over not in institutions had cash incomes below $1,000 in that year.
>
> Income data for persons have the limitation that they do not indicate how many persons depend on the income. In the case of the married, some may be under 65. Similarly, wives dependent on their husbands will be shown as having little or no income. However, less than one-fifth of all persons 65 and over are married women, and many older married couples have less than $2,000 between them. Therefore, even if the reported income data were adjusted to reflect an equal sharing by husband and wife, the proportion of persons 65 and over having less than $1,000, would be very little less than the 52 percent shown.

A national survey of aged beneficiaries under old-age and survivors insurance in 1957 showed that half the aged married couples had an annual income of less than $2,250—that is, less than $1,125 per person—half the nonmarried retired worker beneficiaries had incomes of less than $1,140, and half the aged widow beneficiaries had incomes of less than $880. It is accurate and not in any way misleading to say that half of these aged beneficiaries had per capita annual incomes of less than $1,100. This figure is consistent with the Census Bureau figures for the entire aged population—including of course those without income from old-age and survivors insurance benefits—which show that about half the aged have incomes of less than $1,000.

In the light of these figures showing the low incomes of the aged, it is hardly relevant for the AMA to stress the well-known fact that "the aged are not a homogeneous group from a financial standpoint." (Page 20.) Neither is it pertinent to a consideration of the proposed health insurance program merely to give, as the AMA does, the number of aged persons receiving income from various sources, rather than the amounts of such income. It is positively misleading for the AMA in giving figures purporting to show "the Nation's present tax support for the elderly" (page 20) to say that "about $650 million is paid out annually under the Railroad Retirement Act." Payments made under a contributory insurance program such as the railroad retirement system are certainly not a measure of "tax support." (Page 20.)

The AMA suggests that the aged who are unable to pay large medical bills should look to their children or relatives for help. The sons and sons-in-law, the daughters, the nephews, and nieces of old people do in fact often provide such help. Too often, however, this burden is borne at the expense of the education and welfare of the third generation. In many instances the relatives are themselves totally unable to meet the heavy costs involved. Few people would consider an appeal to relatives to be an acceptable alternative to a health insurance program.

The AMA quotes figures on the net worth and assets of beneficiary couples under old-age and survivors insurance as shown by a survey in 1957. (Page 21.) It fails to say that of all the aged beneficiaries surveyed, nonmarried as well as married, half had a net worth of less than $4,920, and that the chief asset of most beneficiaries was their equity in

their home, an asset which old people very wisely hesitate to convert into cash. While most beneficiaries had some liquid assets, half of them had less than $610, an amount which would not go far in meeting the costs of a long illness.

For statistics to bolster its position against the health insurance program, the AMA resorts to a small study made in three lower middle income parishes located in three large cities. (Page 22.) It would have been more helpful to the committee if the AMA had referred to a national cross-section study of the aged sponsored by the Health Information Foundation: "Financial Resources of the Aged"—Health Information Foundation, Research Series 10. A report from that study states that one-fifth of all older people had no financial resources. Furthermore, when the aged without any resources were combined with those whose only assets were homes they owned, the cash value of their life insurance or the help of children, it was found that two-fifths of all older people would have no ready resources from which to meet a medical bill.

The data from the Health Information Foundation study are confirmed by the 1960 Survey of Consumer Finance, which showed that 30 percent of all spending units headed by aged persons have no liquid assets and that an additional 6 percent had less than $200 in liquid assets. These facts, based on national samples rather than a small local study, present a more reliable picture of the situation of the aged than that portrayed by the AMA.

As false premise No. 4 the AMA statement offers:

> The problem of the aged in financing their health costs will get worse before it gets better. A permanent program is essential to its solution. (Page 22.)

Here the premise they claim to be false is true—there is every reason to believe that the problem faced by the aged in financing health costs will, in the absence of Federal action, get worse. Although the costs of health care increasing more rapidly than costs of all consumer items and substantially more rapidly than the income of aged persons—cannot be predicted with precision into the distant future, it would seem highly unrealistic to assume any immediate sharp reversal of the upward trend in such costs that has continued over decades. The official cost estimates for my bill, incidentally, assume such substantial further increases in costs.

Unless income and resources increase in direct ratio to any increases in medical care costs, it is obvious that the aged will face an increase in the difficulty of financing needed health care. It is quite likely that the financial resources of aged persons will increase somewhat as time goes on. Allowing for increases in monthly OASI benefits, in earned income, and in the limited amounts paid by private health insurance, and assuming increases in all of these amounts in the future, we are still left with the question of how these resources could grow at a rate equal to or faster than the justifiable costs of health care we must expect as medical science continues its phenomenal progress toward improving health and increasing longevity for all of us.

The AMA statement, in discussing the future sources of income of the aged, quotes some current figures on income from these sources and suggests that they are already substantial. Of course, billions of dollars sounds like a great deal of money, but the present total income to the aged from private pension plans quoted by the AMA—$1 billion annually—does not sound so impressive when divided among total present aged persons—a per capita figure of less than $60 per year. The same situation appears with regard to the $4.3 to $8.3 billion estimated as total annual income of the aged from private investments (page 23), which would provide a per capita figure of about $250 to $490. It would seem a mathematical certainty that not all our aged citizens can be receiving very substantial income from these sources.

The AMA statement offers as the fifth false premise: Voluntary health insurance and prepayment plans, private effort, and existing law will not do the job that needs doing. (Page 25.) Again, the statement they claim to be false is true; these mechanisms alone will not do the entire job. I shall comment in some detail in following sections on the effectiveness of the three mechanisms cited in meeting the problem.

COMMENTS ON SECTION IV—PHILOSOPHICAL ARGUMENTS AGAINST THE BILL

One had best ignore the title of this section of the AMA statement. The alleged arguments are not relevant to H.R. 4222. They are arguments against socialized medicine and against Federal encroachment on individual freedom. The whole philosophy of my bill and the implementing provisions are in direct opposition to these evils. And to label the AMA arguments "philosophical" completely ignores the noble root of this word.

It has already been shown that the assertions made in the previous section of the AMA statement are incorrect, except for the recognition that our aging population poses a very real problem. Even this one exception is developed by the AMA to the point of an incorrect conclusion. The AMA concludes that since some of the problems of the aged are not susceptible to legislative solution, legislation can be of no help in solving any of the problems. (Page 26.) This is a very strange conclusion indeed. Hardly anyone would deny that the Congress has already enacted legislation that makes significant inroads on the problems of the aged. And even the AMA apparently sees some merit in certain legislative approaches to the problem, for it now endorses medical care paid for by Federal funds granted through the assistance program.

The core of the principal "philosophical" argument that the AMA tries to make against H.R. 4222 is that this bill is a part of some master plan that somebody [unnamed] or some group or groups [unnamed] has devised with the aim of setting up a socialized system of medicine in the United States. (Page 27.) It little matters what villains the AMA has in mind, for this bill is no more a part of a plan to establish socialized medicine than were the disability benefit provisions of the law, which the Congress wisely enacted in spite of the cries of wolf that were heard far and wide from AMA representatives.

To charge that H.R. 4222 represents socialized medicine or is the forerunner of socialized medicine or that it is in any way like socialized medicine is not only ridiculous but also irresponsible. Here are the facts. Under socialized medicine, doctors work for the Government and the Government owns the medical facilities and furnishes the services. The proposed program would not furnish any medical services but would only help people finance the costs of their health care. There are specific guarantees that the Government would in no way control, regulate, or interfere with the practice of medicine.

In an apparent attempt to win some adherents the AMA professes not to oppose social security. (Page 27.) They say that "the medical profession has not and does not oppose the principle of social security." It is hard to see anything but opposition to the principle of social security in the many statements made over the years by AMA presidents, by other spokesmen, and in editorials in the Journal of the AMA. Thus, for instance, it is hard to see anything but opposition to the principle of social security in such a statement as that made in 1939 by Dr. Morris Fishbein, published in the Journal of the AMA and referred to by Dr. Fishbein as made at the request of the AMA's Board of Trustees. In this statement Dr. Fishbein said "all forms of security, compulsory security, even against old age and unemployment, represent a beginning invasion by the States into the personal life of the individual, represent a taking away of individual responsibility, a weakening of national caliber, a definite step toward either communism or totalitarianism." But the AMA has certainly made clear on many occasions that its attitude is: If we have to have a social security program, let us do our best to restrict it to the barest "floor of protection" possible.

In the present statement the AMA spokesmen take us back to 1917 for a quote from Samuel Gompers. (Page 30.) The AMA calls "a wise and timely warning" the quotation indicating Samuel Gompers was opposed to "compulsory social insurance." Our present social security system is a compulsory social insurance system; the medical profession, the AMA says, does not oppose the principle of our social security system. Now where does that leave the AMA—is it with Mr. Gompers or not with him? It is characteristic of much of the AMA testimony that we find—as here—that they favor something on one page and are against it several pages later.

A highly significant indication of how the AMA regards the social security program is a statement by Dr. Annis that appears on page 3 of his testimony. Speaking of the aged, Dr. Annis warns that H.R. 4222 would place them in a

broad category labeled: "These are people who can't take care of themselves. These are people who must be cared for by the Federal Government at the expense of the rest of the population." This statement clearly shows the AMA's attitude toward the whole social security program. The rest of the population of course understands that there is no stigma attached to social security benefits. There is no means test. Rich and poor are treated the same. If social security beneficiaries are labeled at all they are labeled as people who have taken care of themselves by having worked and having contributed to the program.

With reference to the AMA charge (page 29) that the Federal Government is seeking, through H.R. 4222, to encroach on individual freedom, let me make clear that this bill preserves individual freedom not only for physicians but also for hospital administrators, for nursing home proprietors and managers, for the aged who would benefit from this bill, and for the individual members of what we call the public. Moreover, my bill would make individual freedom a reality for many who, because they don't have the means to meet the cost of needed health care, cannot now enjoy their freedom in old age.

There is nothing in the bill that would in any way interfere with the established practices of providing health care. Health care would remain—as it is now—a matter determined by the patient, his physician, and the hospital or other provider of services. The Government would provide no care and offer no services; it would establish only the means of paying for the health care of the aged.

The medical profession would continue to be responsible for the quality of the care available to the people of the United States; the providers of service would still be responsible for determining what services they would make available. The process by which they would be paid for the services furnished would be much the same as that now used by Blue Cross and other large insurers of health service costs. The program would follow practices already well established and accepted by the hospitals in their relationships with Blue Cross, the States, and other Federal programs.

I gladly give credit to the medical profession for its great contribution to improvements in medicine and health care that today help us to live longer and more comfortable lives than ever before. Even though I believe that other groups should be mentioned for their significant contributions to this process. I would take no credit from the physicians of this country; they have my highest respect and my deepest gratitude. It is preposterous, however, to suggest that provisions that would enable our people to prepay, through the accepted social security system, some of the costs of the health care that they will need in old age might impede, or in some way interfere with, the efficiency of the medical profession. The physician in this country is a well-trained, highly skilled, humane expert in medical care. He does not, I believe, profess to be an expert in economics or insurance, though the AMA representatives pose as such experts. He does not look upon himself as a Solomon whose business is to advise people how they should go about paying their medical bills, though the AMA does. He does not always share the views of the AMA; however, because he may fear AMA sanctions he sometimes is constrained to ask, when writing to his Representative in the Congress, that his position favoring H.R. 4222 not be made public. This bill, let me repeat, has nothing to do with the practice of medicine; it simply affords a means for helping people to pay for the cost of certain medical services in old age.

Furthermore, this bill is, contrary to the AMA's charges (page 29) in keeping with the purpose of the social security system and with the basic principles of this system. While the insurance provided by social security has been in the form of monthly cash benefits there is nothing in the nature of this system or in its history that would make the payments provided under my bill inconsistent or incompatible with the objectives, the principles, and the philosophy of social security in this country. H.R. 4222 would provide for payments to be made to hospitals and certain other medical facilities—but not to physicians—for specified and limited medical services received by social security beneficiaries. The bill would authorize neither the Federal Government nor any other level of government to furnish health services to anybody. No one would be required to accept health services by reason of this bill—and the AMA persists in spreading the contrary impression. The charge that this bill is contrary to the principles of the social security system is not only false but also strange coming from the AMA—strange because available evidence indicates that the AMA knows little about the principles of the social insurance system and cares less.

The charge is also made that my bill is paternalistic—that it implements a "Government knows best" kind of thinking. (Page 30.) Nonsense. I am convinced that the people are capable of deciding how to spend their money and know how to do it without AMA advice. That is why they are for this bill. I am confident that the people know that my bill would give them valuable protection, and the correspondence that I have received indicates that they know better than the AMA what is good for them.

If the AMA seeks to substantiate its charges of impending Federal encroachment, it should in all fairness approach this task, however impossible, by dealing with the provisions of my bill rather than talking about what could happen under some other plan that has not been proposed, and talking about that other imaginary plan as if it were that proposed in my bill. Under H.R. 4222 the Federal Government could not "regiment doctors, nurses, patients, hospitals, nursing homes, and any other element of our health care system" and the AMA knows the Government could not, even though the AMA statement deftly leads one to infer the opposite. (Page 30.)

COMMENTS ON SECTION V—EFFECT OF BILL IMMEDIATELY AND POTENTIALLY ON THE QUALITY OF MEDICAL CARE

In section V of the statement, the AMA has said repeatedly that a Federal health insurance program "would lower the quality of medical care available to older people." According to the AMA, the program would do this by substituting a concern with costs for a concern with quality. The Government, in its search for methods to reconcile the need for care with the need for cost controls would "decide for the patient what services should be provided and by whom." (Page 33.) As a result, the AMA says, the Federal insurance program would produce a series of catastrophes: "The disruption of the doctor-patient relationship, delays in admissions to hospitals, time wasted in the overcrowded offices of doctors, the regimentation of medical practice," and impairment of medical research. (Page 32.)

In vain do we look for any concrete evidence, beyond bald unsupported statements about medical care in other countries, to corroborate the AMA's assertions, or for any consistent logic which demonstrates that a Government plan must have results which its counterparts outside of Government—Blue Cross for example—have not produced.

The facts of the case are quite different, and when carefully examined they demonstrate that the charges of "regimentation" and "deterioration of quality" are baseless. Under this bill, there is no compulsion imposed on any provider of service to participate in the program. The conditions of participation which are provided in the bill are based upon requirements formulated and recommended by professional bodies concerned with the quality of care. Freedom of choice of physician and hospital by patients is guaranteed. There are provisions designed to assist the physician in resisting pressures which may be exercised to secure unnecessary care; for example, the utilization committee. And the bill provides, through the Advisory Council, for the effective expression of all shades of opinion on the administration and future development of the program.

The AMA's argument, as developed in section V, is largely incoherent. An attempt is made to sneak in certain false premises and to then present a series of conclusions as if they were derived from sound premises and factual data.

The AMA asserts, for example, that a high quality of care can be obtained only when the needs of the patient are placed first, "and financing is placed second." (Page 33.) This truism is followed by the statement that at present medical care is aimed at "treatment of the illness." We are then exhorted to contrast this with a system under which "Government pays for care directly," because under this system emphasis is "shifted from quality to cost." (Page 33.) This extraordinary set of assertions is supposed to prove something. Yet, all that has actually been said is

that quality care can be furnished only if we treat the patient and he pays for it. But if the cost is paid for through insurance we presumably stop "treatment of the illness."

We are treated elsewhere in this document to similarly empty statements; "under H.R. 4222—the dollar approach instead of the medical care approach is stressed." (Page 34.) Is not an insurance program supposed to deal with the financial aspects of care? Moreover, is it not possible to couple concern for costs with a concern for standards, as in fact H.R. 4222 does? But the AMA is not really interested in looking at the merits of the case, nor in being logically consistent, for it later predicts with horror that "Government would be preoccupied with efforts to regulate quality." (Page 36.)

COMMENTS ON SECTION VI—COST ESTIMATES FOR H.R. 4222

After admitting its lack of statistical and actuarial competence, the AMA proceeds to demonstrate another of its lacks—its ignorance of the provisions of my bill. The AMA apparently does not know that the social security tax increases being proposed by the administration would cover, in addition to the health insurance costs, the costs of higher benefits for workers who earn over $4,800 a year that would be paid because of the proposed increase in the social security earnings base from $4,800 to $5,200. In effect, the employee contribution for health insurance protection alone would be $16.90 a year at the maximum—as opposed to the AMA statement indicating that the cost would be $25.

I have asked Robert J. Myers, Chief Actuary of the Social Security Administration, to prepare a brief statement on the AMA's attempt to diagnose the financing of my bill. His statement appears in the record of the hearings on H.R. 4222, beginning on page 1469.

Memorandum dated August 3, 1961, is included in the RECORD immediately following these comments.

COMMENTS ON SECTION VII—EFFECT OF H.R. 4222 ON THE SOCIAL SECURITY SYSTEM

I believe my 19 years of experience as a Member of the House of Representatives and my years as a member of the Committee on Ways and Means make me somewhat of an expert in detecting the misleading statements about our social insurance system that are included in section VII of the AMA statement. The old-age, survivors, and disability insurance program is far too important to allow the attempts of the AMA to discredit it, to go unchallenged. I intend to challenge some of the misleading and erroneous statements that the AMA has made about the program.

The AMA testimony implies that the financial soundness of the old-age, survivors, and disability insurance program is open to question. This of course is not true. The program has operated successfully for 26 years and has proved to be an effective method of protecting the families of America against the poverty that would otherwise be the common result of the old age, disability, or death of the breadwinner. The Congress under both political parties has been careful to assure the soundness of the program. Whenever liberalizations have been adopted by the Congress, the Congress has made sure that there were adequate provisions for meeting the cost of those liberalizations. It is because the public has confidence in the intention of the Congress to keep the program sound that increases in the tax rates provided for have been accepted.

The AMA has tried to give the impression that the old-age, and survivors insurance program is not financially sound because it is not fully funded. (Page 52.) This is a complete misrepresentation of the nature of a social insurance program. In a compulsory Government program of social insurance it is not necessary to accumulate the full reserves that are needed in a private insurance company. Compulsory social insurance is assured of continuing income. Thus, a social insurance program is financially sound if future income will support future disbursements. On this basis the system is in actuarial balance since it is expected, on the basis of the best available estimates, to have enough income from contributions based on the tax schedule now in the law and from interest earned on investments to support it now and over the long-range future.

The AMA says that if the Government suspended social security taxation the system would collapse. This is like saying that if a workman is never paid any more wages, he will not be able to meet his obligations. In other words, in assessing the financial soundness of the system the AMA considers only its future obligations and ignores its future income. Considered on this basis, not only the social security system, but the U.S. Government itself and practically every American family are financially "busted."

The basic soundness of this program has been reaffirmed on several occasions by distinguished groups which have made a careful examination of the financing of the program. Such a study was made in 1958 by the Advisory Council on Social Security Financing, which included, among others, outstanding economists, representatives of the insurance industry, and leading employers. The Council stated in its major findings:

> The Council finds that the present method of financing the old-age, survivors, and disability insurance program is sound, practical, and appropriate for the program. It is our judgment, based on the best available cost estimates, that the contribution schedule enacted into law in the last session of Congress makes adequate provision for financing the program on a sound actuarial basis.

The AMA has also criticized the social security program because present beneficiaries have not contributed enough to pay for the benefits they are getting. (Page 53.) There is nothing irregular or unsound about this situation. As a matter of fact, it reflects a wise and practical decision by the Congress to make the program effective for people who were already old when their jobs were first covered by social security. In the future, of course, when all covered workers have had an opportunity to contribute substantially to the program, retirement benefits will be paid only to people who have contributed for at least 10 years and full-rate benefits will be paid only to those who have contributed over their working lifetime.

In a social insurance program it is proper to give full protection to those who retire before they had the opportunity to contribute more than a small part of the value of the benefits they will receive. It is proper to insure that no one who, by acquiring the specified number of social security credits through his past work, has demonstrated that he was part of the covered labor force will be denied social security benefits. Indeed, the only alternative is to leave the urgent problems of dependency untouched for decades. And of course, the method of giving full protection at once to meet an existing problem is not peculiar to social insurance. Similar treatment is usually given under private pension plans to workers who are already nearing retirement when the plans are set up. The costs of doing so are generally borne by employer contributions, just as under social security the cost of full protection for people nearing retirement age at the beginning of the program can be thought of as being met from the employer tax.

The AMA says that extending health insurance protection to people now receiving old-age and survivors insurance benefits would junk the contributory principle inherent in the social security system. (Page 54.) I am glad to see that the AMA does admit that there is at least one good principle inherent in our social insurance system, but I must take issue with their allegation that H.R. 4222 would violate that principle. By extending protection immediately to the 14¼ million aged who will be eligible when the major provisions of the program become effective, the new health insurance program would follow the precedent established in 1939 and reaffirmed time and again through subsequent legislation. As the program has been expanded and improved over the years, immediate protection has been provided for people who had worked under the program in the past. For example, in 1957 when cash disability benefits were made available to people age 50 and over, those who were already disabled and who had had substantial work in covered employment in the past were able to get benefits immediately. They were not required to make a contribution to the disability insurance trust fund.

The AMA would have us believe that the old-age, survivors, and disability insurance program has been expanded beyond the role that was originally intended for it. (Page 53.) They would have us believe that its role is to provide a floor of protection, which the AMA equates with subsistence-level benefits. Whether old-age, survivors, and disability insurance is a floor depends on your definition of the term, but it is quite clear that there was never any intention to keep benefits paid under the program at subsistence levels or below. If we go

back to the original bill that created the program in 1935 we find that the Committee on Ways and Means spoke of benefits "in amounts which will insure not merely subsistence but some of the comforts of life," and the Committee on Finance of the Senate spoke of benefits "which will provide something more than merely reasonable subsistence." Personally, I do not believe that the program has yet reached these fine goals. Present benefit levels, in my opinion, are far too low, not too high.

The AMA contends that use of the term "insurance" to refer to old-age, survivors, and disability insurance has misled the public as to the real nature of the program. (Page 51.) They would even invoke the sanction of the Supreme Court to support their position by implying that the Court has denied that the program is insurance. (Page 52.) If we look at the Court's opinion in the case the AMA has referred to, we find that, far from supporting the AMA contention, the Court has said:

> The social security system may be accurately described as a form of social insurance, enacted pursuant to Congress' power to spend money in aid of the general welfare.

It is the use of the insurance principles of sharing the cost and spreading the risk rather than the fact that a contract exists that makes a particular program "insurance." The old-age, survivors, and disability insurance program is income insurance. The risk insured against is loss of family income occasioned by the disability, old age, or death of the family breadwinner. Thus, although the right to benefits under the program is based on the provisions of the Social Security Act rather than on a contract, it is clearly an insurance system. The fact that rights under the program are statutory, not contractual, has been used by some critics to infer that social insurance is somehow inferior to private insurance. In reality, the fact that Congress can change the law is an advantage rather than a disadvantage. As we all know, the protection offered the American people under the old-age, survivors, and disability insurance program has grown with the growth and expansion of the American economy, and will continue to be adjusted to changing conditions.

The AMA goes on to imply that enactment of H.R. 4222 would create a tax load that future generations of workers would be unwilling or unable to bear. (Page 54.) There is no reason whatever to expect that this will happen. In the first place, coverage of the group now on the beneficiary rolls will have very little cost impact since the cost will be spread over future generations of workers as well as those now in the labor force. In fact, to exclude from protection under the bill all those now on the beneficiary rolls and all those who did not have a significant amount of covered employment after the time the proposed plan went into effect would reduce costs by only about 0.06 percent of covered payroll.

Another support offered by the AMA for its prediction that future generations will not be willing to pay their social security taxes is the statement, currently being circulated both by the AMA and by some people in the insurance industry, that younger workers are "subsidizing" with their social security taxes the payment of benefits for people who are now retired, and that these younger workers will not get their money's worth in protection for themselves and their families. Such statements are not correct. Even workers who will be covered by the program over a whole working lifetime and who will be paying contributions at the maximum rate, that is, the rate scheduled to go into effect in 1968, will be getting insurance protection whose value is at least equal to the value of their contributions. The reason this is possible relates to the fact that the employer contributions paid under the program are not earmarked for any particular employees or groups of employees. Because of the availability of these employer contributions, the value of the protection received by those who become beneficiaries in the early years of the program can exceed the value of the protection received by those and the equal amounts paid by their employers without there being any overcharge of workers who are now young.

COMMENTS ON SECTION VIII—EFFECT OF H.R. 4222 ON PRIVATE, VOLUNTARY EFFORTS

The AMA here advances the preposterous argument that H.R. 4222 will damage or destroy such varied activities as community meals-on-wheels programs, construction of hospitals through philanthropic grants, community chest activities, and voluntary efforts to build chronic disease centers, retirement villages, church homes for the aged, and nursing homes.

It is true of course that if the bill is enacted, individuals and voluntary organizations will be relieved, to a large extent, of one burden they now carry: If the bill is enacted, many thousands of older Americans will no longer have to seek charity from voluntary organizations when they become ill. I know that both the charitable organizations and the aged will look upon this as a blessing. It is as absurd to argue that narrowing this area of need will be disastrous to voluntary charitable organizations as it is to argue that the discovery of penicillin has damaged the medical profession because people with infectious diseases now require less medical care, or to argue that the patient has been disadvantaged because penicillin has robbed him of the need to undergo intensive medical care over an extended period of time.

Just as the efficiencies of modern medicine have enabled physicians to devote more time and energy to the field of chronic illness and other fields that heretofore received too little attention, the enactment of my bill would enable charity organizations to devote their energies and resources to meet more completely the varied needs of the community. For example, voluntary hospitals, or nursing homes that are constantly in financial difficulty because they must accept older people who cannot pay for the care they receive would be relieved of this problem. The funds that are released would be available for improving the services these hospitals and nursing homes give to their patients; or the funds would be available to reduce the rates that now have to be charged to paying patients.

If H.R. 4222 is enacted, community chests and other large and small voluntary organizations that contribute to support hospitals and nursing homes will of course benefit in the same way. These organizations will then be able to devote more of their resources and energies to building retirement villages, meals-on-wheels programs, and a myriad of other needed services.

COMMENTS ON SECTION IX—WHAT THE MEDICAL PROFESSION IS DOING

The AMA has described in detail the efforts that many American doctors and medical organizations are voluntarily making to meet the health problems of older Americans. I was impressed primarily with the wide range of activities that physicians carry on in order to advance science, promote better public understanding of the problems of aging, and encourage better medical, public health and rehabilitation services for aged people. I think it is also important to point out, however, that the bill would not alter or in any way affect these activities of physicians.

I would like to add that whatever progress has been made in improving the medical and vocational services available to older people has been due not only to the efforts of physicians but also to the efforts of Americans in many different occupations who have joined in bringing to bear their energies, their different skills, and their money to common purposes. Also, it is fair to point out that the Federal Government has played an important and active part in these achievements.

The AMA rightly emphasizes that there still remains a great need for additional hospitals, nursing homes and other community health facilities. Enactment of the community health services and facilities bill—H.R. 4998 and S. 1097—would supplement the Hill-Burton program to make possible Federal support for the development of a balanced network of services throughout the land, including hospital, nonprofit nursing home, home nursing, and organized home care programs. H.R. 4222 would assist in this effort by enabling the aged to pay for the health care they receive. It is common knowledge that providing free care and below-cost care for the aged has placed a considerable financial strain on hospitals that has impeded improvements in hospital care. Obviously, the inability of aged people to pay for needed health care has also hampered the development of facilities designed to meet the health needs of old age. The current low level of care in nursing homes is a good example of the quality of the health care the aged now get through present financing arrangements. When provision is made so that the aged are able to finance the care they need, facilities will be constructed to provide that care.

The recent exposé in Baltimore of the deplorable conditions in homes licensed by the State health department to provide care for the aged is a striking case in point. I want to insert for the record an article from the Baltimore Sun for July 15, 1961, which describes the situation in some detail. Suffice it for me to say that Baltimore is not a unique city in this respect, and that the existence in great numbers of overcrowded, dilapidated, unsanitary nursing homes throughout the United States is a matter that ought to concern and disturb us all.

Article from the Baltimore Sun, July 15, 1961:

FIFTEEN IN CARE HOME FOUND UNDER LOCK—23 OF 27 IN ROSLYN AVENUE PLACE TAKEN TO CITY HOSPITALS

State health authorities closed a northwest Baltimore care home late yesterday after discovering 15 elderly patients were being kept behind a padlocked door on the third floor.

Miss Esther Lazarus, director of the city's Department of Public Welfare, said 27 patients were found in the house in the 2300 block Roslyn Avenue although it had originally been licensed for only 11 persons.

Twenty-two patients—all welfare recipients—were transferred to the city hospitals on an emergency basis by a fleet of municipal ambulances.

SAYS PERMIT HAD EXPIRED

Miss Lazarus said she was told the home, operated by Mrs. Ethel Camphor, had been unlicensed since her State permit had reportedly expired last month.

The welfare director said State officials reported that the home's operator had told them the third floor was being used as her living quarters.

The discoveries were made when officials of the State Department of Health inspected the house preliminary to relicensing the premises, she continued. The Health Department is charged with regulating care and nursing homes.

When the inspectors arrived at the Roslyn Avenue house yesterday morning, Miss Lazarus related, Mrs. Camphor was not at home.

VOICES HEARD OVERHEAD

They found 12 men and women on the first two floors of the racially integrated home—one above the legal limit, she continued.

The attention of the inspectors was attracted to the third floor when voices were heard coming from the area, Miss Lazarus said.

When they ascended the stairs to the third floor, they found the door at the head of the staircase padlocked, it was stated.

No key was available, according to reports reaching the welfare director.

It was later learned that the group of patients were being housed here.

Mrs. Camphor did not return until about 2 p.m., Miss Lazarus said, and during the entire period, the patients were not fed.

Health officials decided to close down the premises and the welfare department made arrangements for its 22 clients to be taken to the City Hospitals Infirmary.

RELATIVES CALLED

The other five were taken away by hastily summoned relatives.

While the patients were considered ambulatory, some of them had to be carried into the waiting ambulances on litters and in chairs. Others were helped by policemen and ambulance attendants.

Their belongings, packed into paper sacks and cardboard boxes, were placed in the ambulances, too.

Mrs. Camphor declined to make a public statement about the incident.

COMMENTS ON SECTION X—WELFARE PROGRAMS—PUBLIC AND PRIVATE

The tenor of this section is that the programs now providing assistance to some of the needy people who cannot meet the costs of their medical care have been ignored by the advocates of the social insurance approach; (page 65) that these programs represent a satisfactory method of dealing with the problems the aged have in meeting these costs; (pages 65 through 67) that setting up a health insurance program under social security would conflict with, and perhaps even destroy these programs, substituting for them an inferior one; and that the public has a greater voice in other programs than in a Federal one. None of these things is the case. (Pages 67 and 68.)

The supporters of my bill have not ignored the existence of public and private welfare programs that now help to meet the costs of medical care of some of the needy aged. In the absence of a social insurance program these programs serve an essential function; and even when health insurance is added to social security they will continue to exist and perform an important function.

There is no conflict between these programs and health insurance under social security, just as there is now no conflict between old-age assistance and old-age and survivors insurance. In fact the effectiveness of old-age and survivors insurance in preventing poverty among the aged has enabled public and private welfare programs to deal much more adequately with the declining residual need than would have been possible if the welfare programs were mistakenly relied upon to do the whole job. Similarly, when hospital insurance for the aged is added to the social insurance program, the Federal-State assistance programs and the other public and private welfare programs mentioned in the statement of the AMA (pages 65 and 66), will be able to meet the cost of residual medical needs much more adequately than they are able to meet these needs at present.

The AMA speaks of "fixing a master-pattern of health services for the aged throughout the entire Nation" as if this were a bad thing. (Page 68.) I do not believe that it is a bad thing to provide basic protection against hospital costs for the aged person no matter where he lives. This is what my bill would do. What we have at present is a situation where a person in Massachusetts or New York who needs hospital care for a given condition and for a given period of time can get assistance while a person in Kentucky, Tennessee, or Mississippi with exactly the same need cannot get assistance. This may seem a desirable situation to the AMA because it reflects the income and resources of the States but it does not seem so to the residents of Kentucky, Tennessee, and Mississippi who need the care but cannot pay for it. A Federal program can reflect fully the needs of local communities through local offices, consultation with the States, and use of State officials to perform appropriate parts of the administration of the program. Under H.R. 4222 all these things would be done. One of the advantages of the Federal program is that it would not be bound by the limited resources of the low-income States.

The AMA makes much of the idea that State and local assistance programs "represent the natural development and the natural implementation of the community's responsibility for its members." (Page 67.) The implication must be that in some way a national social insurance program like we have today is unnatural. How the AMA reaches this conclusion is beyond me. It is natural and highly desirable that the mind of man devise better solutions to his problems as time goes on. There is practically universal agreement that so far as income maintenance is concerned social insurance is the preferred approach over public assistance; surely it was natural, then, to turn to the insurance approach. So, too, it is quite natural for our people to prefer social insurance against the costs of medical care in old age to the inferior method of assistance, which requires people to exhaust their resources and declare themselves unable to meet their own needs before they can get help.

The AMA says it has no desire to "pauperize" the aged. (Page 65.) Of course it does not desire to do so and would not do so. Nevertheless, the end result of the program it advocates would be that many older people would be pauperized. Any program relying on a means test—any program that, as the AMA advocates, helps only those who establish inability to care for themselves—is by definition a program that requires older people to exhaust their resources before they can get help. If exhaustion of resources is not pauperizing people, what is it?

The AMA makes the preposterous suggestion that the only reason why people prefer insurance to assistance is "propaganda for the Federal approach." (Page 67.) I find it hard to deal with this suggestion seriously. Does the AMA really believe that the only reason why people do not want to subject themselves to an examination of their and their children's income, resources and other personal circumstances—that the only reason why they do not want to declare themselves incapable of meeting their own needs—is that they have been propagandized into this attitude? Of course the AMA does not believe this. The fact of the matter is that a means test approach to any problem requires the division of people into two groups—one labeled "successful" and the other "unsuccessful." It is innately distasteful to any man who has supported himself and his family throughout his entire working life to have to come, hat in hand, to the welfare agency in his old age and say: "I have failed. I cannot pay my bills. Please give me help." This is the reason why the American people overwhelmingly prefer the insurance approach, and why the present complex of assistance programs, helpful and necessary as it may be, is not a satisfactory approach to the problem.

The provision of health insurance benefits at age 65 is attacked by the

AMA because it might encourage people to defer treatment until age 65. (Page 67.) Social insurance proponents do not argue that the protection provided under the program will cover all problems. Because it does not try to cover all problems, social insurance can concentrate on the problems of the aged, among whom the need for protection is most acute. But is the AMA concerned because medical assistance for the aged and old-age assistance are available only after 65, and is it concerned because such help as the States offer to persons below age 65, for whom there are no Federal grant-in-aid programs, is even more woefully inadequate than the help offered to the aged?

COMMENTS ON SECTION XI—ADVANCEMENTS OF PRIVATE INSURANCE AND PREPAYMENT MECHANISMS

In the AMA statement, the supporters of H.R. 4222 are accused of being opposed to the development of private health insurance for the aged. (Pages 73 and 74.) Nothing could be further from the truth. And the allegation—presumably attributed to me and to the supporters of my bill—that 49 million people cannot afford health insurance is something I never head of before. (Page 73.) I accept the AMA's proof that this allegation, which I presume was originated by the AMA, has no base. I have watched with interest the growth of health insurance for the younger population and hoped that their coverage would be paralleled by comparable coverage for the aged, which would have helped solve their health care cost problems. However, this has not occurred—less than 50 percent of the aged have any kind of insurance and much of it is completely inadequate for their health care needs.

Now, it should be made clear that I do not criticize the Blue Cross plans nor the insurance companies for this. On the other hand, I applaud their commendable efforts and ingenuity and I admire, along with the AMA, the noteworthy recent efforts of the Connecticut insurance companies and the Pennsylvania Medical Society to provide adequate insurance for the aged.

The AMA statement completely avoids any discussion of the underlying problems which have prevented the provision of adequate health protection to the aged. These problems were outlined by Dr. Basil C. MacLean, recently retired president of the Blue Cross Association—the organization which has, let me point out, done most to meet the insurance needs of the aged—who said:

> A lifetime's experience has led me at last to conclude that the costs of care of the aged cannot be met, unaided, by the mechanisms of insurance or prepayment as they exist today. The aged simply cannot afford to buy from any of these the scope of care that is required, nor do the stern competitive realities permit any carrier, whether nonprofit or commercial, to provide benefits which are adequate at a price which is feasible for any but a small proportion of the aged.

The difficulties mentioned here are obvious when we realize that the total health care expenses of an average aged person amount to one-fourth or one-fifth of his income. Private and nonprofit health insurance carriers are struggling with the dilemma of providing adequate insurance for the aged without passing the heavy financial burden to their younger subscribers or charging higher rates for the aged than they can afford to pay. The dilemma has not been solved. It is certainly not solved by selling insurance with inadequate benefits.

The AMA, after "adjusting" the figure on aged people without health insurance to take out the people on public assistance, proudly announces that "We can safely conclude that 70 percent of the aged who are in the market for voluntary insurance now have it." (Page 70.) Since illness and high-health-care costs are major reasons for applying for assistance and many of these people would not be on assistance if they had health insurance, it is remarkable that the AMA chooses to count those on assistance as "not in the market." They, like all the low-and-moderate-income aged, are "not in the market" for adequate commercial insurance in the same sense that they are not in the market for automobiles—they cannot afford them. This kind of measurement is appropriate for market research purposes but not for the purpose of determining the need for health insurance for the aged.

Furthermore, it is not enough to provide figures on how many aged persons are covered; it is important to note the characteristics of people who do not have insurance, a subject which the AMA statement avoids. According to the National Health Survey, in 1959 health insurance coverage was carried by only 33 percent of the aged in families with less than $2,000 yearly income, by only 42 percent of the retired aged, and by only 30 percent of the aged unable to work or keep house due to chronic conditions. Thus, extension of insurance coverage to the aged who are not insured becomes increasingly difficult to achieve because they are more likely to be persons in the low-income and poor health-risk groups who cannot afford insurance and are poor prospects from a commercial insurance point of view.

In view of these facts, I am not impressed with the AMA figures on the number of insurance plans offering health insurance to the aged or on the number of workers with insurance that could continue into retirement. (Page 71.) It would be more significant if the AMA would provide data on the premium costs of adequate insurance for the aged and the number of aged persons who could afford to pay these costs.

I have several times referred to the inadequacy of insurance for the aged, a subject on which the AMA statement does not provide the facts, and I would like to offer some specific information about this matter. The Department of Health, Education, and Welfare has provided me with the following information which is based on the Health Insurance Institute's 1960 report on "Health Insurance Plans and Policies of Insurance Companies Available to Americans 65 Years of Age and Older."

A. INDIVIDUAL AND FAMILY HOSPITAL-SURGICAL EXPENSE PLANS GUARANTEED RENEWABLE FOR LIFE

Many such policies are offered, all requiring applicant to be of normal health. Examples are:

Company	Daily room and board payments	Maximum days covered	Miscellaneous extras	Maximum surgical schedule	Annual premium at age 65 (male)
The Travelers Insurance Co	$10	50	Up to $100 for 8-day stay or more.	$200	$86.52
	15	50	Up to $150 for 8-day stay or more.	300	118.67
Aetna Life Insurance Co	10	60	$100	300	92.99
Metropolitan Life Insurance Co	10	31	$50	200	80.67
	15	31	$75	300	121.00
Prudential Insurance Co	8	35	$60	250	73.32
	16	35	$120	250	122.66

B. SENIOR CITIZENS HOSPITAL-SURGICAL GROUP PLANS

These are open for membership on a statewide basis during periodic enrollment periods. All have a 6-month waiting period for preexisting conditions, but no limitations because of physical condition. They can be canceled and premiums can be adjusted only on a statewide basis.

	Daily room and board	Maximum days covered	Miscellaneous extras	Maximum surgical schedule	Annual premium at age 65
65-plus plan, Continental Casualty	Up to $10 a day	31	Up to $100	$200	$78
65 plan, Fireman's Fund Insurance Group.	do	31	do	$200	$78
Senior security plan, Mutual of Omaha	do	60	80 percent of charges above $100 to $1,000 maximum.	$225	$102

It is instructive to compare the premiums of the policies with broader coverage—though all are quite limited—to the median income of an aged person, namely, about $1,000. Such policies do not provide payment for nursing home care, home health services, outpatient diagnostic procedures, physician home and office visits, drugs, dental care nor eyeglasses; the payments provided for hospital room and board are far below the usual charges to the patient, and

those for miscellaneous extras would rarely cover all the charges for operating room, recovery room, laboratory, and special diagnostic services; but the premiums run as high as $122 for an individual, which would amount to over 12 percent of income for aged persons with average income.

Even Blue Cross often does not provide coverage for some of the aged subscribers equal to that which it offers to the younger members. Senior certificates typically provide for no more than 31 days of hospital benefits and many provide limited allowances—$7 to $10 a day—toward the cost of room and board, or provide for a deductible or for coinsurance. In most cases there is an exclusion or limitation on hospitalization coverage for preexisting conditions.

The AMA statement says that the passage of H.R. 4222 "would unquestionably undermine private health insurance." I think the AMA is unquestionably wrong on this point. The proposed health insurance benefits would not cover the younger group who number nine-tenths of the population; nor would they cover all the health care costs of the aged. Many aged persons will want to buy insurance protection against the costs of drugs, medical appliances, and physicians' services and will in fact be encouraged to do so by reason of having the basic coverage of health service costs under the bill.

In a speech before the last annual meeting of the Health Insurance Association, Frederic M. Peirce, president of General American Life, although opposed to the administration's bill, stated that such a program would not end private health insurance. He pointed to the growth of life insurance since enactment of the Social Security Act, and went on to say, "It is a record which provides a fitting analogy and a sound precedent upon which to base the expectation that the health insurance business will continue to grow and prosper despite the advent of Government-provided health insurance, if that unwelcome development should come to pass." Many other spokesmen for commercial health insurance agree with Mr. Peirce. Why should the allegations of the AMA then, that health insurance would be undermined, be given credence?

I was amused by the AMA's fumbling attempt to discredit a statement taken, out of context, from a report submitted to the Committee on Ways and Means by the Department of Health, Education, and Welfare in 1959. The statement excerpted from the report is:

> Relatively few—14 percent of the couples and 9 percent of the nonmarried beneficiaries—had any of their [total medical care] expenses covered by insurance. (Page 73.)

The AMA would have us believe that the small proportion of the aged with medical expenses covered by insurance is proof that the aged are healthy. This must be the case, they imply, since "one must use medical care to receive a health insurance benefit." (Page 74.) This is a fantastic extreme of misinterpretation. The part of the report from which the AMA lifted its quote had reference to "beneficiary groups incurring medical costs." The report brought out that of those incurring costs relatively few had any of their costs covered by insurance. Far from saying that few of the aged received medical care or had medical expenses, the report brought out that actually only 3 percent of the aged couple beneficiaries and only 8 percent of the nonmarried aged beneficiaries in the survey had no medical expenses during the survey year.

The AMA statement places much emphasis on the multiplicity of plans and "the wide variety of choice in the selection of a health plan." (Page 74.) Let me point out that, with the small incomes of aged people, choice is limited to what can be afforded. The services covered under the bill are basic ones. With the coverage of these basic costs, then aged people will really be able to choose among the additional benefits available under private health insurance.

COMMENTS ON SECTION XII—KERR-MILLS IMPLEMENTATION AND REASONS WHY WE PREFER THIS APPROACH

The AMA makes the point that doctors have given freely of themselves and of their skills to the needy without recompense. (Page 76.) The association also states that they have worked toward the provision of high quality care for the needy. I, for one, would not want to question these statements. I have no doubt that doctors have done both of these things, and done them to the very best of their capacities and abilities.

However, I do question that these worthy actions support the conclusion that the medical-assistance-for-the-aged program provides the most effective answer to the problem that exists. The problem is that so many of the aged cannot afford the expenses of proper medical care, and lacking the means, many do not seek the necessary care. As long as the method the AMA supports is that of giving help to those who must prove their financial need, there is going to be a strong deterrent to seeking timely medical care. I am not going to say that a pauperized person will be refused medical attention when he finally seeks it or that a doctor will intentionally give perfunctory treatment to such a person. But this is a far cry from a system of prepaid medical care where a person feels free to seek services at the time the need first shows itself; free of the strong deterrent of having to subject himself and his family to the scrutinies and personal investigations into the details of life—examinations into how and what they buy and how their children live and spend their money, and often even investigations at their homes to determine whether their statements should not be questioned.

Then, let us not overlook the fact that whether a person qualifies under medical assistance for the aged depends upon whether he meets the State definition of "need." In other words what a person can get under medical assistance for the aged depends upon what the State sets as the requirements of "'medical indigence," and what, even after the person meets these requirements, the State can afford to provide for him in the way of medical services. The whole point is that one does not know what, if anything, will be done. Some States will be in a position to do very little and then for only those who have very little. I do not see how this kind of program can match a system of prepayment for assured protection against the costs of specified types of services.

The AMA obviously fails to see the distinction in approach between an individual needs test and the provision of health benefits under the old-age, survivors, and disability insurance program. It claims that the old-age, survivors, and disability insurance approach automatically labels all those over age 65 as "medically indigent" and is therefore demeaning of the whole group. (Page 83.) By making this comparison I think the AMA has clearly demonstrated that it does not understand how requiring a person to seek assistance as one who cannot meet his expenses differs from claiming a benefit of a planned contributory program made available to all members of the group without loss of dignity to any member.

This point is not one that lends itself to parrying with words—it is a point where we are dealing with human feelings and we must accept the facts. The plain fact is that the old-age, survivors, and disability insurance program does result in people retaining their dignity—the means test does not have that strength. The plain fact is that old-age, survivors, and disability insurance has been accepted as the preferred approach.

The AMA admits that the medical-assistance-for-the-aged programs "have not yet been fully implemented," and offers as an explanation the "laudable fiscal caution" exercised by States that have established limited programs because of a lack of information on the cost of such programs. (Pages 79 and 80.) The misinformation of the AMA's hard-sell advertisement, published in a large number of newspapers on April 19, 1961, which said about the Kerr-Mills program of medical assistance for the aged, "it is now being put into operation in 46 States"—actually, even as of mid-August only 14 States had programs in effect—has now been replaced by a newer soft-sell approach—one presenting somewhat less in the way of outright misinformation. However, it is common knowledge that the reason that so many States have no programs is not because of some abstract laudable fiscal caution but because State and local taxes in many parts of the country have reached the outer limits of practicability and painful searches for new tax sources have met with frustration. It is not surprising that States, wishing to compete with their neighbors for new business, are unable—not that they are unwilling—to embark on a brand new welfare program when in State after State existing State and local services are starved for adequate support.

In explaining why States without any medical-assistance-for-the-aged program have not acted, the AMA statement refers to a "campaign of active disparagement of medical assistance for the

aged, hampering its implementation. The very people who support H.R. 4222 have been most active in this campaign." (Page 80.) It is strange that laudable fiscal caution is used to explain the severe limitation found in some of the handful of existing medical-assistance-for-the-aged programs but not to explain why the majority of States have taken no action. In any case, I will take this opportunity to point out that I as well as the other advocates of H.R. 4222 have for many years worked hard to bring adequate public assistance to the needy aged. I might add that organized medicine did nothing to help to create the assistance programs, including the vendor payment program for medical care under old-age assistance. I also know the California Medical Association opposed the start of the vendor payment program under old-age assistance there, and called the program socialized medicine, until it seemed good tactics to support public assistance as part of an attempt to defeat what they feel is a greater evil—the King bill. I am delighted at the AMA's change of heart and their support of medical assistance for the aged, in spite of their motives. I am disgusted, however, at their allegations that people who have always supported public assistance have changed their minds. I believe that medical assistance for the aged and H.R. 4222 are both necessary, as do all the supporters of H.R. 4222 I am acquainted with. Thus, nothing could be farther from the truth than the impression given by the AMA that those recommending enactment of H.R. 4222 are in favor of destroying the medical-assistance-for-the-aged programs. (Page 79.) H.R. 4222 and medical assistance for the aged are not alternatives, as the AMA suggests, any more than the existing public assistance and social insurance programs are alternatives.

One of the most startling contradictions in the entire AMA testimony appears on page 79 of the statement. Previously, the AMA has declared that its official policy is to give full support to the Kerr-Mills program and the passage of State legislation to put that program into effect. (Page 77.) Now, two pages later, we are astonished to find the AMA saying: "Most important, it must be realized that in the opinion of some States the law is not required and thus they have wisely not implemented it." Is this the way that the AMA gives full support to the development of the Kerr-Mills program? Is the AMA now suggesting that in some of the States without such a program older persons should not even have help through the Kerr-Mills legislation? Or that in some States no aged persons outside of those receiving old-age assistance have a problem of meeting health care costs? One must wonder whether the AMA really is sincere in its professed support of the Kerr-Mills legislation or is merely using that legislation to attempt to confuse the issue and thus delay enactment of H.R. 4222.

One reason the AMA gives for the lack of State action to implement medical-assistance-for-the-aged programs is that:

> Some State legislatures * * * have been reluctant to devote State funds to medical assistance for the aged on the grounds that it might be superseded [by H.R. 4222.] (Page 80.)

It should be obvious that there is a need for medical assistance for the aged that is separate and apart from the need for H.R. 4222. If such were not the case, the States might be expected to abandon cash payments under their existing public assistance programs because of the existing OASDI program. On the contrary, at least one State, West Virginia, adopted a fuller medical-assistance-for-the-aged program—as a temporary expedient in anticipation of Federal health insurance legislation—than it really could afford to carry on a continuing basis, counting on passage of the insurance program to reduce the assistance program to manageable proportions. It is not unlikely that the expectation that H.R. 4222 will be enacted has led some other States to go further than they will be able to finance if H.R. 4222 is not enacted. If H.R. 4222 is not enacted, these States may well have to cut back on medical assistance for the aged.

It is the AMA, not the sponsors of H.R. 4222, who are the Johnny-come-latelies in supporting medical assistance. The sponsors of H.R. 4222 recognize that the medical-assistance-for-the-aged plans will do a more effective job if they have the basic provisions of H.R. 4222 on which to build. Freed from the terrible financial burden of coping with the whole problem through public assistance, the States will be able to concentrate on supplementing the basic plan to take care of special needs where such are found to exist. While the AMA does not understand why State revenues are overburdened and why social security financing is practical, any of us who know of the practical limits to sources of State revenues understand the impossible choices faced by the States in allocating available funds which fall far short of meeting the total needs for education, mental hospitals, highways, assistance to the indigent aged, and now medical assistance to the medically indigent aged. (Page 81.) The full programs the medical-assistance-for-the-aged legislation is capable of producing would cost the State at least three times the $137 million the States paid toward vendor payments for medical care under old-age assistance in fiscal year 1960 even if they continue to exercise what the AMA calls laudable fiscal caution. Obviously, the hard-pressed States will be able to meet the needs of the medically indigent aged only after the biggest part of the job is done through social insurance. Even the present cautious steps taken by some States will prove too much for a great many States, particularly the ones with lowest income, to take. In evaluating the potential of the medical-assistance-for-the-aged programs, it should also be borne in mind that future new tax money that may become available in the States for welfare programs will not necesarily be channeled into medical assistance for the aged. Other unmet welfare needs may often have higher priority. Even the long-established cash old-age assistance programs of a number of States do not cover what the States themselves have determined to be the recipients' needs. In a survey of 49 States conducted for the 1960 Advisory Council on Public Assistance, it was found that the old-age assistance payments made by 36 States failed to meet the State's own standards of needs for the aged on the rolls, and these standards are in many cases very low. The assistance payments made under the State's aid-to-dependent-children programs were reported to fall much shorter of need than those for the aged.

The AMA speaks of past improvements in medical assistance for the aged and predicts further improvements. (Page 79.) Yet it does not tell of the experience of West Virginia, which I have mentioned above, where the State was not able to sustain its original program because a program such as H.R. 4222 was not enacted. To assure that with their limited resources States will provide truly adequate medical assistance to the aged who need it, the primary role in financing basic health care for the aged must be assigned to social security.

COMMENTS ON THE SUMMARY

The AMA concludes its statement with a reiteration of many of the irrelevancies and gross misrepresentations that I have already commented on—ranging from the untenable contention that the aged are in "reasonably" good financial circumstances to a statement that the problem the aged have in financing medical care can only be solved by some undefined "adjustment by society."

In appraising the accusations made by the AMA concerning the loss of freedom they predict will occur if H.R. 4222 is enacted, I believe we should also inquire into the view of life that produced their statements. The fact is that the representatives of organized medicine have become quite isolated from the general stream of American thinking and the desires and aspirations of the American people. Listen to Dr. Garland, who testified before this committee on behalf of the American College of Radiology, when he equates work as an employee with slavery: "Most radiologists," he says, "desire to be free, not employees of hospitals." I believe that the great majority of American workers would not accept this equation of slavery and work as an employee. I am certain that this and similar pronouncements lead Americans to rightfully feel that when organized medicine speaks from its lofty position on matters not related to health services, it does not speak for the American people. I believe—and I am sure that the American people will agree—that the AMA has a view alien to that of the majority when it tells us that everyone gets the health care he needs; that there is no humiliation or loss of dignity when an individual applies for charity; and that the aged are financially well off. Also, the AMA does not speak for the American people when it urges that a plan that would enable the American people to pay for their health care in old age should be dismissed be-

632084—83231

cause the aged can get charity. Such statements do not reflect the experiences of the American people or their desire to remain free and independent—free even if they have been wage earners. Americans want to be able to make provisions against the costs of the health care they will need when they become old. They do not want to rely on charity.

MEMORANDUM

AUGUST 3, 1961.

ROBERT J. MYERS.

Subject: Comments on cost estimates section of statement of American Medical Association on H.R. 4222.

This memorandum will present certain factual comments on "Section VI: Cost Estimates for H.R. 4222," in the statement of the American Medical Association before the House Ways and Means Committee on H.R. 4222 on August 2.

In the fifth full paragraph on page 43, there is the criticism that, as late as July, we were still developing the cost estimates for each of the separate four types of benefits even though the total cost estimate had long ago been established. There is the implication that we decided in advance what the cost would be and then tried to figure out how to arrive at this figure by adjusting the cost estimates for each of the components. This is not the case. In actual fact, there was no change in the original estimate for the hospitalization benefits that was developed in early 1961. The only question was the early-year costs for the three minor benefits. Because of the limited facilities initially available to provide these minor benefits and therefore the resulting low-early-year costs, it was certain that any revisions of estimates therefor would have little effect on the total estimate. Thus, as shown on page 16 in Actuarial Study No. 52, the three minor benefits amount to less than 5 percent of the total first-year cost—as was also the case in the original estimates, although the distribution by type of benefit was considerably different.

In the last paragraph on page 44, it is pointed out that in the estimates of the first-year costs, the proportion of the total expenditures for the nursing-home benefit is relatively small, being only $25 million, or less than 2½ percent of total disbursements—all this being despite the argument that these nursing-home benefits are provided to promote the economical use of hospital facilities. The statement does not take into account the long-range cost estimates, under which the nursing-home benefits account for 12 percent of the total cost (since in these estimates it is assumed that there will be increasing availability of such nursing-home facilities).

In the third full paragraph on page 45, it is stated that we have estimated the cost of nursing-home benefits for the first year of operation as somewhere between $25 and $255 million. The source from which these figures were taken (namely, the Wall Street Journal article) did not adequately understand the significance of the upper figure, which, in essence, was developed under high-cost assumptions for what the situation would be currently if the program had been in effect for many years and if adequate acceptable facilities had been developed. As indicated previously, the higher potential costs that may result from the development of adequate facilities are recognized in the long-range cost estimates.

In the last paragraph on page 45, there are given figures (which are considerably higher than those quoted above) for general-nursing-home benefits. It should be clearly recognized that the latter figures are for general custodial care and do not relate to the skilled-nursing-home-care benefits provided under the bill for persons transferred from a hospital for continued treatment of the conditions for which the individuals were hospitalized.

In the last paragraph on page 46, it is stated that our cost estimates allow for nursing-home benefits to be less than 3 percent of the total benefit cost. As I indicated previously, this is only for the first year of operation, and a much higher proportion of the cost is represented by the nursing-home benefits over the long run.

In the third full paragraph on page 47, there is presented an often-used argument that the actual cost of the British National Health Service in the first year of operation was nearly 3 times what it had been estimated to cost. The facts of the situation are as follows. The original estimate for the net cost to the Government was made in 1942 (£110 million). The actual experience for the first full fiscal year of operation (April 1949 to March 1950) was £305 million. The latter figure, however, is not comparable with the original estimate for a number of reasons—changes in the size of the population protected; changes in the price level; and the inclusion of certain features in the final plan that were not contemplated initially (such as dental and ophthalmic services and the provision of a staff retirement plan). Also, it may be noted that although the cost of the national health service in terms of pounds rose by almost 70 percent in the first decade of operation, the real increase—after account is taken of rises in the price level and in the population—was only about 5 to 10 percent. Furthermore, if the costs are expressed in terms of gross national product, they have been stable over the entire decade (at a little less than 4 percent).

In the third paragraph on page 48, it is pointed out that the cost of the health benefits will rise over the years as the beneficiary roll grows. For one thing, partially offsetting this trend is the estimated growth in the covered population paying contributions to support the system. More important, however, is the fact that the financing arrangements of the bill recognize this trend in the number of beneficiaries, since the proposal is financed on a level basis that is considerably in excess of the anticipated early-year costs. As a minor point, this paragraph contains two factual errors. It is stated that the beneficiary roll increases by 300,000 aged persons per year, whereas the correct figure is about 700,000. Also, it is stated that in 1970 there will be 20 million persons aged 65 and over who will be entitled to the health benefits; actually, this figure represents the total aged population of the country at that time, whereas it is estimated that the total eligibles will number only 18 million.

In the last two paragraphs on page 48, general criticism of our cost estimates is made—namely, to the effect that they have generally been too low. I do not believe that this is the case since there are a number of instances when costs have been overestimated, as well as cases where they have been underestimated. This is particularly true when costs are considered relative to taxable payroll rather than in dollars; the former comparison is the more significant one since the financing of the program is based on a percentage tax rate. An example is given in the statement with the intention of proving the gross understatement in the cost estimates. This allegation is worthy of considerable analysis.

The statement points out that one of our studies, made in 1958, gives an intermediate-cost estimate for the disability insurance program of $548 million in benefit expenditures in 1965—as against actual 1960 disbursements of $568 million. It would indeed be a serious situation if the actual figure for 1960 were already larger than the intermediate estimate for 1965. Such is not the case, however, because the two figures cited are not comparable.

The 1965 estimate is taken from Actuarial Study No. 48 and relates to the 1956 act. On the other hand, the actual 1960 figure represents the resulting experience after the liberalizations in the 1958 act—provision of dependents benefits; liberalization of insured-status provisions; elimination of the provision providing for offsetting of other Federal disability benefits and State workmen's compensation benefits; and general 7-percent increase in the benefit level (and also for December 1960, the effect of eliminating the age-50 requirement). The effect of the addition of dependents benefits can readily be eliminated from the actual 1960 experience; $79 million was paid in such benefits, leaving $489 million payable in benefits to disabled workers. The combined effect of the 7 percent benefit increase, the liberalized insured-status provisions, and the elimination of the offset provision is a relative increase in cost of about 25 percent. Thus, the original estimate of $548 million for 1965 should be increased by 25 percent to $685 million, before it is compared with the 1960 figure of $489 million in benefits for disabled workers (i.e., exclusive of dependents benefits).

The original estimate for 1960 (shown in table 15 of Actuarial Study No. 48) was $350 million for the intermediate-cost estimate. When this figure is adjusted upward by 25 percent to reflect the liberalizations in the 1958 amendments, it becomes $438 million. Thus, the actual benefit experience of $489 million was about 10 percent above the original estimate. Even this does not take into account the fact that the original estimate was based on 1956 earnings levels, while the actual benefits paid resulted from the higher earnings that arose. These higher earnings also resulted in higher contribution income in 1960 than was originally estimated—namely, an actual figure of $1,010 million, as against the original estimate of about $925 million. In other words, about $85 million more in income was received than initially estimated, versus about $50 million more in actual benefit payments than originally estimated (after adjustment for changes in the law in 1958).

632084—83231

HEALTH INSURANCE PROPOSALS

87th Congress
2d Session

COMMITTEE PRINT

COMPARISON OF HEALTH INSURANCE PROPOSALS FOR OLDER PERSONS, 1961–62

PREPARED BY THE STAFF

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

MAY 10, 1962

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
83871 WASHINGTON : 1962

SPECIAL COMMITTEE ON AGING

PAT McNAMARA, Michigan, *Chairman*

GEORGE A. SMATHERS, Florida
CLAIR ENGLE, California
HARRISON A. WILLIAMS, JR., New Jersey
OREN E. LONG, Hawaii
MAURINE B. NEUBERGER, Oregon
WAYNE MORSE, Oregon
ALAN BIBLE, Nevada
JOSEPH S. CLARK, Pennsylvania
FRANK CHURCH, Idaho
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
EDWARD V. LONG, Missouri
BENJAMIN A. SMITH II, Massachusetts

EVERETT McKINLEY DIRKSEN, Illinois
BARRY GOLDWATER, Arizona
FRANK CARLSON, Kansas
WALLACE F. BENNETT, Utah
PRESCOTT BUSH, Connecticut
JACOB K. JAVITS, New York
WINSTON L. PROUTY, Vermont

WILLIAM G. REIDY, *Staff Director*

INTRODUCTORY NOTE

This comparison of the major health insurance proposals for older persons which have been introduced thus far in the 87th Congress has been prepared by the Staff of the Special Committee on Aging. The basic provisions of the various bills have been charted without editorial comment. However, because I believe it is essential to safeguard the user against misinterpretation, I am prefacing the chart with a few words of explanation.

Some of these proposals, although financed through the Federal Government, offer the beneficiary the option of choosing among private health insurance plans—indeed one proposal relates exclusively to private insurance. The fact that a legislative proposal spells out a package of health benefits to be obtained through private insurance does not mean that such benefits are actually available, nor does it mean that the benefits specified could be made available for anything like the premium amount provided through the proposed plan. Language that says the private plan must have an "actuarial value" equal to that of the Government plan does not mean that the individual would pay no more in premiums than the cost of the Government plan.

It is obvious that commercial insurers cannot offer equivalent benefits at a lower cost than that of a Government plan even if they were to forego all profits—a very unlikely possibility. Yet so long as an option is provided, the sales pressure which insurance companies could bring to bear on those older people who constitute the better risks might be such that many individuals unskilled in the complex art of understanding insurance policies would contract for coverage costing more than equal protection under the Government plan. By the same token, such an approach would also tend to leave the poorer, more expensive risks to burden the Government plan. It is essential that a social insurance health plan be based on community rating, as Blue Cross and Blue Shield were supposed to be on their initiation. The entire group of older people to be insured, the good and the bad risks together, must be in the one plan if it is to be soundly financed.

Moreover, option provisions would mean that social insurance contributions would be used to pay profits to private insurance companies, thus spending dollars which buy no protection.

Terms also can be confusing. For example, "guaranteed renewable" means only that premiums or benefits may not be modified for an individual, but is no guarantee against rising premiums for all those covered by the policy. Options for private insurance must be carefully scrutinized with respect to such provisions as lifetime maximums and exclusions of preexisting conditions.

Another such example is the use of the phrase "free choice" to characterize proposals offering options for private insurance. Such options invariably result in higher costs, or less protection for the same costs. "Free choice" when it means the right to choose one's own doctor is meaningful and most important. "Free choice" when it means merely the right to choose among insurance carriers offering less protection or charging higher premiums than the Government plan lacks all meaning and represents only a misleading slogan.

Three basic questions should be kept in mind in assessing these various proposals. Is not our Social Security system the one mechanism through which people can provide for themselves, on a group basis and at a price they can afford to pay, hospital insurance for their later years which is paid up prior to old age? Is not this the method through which our older population can be relieved of the intolerable burden of rising and unpredictable health costs or of ever higher insurance premiums against these costs? Will not the utilization of this social insurance method to help meet the necessarily higher health costs of older people provide both stimulus and opportunity for private profit and nonprofit insurance plans to devise more acceptable and less expensive programs to meet the health costs not covered by the legislation or of younger groups in the population?

PAT MCNAMARA,
Chairman, Special Committee on Aging.

COMPARISON OF HEALTH INSURANCE

Administration bill Anderson (S. 909), King (H.R. 4222)	*McNamara (S. 65)	*Holland (H.R. 94)[1]
The Method in Brief		
Through Social Security financing, provides health benefits at age 65 without further contribution. Benefits are specified and uniformly available for hospitalization, nursing homes, home health services, and outpatient diagnostic services.	Through Social Security financing, provides health benefits on retirement without further contributions; through general revenue financing, covers other retired aged. Benefits similar to King-Anderson, except no deductibles.	Through Social Security financing, provides health benefits for all persons eligible for OASDI benefits, including younger beneficiaries. Benefits similar to King-Anderson (except no deductibles) plus surgeon's fees.
Eligibility		
All persons 65 or over eligible for OASI or railroad retirement benefits regardless of current earnings. Eligibility automatic.	All "retired" men 65 or over and women 62 or over—i.e., who have total earnings of less than $2,400 a year or $100 in each of 3 months or who are 72 or over (other than railroad and Federal retirees)[2].	All persons eligible for OASDI benefits, including younger beneficiaries.
Includes 15 million—5 out of 6—aged in 1964. Almost all aged eligible in future.	1962 coverage estimate 16.1 million (15 out of 16) including 13.2 million OASI beneficiaries, 1.5 million OAA recipients, and 1.4 million other retirees.	January 1962 coverage estimate approximately 17.5 million, of whom roughly 14.6 million are aged.

See footnotes at end of table, pp. 6 and 7.

PROPOSALS FOR OLDER PERSONS, 1961–62

Javits (S. 2664 as amended May 2, 1962)	Lindsay (H.R. 11253)	Bow (H.R. 10755)
The Method in Brief		
Uses Social Security financing, plus general revenue financing for uninsured aged who are subject to an income test unless past age 72. (Prior to amendment, all under 72 were subject to income test.) Beneficiary selects among (a) short-term benefits with no deductible, (b) longer-term benefits with deductibles or (c) payment of up to $100 toward premiums for approved private health insurance policy.	Uses Social Security financing and benefits, identical to King-Anderson, in combination with (1) a cash option for individuals having private insurance of specified requirements and (2) "Buying-in" for the Government plan benefits through a Kerr-Mills-type program for aged not eligible under Social Security.	Financed entirely from general revenues. Provides for an income tax credit (or certificate for purchasing insurance) of up to $125 a year for private medical insurance of specified types purchased by or on behalf of persons 65 and older.
Eligibility		
Persons 65 or over who are eligible for OASI benefits or who meet income test—i.e., have income of no more than $3,000 ($4,500 for a married couple)—or are age 72; but excludes anyone receiving "medical aid" under a federally supported assistance program.	Same as King-Anderson and in addition, would cover aged persons who meet State means tests and are brought in through State action.	Any person 65 and over who is a beneficiary of a qualified private insurance policy.
As amended, estimated to cover 16 million in mid-1963.[3]	Includes 15 million eligible for OASI or railroad retirement benefits in 1964 plus an unknown number who might be covered by States which "buy-in."	Potentially includes the total population 65 and over (17½ million as of 1963) but actually would be limited to those aged who are acceptable risks to private insurance carriers.

COMPARISON OF HEALTH INSURANCE

Administration bill Anderson (S. 909), King (H.R. 4222)	*McNamara (S. 65)	*Holland (H.R. 94) [1]
Benefits		
Hospitalization: Inpatient hospital services for up to *90* days per benefit period, with $10 per day deductible required for first 9 days, with a minimum deductible of $20. *Nursing Home:* Skilled nursing home services after transfer from a hospital, for up to *180* days per benefit period. *Maximum* on combination of hospital services and nursing home services: 150 units of service with one "unit" equalling 1 day of hospital service or 2 days of nursing home service. *Home Health Services:* Intermittent nursing care, therapy, and homemaker services for up to *240* visits a year. *Outpatient Hospital Diagnostic Services:* As required, but subject to $20 deductible for each diagnostic study. *Drugs:* All drugs used in hospital or nursing home.	*Hospitalization:* Inpatient hospital services for up to *90* days a year. *Nursing Home:* Skilled nursing home services after transfer from a hospital, for up to *180* days a year. *Home Health Services:* For up to *240* days a year. Includes therapy and homemaker services; medical social work, etc. *Maximum* on combination of hospital services, nursing home services and home health services: 90 units of service with 1 "unit" equalling 1 day of hospital service, 2 days of nursing home services or 2⅔ days of home health services. *Outpatient Diagnostic Services:* Necessary laboratory tests and X-rays in a hospital. *Drugs:* All drugs used in hospital; for outside hospital, a portion of such drugs when prescribed generically. Precise amount and kinds of coverage to be determined by Secretary of HEW, after study, and within actuarial limits. *Research:* Research and demonstration projects to improve quality and efficiency of health services.	*Hospitalization:* Inpatient hospital services for up to *60* days a year. *Nursing Home:* Skilled nursing home services after transfer from a hospital for up to *120* days minus the number of days of hospital services. *Surgical Services:* Full payment of fees for surgery provided in hospital, or for emergency or minor surgery in outpatient department of hospital or in doctor's office. *Drugs:* All drugs used in hospital.

See footnotes at end of table, pp. 6 and 7.

PROPOSALS FOR OLDER PERSONS, 1961–62

Javits (S. 2664 as amended May 2, 1962)	Lindsay (H.R. 11253)	Bow (H.R. 10755)
Benefits		
Eligible individuals may choose 1 of 3 options of which the first 2 are Government plans: (1) Preventive short-term illness benefits consisting, during the calendar year, of (a) 21 days of hospital care (except that the individual could request substitution of skilled nursing home services at a rate of 3 days for 1 day of hospital care); (b) physicians' services for 12 days; (c) up to $100 of ambulatory diagnostic laboratory or X-ray services; and (d) 24 days of organized home health care services; *OR* (2) Long-term and chronic illness benefits, providing payment of 80 percent of the cost in excess of $125 incurred by the beneficiary during the calendar year of (a) 120 days of hospital care; (b) surgical services provided in a hospital; (c) skilled nursing home services after transfer from a hospital; and (d) organized home health care services; *OR* (3) Payment to an insurance carrier of premiums up to $100 per year on a renewable private health insurance policy that provides benefits which the Secretary of HEW determines to be of a value not less than the value of benefits under options (1) or (2).	Eligible individuals have option between: (1) coverage under the "Government plan" which provides the same benefits as the King-Anderson bill; *OR* (2) monthly cash payment if covered by a qualified private health insurance policy or health benefits plan which has an actuarial value equal to that of the Government plan; (cash payment is to be $8 per month initially, but after 2 years of operation could be varied according to age to take account of adverse selection of risks against the Government plan). To qualify, a private health benefits plan must be "guaranteed renewable for life." A plan may qualify even though it has a range of benefits different from the Government plan so long as (a) its benefits in the categories covered by the Government plan have a value of at least 60 percent of the Government plan and (b) its benefits for all categories combined have an actuarial value at least equal to that of the Government plan. Beneficiary choosing option (2) may assign his cash payment to a carrier.	A tax credit (or certificate for purchasing insurance) up to $125 a year on a guaranteed renewable insurance policy, the minimum benefits of which are either of the following two options: (1) (a) Hospital room and board up to $12 per day, and up to $1,080 in a calendar year; (b) up to $120 in a calendar year for ancillary hospital charges; (c) convalescent hospital room and board up to $6 per day, and up to $186 in a calendar year, following confinement in a general hospital; and (d) surgical charges according to a fee schedule with a $300 maximum; *OR* (2) A plan with up to 25 percent coinsurance and subject to a deductible and lifetime maximum (either a deductible of not more than $100 in a calendar year with a lifetime maximum of not less than $5,000, or a deductible of not more than $200 in a calendar year with a lifetime maximum of not less than $10,000) which provides more extensive benefits of the type under option (1) plus physicians' and nurses' fees and drugs and related requirements.

COMPARISON OF HEALTH INSURANCE

Administration bill Anderson (S. 909), King (H.R. 4222)	*McNamara (S. 65)	*Holland (H.R. 94)[1]
Financing		
Increase of ¼ of 1 percent in social security tax for employees and employers (⅜ percent for self-employed) and increase in amount of earnings taxable from $4,800 to $5,000.[4]	(a) For Social Security eligibles, increase of ¼ of 1 percent in social security tax for employees and employers (⅜ percent for self-employed); additional increase of ⅛ of 1 percent in 1971. (b) General revenue financing of benefits for uninsured.[5]	Increase of ¼ of 1 percent in social security tax for employees and employers; ⅜ percent for self-employed.
Costs (First year)		
$1¼ billion.	$1.1 billion.	$1.4 billion.
Administration		
Under established Federal OASDI system, with States and accrediting bodies used in determining eligibility of providers to participate, etc. Providers could use nonprofit agents to represent them.	Generally same as King-Anderson. Secretary of HEW may use public agencies and nonprofit organizations for appropriate tasks.	Generally same as King-Anderson. Secretary of HEW may use nonprofit organizations for appropriate tasks.

*These bills were introduced early in 1961 before the most recent amendments to the Social Security Act. The estimates of the number of Social Security eligibles and of costs have not been revised to reflect these amendments; they are shown as originally developed in order to coincide with the financing provided in the bill.

[1] H.R. 94 is the same as the Forand bill (H.R. 4700) of the 86th Cong.

[2] The bill provides that Congress should take action as soon as possible to make available to railroad retirement and civil service annuitants a program under which they can obtain the same type of services as those made available to OASI beneficiaries.

[3] Prior to the amendment which eliminated the income test for persons eligible for OASI benefits, the sponsor's summary of the bill stated: "Out of an estimated 16 million persons 65 and over, 12.3 million would be eligible. Excluded are 2.2 million on old-age assistance; over 1 million have earnings over $3,000; and more than ½ million are covered under other Federal programs." The sponsor's estimate of costs based on the estimate of 12.3 million eligibles was $1¼ billion.

PROPOSALS FOR OLDER PERSONS, 1961–62

Javits (S. 2664 as amended May 2, 1962)	Lindsay (H.R. 11253)	Bow (H.R. 10755)
Financing		
(a) For Social Security eligibles, increase of ¼ of 1 percent in social security tax for employees and employers in 1963 (⅜ percent for self-employed); additional increase of ⅛ of 1 percent in 1972. (b) General revenue financing of benefits for uninsured.	(a) Same as King-Anderson for Social Security eligibles; (b) General revenues of States and Federal Government for uninsured; Federal share—55 to 85 percent of expenditures in State.	Financed from general revenues.
Costs (First year)		
As amended, estimated at $1.6 billion.[3]	Amount by which cost would exceed King-Anderson would depend on effect of option. Cost of buying in for uninsured could exceed cost of present Kerr-Mills programs.	If all qualify, total cost about $2.1 billion in 1963. Allowing for savings in public assistance funds and offset of medical deductions on tax returns, net cost could exceed $1¾ billion.
Administration		
States make payments for health services. Other functions Federal except as may be delegated to States.	Generally same as King-Anderson. State insurance commissioners would determine whether private insurance plans qualified under the option for cash payments toward premiums, and State agencies would determine if uninsured meet means tests.	Treasury Department would administer.

In relation to the estimates for the bill as originally introduced, however, it should be noted that the population 65 and over will be about 17½ million (not 16 million) in mid-1963 when the proposal would be effective. The amendment was not accompanied by the sponsor's estimate of coverage and costs. An estimate by the Department of Health, Education, and Welfare places the number of eligibles under the amended bill at about 16 million, and the annual rate of benefit outgo at about $1.6 billion, assuming no old-age assistance recipients eligible (estimates would be higher to the extent that States took advantage of this program rather than providing "medical aid" under the assistance programs).

[4] Administration has recommended increasing the taxable earnings base to $5,200 instead of $5,000. The tax resulting from the increase in earnings would also finance an increase in monthly benefits to the earners involved.

[5] Estimates developed at the time the bill was introduced indicated a cost for the noninsured of $290 million, part of which is already being spent; approximately $265 million in Federal funds is now expended for OAA, MAA, and other Federal medical programs for aged; net new cost estimated at about $25 million.

LIST OF HEALTH INSURANCE BILLS

Other health insurance bills introduced in the House of Representatives of the 87th Congress through May 10, 1962, are listed here, classified according to the Legislative Calendar of the Committee on Ways and Means:

Health insurance benefits for social security beneficiaries through OASI	Federal grants to States to provide health insurance for aged with limited incomes	Credit against income tax for medical care insurance premiums
H.R. 195—Ashley. 676—Gilbert. 1765—Dulski. 2407—Dingell. 2443—Roberts. 2518—Rabaut. 2762—Gilbert. 3448—Kowalski. 4111—Halpern. 4168—St. Germain. 4222—King. 4309—Dingell. 4313—Karsten. 4314—Machrowicz. 4315—Green (Pennsylvania). 4316—Ullman. 4447—McFall. 4534—Pucinski. 4921—O'Neill. 7793—Santangelo. 11390—Bennett (Michigan). 11641—Daniels.	H.R. 4731—Curtis (Massachusetts). H.R. 4766—Stafford.	H.R. 10981—Bow.* 11039—Harsha. 11043—Berry. 11053—Derwinski. 11064—Kearns. 11065—Knox. 11066—MacGregor. 11075—Schenck. 11087—Collier. 11089—Ellsworth. 11091—Harrison (Wyoming). 11092—Hiestand. 11095—King (New York). 11096—Michel. 11097—Miller (New York). 11098—Nelsen. 11101—Bass (New Hampshire). 11105—Johansen. 11106—Lipscomb. 11107—May. 11109—Van Pelt. 11110—Shriver. 11114—Clancy. 11116—Harvey (Indiana). 11119—Hosmer. 11120—Mailliard. 11139—Moorehead (Ohio). 11189—Glenn. 11194—McDonough. 11203—O'Konski. 11276—Mosher. 11466—Barry.

*Differs from Representative Bow's H.R. 10755 primarily through addition of a statement of purpose.

Senate bills:

In the Senate, the earlier Javits bill (S. 937) was cosponsored by Mr. Cooper, Mr. Scott, Mr. Aiken, Mr. Fong, Mr. Cotton, Mr. Keating, Mr. Prouty, Mr. Saltonstall, and Mr. Kuchel.

S. 909 (Anderson) is cosponsored by the following Senators: Mr. Douglas, Mr. Hartke, Mr. McCarthy, Mr. Humphrey, Mr. Jackson, Mr. Long of Hawaii, Mr. Randolph, Mr. Engle, Mr. Magnuson, Mr. Pell, Mr. Burdick, Mrs. Neuberger, Mr. Morse, Mr. Long of Missouri, Mr. Moss, and Mr. Pastore.

○

Calendar No. 1549

87TH CONGRESS
2D SESSION

H. R. 10606

IN THE SENATE OF THE UNITED STATES

JUNE 29, 1962

Ordered to lie on the table and to be printed

AMENDMENTS

Intended to be proposed by Mr. ANDERSON (for himself, Mr. HUMPHREY, Mr. DOUGLAS, Mr. JAVITS, Mr. MAGNUSON, Mr. PELL, Mr. HARTKE, Mr. CASE, Mr. BURDICK, Mr. MCCARTHY, Mr. MORSE, Mrs. NEUBERGER, Mr. ENGLE, Mr. MOSS, Mr. PASTORE, Mr. KUCHEL, Mr. LONG of Hawaii, Mr. JACKSON, Mr. LONG of Missouri, Mr. KEATING, Mr. COOPER, Mr. HART, Mr. RANDOLPH, Mr. METCALF, Mr. MCGEE, and Mr. CLARK) to the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes, viz:

On page 1, line 4, strike out "Public Welfare Amendments of 1962" and insert in lieu thereof "Public Welfare and Health Insurance Amendments of 1962".

On page 100, line 16, strike out "II" and insert in lieu thereof "III".

On page 100, line 18, strike out "201" and insert in lieu thereof "301".

On page 100, line 23, strike out "202" and insert in lieu thereof "302".

On page 100, betwen lines 15 and 16, insert the following:

"TITLE II—HEALTH BENEFITS

"FINDINGS AND DECLARATION OF PURPOSE

"SEC. 200. (a) The Congress hereby finds that (1) the heavy costs of hospital care and related health care are a grave threat to the security of aged individuals, (2) most of them are not able to qualify for and to afford private insurance adequately protecting them against such costs, (3) many of them are accordingly forced to apply for private or public aid, accentuating the financial difficulties of hospitals and private or public welfare agencies and the burdens on the general revenues, and (4) it is in the interest of the general welfare for financial burdens resulting from hospital services and related services required by these individuals to be met primarily through social insurance.

"(b) The purposes of this Act are (1) to provide aged individuals entitled to benefits under the old-age, survivors, and disability insurance system or the railroad retirement

system with basic protection against the costs of inpatient hospital services, and to provide, in addition, as an alternative to inpatient hospital care, protection against the costs of certain skilled nursing facility services, home health services, and outpatient hospital diagnostic services; to utilize social insurance for financing the protection so provided; to encourage, and make it possible for, such individuals to purchase protection against other health costs by providing in such basic social insurance protection a set of benefits which can easily be supplemented by a State, private insurance, or other methods; to assure adequate and prompt payment on behalf of these individuals to the providers of these services; and to do these things in a manner consistent with the dignity and self-respect of each individual, without interfering in any way with the free choice of physicians or other health personnel or facilities by the individual, and without the exercise of any Federal supervision or control over the practice of medicine by any doctor or over the manner in which medical services are provided by any hospital; and (2) to provide such basic protection, financed from general revenues, to those persons who are now age 65 or over or who will reach age 65 within the next several years and who are not eligible for benefits under the old-age, survivors, and disability insurance or railroad retirement systems.

"(c) It is hereby declared to be the policy of the Con-

gress that skilled nursing facility services for which payment may be made under this Act shall be utilized in lieu of inpatient hospital services where skilled nursing facility services would suffice in meeting the medical needs of the patient, and that home health services for which payment may be made under this Act shall be utilized in lieu of inpatient hospital or skilled nursing facility services where home health services would suffice.

"PART A—HEALTH INSURANCE BENEFITS FOR THE AGED

"BENEFITS

"Sec. 201. The Social Security Act is amended by adding after title XVI the following new title:

"'TITLE XVII—HEALTH INSURANCE BENEFITS FOR THE AGED

"'PROHIBITION AGAINST INTERFERENCE

"'SEC. 1701. (a) Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any hospital, skilled nursing facility, or home health agency; or to exercise any supervision or control over the administration or operation of any such hospital, facility, or agency.

"'(b) Nothing contained in this title shall be con-

strued to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of health or medical care services in addition to those for which payment may be made under this title.

"'FREE CHOICE BY PATIENT

"'SEC. 1702. Any individual entitled to have payment made under this title for services furnished him may obtain inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services from any provider of services with which an agreement is in effect under this title and which undertakes to provide him such services.

"'DESCRIPTION OF SERVICES

"'SEC. 1703. For purposes of this title—

"'Inpatient Hospital Services

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

"'(1) bed and board (subject, however, to the limitations in section 1709(c) and (d) on the amount which is payable with respect to certain accommodations),

"'(2) such nursing services and other related services, such use of hospital facilities, and such medical

social services as are customarily furnished by such hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in such hospital, as are customarily furnished by such hospital for the care and treatment of inpatients, and

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

excluding, however—

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

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

"'Skilled Nursing Facility Services

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

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

"'(2) bed and board in connection with the furnishing of such nursing care (subject, however, to the limitations in section 1709 (c) and (d) on the amount which is payable with respect to certain accommodations),

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

"'(4) medical social services,

"'(5) drugs, biologicals, supplies, appliances, and equipment which are furnished for use in such skilled nursing facility,

"'(6) medical services provided by an intern or resident-in-training of the hospital, with which the facility is affiliated or under common control, under a teach-

ing program of such hospital approved as provided in subsection (a) (4), and

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

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

"'HOME HEALTH SERVICES

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

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

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

"'(3) medical social services,

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

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

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

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

"'Outpatient Hospital Diagnostic Services

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

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

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

excluding, however—

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

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

"'Drugs and Biologicals

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

"'Arrangements for Certain Services

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

"'DEDUCTIBLE; DURATION OF SERVICES

"'Deductible

"'SEC. 1704. (a) (1) Payment for inpatient hospital services furnished an individual during any benefit period shall be reduced by a deduction equal to $20, or if greater, $10 multiplied by the number of days, not exceeding nine, for which he received such services in such period.

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

" 'Duration of Services

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

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

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

Payment under this title for inpatient hospital services or skilled nursing facility services furnished an individual during a benefit period may also not be made for any such services after one hundred and fifty units of services have been furnished to him in such period; and, for purposes of this sentence—

" '(3) a "unit of service" shall be equal to one day of inpatient hospital services or two days of skilled nursing facility services, and

" '(4) there shall not be counted any inpatient hospital services furnished in a benefit period for any days in excess of ninety days or any skilled nursing facility services furnished in a benefit period for any days in excess of one hundred and eighty.

For purposes of the preceding provisions of this subsection, inpatient hospital services or skilled nursing facility services shall be counted only if payment is or would, except for this subsection and except for the failure to comply with the procedural and other requirements of or under section 1709 (a) (1), be made with respect to such services under this title. Payment under this title for home health services furnished an individual during a calendar year may not be made for any such services after such services have been furnished him during two hundred and forty visits in such year.

"'Benefit Period

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

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

"'(2) ending with the last day of the first ninety-day period thereafter during each day of which he is neither an inpatient in a hospital nor an inpatient in a skilled nursing facility.

"'Day

"'(d) For the purposes of this section, a "day" on or for which inpatient hospital services or skilled nursing facility services are furnished shall have the meaning customarily assigned to it by the hospital or skilled nursing facility furnishing such services, but in no event shall it be less than twenty-four hours (except the day on which such individual is admitted to, or discharged from, such hospital or such skilled nursing facility).

"'ENTITLEMENT TO BENEFITS

"'SEC. 1705. (a) Every individual who—

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

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

shall be entitled to health insurance benefits for each month for which he is entitled to such benefits under section 202, beginning with the first month with respect to which he meets the conditions specified in paragraphs (1) and (2). Notwithstanding the preceding provisions of this subsection, no payments may be made under this title for inpatient hospital services, outpatient hospital diagnostic services, or home health services furnished an individual prior to January 1, 1964, or for skilled nursing facility services furnished him prior to July 1, 1964.

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

"'(1) entitlement of an individual to health insurance benefits under this title for a month shall consist of entitlement to have payment made under, and subject to the limitations in, this title on his behalf for inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services furnished him in the United States (as defined in section 210(i)) during such month; and

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

"'DEFINITIONS OF PROVIDERS OF SERVICES

"'SEC. 1706. For purposes of this title—

"'Hospital

"'(a) The term "hospital" (except for purposes of section 1704(c)(2), section 1709(f), paragraph (6) of this subsection, and so much of section 1703(b) as precedes paragraph (1) thereof) means an institution which—

"'(1) is primarily engaged in providing, by or under the supervision of physicians or surgeons, to inpatients (A) diagnostic services and therapeutic serv-

ices for surgical or medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation facilities and services for the rehabilitation of injured, disabled, or sick persons,

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

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

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

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

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

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

For purposes of section 1704 (c) (2), such term includes any

institution which meets the requirements of paragraph (1) of this subsection. For purposes of section 1709(f) (including determination of whether an individual received inpatient hospital services for purposes of such section 1709(f)), and so much of section 1703(b) as precedes paragraph (1) thereof, such term includes any institution which meets the requirements of paragraphs (1), (2), (4), and (6) of this subsection. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of section 1704(c)(2), include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients.

"'Skilled Nursing Facility

"'(b) The term "skilled nursing facility" means (except for purposes of section 1704(c)(2)) an institution (or a distinct part of an institution) which is affiliated or under common control with a hospital having an agreement in effect under section 1710 and which—

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

"'(2) has policies, which are established by a group of professional personnel (associated with the fa-

cility), including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides and which include a requirement that every patient must be under the care of a physician,

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

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

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

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

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

"'(8) meets such other conditions of participation under this section as the Secretary may find necessary

in the interest of the health and safety of individuals who are furnished services by or in such institution; except that such term shall not (other than for purposes of section 1704(c)(2)) include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients. For purposes of section 1704(c)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.

"'Home Health Agency

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

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

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

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

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

"'(5) in the case of an agency in any State in which State or local law provides for the licensing of agencies of this nature, (A) is licensed pursuant to

such law, or (B) is approved, by the agency of such State responsible for licensing agencies of this nature, as meeting standards established for such licensing, and

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

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

"'Physician

"'(d) The term "physician" means an individual (including a physician within the meaning of section 1101(a)(7)) legally authorized to practice surgery or medicine by the State in which he performs the functions referred to in this title.

"'Utilization Review

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

"'(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services furnished (A) with respect to the medical necessity of the services, and

(B) for the purpose of promoting the most efficient use of available health facilities and services;

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

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

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

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

" 'Provider of Services

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

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

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

" '(1) the facility will be operated under standards, with respect to—

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

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

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

which are developed jointly by or are agreed to by the two institutions;

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

extent practicable) of clinical records of the two institutions; and

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

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

"'SEC. 1707. In carrying out his functions, relating to determination of conditions of participation by providers of services, under section 1706(a)(7), section 1706(b)(8), or section 1706(c)(6), the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1712, appropriate State agencies, and recognized national listing or accrediting bodies. Such conditions prescribed under any of such sections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide (subject to the limitation

provided in section 1706(a)(7)) higher requirements for such State than for other States.

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

"'SEC. 1708. (a) The Secretary may, pursuant to agreement, utilize the services of State health agencies or other appropriate State agencies for the purposes of (1) determining whether an institution is a hospital or skilled nursing facility, or whether an agency is a home health agency, or (2) providing consultative services to institutions or agencies to assist them (A) to qualify as hospitals, skilled nursing facilities, or home health agencies, (B) to establish and maintain fiscal records necessary for purposes of this title, and (C) to provide information which may be necessary to permit determination under this title as to whether payments are due and the amounts thereof. To the extent that the Secretary finds it appropriate, an institution or agency which such a State agency certifies is a hospital, skilled nursing facility, or home health agency may be treated as such by the Secretary. The Secretary shall pay any such State agency, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of

performing the functions specified in the first sentence of this subsection, and for the fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under this title, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

"'(b) (1) An institution shall be deemed to meet the conditions of participation under section 1706(a) (except paragraph (5) thereof) if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals. If such Commission hereafter required a utilization review plan, or imposes another requirement which serves substantially the same purpose, as a condition for accreditation of a hospital, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1706(a) (5).

"'(2) If the Secretary finds that accreditation of an institution by a national accreditation body, other than the Joint Commission on the Accreditation of Hospitals, provides reasonable assurance that any or all of the conditions of section 1706(a), (b), or (c), as the case may be, are met, he may, to the extent he deems it appropriate, treat such insti-

tution as meeting the condition or conditions with respect to which he made such finding.

"'CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

"'Requirement of Requests and Certifications

"'SEC. 1709. (a) Except as provided in subsection (f), payment for services furnished an individual may be made only to eligible providers of services and only if—

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

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

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

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

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

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

"'(3) with respect to inpatient hospital services or skilled nursing facility services furnished such individual after the twenty-first day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1710(e) (based on a finding that timely utili-

zation review of long-stay cases is not being made in such hospital or facility) ;

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

"'Determination of Costs of Services

"'(b) The amount paid to any provider of services with respect to services for which payment may be made under this title shall be the reasonable cost of such services, as determined in accordance with regulations establishing the method or methods to be used in determining such costs for various types or classes of institutions, services, and agencies. In prescribing such regulations, the Secretary shall consider, among other things, the principles generally applied by national organizations (which have developed such principles) in computing the amount of payment, to be made

by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for payment on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, and may provide for the use of estimates of costs of particular items or services.

"'Amount of Payment for More Expensive Services

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

"'(2) Where a provider of services with which an agreement under this title is in effect furnishes to an individual, at his request, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, the Secre-

tary shall pay to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which payment under this title may be made.

"'Amount of Payment Where Less Expensive Services Furnished

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

"'No Payments to Federal Providers of Services

"'(e) No payment may be made under this title (except under subsection (f) of this section) to any Federal provider of services, except a provider of services which the Secretary determines, in accordance with regulations, is providing services to the public generally as a community

institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

"'Payment for Emergency Inpatient Hospital Services

"'(f) Payments shall also be made to any hospital for inpatient hospital services or outpatient hospital diagnostic services furnished, by the hospital or under arrangements (as defined in section 1703(e)) with it, to an individual entitled to health insurance benefits under this title even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payment shall be made only in amounts determined as provided in subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1710(a).

"'Payment for Services Prior to Notification of Noneligibility

"'(g) Notwithstanding that an individual is not entitled to have payment made under this title for inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services fur-

nished by any provider of services, payment shall be made to such provider of services (unless such provider elects not to receive such payment or, if payment has already been made, refunds such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification from the Secretary of his lack of entitlement if such payments are not otherwise precluded under this title and if such provider complies with the rules established hereunder with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed.

"'AGREEMENTS WITH PROVIDERS OF SERVICES

"'SEC. 1710. (a) Any provider of services shall be eligible for payments under this title if it files with the Secretary an agreement not to charge any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1709(g)), and to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, except that such

provider of services may charge such individual or other person the amount of any deduction imposed pursuant to section 1704 (a) with respect to such services (not in excess of the amount customarily charged for such services by such provider) and, where the provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider may also charge such individual or other person for such more expensive items or services but not more than the difference between the amount customarily charged by it for the items or services furnished at such request and the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

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

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

"'(2) by the Secretary at such time and upon such

notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined, and has given such provider notification thereof, (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider no longer substantially meets the applicable provisions of section 1706, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information.

Any termination shall be applicable—

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

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

date, with respect to such services furnished to such individual after the calendar year in which such termination is effective, and

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

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

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

"'(e) If the Secretary finds that timely review in accordance with section 1706(e) of long-stay cases in a hospital or skilled nursing facility is not being made with reasonable regularity, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or skilled nursing

facility after a date specified by him, no payment shall be made for inpatient hospital services or skilled nursing facility services after the twenty-first day of a continuous period of such services. Such decision may be made only after such notice to the hospital, or (in the case of a skilled nursing facility) to the hospital and the facility, and to the public as may be prescribed by regulations, and its effectiveness shall be rescinded when the Secretary finds that the reason therefor has been removed and there is reasonable assurance that it will not recur.

"'PAYMENT TO PROVIDERS OF SERVICES

"'SEC. 1711. The Secretary shall periodically determine the amount which should be paid to each provider of services under this title with respect to the services furnished by it, and the provider shall be paid, at such time or times as the Secretary believes appropriate and prior to audit or settlement by the General Accounting Office, from the Federal Health Insurance Trust Fund the amounts so determined; except that such amounts may be reduced or increased, as the case may be, by any sum by which the Secretary finds that the amount paid to such provider of services for any prior period was greater or less than the amount which should have been paid to it for such period.

"'HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

"'SEC. 1712. For the purpose of advising the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, there is hereby created a Health Insurance Benefits Advisory Council which shall consist of fourteen persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as Chairman. Not less than four of the appointed members shall be persons who are outstanding in the fields pertaining to hospitals and health activities. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, three at the end of the first year, four at the end of the second year, three at the end of the third year, and four at the end of the fourth year

after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms. The Secretary may, at the request of the Council, appoint such special advisory or technical committees as may be useful in carrying out its functions. Appointed members of the Advisory Council and members of its advisory or technical committees, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such a committee or committees, shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of four or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.

"'REVIEW OF DETERMINATIONS

"'SEC. 1713. Any individual dissatisfied with any determination made by the Secretary that he is not entitled to health insurance benefits under this title or that he is not entitled to have payment made under this title with respect

to any class of services furnished him, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205 (b) with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205 (g).

"'OVERPAYMENTS TO INDIVIDUALS

"'SEC. 1714. (a) Any payment under this title to any provider of services with respect to inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services, furnished any individual shall be regarded as a payment to such individual.

"'(b) Where—

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

"'(2) any payment has been made under section 1709 (g) to a provider of services for services furnished an individual,

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

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

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

"'(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1709(g)) for services furnished to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience.

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

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

"'SEC. 1715. (a) The Secretary is authorized to enter into an agreement with any organization, which has been designated by any group of providers of services, or by an association of such providers on behalf of its members, to receive payments under section 1711 on behalf of such providers, providing for the determination by such organization (subject to such review by the Secretary as may be provided for in the agreement) of the amount of payments required pursuant to this title to be made to such providers, and for making such payments. The Secretary shall not enter into an agreement with any organization under this section unless he finds it consistent with effective and efficient administration of this title.

"'(b) To the extent that the Secretary finds that performance of any of the following functions by an organization with which he has entered into an agreement under subsection (a) will be advantageous and will promote the efficient administration of this title, he may also include in

the agreement provision that the organization shall (with respect to providers of services which are to receive payments through the organization)

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

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

"'(3) assist in the application of safeguards against unnecessary utilization of services furnished by providers to individuals entitled to have payment made under section 1711;

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

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

and proper for carrying out the functions covered by the agreement.

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

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

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

"'(2) by the Secretary at such time and upon such notice to the organization, and to the providers which have designated it for purposes of this section, as may be provided in regulations, but only if he finds, after reasonable notice and opportunity for hearing to the

organization, that (A) the organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the organization is disadvantageous or is inconsistent with efficient administration of this title.

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

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

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

"'OPTION TO BENEFICIARIES TO CONTINUE PRIVATE HEALTH INSURANCE PROTECTION

"'SEC. 1716. (a) In lieu of paying a provider of services under an agreement under this title, payments may be made to an eligible carrier under an approved plan with respect to services which are furnished by such provider of services to any individual entitled to health insurance benefits (hereinafter in this section referred to as an "eligible individual") and for which payment would otherwise be made under the preceding provisions of this title (hereinafter in this section referred to as "reimbursable health services"), if such individual elects to have payment for such services made to such carrier.

"'(b) (1) An individual may make an election under subsection (a) with respect to the plan of an eligible carrier only if he was covered by a plan of such carrier (or an affiliate thereof), providing or paying for the costs of inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services which are subject to no greater limitations and deductibles than are provided in section 1704, and providing or paying for the costs of some additional health services, continuously during whichever of the following periods is the shorter—

"'(A) a period of not less than five years ending

with the close of the month in which such individual becomes entitled to health insurance benefits, or

"'(B) (i) if the month in which such individual becomes entitled to health insurance benefits is January, February, or March of 1964, a period of not less than ninety days ending with the close of the month before such month, or (ii) if the month in which he becomes so entitled is April 1964 or a subsequent month, the period beginning January 1, 1964, and ending with the close of the month before such month in which he becomes so entitled.

"'(2) An election may be made under subsection (a) in such manner and within such period after an individual becomes entitled to health insurance benefits, but in no event more than three months after the month in which he becomes so entitled, as the Secretary may prescribe; and an individual shall be permitted only one such election. An election so made may be revoked at such time or times and in such manner as may be so prescribed.

"'(c) To be approved with respect to any eligible individual, a plan must—

"'(1) include (A) provision of all reimbursable health services or payment to providers of services for the cost of all reimbursable health services furnished by them (as provided in subsection (d) (3)), and (B)

provision of or payment for the cost of some additional health services; and

"'(2) provide for adequate notice to the Secretary and to such individual of termination of such individual's coverage under such plan.

"'(d) A carrier shall be eligible for purposes of this section if it—

"'(1) (A) is exempt from income tax under section 501(c) of the Internal Revenue Code of 1954, and is licensed in the State with respect to which it requests approval hereunder to provide or pay for the costs of reimbursable health services, or

"'(B) (i) is licensed in the fifty States and the District of Columbia to issue health insurance and, in the most recent year for which data are available, has made health insurance benefit payments aggregating at least 1 percent of all such payments in the fifty States and the District of Columbia, or (ii) is determined by the Secretary to be national in scope, or

"'(C) is licensed to issue health insurance in the State with respect to which it requests approval hereunder and, in the most recent year for which data are available, has made health insurance benefit payments aggregating at least 10 percent of such payments in such State, or

"'(D) in the case of a carrier which is not included in subparagraph (A), (B), or (C), is licensed to issue group health insurance in the State with respect to which it requests approval hereunder (but in such case it shall be eligible only with respect to such group health insurance);

"'(2) agrees to provide the Secretary, on request, such reports as may reasonably be necessary to enable him to determine the amounts due, under any plan with respect to which an election has been made under this section, on account of reimbursable health services and the administrative expenses of the carrier in connection therewith, and to permit such access by the Secretary to the records on which such reports are based as may be necessary to enable him to determine the accuracy of such reports; and

"'(3) agrees to make payments for reimbursable health services to providers of services in the same amounts, under the same conditions, and subject to the same limitations as are applicable in the case of such services for which payments are made under the preceding sections of this title.

"'(e) An eligible carrier shall be paid from time to time amounts equal to the payments made or the costs of services provided by it under approved plans for reim-

bursable health services and, in addition, such amounts as the Secretary finds to be the administrative costs of such carrier reasonably necessary to the provision of or payment for the cost of reimbursable health services under an approved plan for eligible individuals.

"'REGULATIONS

"'SEC. 1717. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

"'APPLICATION OF CERTAIN PROVISIONS OF TITLE II

"'SEC. 1718. The provisions of sections 206, 208, and 216(j), and of subsections (a), (d), (e), (f), and (h) of section 205 shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

"'DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

"'SEC. 1719. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.'

"FEDERAL HEALTH INSURANCE TRUST FUND

"SEC. 202. (a) Section 201 of the Social Security Act is amended by redesignating subsections (c), (d), (e),

(f), (g), and (h) as subsections (d), (e), (f), (g), (h), and (i), respectively, and by adding after subsection (b) the following new subsection:

"'(c) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Health Insurance Trust Fund". The Federal Health Insurance Trust Fund shall consist of such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Health Insurance Trust Fund for the fiscal year ending June 30, 1963, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

"'(1) (A) 0.18 of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1962, and before January 1, 1964, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

"'(B) 0.68 of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of

1954) paid after December 31, 1963, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

"'(2) (A) 0.135 of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1962, and before January 1, 1964, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns; and

"'(B) 0.51 of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1963,

which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.'

"(b) The first sentence of the subsection of such section 201 herein redesignated as subsection (d) is amended by striking out 'and the Federal Disability Insurance Trust Fund' and inserting in lieu thereof ', the Federal Disability Insurance Trust Fund, and the Federal Health Insurance Trust Fund'.

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

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

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

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

"(g) Section 221(e) of such Act is amended—

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

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

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

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

"INCREASE IN EARNINGS BASE

"Definition of Wages

"SEC. 203. (a)(1) Paragraph (3) of section 209(a) of the Social Security Act is amended by inserting 'and prior to 1963' after '1958'.

"(2) Such section 209(a) is further amended by adding at the end thereof the following new paragraph:

"'(4) That part of remuneration which, after re-

muneration (other than remuneration referred to in the succeeding subsections of this section) equal to $5,200 with respect to employment has been paid to an individual during any calendar year after 1962, is paid to such individual during such calendar year;'.

"Definition of Self-employment Income

"(b) (1) Subparagraph (C) of section 211 (b) (1) of such Act is amended by inserting 'and prior to 1963' after '1958'; and by striking out '; or' and inserting in lieu thereof '; and'.

"(2) Such section 211 (b) (1) is further amended by adding at the end thereof the following new subparagraph:

"'(D) For any taxable year ending after 1962, (i) $5,200, minus (ii) the amount of wages paid to such individual during the taxable year; or'.

"Definitions of Quarter and Quarter of Coverage

"(c) (1) Clause (ii) of section 213 (a) (2) of such Act is amended by striking out '1958' and inserting in lieu thereof '1958 and before 1963, or $5,200 in the case of a calendar year after 1962'.

"(2) Clause (iii) of section 213 (a) (2) of such Act is amended by striking out '1958' and inserting in lieu thereof '1958 and before 1963, or $5,200 in the case of a taxable year ending after 1962'.

"Table for Determining Primary Insurance Amount

"(d) (1) The table in section 215(a) of such Act is amended by striking out all the figures in columns II, III, IV, and V beginning with the line which reads

"'101.50	102.30	315	319	109	254.00'

and down through the line which reads

		"'399	400	127	254.00'

and inserting in lieu thereof the following:

"'101.50	102.30	315	319	109	255.20
102.40	103.20	320	323	110	258.40
103.30	104.20	324	328	111	262.40
104.30	105.10	329	333	112	266.40
105.20	106.00	334	337	113	268.00
106.10	107.00	338	342	114	268.00
107.10	107.90	343	347	115	268.00
108.00	108.50	348	351	116	268.00
		352	356	117	268.00
		357	361	118	268.00
		362	365	119	268.00
		366	370	120	268.00
		371	375	121	268.00
		376	379	122	268.00
		380	384	123	268.00
		385	389	124	268.00
		390	393	125	268.00
		394	398	126	268.00
		399	403	127	268.00
		404	407	128	268.00
		408	412	129	268.00
		413	417	130	268.00
		418	421	131	268.00
		422	426	132	268.00
		427	431	133	268.00
		432	433	134	268.00

"(2) The amendment made by paragraph (1) shall be applicable with respect to monthly insurance benefits under title II of such Act for months after December 1962 and with respect to lump-sum death payments in the case of deaths after December 1962.

"Average Monthly Wage

"(e) Paragraph (1) of section 215(e) of such Act is amended by striking out 'and the excess over $4,800 in the

case of any calendar year after 1958' and inserting in lieu thereof 'the excess over $4,800 in the case of any calendar year after 1958 and before 1963, and the excess over $5,200 in the case of a calendar year after 1962'.

"TECHNICAL AMENDMENTS

"Suspension in Case of Aliens

"SEC. 204. (a) Subsection (t) of section 202 of such Act is amended by adding at the end thereof the following new paragraph:

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

"Persons Convicted of Subversive Activities

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

"Advisory Council on Social Security Financing

"(c) (1) Subsection (a) of section 116 of the Social Security Amendments of 1956 is amended by striking out

'and of the Federal Disability Insurance Trust Fund' and inserting in lieu thereof ', of the Federal Disability Insurance Trust Fund, and of the Federal Health Insurance Trust Fund'. Such subsection is further amended by inserting before the period at the end thereof 'and the health insurance benefits program'.

"(2) Subsection (d) of such section is amended by striking out 'and the Federal Disability Insurance Trust Fund' and inserting in lieu thereof ', the Federal Disability Insurance Trust Fund, and the Federal Health Insurance Trust Fund'.

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

"PART B—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1954

"CHANGES IN TAX SCHEDULES

"Self-Employment Income Tax

"SEC. 211. (a) Section 1401 of the Internal Revenue Code of 1954 (relating to the rate of tax on self-employment income) is amended to read as follows:

"'SEC. 1401. RATE OF TAX.

"'In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows—

"'(1) in the case of any taxable year beginning after December 31, 1962, and before January 1, 1964, the tax shall be equal to 5.4 percent of the amount of the self-employment income for such taxable year;

"'(2) in the case of any taxable year beginning after December 31, 1963, and before January 1, 1966, the tax shall be equal to 5.8 percent of the amount of the self-employment income for such taxable year;

"'(3) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1968, the tax shall be equal to 6.6 percent of the amount of the self-employment income for such taxable year; and

"'(4) in the case of any taxable year beginning after December 31, 1967, the tax shall be equal to 7.3 percent of the amount of the self-employment income for such taxable year.'

"Tax on Employees

"(b) Section 3101 of such Code (relating to rate of tax on employees under the Federal Insurance Contributions Act) is amended to read as follows:

"'SEC. 3101. RATE OF TAX.

"'In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

"'(1) with respect to wages received during the calendar year 1963, the rate shall be $3\frac{5}{8}$ percent;

"'(2) with respect to wages received during the calendar years 1964 and 1965, the rate shall be $3\frac{7}{8}$ percent;

"'(3) with respect to wages received during the calendar years 1966 and 1967, the rate shall be $4\frac{3}{8}$ percent; and

"'(4) with respect to wages received after December 31, 1967, the rate shall be $4\frac{7}{8}$ percent.'

"Tax on Employers

"(c) Section 3111 of such Code (relating to rate of tax on employers under the Federal Insurance Contributions Act) is amended to read as follows:

"'SEC. 3111. RATE OF TAX.

"'In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of

the wages (as defined in section 3121 (a)) paid by him with respect to employment (as defined in section 3121 (b))—

"'(1) with respect to wages paid during the calendar year 1963, the rate shall be $3\frac{5}{8}$ percent;

"'(2) with respect to wages paid during the calendar years 1964 and 1965, the rate shall be $3\frac{7}{8}$ percent;

"'(3) with respect to wages paid during the calendar years 1966 and 1967, the rate shall be $4\frac{3}{8}$ percent; and

"'(4) with respect to wages paid after December 31, 1967, the rate shall be $4\frac{7}{8}$ percent.'

"Effective Dates

"(d) The amendment made by subsection (a) shall apply with respect to taxable years beginning after December 31, 1962. The amendments made by subsections (b) and (c) shall apply with respect to remuneration paid after December 31, 1962.

"INCREASE IN TAX BASE

"Definition of Self-Employment Income

SEC. 212. (a) (1) Subparagraph (C) of section 1402 (b) (1) of the Internal Revenue Code of 1954 is amended by adding 'and before 1963' after '1958'; and by striking out 'or' and inserting in lieu thereof 'and'.

"(2) Such section 1402 (b) (1) is further amended by adding at the end thereof the following new subparagraph:

"'(D) for any taxable year ending after 1962, (i) $5,200, minus (ii) the amount of the wages paid to such individual during the taxable year; or'.

"Definition of Wages

"(b) Section 3121(a)(1) of such Code is amended by striking out '$4,800' wherever it appears and inserting in lieu thereof '$5,200'.

"Federal Service

"(c) Section 3122 of such Code is amended by striking out '$4,800' and inserting in lieu thereof '$5,200'.

"Returns in the Case of Governmental Employees in Guam and American Samoa

"(d) Section 3125 of such Code is amended by striking out '$4,800' wherever it appears and inserting in lieu thereof '$5,200'.

"Special Refunds of Employment Taxes

"(e)(1) Section 6413(c)(1) of such Code is amended—

"(A) by inserting 'and prior to the calendar year 1963' after 'the calendar year 1958';

"(B) by inserting 'or (C) during any calendar year after the calendar year 1962, the wages received by him during such year exceed $5,200,' after 'exceed $4,800,'; and

"(C) by inserting before the period at the end thereof 'and before 1963, or which exceeds the tax with respect to the first $5,200 of such wages received in such calendar year after 1962'.

"(2) Section 6413 (c) (2) (A) of such Code is amended by striking out 'or $4,800 for any calendar year after 1958' and inserting in lieu thereof '$4,800 for the calendar year 1959, 1960, 1961, or 1962, or $5,200 for any calendar year after 1962'.

"Effective Date

"(f) The amendments made by subsections (b), (c), and (d) shall be applicable with respect to remuneration paid after 1962.

"TECHNICAL AMENDMENT

"SEC. 213. Section 3121 (l) (6) of the Internal Revenue Code of 1954 is amended by striking out 'and the Federal Disability Insurance Trust Fund,' and inserting in lieu thereof ', the Federal Disability Insurance Trust Fund, and the Federal Health Insurance Trust Fund,'. The amendment made by this section shall be effective January 1, 1963.

"PART C—RAILROAD RETIREMENT AMENDMENTS

"Health Insurance Benefits for the Aged

"SEC. 221. (a) The Railroad Retirement Act of 1937 is amended by adding after section 20 of such Act the following new section:

" 'Health Insurance Benefits for the Aged

" 'SEC. 21. (a) For the purposes of this section, and subject to the conditions hereinafter provided, the Board shall have the same authority to determine the rights of individuals described in subsection (b) of this section to have payments made on their behalf for health insurance benefits consisting of inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services within the meaning of title XVII of the Social Security Act as the Secretary of Health, Education, and Welfare has under such title XVII with respect to individuals to whom such title applies. The rights of individuals described in subsection (b) of this section to have payment made on their behalf for the services referred to in the next preceding sentence shall be the same as those of individuals to whom title XVII of the Social Security Act applies and this section shall be administered by the Board as if the provisions of such title XVII were applicable, references to the Secretary of Health, Education, and Welfare were to the Board, references to the Federal Social Insurance Trust Fund were to the Railroad Retirement Account, references to the United States or a State included Canada or a subdivision thereof, and the provisions of sections 1707 and 1712 of such title XVII were not included in such title. For purposes of section 11, a determination with respect to the

rights of an individual under this section shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

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

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

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

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

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

"'(c) No individual shall be entitled to have payment made for the same services, which are provided for in this section, under both this section and title XVII of the Social Security Act, and no individual shall be entitled to have payment made under both this section and such title XVII for more than ninety days of inpatient hospital services or more than one hundred and eighty days of skilled nursing facility services or more than one hundred and fifty units of such services during any benefit period, or more than two hundred and forty visits in any calendar year in which home health services are furnished. In any case in which an individual would, but for the preceding sentence, be entitled to have payment for such services made under both this section and such title XVII, payment for such services to which such individual is entitled shall be made in accordance with the procedures established pursuant to the next succeeding sentence, upon certification by the Board or by the Secretary of Health, Education, and Welfare. It shall be the duty of the Board and such Secretary with respect to such cases jointly to establish procedures designed to minimize duplications of requests for payment for services and determina-

tions and to assign administrative functions between them so as to promote the greatest facility, efficiency, and consistency of administration of this section and title XVII of the Social Security Act; and, subject to the provisions of this subsection to assure that the rights of individuals under this section or title XVII of the Social Security Act shall not be impaired or diminished by reason of the administration of this section and title XVII of the Social Security Act. The procedures so established may be included in regulations issued by the Board and by the Secretary of Health, Education, and Welfare to implement this section and such title XVII, respectively.

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

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

filed under such title shall be deemed to be a request for payment for services filed as of the same time under this section.

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

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

"(b) Section (1) (q) of such Act is amended by striking out '1961' and inserting in lieu thereof '1962'.

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

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

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

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

"(C) by adding at the end of the subparagraph redesignated as subparagraph (A) by subparagraph

(A) of this paragraph the following new subdivision:

"'(iii) At the close of the fiscal year ending June 30, 1963, and each fiscal year thereafter, the Board and the Secretary of Health, Education, and Welfare shall determine the amount, if any, which, if added to or subtracted from the Federal Health Insurance Trust Fund would place such fund in the same position in which it would have been if service as an employee after December 31, 1936, had been included in the term "employment" as defined in the Social Security Act and in the Federal Employment Contributions Act. Such determination shall be made no later than June 15 following the close of the fiscal year. If such amount is to be added to the Federal Health Insurance Trust Fund the Board shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Retirement Account to the Federal Health Insurance Trust Fund; if such amount is to be subtracted from the Federal Health Insurance Trust Fund the Secretary of Health, Education, and Welfare shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Federal Health Insurance Trust Fund to the Re-

tirement Account. The amount so certified shall further include interest (at the rate determined under subparagraph (B) for the fiscal year under consideration) payable from the close of such fiscal year until the date of certification.';

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

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

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

the Board or the Secretary of Health, Education, and Welfare for transfer from the Retirement Account or from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, or the Federal Health Insurance Trust Fund.'

"(2) The amendments made by paragraph (1) of this subsection shall be effective January 1, 1963. Such amendments and the amendments made by section 202(a) shall not be construed to increase or diminish the sums to be transferred, under the provisions of section 5(k)(2) of the Railroad Retirement Act before their amendment by paragraph (1) of this subsection, between the Railroad Retirement Account and the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund.

"Tax on Employees

"SEC. 222. (a) Section 3201 of the Railroad Retirement Tax Act is amended by striking out ': *Provided*' and inserting in lieu thereof the following: '. With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3101 of the Federal Insurance Contributions Act are increased with respect to wages by section 220(b) of the Act which amended the Social Security Act by adding title XVII the rates of tax imposed by this section shall

be increased, with respect only to compensation paid for services rendered before January 1, 1965, by the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3101 are so increased with respect to wages: *Provided'*.

"Tax on Employee Representatives

"(b) Section 3211 of the Railroad Retirement Tax Act is amended by striking ': *Provided*' and inserting in lieu thereof the following: '. With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3101 of the Federal Insurance Contributions Act are increased with respect to wages by section 220(b) of the Act which amended the Social Security Act by adding title XVII the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by twice the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3101 are so increased with respect to wages: *Provided'*.

"Tax on Employers

"(c) Section 3221 of the Railroad Retirement Tax Act is amended by inserting after '$400' the first time it appears the following: '. With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3111 of the Federal

Insurance Contributions Act are increased with respect to wages by section 220(c) of the Act which amended the Social Security Act by adding title XVII the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3111 are so increased with respect to wages'.

"PART D—HEALTH INSURANCE BENEFITS FOR PRESENTLY UNINSURED INDIVIDUALS

"COVERAGE PROVISIONS

"SEC. 231. Anyone who—

"(1) has attained the age of 65,

"(2) (A) attained such age before 1967, or (B) has not less than 3 quarters of coverage (as defined in title II of the Social Security Act or section 5 (1) of the Railroad Retirement Act of 1937), whenever acquired, for each calendar year elapsing after 1964 and before the year in which he attained such age,

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

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

shall (subject to the limitations in this part) be deemed, solely for purposes of section 1705 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month in which he dies or, if earlier, the month before the month in which he becomes entitled to monthly insurance benefits under such section 202 or meets the requirements set forth in subparagraph (B) of section 21(b) of the Railroad Retirement Act of 1937.

"LIMITATIONS

"SEC. 232. (a) The provisions of section 231 shall apply only in the case of an individual who—

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

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

"(b) The provisions of section 231 shall not apply to any individual who—

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

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

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

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

"PAYMENTS TO TRUST FUND

"SEC. 233. There are hereby authorized to be appropriated to the Federal Health Insurance Trust Fund (established by section 201 of the Social Security Act) from time to time such sums as the Secretary deems necessary, on account of—

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

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

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

in order to place such Trust Fund in the same position in which it would have been if sections 231 and 232 of this Act had not been enacted.

"PART E—MISCELLANEOUS PROVISIONS

"STUDIES AND RECOMMENDATIONS

"SEC. 241. The Secretary of Health, Education, and Welfare shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to (1) the adequacy of existing facilities for health care for purposes of the program established by this Act; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; (3) the feasibility of providing additional types of health insurance benefits within the financial resources provided by this Act; and (4) the effects of the deductibles upon beneficiaries, hospitals, and the financing of the program."

Make appropriate changes in the table of contents.

TABLE OF CONTENTS

TITLE II—HEALTH BENEFITS

TABLE OF CONTENTS—Continued

TITLE II—HEALTH BENEFITS—Continued

PART A—HEALTH INSURANCE BENEFITS FOR THE AGED—continued

TABLE OF CONTENTS—Continued

TITLE II—HEALTH BENEFITS—Continued

Calendar No. 1549

87TH CONGRESS
2D SESSION

H. R. 10606

AMENDMENTS

Intended to be proposed by Mr. ANDERSON (for himself, Mr. HUMPHREY, Mr. DOUGLAS, Mr. JAVITS, Mr. MAGNUSON, Mr. PELL, Mr. HARTKE, Mr. CASE, Mr. BURDICK, Mr. MCCARTHY, Mr. MORSE, Mrs. NEUBERGER, Mr. ENGLE, Mr. MOSS, Mr. PASTORE, Mr. KUCHEL, Mr. LONG of Hawaii, Mr. JACKSON, Mr. LONG of Missouri, Mr. KEATING, Mr. COOPER, Mr. HART, Mr. RANDOLPH, Mr. METCALF, Mr. MCGEE, and Mr. CLARK) to the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

JUNE 29, 1962

Ordered to lie on the table and to be printed

LEGISLATIVE PROGRAM—EXTENSION OF PUBLIC ASSISTANCE AND CHILD WELFARE SERVICES PROGRAM OF THE SOCIAL SECURITY ACT—THE MEDICARE AMENDMENT

Mr. HUMPHREY. Madam President, the Senator from New Mexico [Mr. ANDERSON] and the Senator from New York [Mr. JAVITS] wish to present this afternoon a revised health, hospital, and medical care program amendment. In order to accommodate these Senators I have discussed the question with the Senator from Georgia [Mr. TALMADGE], and I shall ask unanimous consent that we interrupt the proceedings on the Renegotiation Act for a limited period of time in order that there may be the presentation of the medicare amendment.

Madam President, first I ask unanimous consent to have laid down as the unfinished business on Monday, July 2, H.R. 10606, the proposed Social Security Act amendments, Calendar No. 1549.

Mr. JOHNSTON. Madam President——

The PRESIDING OFFICER. The bill will be stated by title.

Mr. SPARKMAN. Madam President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator will state it.

Mr. SPARKMAN. Is the Senator making a unanimous-consent request?

Mr. HUMPHREY. Yes.

Mr. SPARKMAN. Madam President, reserving the right to object, and of course I do not intend to object, I should like to ask the acting majority leader one or two questions with reference to the expectation as to action on the bill.

I understand the Senator proposes to lay the bill before the Senate on Monday next. How much debate is there likely to be? When is it felt there will be a vote on the question?

Mr. HUMPHREY. The Senator from Minnesota claims no prophetic vision on this question or on any other. I am only proposing that we start the debate on Monday. I hope we may be able to move right along, because the subject is something which is well known to all; upon which there is, however, considerable controversy. It appears to me that when the Senator from New Mexico [Mr. ANDERSON] places his amendment before the Senate he might be able to give us some indication as to what he thinks would be the duration of the debate. We will, however, continue consideration of the so-called welfare bill.

Mr. SPARKMAN. The Senate will not be swinging back and forth between it and the space satellite bill?

Mr. HUMPHREY. No. The Senate will continue consideration of the welfare bill and the medicare amendment and any other amendments until action has been completed.

Mr. SPARKMAN. The Fourth of July is next Wednesday. It is not intended there will be a session that day?

Mr. HUMPHREY. There will be no session next Wednesday. I am happy to announce there will be no session tomorrow. There was some possibility of a session on Saturday, but there is no need for the session on Saturday since the conference report relating to the Sugar Act is as yet not completed. Furthermore, I have discussed the problem with the Acting Secretary of State, and it will not cause any great inconvenience if the Senate should not act on the conference report on the Sugar Act until Monday, or even next Tuesday. That is a privileged matter, however, and can be taken up for consideration at any time.

So there will be no session tomorrow, Saturday. The Senate will convene on Monday. At the proper time I shall move that the Senate meet at 12 o'clock on Monday.

My present request is that the unfinished business for Monday, July 2, be Calendar No. 1549, H.R. 10606, relating to proposed Social Security Act amendments.

Mr. SPARKMAN. May I ask the Senator if he can tell, this far ahead of time, what time it is contemplated the Senate will meet on Tuesday? Will that be at 12 o'clock?

Mr. HUMPHREY. There will be a session on Tuesday. There will be no session on Wednesday.

Mr. SPARKMAN. Will there be a session on Thursday?

Mr. HUMPHREY. There will be a session on Thursday. There will be a session on Friday. I hope every Senator will be here, but I doubt it. [Laughter.]

Mr. SPARKMAN. So do I. [Laughter.]

The PRESIDING OFFICER. Is there objection to the request of the Senator from Minnesota?

Mr. JOHNSTON. Madam President, I should like to ask a question before I agree to the unanimous-consent request. When will I have an opportunity to make a speech of about 10 minutes?

Mr. HUMPHREY. The Senator will have an opportunity to do that as soon as the Senate returns to consideration of the bill to extend the Renegotiation Act.

The rule of germaneness does not apply in the Senate. Because of the Senator's charm, ability, and the respect of his colleagues for him, he will have no difficulty in obtaining the floor.

Mr. JOHNSTON. I wished to present the statement as soon as I could today.

Mr. HUMPHREY. The acting majority leader will cooperate to the fullest extent.

Mr. CLARK. Madam President, will the Senator yield?

Mr. HUMPHREY. I yield.

Mr. CLARK. Does the acting majority leader deplore the fact that there is no rule of germaneness in the Senate?

Mr. HUMPHREY. Not at this moment.

The PRESIDING OFFICER. The bill will be stated by title.

The LEGISLATIVE CLERK. A bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. HUMPHREY. Madam President, has unanimous consent been granted?

The PRESIDING OFFICER. Is there objection? The Chair hears none, and it is so ordered.

Mr. ANDERSON. Madam President, on behalf of myself, and Senators HUMPHREY, DOUGLAS, JAVITS, MAGNUSON, PELL, HARTKE, CASE, BURDICK, MCCARTHY, MORSE, NEUBERGER, ENGLE, MOSS, PASTORE, KUCHEL, LONG of Hawaii, JACKSON, LONG of Missouri, KEATING, COOPER, HART, RANDOLPH, METCALF, MCGEE, and CLARK, I submit amendments, intended to be proposed by us, jointly to the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act and for other purposes.

Madam President, because of the widespread interest in these amendments and the difficulty of following all of their provisions as they amend other sections of the Social Security Act, I ask unanimous consent that the table of contents which has been prepared may appear just ahead of the text of the amendments when the amendments are printed, or if that is not regarded as desirable, that the table of contents may be incorporated in the printed amendments at the appropriate places.

The PRESIDING OFFICER. Without objection, it is so ordered, and the amendments will be received, printed, and lie on the table.

Mr. ANDERSON. Madam President, I ask unanimous consent that at the conclusion of my address there may be printed in the RECORD a statement on significant improvements in the Anderson bill (S. 909) made by the Anderson amendments to the welfare bill (H.R. 10606).

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. ANDERSON. Madam President, at the outset let me say that I have enjoyed immensely the opportunities I have had for discussions in the past few days with members of the minority party. I mention particularly the distinguished Senator from New York [Mr. JAVITS], with whom I have had many discussions. I have found his assistance to be extremely valuable. I mention also the other Senator from New York [Mr. KEATING], with whom I have had an opportunity to discuss the subject; the distinguished Senator from Kentucky [Mr. COOPER], who has long been known for his position in this field; the Senator from New Jersey [Mr. CASE]; and the Senator from California [Mr. KUCHEL]. It has been a pleasant experience, because in a long experience in public life those Senators have made contributions to me which I have deeply appreciated, and by their public discussions they have made it possible for me to envision certain aspects of the bill which had not heretofore been considered.

Their assistance has made possible many features in the present bill. I pay tribute to them now as I have paid tribute to them many times in the past.

I point out also that twice upon the floor of the Senate the Senator from New York [Mr. JAVITS] has said that we would make every effort possible to arrive at some sort of harmonious arrangement under which he might join me as a cosponsor of the bill. We do not completely subscribe to everything in the same way. No Senator would wish it that way. But I point out that the Senator from New York [Mr. JAVITS] is a cosponsor on the bill. Therefore I think he has made good on the solemn promise which he made to the Senate on two different occasions, that every effort would be made to work on these questions in a proper and harmonious fashion.

Our proposed amendment to H.R. 10606 is a considerably improved version of S. 909.

It was developed after careful consideration of the comments, questions, and criticisms arising during discussion of the provisions of S. 909. I have studied other bills that have been introduced. I have welcomed suggestions from all who sincerely want a bill to be enacted.

We have revised S. 909 to make many improvements. Our proposed amendment is one which can be supported by all who agree, in principle, on the social security approach and by all who sincerely want a bill passed.

Unless favorable action is taken now, health insurance for the aged could become a major issue in the fall elections, and next year a bill will be passed. But the problem that confronts our aged people is so pressing that I hope we will not delay a solution another year.

The proposed amendment is a conscientious effort to meet the reasonable objections to S. 909, while at the same time preserving its essential points—health insurance benefits for aged social security beneficiaries and railroad retirement annuitants without a means test and financed through the contributory social security system.

THE SOCIAL SECURITY APPROACH IS ESSENTIAL

On these essential social security features, I cannot compromise. Our proposed amendment would utilize the social security financing mechanism, for through this mechanism the health insurance needs of our people in their later years can be met by payments made during their working years.

Health insurance will go far to make retirement protection under social security truly adequate in a way that increased cash monthly payments can never achieve. Health costs of the aged are not evenly distributed from month to month or even from year to year. A person over 65 may have no appreciable health costs for several years and then in a short time have health costs running into thousands of dollars. It is clearly not possible to increase the cash benefit under OASI sufficiently to cover such large expenses.

The health insurance payments to which the elderly would be entitled would be paid as a right earned through the social security system which they have helped support by their contributions during their working years. There would be no means test.

The amendment would follow the same threefold attack on dependency in old age as that carried out by the present social security program. First, basic health insurance protection against hospital costs and certain alternatives to hospitalization would be afforded the elderly through social security; second, the existence of a program of basic protection would encourage the development of additional, private protection which the individual could purchase by his own means; third, all the States would be placed in a far better financial position to provide adequate medical assistance to help the relatively small group whose special needs and circumstances make it impossible for them to meet health costs that exceed those covered in this bill.

The proposed program would be financed on the same financially sound basis as the present social security program. Its cost over the long-run future has been carefully calculated, and sufficient income to meet both short-term and long-run program obligations is provided for.

HEALTH BENEFITS FOR THOSE NOT INSURED UNDER SOCIAL SECURITY

It is estimated that by January 1964—the effective date of my proposed amendment—the total population age 65 and over in the United States will be 17.9 million. Of this number, over a quarter of a million, although not eligible for social security or railroad retirement protection, would have their health needs taken care of under various other governmental programs—including retired Federal employees who have governmental health insurance protection available to them. This leaves approximately 17½ million persons 65 and over, of which about 15 million would be eligi-

ble for health insurance under social security or railroad retirement. We have included in this amendment a provision for furnishing to these 2½ million aged people, from general revenues, the same health benefits as provided to those insured under the social security and railroad retirement programs.

The gross cost of the provision would be about $250 million in calendar year 1964, the year the health benefits program would go into effect. This cost would be offset by savings in Federal medical care expenditures in 1964 that except for the passage of my bill would be made under public assistance and the veterans' programs. These savings would be about $200 million, leaving a net cost to general revenues of about $50 million in 1964. The annual cost of the provision would drop sharply in following years and eventually wash out altogether.

IMPROVED ADMINISTRATIVE PROCEDURES

Since the introduction of S. 909 last year I have had the benefit of many helpful suggestions from physicians and hospital administrators all over the country pointing out ways in which the administrative features of the bill could be improved. I have also studied the sincere concerns expressed by some that the Federal procedures might impose difficult requirements or administrative burdens on hospitals. Our proposed amendment meets each of the specific criticisms that some provisions of S. 909 might possibly—though the possibility be remote—result in Government interference with the operation of hospitals or the practice of medicine.

SIGNIFICANT ADMINISTRATIVE ROLE FOR PRIVATE ORGANIZATIONS

Under our proposed amendment the Secretary of Health, Education, and Welfare would be given specific statutory authority to delegate some of the more sensitive administrative functions to Blue Cross or to other similar voluntary organizations that are experienced in dealing with hospitals and other providers of health services. Any group of hospitals—or group of other providers of health services—could designate a private organization of their own choice to receive their bills for services and to pay these bills. If advantageous, additional administrative functions could be included in the contract between the Government and the organization. These administrative functions would include reviewing hospital fiscal records as a part of the determination of the cost of services, and acting as a center for communicating and interpreting payment procedures to hospitals.

I should point out that representatives of the American Hospital Association appearing before the Committee on Ways and Means last summer urged an approach that would utilize the services of voluntary organizations if a bill of this type were to be enacted, and I am convinced from numerous conversations with individuals in the field of hospital administration that the provisions I am now outlining will prove to be eminently satisfactory to them. The principal advantage hospitals and other providers of services would find in this arrangement would be that policies and procedures of the Federal program would be applied by the same organization administering the private, voluntary benefit program with which most of them deal.

The role that Blue Cross plans and similar expert organizations could play in carrying out the provisions of my proposed amendment would have advantages that go beyond the benefits that would be derived from their experience in dealing with hospitals and the working relationships already established. With such organizations serving as intermediaries between the Government and providers of services, those who are concerned that the Government might try to intervene in hospital affairs would feel much more comfortable.

ROLE OF STATE AGENCIES

The Federal Government would use State agencies to determine whether hospitals which are not accredited by the Joint Commission on the Accreditation of Hospitals or skilled nursing facilities and other providers of health services are qualified to participate in the program. The conditions of participation for such providers are spelled out in my bill. State agencies would determine whether they are met. State health departments or other appropriate agencies designated by each State would also give professional consultation to providers of health services to assist them in meeting the conditions for participation and in establishing and maintaining necessary fiscal records and providing information necessary to derive operating costs which are the basis for payment for their services.

State governments are well fitted to perform these functions since they already license health facilities.

CONDITIONS FOR PARTICIPATION

Many people in the health field have applauded the intention—clearly reflected in S. 909—to be specific about any conditions that hospitals or other organizations would have to meet before they could participate in the proposed program. To make sure that the new program would not in any way undercut the efforts of the health profession and would not permit payment to substandard institutions, the participation requirements of S. 909 paralleled requirements of the health professions as they define and accredit institutions. A misunderstanding of the provision has produced the notion that the Government would impose additional requirements beyond those necessary for accreditation. The amendment we are offering makes very explicit that the requirements for participation may not go beyond the professionally set and professionally accepted standards established for hospitals, save for the requirement of a utilization review arrangement. The amendment even goes so far as to name the Joint Commission on the Accreditation of Hospitals and to require use of the Commission's provisions and findings; it provides that, with the one exception of the review arrangement, a hospital that is accredited by the Joint Commission would be conclusively presumed to meet the conditions for participation.

Our amendment would assure that participating nursing homes are of high quality by requiring that only nursing facilities affiliated with hospitals may participate.

FINANCING OF THE PROGRAM

The Chief Actuary of the Social Security Administration has assured me that the benefits of the proposal would be financed on a sound actuarial basis under the usual cost assumptions, which involve, among other things, level-earnings assumptions. The financing of both the cash benefits, including the higher ones that would result from raising the earnings base, and the new health benefits, would be accomplished by raising the maximum taxable earnings base to $5,200 per year and by an additional combined employer-employee tax of one-half percent. Whereas S. 909 provided for a separate Health Insurance Account to be maintained in the social security trust fund, our amendment would attach even more importance to separate accounting for health benefits by establishing a distinct and separate Health Insurance Trust Fund.

The proposed health benefits would be financed by an allocation to the Health Insurance Trust Fund from the total social security tax receipts—an allocation equal to what a combined employer-employee tax of .68 percent would yield. Part of this—.50 percent—comes from the increase in the scheduled contribution rates in all future years. The remainder comes from the net gain resulting in the cash-benefits portion of the system from raising the earnings base from $4,800 to $5,200. The health benefits of the proposal and those of the existing system as a whole would be on a sound actuarial basis under these proposed financial provisions.

SUMMARY

Our amendment would embody all of the great merit of the social security approach and at the same time provide meaningful assistance for the relatively few older people who are not now protected by the social insurance system. It has strong safeguards against any possibility that Government would exert control over providers of services and established medical practices. It would have the additional advantage of not requiring Government and the doctors to come to agreement on fees and other sensitive matters that are best left to the private sector. It represents the vast area of agreement that has been reached by those of us who sincerely seek a way by which much needed protection against the cost of serious illness can be provided for our senior citizens.

There is no justification for further delay; we must not wait longer to provide an effective program of protection for the Nation's elderly people.

EXHIBIT 1

SIGNIFICANT IMPROVEMENTS IN ANDERSON BILL (S. 909) MADE BY ANDERSON AMENDMENT TO WELFARE BILL (H.R. 10606)

1. BLANKETING IN PRESENT NONINSURED

(Pp. 69–72, secs. 231–233): A provision has been made under the amendments providing coverage for health benefits for all those who are presently aged and not protected by a Federal program. People who reach age 65 before 1967 and who do not meet the regular insured status requirements of the social security system would be deemed insured for health insurance purposes. Uninsured people who will reach age 65 in 1967 would be deemed to be insured for social security health benefits if they had earned as few as 6 quarters of coverage in covered work at any time. For people who reach age 65 in each of the succeeding years, the number of quarters of coverage needed to be insured for health insurance protection increases by three each year, thus, people reaching age 65 in 1968 would need 9 quarters of coverage, people reaching 65 in 1969 would need 12 quarters of coverage, and so on. By 1972, the special insured status requirements for health insurance would have caught up with the regular insured status requirements for other social security benefits for both men and women and will wash out. The cost of health insurance benefits for these individuals would be paid into the Federal Health Insurance Benefits Trust Fund from the general funds of the Treasury.

2. SEPARATE TRUST FUND PROVIDED

(P. 45, et seq.; sec. 202): The amendment establishes a new Federal Health Insurance Trust Fund, completely separate from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, into which an amount equal to the taxes collected for health benefits would be deposited and from which health insurance benefit payments would be made.

3. USE OF VOLUNTARY ORGANIZATIONS SUCH AS BLUE CROSS PLANS

(P. 40, sec. 1715): A new provision has been added authorizing the Secretary to enter into agreements with an organization designated by any group or association of providers of services to perform certain administrative functions in connection with the program, including determination of the amount of payments due and making the payments. These provisions would make it possible for Blue Cross plans, the Kaiser plan or similar organizations, to participate substantially in the administration of the program.

4. USE OF STATE AGENCIES IN ADMINISTRATION

(P. 23, sec. 1708): The amendment provides for the use of State agencies to determine eligibility and to provide consultative services to providers of services and payment for such use including Federal sharing in the costs of planning and other activities directed at coordinating these services with other activities of the State related to health and medical services and the personnel and facilities required for this purpose.

5. SUPPLEMENTATION OF BENEFITS BY STATES AND PRIVATE INSURERS PROVIDED

(P. 4, sec. 1701(b)): The amendment contains a new provision disclaiming any intention to preclude supplementation of the basic protection provided by the bill through other health and medical care provided by States or through purchase from private carriers or otherwise.

The findings and declaration of purposes (p. 2, sec. 200(b)) also makes clear the intention to encourage and facilitate supplementation by States, private insurance, or other methods by providing, as does the present old-age, survivors, and disability insurance, a basic social insurance benefit.

6. ACCREDITATION OF HOSPITALS

(P. 24, sec. 1708(b)): Under the amendment accreditation of a hospital by the Joint Commission on Accreditation of Hospitals (AMA and AHA) would automatically make it eligible to participate if it had a satisfactory plan for utilization review by doctors on the hospital staff.

(Pp. 15–16, sec. 1706(a)(7)): Moreover, any health and safety requirements added by the Secretary to those spelled out in the bill could not exceed the requirements of the Joint Commission for Accreditation.

PUBLIC WELFARE AMENDMENTS OF 1962

Mr. MANSFIELD. Madam President, under the unanimous-consent agreement of Friday, June 29, I ask unanimous consent that the Chair lay before the Senate the unfinished business.

The PRESIDING OFFICER. The Chair lays before the Senate the unfinished business, which will be stated, by title.

The LEGISLATIVE CLERK. A bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

PUBLIC WELFARE AMENDMENTS OF 1962

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the unfinished business be laid before the Senate for its consideration.

The PRESIDING OFFICER. Is there objection to the request of the Senator from Montana?

There being no objection, the Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. KERR obtained the floor.

Mr. MANSFIELD. Mr. President, will the Senator from Oklahoma yield to me, so that I may suggest the absence of a quorum, with the understanding that he will not lose his right to the floor?

Mr. KERR. I yield to the majority leader with that understanding.

Mr. MANSFIELD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DIRKSEN. Mr. President, I move that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Is there objection? The Chair hears none, and it is so ordered.

Mr. KERR. Mr. President, I ask unanimous consent that Frederick B. Arner and Helen E. Livingston from the Education and Welfare Division, Legislative Reference Service, Congressional Library, who have been assigned to the Committee on Finance to work on the pending legislation, may be permitted to be present in the Chamber during the discussion of the bill, to assist me and other Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KERR. Mr. President, the public welfare amendments bill which we have before us today represents, in my opinion, a significant milestone in the development of programs for the help and the care of needy people in this country. I regard it as one of the most constructive public welfare measures ever brought before this body.

It heralds a turning point in the programs which we have constructed over the last quarter of a century and more to assist the least fortunate of our fellow citizens—the men, women, and children who are ill or handicapped or aged or destitute for a great variety of causes.

Under this bill they can be given more than a grant of money to keep body and soul together. Financial assistance of course is now, and will remain, the first and most essential objective of public welfare. We are committed to the extent possible, to help see to it that no one be permitted to go hungry or unsheltered.

But in addition, through this bill, we will offer something else. We will extend hope—hope of a future in which children helped by public assistance will grow up to be self-supporting, responsible adults; hope for putting unskilled and deprived adults back to work through counseling and training; hope for reuniting families parted by desertion and despair; hope for assuring children freedom from neglect and abuse, and hope for the aged and the most severely handicapped of becoming less helpless and lonely than so many of them are today.

LOOKING TOWARD PREVENTION

There has been an increasing recognition in many quarters that money alone is not enough to transform economic dependency into personal independence. In many parts of the Nation, attempts have been made to provide other constructive services. This legislation places emphasis upon rehabilitation and the prevention of dependency, and this approach seems to me the most

practical and realistic step we can take at this time to relieve the welfare burden.

I believe that citizens everywhere want to see this great and useful program yield greater returns in stronger, more stable, and more productive lives.

The public welfare amendments of 1962 are a testimony to the belief of the Congress in the dignity of every individual, whatever his circumstances, and his right to an opportunity to develop to his fullest capacity.

The Committee on Finance, under the experienced and able leadership of the Senator from Virginia [Mr. BYRD], has given careful consideration to each aspect of this comprehensive measure. We have had the benefit of testimony from many sincere and respected persons connected with the operation of public and private welfare programs as well as those looking at public welfare from the outside. There is nearly unanimous agreement that the proposed legislation will help bring welfare programs up to date and make them more effective in answering the needs of people who, for various reasons, do not fit easily into our rapidly changing, complicated, modern society. I think that we are fortunate to have at the head of the Department of Health, Education, and Welfare in this period of shifting focus a man who has been willing and able to call attention to the urgent needs of these times. A tremendous amount of constructive work under his able leadership has gone into his proposals to the Congress. Secretary Ribicoff has clearly pointed out that additional emphasis must be given to rehabilitation and prevention efforts if we in Government are to fulfill our responsibilities to the recipients of public assistance and to the public at large.

I would like to discuss some of the things which distinguish this measure from previous legislative proposals in this important and complex field.

EXTENDING HELP THROUGH SERVICES

I am deeply concerned, as many other Members are, over the fact that so many persons depend upon public assistance today for their main or sole support. We have more than 6½ million individuals now receiving aid from the Federal-State programs. Many studies have shown why they are there. Stated simply, the major causes could be summed up as old age, severe physical handicap, and the breakup of family life.

For many of these present recipients of aid, there is no alternative to continuing support. Our best efforts at rehabilitation cannot put them into the labor force if they are old, infirm or seriously disabled. We can however, do much more to help a great many of them make better use of what capacities they do have.

There are today some 2¼ million persons over 65 receiving old-age assistance. I am pleased to see this number is declining as the old age and survivors' insurance program proves increasingly successful in meeting basic economic needs after retirement. The numbers of needy blind and disabled persons on assistance total only another half million, but for all of these groups of individuals, this bill encourages States to provide social services which will help them to be less isolated, to be more personally independent, and to maintain some place in family and community life.

Many will be encouraged to find in this bill a provision for increasing the money payments to these elderly and handicapped recipients. Average payments today amount to only $72 a month for the old people, $76 for the blind, and $71 for the disabled. These monthly assistance grants are in many cases inadequate.

The Finance Committee was very much aware of this problem and believes that the proposal which originated in the other body changing the formula which increases the Federal share of the welfare payment is justified. The $1 monthly increase in the Federal share voted last year has been made permament, and starting October 1 this will be augmented by another $4 a month from Federal funds, under this bill. Past experience has shown that increases of this nature have been passed on by the States directly to the recipients, and it is anticipated that the same result will occur this time. The effective starting date gives the States enough time to make the necessary changes in their payment plans.

The aid to dependent children program also will be strengthened financially by the provision for Federal sharing in the payment for both parents when both are living in the home. This will help reduce hardship in those homes where the father is disabled or unemployed. Up to now, the Feedral Government has recognized as a recipient only one adult relative in the child's home.

STRENGTHENING FAMILY LIFE

Although the rehabilitation services this bill encourages in all categories will be helpful to recipients in the three adult categories specifically mentioned above, these services may be expected to yield the most impressive results in the aid to dependent children program, under which more than 950,000 families with some 2,800,000 children are now receiving help.

Here we can see greater possibilities of helping some adult relatives—an incapacitated father, perhaps, or a mother who can make some safe and suitable arangement for the daytime care of her children—develop useful skills and obtain self-supporting work. And there is the strong prospect of strengthening family life through expert services which can break the alamring cycle of dependency.

Many of the children who are on our aid to dependent children program today are there because their fathers have deserted them. Some of these broken family ties can be mended, but it takes the time and effort of a skilled welfare worker to reunite the family or obtain some support from the absent father. I have been pleased to see that one of the administrative actions taken by Secretary Ribicoff several months ago directed the States to take more responsibility for this important activity. The developments already stimulated by that action will be strengthened by this legislation. There are other problems reflected in the caseload of the children's program, among them illegitimacy, which can be approached through services. This is a problem which can be more effectively attacked with what this legislation provides in the way of skilled services. This means guidance, counseling, referral to all possible community resources whether public or private, arrangements for vocational training or better housing, encouraging children to stay in school, and similar concentrated efforts.

INCREASED FEDERAL AID

The bill encourages States to provide rehabilitative services by substantially increasing the amount of Federal funds which will be available if the States provide the minimum social services specified by the Secretary. Some of the States have made some progress along this path. Others will be able to move ahead only with the additional financial help provided in the bill. When the new plan is in operation, the Federal Government will pay 75 percent of the administrative cost of the specified social services instead of half, as it does now. In addition, States may choose not to provide social services, and if they so decide, they will still receive Federal sharing, but at a reduced level, for administrative costs. However, I believe all States should and will move in the direction of providing such services.

This will be one of the most difficult and challenging fronts in the long battle against dependency. Experimental programs conducted by forward looking States and counties have demonstrated many times, however, that social services provided by skilled staff can make inroads on the problems which force so many families to look to the public for their support.

Most of these services will have to come from the staff of public welfare agencies, but it is also possible under this bill for a public welfare agency to purchase services from other appropriate State agencies, such as a health department or vocational rehabilitation service.

The volume of unmet need is so great, and the problems which public welfare faces are so complex, that every effort must be made to meet them, using all available staff without duplicating efforts. Under this bill, it will be possible for a public assistance recipient who is physically handicapped to receive the vocational rehabilitation he needs only through a vocational rehabilitation agency.

TRAINING MORE WELFARE WORKERS

Public assistance can do little to affect the broad social and economic forces which affect the welfare of so many of our people and often the size of welfare loads. But for those already dependent, social services—to the best of our knowledge today—should be able to reduce or even in some cases cure their handicapping conditions. The key will be highly skilled welfare workers. This means that much more must be done about training.

The size of the training problem in public welfare almost defeats the imagi-

nation. There is about one trained person for every 23,000 recipents in the entire program today. Yet the problems they are called upon to solve are among the most difficult society presents.

This bill will provide for direct Federal training activities in this field, such as those already undertaken in other fields including medical social service and mental health. The Federal Government will be able, if this bill is passed, to offer special courses of study, short-term seminars and experimental training by grants made directly or through contracts to institutions of higher learning. This will help find new and better methods of training to strengthen present day staff. The money also would make possible increased training facilities at colleges and universities to increase the number of fully trained people.

EXPANSION OF CHILD WELFARE SERVICES

Through provisions for steady expansion of the present program of child welfare services under title V, part 3, of the Social Security Act, the bill gives further emphasis to providing a wider range of constructive welfare services for children. Child welfare services would be gradually expanded so that they would become available in all areas of the country. The ceiling authorized for annual appropriation for grants for these services would be increased gradually for this purpose.

In 1963 and 1964, the additional money would be used to encourage the establishment and development of day care facilities and services. At the present time there are about 4 million children under 6, and another 5 million children between the ages of 6 and 11 years, whose mothers are working. Day care services and facilities are grossly inadequate throughout the country. Consequently, the bill would make available, for the first time, separate Federal child welfare funds for the provision of day care services and facilities under State child welfare plans. Day care would be provided only in those instances where it was determined to be in the interest of the child and of the mother and that a need for it exists. Priority would be given to low-income families, and to other groups and to geographical areas with the greatest relative needs for this type of care.

Another amendment would permit expanding training resources and enlarging the supply of trained child welfare personnel. The present law authorizes grants for research and demonstrations in the field of child welfare. The bill would add authorization for grants to institutions of higher learning for special projects for training, including traineeships, in child welfare. This provision complements the amendments in the bill which provide for expanding training programs for workers in the public assistance program. The success or failure of services to children is largely dependent on the competency and understanding of the workers providing these services. The training provisions of this bill are, therefore, of fundamental importance in achieving the redirection of public welfare programs which this bill contemplates to give greater emphasis to preventive and rehabilitative services.

MEETING THE SPECIAL NEEDS OF CHILDREN

Two provisions enacted by the Congress last year were temporary, but both have proven their value. This bill makes permanent the provision permitting Federal financial sharing in the cost of care for children who must be removed from unsuitable homes where they had been receiving aid to dependent children. This is a very small program. It is in use in 18 States and only some 1,200 children among those receiving aid to dependent children are living in foster families. But the provision makes it possible for States to offer this kind of help to those few children who are in home situations which threaten their wholesome development.

Another temporary provision recognized the plight of children in families where the father is unemployed. This made it possible for States which adopted the program to add unemployment to the eligibility factors for receiving aid to dependent children, along with the death, absence, or incapacity of the parent. This program would have ended June 30. The bill extends it for another 5 years. This program has proved to be a useful and effective resource in the 15 States where it is in operation. These include most of the areas where unemployment has been a particularly severe problem. More than 60,000 families are helped, and in two-thirds of the cases they could not be helped through general assistance or unemployment compensation. This new program already has shown its adaptability to current needs. In April this year, the caseload declined for the first time because work opportunities improved.

We all know that there are some cases in the children's program where the parent does not handle the money payment in such a way that it meets the essential needs of the child or children in the household. In these problem situations, which threaten a child's well-being and arouse criticism out of all proportion to their numbers, the States cannot at present provide anything except a money payment and still have Federal financial participation.

PROTECTIVE PAYMENT PLAN

The bill we are considering today offers States a new method for handling these troublesome situations without any financial penalty. It provides that in clearly determined cases where the funds are being misused, payment may be made on behalf of the child or children to an interested third party. The arrangements would be safeguarded as to numbers involved, and the rights of the recipients, and the protection of the child are carefully weighed. Of the many ways which have been broached for handling this vexing problem, this one offers the most hope of dealing sensibly with the issue without undermining basic human rights and the constructive objectives of the program.

There are other forward-looking aspects to this public welfare amendments bill which I would like to call to your attention. The proposed legislation attempts to encourage persons receiving assistance to obtain work or go back to work wherever possible. I have mentioned the social services which would pursue these possibilities in connection with other efforts to help dependent families. This bill also gives welfare departments another implement to use.

WORK AND TRAINING PROJECTS

A number of our States and localities already have community work relief projects, in which recipients of general assistance are employed to earn their assistance checks in whole or in part. The Federal Government does not, as you know, participate financially in the costs of general relief. However, since the extension of the aid-to-dependent-children program to include children of unemployed parents, employable adults are for the first time in the area of Federal-State responsibility. We must think of the unemployed parent's need to retain his job skills or to be retrained for employment which might be available if his own type of work offers no further opportunity.

Under this bill, Federal participation in aid-to-dependent-children payments would continue if the unemployed parent were assigned to a useful job in a community work and training project. Local and State resources would pay for materials, administration, and equipment. The program would be useful not only for the father who is out of work temporarily but also for some mothers who need experience or preparation for work.

The bill makes sure that the rights of the individuals involved are protected so that they are not forced to work under circumstances which would undermine their health or lower the community wage scales or leave children without care and protection.

As a further stimulant to recipients to find work to supplement—and ultimately to replace—the assistance check, the present Federal policy allows States to take into account the expenses incurred by the unemployed in earning other income. This might include bus fare, necessary articles of clothing, and similar items. In other words, the total earned income is not automatically deducted from the estimated budget need of the family for its essential food, clothing, and shelter. This is optional with the States. Some make the allowance and some do not. The bill requires all States to consider such expenses when the payment is being determined. In the particular case of the blind recipient, this bill would make it possible also to disregard—in determining the assistance payment—an additional sum which the recipient would require to complete an organized rehabilitation plan.

SUMMARY OF THE PRINCIPAL PROVISIONS OF THE BILL—PUBLIC ASSISTANCE

A. REHABILITATIVE SERVICES AND TRAINING IN THE PUBLIC ASSISTANCE PROGRAMS

A State, at its option, may now provide such services under all the public assistance programs except medical assistance for the aged. The Federal Government matches these expenditures on a 50–50 under the provision which governs administrative expenses.

Under the bill as passed by the House, States would be required to provide certain minimum services for applicants and recipients, which the Secretary would prescribe, to help them attain self-care—old-age assistance; self-support and self-care—the blind and the disabled; and to strengthen family life—aid to dependent children. There were no required services for medical assistance for the aged.

The committee's bill would leave the provision of such services optional with the States; but, if they are not provided by a State, the Federal matching of all administrative costs for that category of assistance—now 50 percent—would be reduced to 25 percent effective June 30, 1963.

The bill would authorize 75 percent Federal matching in all public assistance titles for certain services—including the minimum services—to be specified by the Secretary of Health, Education, and Welfare. These services—including the minimum services—could apply to applicants and recipients of assistance as well as to those likely to become or who have been recipients, on the request of such persons—within such periods as the Secretary may prescribe.

The 75-percent matching would also be available for training personnel who are employed, or who are preparing to work, in State or local welfare agencies.

Other services which the Secretary does not designate would be continued at 50-percent matching, as would all other administrative costs. Cost: HEW estimate, $40.8 million—cost figures for fiscal 1963—with over half going into the aid-to-dependent-children program.

B. INCREASE IN FEDERAL MATCHING FORMULA FOR THE AGED, BLIND, AND DISABLED

The committee bill, as does the House bill, increases the Federal matching share in the case of the programs for the aged, the blind, and the disabled to twenty-nine thirty-fifths of the first $35 of the average monthly payment per recipient; the maximum for matching would be raised to $70 on a permanent basis effective October 1, 1962. The bill passed by the House makes the same increase in the matching formula on a permanent basis effective July 1, 1962. The temporary provision now in effect which uses matching on four-fifths of the first $31, with a maximum of $66 through June 30, 1962, was extended through September 30, 1962. Without such an extension the formula would revert to four-fifths of the first $30 with a maximum of $65. The change does not affect the special provision for medical care in the old-age assistance program. Cost: HEW estimate, $105.5 million—cost figure for fiscal 1963—$140.6 million for first full year of operation.

C. CHANGES IN THE AID TO DEPENDENT CHILDREN (ADC) PROGRAM

First. Additional authority to States to prevent abuses in aid to dependent children payments: The committee bill would provide that, beginning October 1, 1962, and ending June 30, 1967, payments—limited in number to 5 percent of recipients—would be authorized to be made to third parties interested in the welfare of the child where it is determined that the parent is so incapable of managing funds that the child's welfare is affected. Certain safeguards and standards would be prescribed. The committee eliminated the provision of the House will which would have allowed the States to use voucher payments—payments directly to grocers, landlords, et cetera. Cost: HEW estimate, negligible—cost figure for fiscal 1963.

Second. Payments on the basis of the unemployment of the parent: This temporary provision of existing law, which is effective May 1, 1961, to June 30, 1962, would be extended for 5 years by the House bill and the committee bill and be expanded to cover both parents instead of one as in existing law. A provision would be added which would deny aid to a parent for refusal to accept retraining without good cause.

Under prior law, aid to dependent children payments could be made only on the basis of the death, disability, or absence of the parent. Cost: HEW estimate, $85 million—of which $12 million is attributable to the second parent provision.

Third. Payments on the basis of the disability of the parent: Federal matching would be expanded to cover payments for both parents of children who are needy because of the disability of the parent. At the present time the Federal Government matches for one adult recipient only. Cost: HEW estimate, $22 million.

Fourth. Community work and training programs: The bill would provide that beginning October 1, 1962, for a period of 5 years, Federal matching funds would be available in cases where payments are made under work programs which are a part of the aid-to-dependent-children program and meet certain standards. Under interpretation of existing law there can be no matching as to payments made for work by a welfare agency; such payments currently are financed wholly by State and local funds. Under an amendment added by the committee, payments to individuals under these programs would be excluded from gross income for Federal income tax purposes. Cost: HEW estimate, negligible—cost figures for fiscal 1963.

Fifth. Payments to children removed by court order into foster care: Under temporary existing law, which is effective May 1, 1961, to June 30, 1962, payments can be made to aid to dependent children removed by court order into foster home care. This provision would be made permanent under the House bill and the committee bill. Payments under prior law were limited to children living with specified relatives. The committee deleted the provision in the House bill which would have expanded the program to include children placed in private child care institutions as well as those receiving family home care as in existing law. The committee bill also includes an amendment which would allow States, for a 1-year period, under the foster care provisions of aid to dependent children program, to utilize the services of other public agencies in the placement and supervision of children in foster home care under agreements with the welfare agency. Cost: HEW estimate, $4.1 million—cost figures for fiscal 1963.

D. OTHER CHANGES IN PUBLIC ASSISTANCE PROGRAMS

First. Incentive for employment through consideration of expenses: The States would be required, in determining the amount of assistance to be provided for the needy aged, blind, disabled, and dependent children, to take into account necessary expenses that may reasonably be attributed to the earning of income. Under current administrative policy, the States may, at their option, consider such expenses.

Also, in determining need in the aid-to-dependent-children program, the States would be allowed to disregard certain earned or other income put aside for the child's future need—for example, such items as education or preparation for employment. Cost: HEW estimate, negligible—cost figures for fiscal 1963; $7 million a year after it goes into effect in July 1963.

Second. Optional single State plan for aged, blind, disabled, and medical assistance for the aged: States would be allowed to operate these programs under a single plan. States which select the single plan would become eligible for Federal matching for medical care for recipients of aid to the blind and to the disabled on the same basis as they are now available for recipients of old-age assistance—that is, up to $15 a month per recipient for vendor medical care. Such additional matching would not be available if States remained under their separate programs. Administration would be allowed, however, by separate existing blind agencies. Cost: HEW estimate, $7.4 million—cost figures for fiscal 1963; increases to $16 million in 1964 and subsequent years.

Third. Training of public assistance workers: Under the House bill, provisions of present law authorizing Federal grants to States to increase the number of adequately trained public welfare personnel to work in public assistance programs, which are due to expire June 30, 1963, would be made permanent, with dollar limitations on authorized appropriations for grants to States for training of public assistance workers—$3.5 million in fiscal 1963 and $5 million a year thereafter. Within the dollar limitations established by the House bill, the committee bill authorizes a program of direct Federal training and grant activity and of scholarships and stipends for persons preparing for employment in public welfare agencies. The committee bill would repeal existing provisions of law that authorize 100 percent Federal funds for expenditures made by States for training of staff. Cost: HEW estimate, negligible—cost figures for fiscal 1963.

Fourth. Assistance to repatriated American citizens: This provision of existing law, which was effective on June 30, 1961, and will expire on June 30, 1962, permits temporary assistance to citizens returning from foreign countries because of illness, destitution, or crisis. It would be extended for 2 years. Cost: HEW estimate, $400,000—cost figures for 1963.

Fifth. Demonstration projects: The bill would permit the Secretary of Health, Education, and Welfare to waive any State plan requirement which he deemed necessary—such as statewide applicability of plan—for pilot or demonstration projects designed to improve the public assistance programs and would provide alternative methods of financing such projects out of public assistance appropriations. Cost: HEW estimate, negligible—cost figures for fiscal 1963.

Sixth. Aid-to-the-blind programs, Missouri and Pennsylvania: The provision of the 1950 amendments, which granted an exemption to certain aid-to-the-blind programs—in effect at that time—from the income and resources test of Federal law, would be placed on a permanent basis. The temporary provision has been extended periodically and would, under existing law, expire in 1964.

Seventh. Other committee amendments: Two provisions were added by the committee which were not contained in the House bill. First, the reported bill increases the dollar limitation which is applicable to public assistance expenditures in Puerto Rico from the present $9,500,000 to $10,500,000, and in the Virgin Islands from the present $320,000 to $400,000. The House bill would have increased these figures to $9,800,000 and $330,000, respectively, to reflect other changes made by the bill. Second, the bill as reported also contains an amendment which provides that, in determining need for aid to the blind, a State shall, in addition to present exempted amounts—$85 a month in earnings plus one-half of the balance exempt such other amounts of income or resources as may be necessary to fulfill a State-approved rehabilitation plan for a blind individual. Such additional exemptions cannot last for more than 1 year.

CHILD WELFARE SERVICES

The authorization for child welfare services would be increased from the present $25 million per year to $30 million for 1963, $35 million in 1964, $40 million in 1965–66, $45 million in 1967–68, and $50 million in 1969 and thereafter. Of the amount between $25 and $35 million, there would be specific earmarking for day care of not more than $5 million in 1963 and not more than $10 million in subsequent years. The committee added an amendment which would permit Federal grants for research or demonstration projects in child welfare to be used for special projects for training personnel in this field. Cost: HEW estimate, $5 million—cost figures for 1963—increasing in subsequent years as noted above.

ADVISORY COUNCIL

The bill provides for an advisory council, to be appointed by the Secretary of Health, Education, and Welfare in 1964, to review the status of the public assistance and child welfare services programs and report their findings to the Secretary. The power to appoint other advisory committees contained in the House bill was somewhat limited in the bill reported by the committee.

CONCLUSION

It is a source of great pleasure to me to be able to commend this bill to you so wholeheartedly. I believe that it offers us great encouragement in our continual effort to make our public welfare programs more effective and more responsive to the needs of the day. We would not shun the responsibilities of public assistance. Many recipients are in need because of actions and decisions and forces of society as a whole, which are beyond individual control. The bill will help to make certain that assistance is provided in the way best calculated to strengthen individual and family life and to restore beneficiaries to a productive and independent economic status at the earliest possible time.

Mr. President, I ask unanimous consent that the committee amendments to the bill be agreed to en bloc and that the bill as amended be considered as original text for the purpose of amendment.

The PRESIDING OFFICER. Is there objection?

Mr. DIRKSEN. Mr. President, there is no objection. The distinguished Senator from Nebraska [Mr. CURTIS] is quite interested in having the bill considered as original text. I think that is in accordance with the request of the Senator from Oklahoma.

Mr. KERR. Yes.

The PRESIDING OFFICER. Without objection, the request of the Senator from Oklahoma is agreed to.

The committee amendments agreed to en bloc are as follows:

In the table of contents on page 1, in the line beginning with "(b)", to strike out "State plan provisions for services." and insert "Requirements for full Federal matching of State administrative expenditure."; on page 2, in the line beginning with "SEC. 107.", to strike out "Use of payments for benefit of child." and insert "Provision of care for child who is in unsuitable home."; in the line beginning "SEC. 109.", after the word "for", to strike out "spouse of relative with whom" and insert "both parents of", and in the next line, after the word "child", to strike out "is living"; in the line beginning with "SEC. 123.", to strike out "Training grants for public welfare personnel." and insert "Increase in adequately trained welfare personnel."; in the line after the one beginning with "SEC. 134.", to strike out "SEC. 135. Federal payments for foster care in child care institutions."; in the line beginning with "SEC. 136", to strike out "136" and insert "135"; on page 3, after the line beginning with "SEC. 153.", to insert "SEC. 154. Income and resources to be disregarded in determining need of individual for aid to the blind."; and, after the amendment just above stated, to insert "SEC. 155. Responsibility for placement and foster care of dependent children."

On page 4, line 7, after the word "to", to strike out "section 2(a)(10)" and insert "subsection (c)(1)"; in line 17, after the word "to", to strike out "section 2(a)(10)" and insert "subsection (c)(1)"; on page 5, line 22, after the word "political", to strike out "subdivision, and" and insert "subdivision: *Provided,* That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and"; on page 7, after line 2, to insert "except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved."; at the beginning of line 9, to strike out "except that any such services which are defined as vocational rehabilitation services under the Vocational Rehabilitation Act and which are available, from the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services, to individuals under programs for their rehabilitation carried on under such State plan, may be provided only by such State agency or agencies (in the manner described in subparagraph (E)) except to the extent agreed to by such State agency or agencies."; on page 8, line 4, after the word "Secretary", to insert "of the Treasury"; on page 9, after line 10, to insert "and"; on page 10, line 7, after the word "to", to strike out "section 402(a)(12)" and insert "subsection (c)(1)"; in line 21, after the word "to", to strike out "section 402(a)(12)" and insert "subsection (c)(1)"; on page 11, after line 13, to strike out "services provided (in accordance with the next sentence) to any child who is an applicant for or recipient of assistance under the plan or who requests such services and (within such period or periods as the Secretary may prescribe) has been or is likely to become an applicant for or recipient of such assistance, or so provided to any relative," and insert "services provided (in accordance with the next sentence) to any relative, specified in section 406(a), with whom any child (who, within such period or periods as the Secretary may prescribe, has been or is likely to become an applicant for or recipient of aid to families with dependent children) is living, or to such child, if such services are requested by such relative or for services so provided to any child who is an applicant for or recipient of such aid, or to any relative,"; on page 12, line 13, after the word "political", to strike out "subdivision, and" and insert "subdivision: *Provided,* That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and"; on page 13, after line 15, to insert "except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved."; after line 21, to strike out "except that any such services which are defined as vocational rehabilitation services under the Vocational Rehabilitation Act and which are available, from the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services, to individuals under programs for their rehabilitation carried on

under such State plan, may be provided only by such State agency or agencies (in the manner described in subparagraph (E)) except to the extent agreed to by such State agency or agencies."; on page 14, line 13, after the word "Act", to strike out "(as amended by section 132(b) of this Act)"; in line 24, after the word "to", to strike out "section 1002(a)(13)" and insert "subsection (c)(1)"; on page 15, line 9, after the word "to", to strike out "section 1002(a)(13)" and insert "subsection (c)(1)"; on page 16, line 12, after the word "political", to strike out "subdivision, and" and insert "subdivision: *Provided,* That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and"; on page 17, line 15, after the word "agencies", to insert "except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved."; at the beginning of line 21, to strike out "except that any such services which are defined as vocational rehabilitation services under the Vocational Rehabilitation Act and which are available, from the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services, to individuals under programs for their rehabilitation carried on under such State plan, may be provided only by such State agency or agencies (in the manner described in subparagraph (E)) except to the extent agreed to by such State agency or agencies."; on page 18, line 13, after the word "Act", to strike out "(as amended by section 132(c) of this Act)"; in line 24, after the word "to", to strike out "section 1402(a)(12)" and insert "subsection (c)(1)"; on page 19, line 9, after the word "to", to strike out "section 1402(a)(12)" and insert "subsection (c)(1)"; on page 20, line 14, after the word "political", to strike out "subdivision, and" and insert "subdivision: *Provided,* That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and"; on page 21, line 17, after the word "agencies", to insert "except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved."; after line 23, to strike out "except that any such services which are defined as vocational rehabilitation services under the Vocational Rehabilitation Act and which are available, from the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services, to individuals under programs for their rehabilitation carried on under such State plan, may be provided only by such State agency or agencies (in the manner described in subparagraph (E)) except to the extent agreed to by such State agency or agencies."; on page 22, after line 15, to strike out:

"STATE PLAN PROVISIONS FOR SERVICES

"(b)(1) Section 2(a) of such Act is amended by striking out paragraph (10)(C), by inserting 'and' after the semicolon at the end of paragraph (10)(A), by redesignating paragraphs (10) and (11) as paragraphs (11) and (12), respectively, and by inserting after paragraph (9) the following new paragraph:

"'(10) provide that the State agency shall make available to applicants for or recipients of old age assistance under the plan at least those services to help them attain or retain capability for self-care which are prescribed by the Secretary; and include a description of the steps taken to assure, in the provision of these and any other services which the State agency makes available to individuals under the plan, maximum utilization of other agencies providing similar or related services;'.

"(2) Section 402(a)(12) of such Act is amended to read as follow: '(12) provide that the State agency shall make available at least those services to maintain and strengthen family life for children, and to help relatives specified in section 406(a) with whom children (who are applicants for or recipients of aid to families with dependent children) are living to attain or retain capability for self-support or self-care, which are prescribed by the Secretary; and include a description of the steps taken to assure, in the provision of these and any other services which the State agency makes available to individuals under the plan, maximum utilization of other agencies providing similar or related services'.

"(3) Section 1002(a)(13) of such Act is amended to read as follows: '(13) provide that the State agency shall make available to applicants for or recipients of aid to the blind at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary; and include a description of the steps taken to assure, in the provision of these and any other services which the State agency makes available to individuals under the plan, maximum utilization of other agencies providing similar or related services'.

"(4) Section 1402(a)(12) of such Act is amended to read as follows: '(12) provide that the State agency shall make available to applicants for or recipients of aid to the permanently and totally disabled at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary; and include a description of the steps taken to assure, in the provision of these and any other services which the State agency makes available to individuals under the plan, maximum utilization of other agencies providing similar or related services'."

And, in lieu thereof, to insert:

"REQUIREMENTS FOR FULL FEDERAL MATCHING OF STATE ADMINISTRATIVE EXPENDITURES

"(b)(1)(A) Paragraph (4) of section 3(a) of such Act, as amended by subsection (a) of this section, is further amended by inserting, in the portion thereof which precedes subparagraph (A), 'whose State plan approved under section 2 meets the requirements of subsection (c)(1)' after 'any State', and by striking out the period at the end of such paragraph and inserting in lieu thereof '; and'.

"(B) Such section 3(a) is further amended by inserting at the end thereof the following new paragraph:

"'(5) in the case of any State whose State plan approved under section 2 does not meet the requirements of subsection (c)(1), an amount equal to one-fourth of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (4) and provided in accordance with the provisions of such paragraph.'

"(C) Section 3 of such Act is further amended by adding at the end thereof the following new subsection:

"'(c)(1) In order for a State to qualify for payments under paragraph (4) of subsection (a), its State plan approved under section 2 must provide that the State agency shall make available to applicants for or recipients of old-age assistance under such State plan at least those services to help them attain or retain capability for self-care which are prescribed by the Secretary.

"'(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

"'(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

"'(B) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (4) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (4) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (5) of such subsection.'

"(2)(A) Paragraph (3) of section 403(a) of such Act, as amended by subsection (a) of this section, is further amended by inserting, in the portion thereof which precedes subparagraph (A), 'whose State plan approved under section 402 meets the requirements of subsection (c)(1)' after 'any State', and by striking out the period at the end of such paragraph and inserting in lieu thereof '; and'.

"(B) Such section 403(a) is further amended by inserting after paragraph (3) thereof the following new paragraph:

"'(4) in the case of any State whose State plan approved under section 402 does not meet the requirements of subsection (c)(1), an amount equal to one-fourth of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.'

"(C) Section 403 of such Act is further amended by adding at the end thereof the following new subsection:

"'(c) (1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 402 must provide that the State agency shall make available at least those services to maintain and strengthen family life for children, and to help relatives specified in section 406(a) with whom children (who are applicants for or recipients of aid to families with dependent children) are living to attain or retain capability for self-support or self-care, which are prescribed by the Secretary.

"'(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to

the State agency administering or supervising the administration of such plan, that—

"'(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

"'(B) in the administration of the plan there is a failure to comply substantially with such provision.

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (3) of subsection (a) but shall instead be made subject to the other provisions of this title, under paragraph (4) of such subsection.'

"(D) Section 408(d) of such Act is amended by inserting 'and (4)' after 'section 403(a)(3)'.

"(E) Section 409(b) of such Act (added by section 105 of this Act) is amended by inserting 'and (4)' after 'section 403(a)(3)'.

"(3)(A) Paragraph (3) of section 1003(a) of such Act, as amended by subsection (a) of this section, is further amended by inserting, in the portion thereof which precedes subparagraph (A), 'whose State plan approved under section 1002 meets the requirements of subsection (c)(1)' after 'any State', and by striking out the period at the end of such paragraph and inserting in lieu thereof '; and'.

"(B) Such section 1003(a) is further amended by inserting at the end thereof the following new paragraph:

"'(4) in the case of any State whose State plan approved under section 1002 does not meet the requirements of subsection (c)(1), an amount equal to one-fourth of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.'

"(C) Section 1003 of such Act is further amended by adding at the end thereof the following new subsection:

"'(c)(1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 1002 must provide that the State agency shall make available to applicants for or recipients of aid to the blind at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

"'(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

"'(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

"'(B) in the administration of the plan there is a failure to comply substantially with such provision.

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (3) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (4) of such subsection.'

"(4)(A) Paragraph (3) of section 1403(a) of such Act, as amended by subsection (a) of this section, is further amended by inserting, in the portion thereof which precedes subparagraph (A), 'whose State plan approved under section 1402 meets the requirements of subsection (c)(1)' after 'any State', and by striking out the period at the end of such paragraph and inserting in lieu thereof '; and'.

"(B) Such section 1403(a) is further amended by inserting at the end thereof the following new paragraph:

"'(4) in the case of any State whose State plan approved under section 1402 does not meet the requirements of subsection (c)(1), an amount equal to one-fourth of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.'

"(C) Section 1403 of such Act is further amended by adding at the end thereof the following new subsection:

"'(c)(1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 1402 must provide that the State agency shall make available to applicants for or recipients of aid to the permanently and totally disabled at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

"(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

"'(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

"'(B) in the administration of the plan there is a failure to comply substantially with such provision.

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (3) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (4) of such subsection.'"

On page 34, line 5, after the word "care", to insert "services (including the provision of such care)"; in line 17, after the word "care", to insert "services"; on page 35, line 7, after the word "exists", to insert a semicolon and "and, in cases in which the family is able to pay part or all of the costs of such care, for payment of such fees as may be reasonable in the light of such ability,"; on page 37, line 17, after the word "for", to strike out "the provision" and insert "use"; in line 18, after the word "part", to strike out "of" and insert "for"; in line 19, after the word "care", to insert "services, including the provision of day care"; on page 48, after line 11, to insert:

"(c)(1) Section 120 of the Internal Revenue Code of 1954 (26 U.S.C. 120) is amended to read as follows:

"'SEC. 120. PUBLIC ASSISTANCE FROM WORK AND TRAINING PROJECTS.

"'Gross income does not include payments of aid to families with dependent children (as defined in title IV of the Social Security Act) received by an individual under a State plan approved under section 402 of such Act even though received in the form of payments for work performed by him.'

"(2) Section 3401(a) of such Code (26 U.S.C. 3401(a)) is amended by striking out the period at the end of paragraph (13) and inserting in lieu thereof '; or' and by inserting after such paragraph the following new paragraph:

"'(14) if such remuneration is in the form of a payment of aid to families with dependent children (as defined in title IV of the Social Security Act) received by an individual under a State plan approved under section 402 of such Act.'

On page 49, line 11, after the word "paragraph", to strike out "(11) (as redesignated by section 101 (b) (1) of this Act)" and insert "(10)"; on page 50, after line 7, to strike out:

"SEC. 107. (a) Section 405 of the Social Security Act is amended to read as follows:

"'USE OF PAYMENTS FOR BENEFIT OF CHILD

"'SEC. 405. Whenever the State agency has reason to believe that any payments of aid to families with dependent children made with respect to a child are not being or may not be used in the best interests of the child, the State agency may provide for such counseling and guidance services with respect to the use of such payments and the management of other funds by the relative receiving such payments as it deems advisable in order to assure use of such payments in the best interests of such child, and may provide for advising such relative that continued failure to so use such payments will result in substitution therefor of protective payments as provided under section 406(b)(2), or in seeking appointment of a guardian or legal representative as provided in section 1111, or in other action authorized under State law which is deemed necessary to protect the interests of such child; and any such action taken by the State agency pursuant to such State law, other than denial of such payments with respect to such child while in the home of such relative, shall not serve as a basis for withholding funds from such State under section 404 and shall not prevent such payments with respect to such child from being considered aid to families with dependent children.'

On page 51, after line 8, to insert:

"PROVISION OF CARE FOR CHILD WHO IS IN UNSUITABLE HOME'

At the beginning of line 11, to strike out "(b)" and insert "SEC. 107."; in the same line, after the word "of", to strike out "such" and insert "the Social Security"; on page 52, line 3, after the word "another", to strike out "person" and insert "individual"; after line 15, to strike out:

"(B) meeting all of the need, as determined by the State, of individuals with respect to whom aid to families with dependent children is paid;" and, in lieu thereof, to insert:

"(B) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to families with dependent children to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;"

On page 53, line 21, after the word "below", to insert "the last"; in the same line, after the word "paragraph", to strike out "(3)" and insert "thereof"; on page 54, line 22, in the headline, after the word "for", to strike out "spouse of relative with whom" and insert "both parents of"; in line 23, in the headline, after the word "child", to strike out "is living"; on page 57, line 15, after the word "this", to strike out "Act" and insert "Act, but not more than ten such committees may exist at any time. The number of mem-

bers appointed to any such committee shall not exceed fifteen."; on page 58, line 18, after the word "the", where it appears the first time, to strike out "private"; on page 60, after line 7, to strike out:

"TRAINING GRANTS FOR PUBLIC WELFARE PERSONNEL

"SEC. 123. Section 705(a) of the Social Security Act is amended by striking out 'for the fiscal year ending June 30, 1958, the sum of $5,000,000, and for each of the five succeeding fiscal years such sums as the Congress may determine' and inserting in lieu thereof the following: 'for the fiscal year ending June 30, 1963, the sum of $3,500,000, and for each fiscal year thereafter the sum of $5,000,000'."

And, in lieu thereof, to insert:

"INCREASE IN ADEQUATELY TRAINED WELFARE PERSONNEL

"SEC. 123. (a) Section 705 of the Social Security Act is amended to read as follows:

"'TRAINING GRANTS FOR PUBLIC WELFARE PERSONNEL

"'SEC. 705. (a) In order to assist in increasing the effectiveness and efficiency of administration of public assistance programs by increasing the number of adequately trained public welfare personnel available for work in public assistance programs, there are authorized to be appropriated for the fiscal year ending June 30, 1963, the sum of $3,500,000 and for each fiscal year thereafter the sum of $5,000,000.

"'(b) Sums appropriated under subsection (a) shall be available to enable the Secretary to provide (1) directly or through grants to or contracts with public or nonprofit private institutions of higher learning, for training personnel who are employed or preparing for employment in the administration of public assistance programs, (2) directly or through grants to or contracts with public or nonprofit private agencies or institutions, for special courses of study or seminars of short duration (not in excess of one year) for training of such personnel, and (3) directly or through grants to or contracts with public or nonprofit private institutions of higher learning, for establishing and maintaining fellowships or traineeships for such personnel at such institutions, with such stipends and allowances as may be permitted by the Secretary.

"'(c) Payments under subsection (b) may be made in advance on the basis of estimates by the Secretary, or may be made by way of reimbursement, and adjustments may be made in future payments under this section to take account of overpayments or underpayments in amounts previously paid.

"'(d) The Secretary may, to the extent he finds such action to be necessary, prescribe requirements to assure that any individual will repay the amount of his fellowship or traineeship received under this section to the extent such individual fails to serve, for the period prescribed by the Secretary, with a State or political subdivision thereof, or with the Federal Government, in connection with administration of any State or local public assistance program. The Secretary may relieve any individual of his obligation to so repay, in whole or in part, whenever and to the extent that requirement of such repayment would, in his judgement, be inequitable or would be contrary to the purposes of any of the public welfare programs established by this Act.'

"(b)(1) Section 526(a) of such Act is amended by inserting before the period at the end thereof '; and for grants by the Secretary to public or other nonprofit institutions of higher learning for special projects for training personnel for work in the field of child welfare, including traineeships with such stipends and allowances as may be permited by the Secretary'.

"(2) The heading of section 526 of such Act is amended by inserting ', TRAINING,' after 'RESEARCH'."

On page 65, line 18, after the word "month", to insert "and"; on page 68, line 5, after the word "month", to insert "and"; on page 69, line 25, after the word "month", to insert "and"; on page 70, line 11, after "303", to insert "(d)"; after line 13, to insert:

"(e) Section 303(e) of the Social Security Amendments of 1961 (Public Law 87-64) is amended by striking out 'July 1, 1962' and inserting in lieu thereof 'October 1, 1962'."

On page 71, after line 5, to strike out:

"FEDERAL PAYMENTS FOR FOSTER CARE IN CHILD-CARE INSTITUTIONS

"SEC. 135. (a) Clause (3) of paragraph (a) of section 408 of the Social Security Act is amended by inserting 'or child-care institution' after 'foster family home'.

"(b) Paragraph (b) of such section is amended by striking out 'of this section in the foster family home of any individual' and inserting in lieu thereof the following: 'of this section—

"'(1) in the foster family home of any individual, whether the payment therefor is made to such individual or to a public or nonprofit private child-placement or child-care agency, or

"'(2) in a child-care insitution, whether the payment therefor is made to such institution or to a public or nonprofit private child-placement or child-care agency, but subject to limitations prescribed by the Secretary with a view to including as "aid to families with dependent children" in the case of such foster care in such institutions only those items which are included in such term in the case of foster care in the foster family home of an individual'.

"(c) Clauses (1) and (2) of paragraph (f) of such section are each amended by inserting 'or child-care institution after 'foster family home'.

"(d) The last sentence of such section is amended by inserting before the period at the end thereof the following: '; and the term "child-care institution" means a nonprofit private-care institution which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing'."

On page 72, at the beginning of line 17, to change the section number from "136" to "135"; on page 76, after line 18, to strike out:

"(10) provide that the State agency shall make available to applicants for or recipients of aid to the aged, blind, or disabled under the plan at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary; and include a description of the steps taken to assure, in the provision of these and any other services which the State agency makes available to individuals under the plan, maximum utilization of other agencies providing similar or related services;".

And, in lieu thereof, to insert:

"(10) provide a description of the services (if any) which the State agency makes available to applicants for or recipients of aid or assistance under the plan to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;".

On page 78, line 7, after the word "disregard", to insert "(A)"; in line 9, after the word "month", to insert "and (B) for a period not in excess of twelve months, such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan"; on page 80, line 5, after the word "separate", to insert "State"; on page 81, line 5, after the word "and", to insert "to which the sentence of section 1002(b) following paragraph (2) thereof is applicable"; on page 82, line 6, after the word "Secretary", to strike out "of the Treasury"; on page 85, in line 21, after the word "State", to insert "whose State plan approved under section 1602 meets the requirements of subsection (c)(1)"; on page 86, line 7, after the word "to", to strike out "section 1602(a)(10)" and insert "subsection (c)(1)"; in line 17, after the word "to", to strike out "section 1602(a)(10)" and insert "subsection (c)(1)"; on page 87, line 22, after the word "political", to strike out "subdivision, and" and insert "subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and"; at the top of page 89, to insert "except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved."; after line 6, to strike out "except that any such services which are defined as vocational rehabilitation services under the Vocational Rehabilitation Act and which are available, from the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services, to individuals under programs for their rehabilitation carried on under such State plan, may be provided only by such State agency or agencies (in the manner described in subparagraph (E)) except to the extent agreed to by such State agency or agencies."; in line 21, after the word "the", to strike out "Secretary." and insert "Secretary; and"; after line 22, to insert:

"(5) in the case of any State whose State plan approved under section 1602 does not meet the requirements of subsection (c)(1), an amount equal to one-fourth of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (4) and provided in accordance with the provisions of such paragraph."

On page 91, after line 15, to insert:

"(c)(1) In order for a State to qualify for payments under paragraph (4) of subsection (a), its State plan approved under section 1602 must provide that the State agency shall make available to applicants for or recipients of old-age assistance under such State plan at least those services to help them attain or retain capability for self-care which are prescribed by the Secretary.

"(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

"(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

"(B) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (4) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments

with respect to the administration of such State plan shall not be made under paragraph (4) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (5) of such subsection."

On page 95, line 25, after "section 2(a)", to strike out "(11)" and insert "(10)"; on page 97, at the beginning of line 15, to strike out "$9,800,000" and insert "$10,500,000"; in line 19, after the word "exceed", to strike out "$330,000" and insert "$400,000"; at the top of page 99, to insert:

"INCOME AND RESOURCES TO BE DISREGARDED IN DETERMINING NEED OF INDIVIDUAL FOR AID TO THE BLIND

"SEC. 154. Effective July 1, 1963, so much of section 1002(a)(8) of the Social Security Act as follows the first semicolon therein is amended to read as follows: 'except that, in making such determination, the State agency shall disregard (A) the first $85 per month of earned income, plus one-half of earned income in excess of $85 per month, and (B) for a period not in excess of twelve months, such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan;'."

After line 13, to insert:

"RESPONSIBILITY FOR PLACEMENT AND FOSTER CARE OF DEPENDENT CHILDREN

"SEC. 155. (a) Clause (2) of section 408(a) of the Social Security Act is amended to read: '(2) whose placement and care are the responsibility of (A) the State or local agency administering the State plan approved under section 402, or (B) any other public agency with whom the State agency administering or supervising the administration of such State plan has made an agreement which is still in effect and which includes provision for assuring development of a plan, satisfactory to such State agency, for such child as provided in paragraph (f)(1) and such other provisions as may be necessary to assure accomplishment of the objectives of the State plan approved under section 402.'.

"(b) The amendment made by subsection (a) shall apply only for the period beginning July 1, 1962, and ending with the close of June 30, 1963. The Secretary shall submit to the President, for transmission to the Congress prior to March 1, 1963, a full report of the administration of the provisions of the amendment made by subsection (a), including the experiences of each of the States in arranging for foster care under the provisions of their respective State plans which are in accord with such amendment, together with his recommendations as to continuation of, and modifications in, such amendment."

At the beginning of line 24, to strike out "101 (b)"; on page 101, at the beginning of line 2, to insert "and 132 (d)"; in line 5, after "(d)", to strike out "132, 135,"; in line 10, after the word "sections", to strike out "107 (a) and"; in line 11, after "109", to insert "and 132 (other than subsection (d) and (e) thereof)"; in line 13, after the word "title", to strike out "IV" and insert "I, IV, X, or XIV"; in line 14, after the word "Act" to insert a comma and "as the case may be,"; in line 16, after "105", to insert "(other than subsection (c))"; after line 21, to insert:

"(f) The amendments made by section 101(b) shall be applicable in the case of expenditures, under a State plan approved under title I, IV, X, or XIV of the Social Security Act, as the case may be, made after June 30, 1963."

And, at the top of page 102, to insert:

"(g) The amendment made by section 105(c)(1) shall apply in the case of taxable years ending after September 30, 1962. The amendments made by section 105(c)(2) shall apply to remuneration paid after September 30, 1962."

The amendments were agreed to.

The amendments were ordered to be engrossed and the bill to be read a third time.

The bill was read the third time and passed.

Mr. KERR. Mr. President, I send to the desk a committee amendment. I ask unanimous consent that the reading of the amendment be dispensed with but that the amendment be printed in the RECORD.

The PRESIDING OFFICER. Without objection, the reading of the amendment will be dispensed with; and, without objection, the amendment will be printed in the RECORD.

The amendment is as follows:

On page 49, between lines 5 and 6, insert the following:

"(d) Expenditures (other than for medical or any other type of remedial care) made at any time during the period beginning July 1, 1961, and ending with the close of September 30, 1962, which would have been considered aid to dependent children or aid to families with dependent children, as the case may be, under a State plan approved under title IV of the Social Security Act except that they were made in the form of payments for work performed by a relative with whom a dependent child (as defined in section 406 or 407 of such Act) is living, shall be deemed to have been made under a State plan approved under title IV of the Social Security Act and to constitute aid to dependent children or aid to families with dependent children, as the case may be, if (1) such expenditures were made under conditions which meet the requirements set forth in section 409 of such Act (added by subsection (a) of this section), other than subparagraphs (D) and (F) of subsection (a)(1) thereof and other than the requirement that the State agency (administering or supervising the administration of such plan) be administering or supervising the administration of the program under which such work is performed, and (2) at the time such expenditures were made, such State plan met the requirements of paragraphs (1), (2), and (3) of section 407 of the Social Security Act. The costs of administration of any such State plan may include, with respect to expenditures described in the preceding sentence, only such costs as are permitted in accordance with the provisions of subsection (b) of such section 409."

On page 101, line 17, strike out "subsection (c)" and insert in lieu thereof "subsections (c) and (d)".

Mr. KERR. Mr. President, I have cleared the amendment with the majority leader, the minority leader, the chairman of the committee, the ranking Republican member of the committee, and the other Democratic members of the committee.

I ask unanimous consent to have printed at this point in the RECORD a brief explanation of the amendment.

There being no objection, the explanation was ordered to be printed in the RECORD, as follows:

EXPLANATION OF AMENDMENT

In this bill we have provided for community work and training programs as a part of the aid to dependent children program. Most of us agree that it is highly desirable that individuals who are unemployed and require assistance have an opportunity to retain their skills and acquire new skills through constructive work projects. This has become particularly important since May 1961 when we made temporary provision for aid to families in which a parent is unemployed. A number of States have operated work projects for years and attempted to accommodate these projects to the new program that we enacted last year—something which, in my judgment, is natural and commendable. However, in a few instances technical problems have arisen which create complications that may affect their right to Federal financial participation in some of their expenditures under the aid to dependent children programs. In view of the fact that these programs are wholly consistent with the spirit of the provisions in this bill which Congress has developed after careful consideration, it seems only fair that the efforts of the States that have been ahead of the Federal Government in this respect be recognized.

Accordingly, the amendment I am offering would make the community work and training provisions of H.R. 10606 effective back to July 1, 1961, the beginning of the quarter following our enactment of the provision for aid to families in which parents are unemployed. It would also not require, prior to October 1, 1962, that some of the rather technical provisions we have developed be in effect. Specifically, the provisions exempted would be those requiring protection of project workers by Workmen's Compensation or its equivalent, that additional expenses of a recipient of aid usually attributable, to such work will be considered, and provision that the program must be administered by, or under supervision of the State welfare agency.

Mr. KERR. Mr. President, I ask that the amendment be agreed to.

The PRESIDING OFFICER. The question is on agreeing to the amendment offered by the Senator from Oklahoma.

The amendment was agreed to.

The PRESIDING OFFICER. The bill is open to further amendment.

Mr. KERR. Mr. President, I yield the floor.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

The PRESIDING OFFICER. The bill is open to amendment.

Mr. MANSFIELD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MATCHING FUNDS ON ADMINISTRATION OF PUBLIC WELFARE

Mr. SYMINGTON. Mr. President, H.R. 10606—as an extension and improvement of public assistance and child welfare services programs—recognizes the need for more rehabilitation services to make it possible to remove more people from the welfare rolls.

And yet, in order to encourage the States to provide more of this type of service, particularly in the area of Aid to Dependent Children, the bill as passed by the House posed a very real problem to current assistance programs. As amended by the Senate Finance Committee, this problem was reduced.

Based on correspondence from Governor Dalton, of Missouri, and conferences with Missouri's director of welfare, however, my colleague, Senator LONG, and I believe further modification is needed.

This need is recognized by a number of other States. On June 23, the senior Senator from Massachusetts, Senator SALTONSTALL, proposed a series of five amendments, numbered "6–23–62–A."

Mr. President, I ask unanimous consent that the Saltonstall amendments be printed at this point in my remarks.

There being no objection, the amendments were ordered to be printed in the RECORD, as follows:

On page 25, line 5, strike out "one-fourth" and insert in lieu thereof "one-half".

On page 27, lines 5 and 6, strike out "one-fourth" and insert in lieu thereof "one-half".

On page 29, lines 12 and 13, strike out "one-fourth" and insert in lieu thereof "one-half".

On page 31, lines 10 and 11, strike out "one-fourth" and insert in lieu thereof "one-half".

On page 90, lines 1 and 2, strike out "one-fourth" and insert in lieu thereof "one-half".

Mr. SYMINGTON. By eliminating the penalty provisions, these amendments will preserve the long-established principle of matching the States on a dollar-for-dollar basis in the basic administrative costs of carrying out the public assistance programs for the aged, the blind, the disabled, aid for dependent children, and medical assistance for the aged.

At the same time, by retaining the House and Senate Finance Committee provision for 75 percent matching of special administrative services, these amendments would encourage the rehabilitation work so essential to the sound improvement of present welfare programs.

The Senate Finance Committee, building on the work of the House of Representatives, has reported a bill containing important changes in the existing programs. We have discussed this problem with the distinguished senior Senator from Oklahoma, who is handling this bill for the Senate Finance Committee, and who has told us he has no objection to the amendments in question.

The proposal to match States on a 75-percent additional administrative basis—if they meet with minimum service requirements in a particular welfare category—is important for the encouragement it will give to States like Missouri that have met administrative standards in the past. The additional Federal assistance will also focus attention on needed rehabilitation aspects of future welfare programs.

On the other hand, serious difficulties would be encountered by attempting to cut the long-established dollar-for-dollar matching formula on present administrative costs for failure to meet minimum rehabilitation service requirements.

Some State laws might be hard to change, and necessary State appropriations might be hard to obtain, particularly because of the widespread concern about minimum standards not yet set up by the Secretary of Health, Education, and Welfare.

Under the penalties provided by the House, failure of a State legislature to act, and consequent inability to comply, could be very serious. As stated, the Senate eased the penalty, but it could still mean penalties of as much as $2 million a year to Missouri on present programs.

Gov. John Dalton, of Missouri, with the support of the Missouri Legislature, is moving ahead in setting up pilot rehabilitative services in our welfare programs. He has assured us of his interest and intention to continue improving the services, but does not want the present necessary dollar-for-dollar administrative funds threatened for possible failure to institute new services.

The 75-percent matching would encourage States to improve their rehabilitative services. This in turn should help make welfare recipients self-supporting members of society, reduce the welfare rolls, and thereby reduce Federal and State expenditures.

If State governments do not meet additional minimum requirements, however, I do not believe they should be penalized on the long-established programs under which they have been meeting, and continue to meet, matching fund requirements.

Mr. President, I ask unanimous consent to have printed in the RECORD at this point the following material: a telegram from Gov. John M. Dalton, dated June 14; a letter from Governor Dalton, dated June 20; a story from the St. Louis Post-Dispatch of June 24, entitled "Ribi-

coff To Get State Welfare Aid Cut Protest"; and a copy of telegram from Governor Dalton to the Honorable Abraham Ribicoff, Secretary of the Department of Health, Education, and Welfare.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

JEFFERSON CITY, MO., *June 14, 1962.*

Hon. STUART SYMINGTON,
U.S. Senate,
Washington, D.C.:

The Senate Finance Committee has approved H.R. 10606 and ordered it favorably reported to the Senate with several amendments. We are greatly concerned with one of these amendments, which potentially could cause heavy decreases in Federal funds for administration in the future in Missouri, and other States. For some 20 years Federal funds have paid 50 percent of the cost of administering the Federal-State public assistance programs. H.R. 10606, as passed by the House, provides that if a State furnishes certain welfare services, as designated by the Secretary of Health, Education, and Welfare, the Federal administrative percentage would be increased from 50 to 75 perecnt. The Senate Finance Committee continued this feature, but further provided that if the services designated by the Secretary were not made available to recipients by the State, the matching of administrative costs from Federal funds, now 50 percent, would be reduced to 25 percent. While Missouri is wholeheartedly in sympathy with the administration's welfare bill aimed at restoring welfare recipients to useful citizenship, strengthening family life and furthering self-help and self-support among recipients, we strongly protest any possibility of reducing the Federal matching of administrative funds to less than 50 percent, as now provided. It is quite conceivable that the Missouri Legislature will not see fit to appropriate State funds to make possible additional Welfare staff members to provide the services hoped for in H.R. 10606. Under such circumstances, and as the Senate amendment now stands, the State could lose as much as $2 million per year, now provided in Federal funds for administration. I strongly urge you to make every effort to see that H.R. 10606, if finally enacted into law, provides that Federal administrative matching funds furnished to States not be allowed to be set below the present 50-percent figure. The importance of this to our State, and I am quite sure to others, cannot be overestimated.

JOHN M. DALTON,
Governor.

EXECUTIVE OFFICE,
STATE OF MISSOURI,
Jefferson City, Mo., June 20, 1962.

Hon. STUART SYMINGTON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR: Thank you for your recent letter and the material regarding H.R. 10606.

We have studied the committee's report and remain of the opinion that the provision which my telegrams concerned is potentially dangerous to the State of Missouri. I certainly am wholeheartedly in accord with the philosophy of rehabilitation of persons receiving welfare benefits. However, under this bill and the Finance Committee's amendment, we have no way of knowing at this time what services the Department of Health, Education, and Welfare might require the State to furnish in order to be entitled to the 75 percent matching funds. We have no way of knowing whether or not the State of Missouri will be in a position to furnish the services which would be required nor have we any assurance that the legislature would be cooperative in authorizing the necessary personnel. If Missouri were unable to furnish the services which the Department might require, the reduction in the Federal matching payments for administration to 25 percent might result in a loss to the State of Missouri of some $2 million per year in Federal matching funds.

In my opinion, the offering of 75 percent as matching funds for the rehabilitation services is a strong incentive to provide such services and I do not see the necessity or desirability of the coercive threat of reduction in administrative matching funds for failure to provide such services.

May I urge you to do what you can to see that this measure would provide in no event less than equal matching funds as are now provided. I do consider this of importance to the State of Missouri not only from a financial standpoint, but also from the standpoint of principle involved.

With best regards, I am,

Sincerely yours,

JOHN M. DALTON,
Governor.

[From the St. Louis Post-Dispatch, June 24, 1962]

RIBICOFF TO GET STATE WELFARE AID CUT PROTEST

(By Thomas W. Ottenad)

WASHINGTON, June 23.—Protests by Missouri officials against proposed changes in Federal welfare expenditures will be put before Secretary of Health, Education, and Welfare, Abraham A. Ribicoff, the Post-Dispatch was told today.

Ribicoff will be asked to approve an amendment that would eliminate from a pending Senate bill a provision cutting the Federal Government's share of the cost of administering State welfare programs from 50 to 25 percent under certain conditions. Missouri officials have said that the cutback might cost the State as much as $2 million a year in Federal funds now provided to help pay for administering State welfare programs.

Stanley R. Fike, administrative assistant to Senator STUART SYMINGTON, Democrat, of Missouri, said agreement on putting the matter before Ribicoff was obtained at a conference here yesterday.

OTHERS AT MEETING

In addition to Fike, participants in the meeting included Daniel Miles, administrative assistant to Senator EDWARD V. LONG, Democrat, of Missouri: Proctor N. Carter, director of the Missouri Division of Welfare; Elmore G. Carter, chief counsel of the division; Robert M. Ball, social security Commissioner; Charles E. Hawkins, legislative reference officer for the Social Security Administration, and experts from the Library of Congress.

Fike said Ball agreed to present to Ribicoff the request by Proctor Carter for an amendment that would eliminate the proposed reduction in Federal funds. The cut in Federal assistance would be made if States failed to provide certain minimum services designed to put more emphasis on rehabilitation of welfare recipients. Under terms of the pending bill, the nature of the services is to be spelled out later by Ribicoff.

Fike said that the Missouri officials endorsed the objective of upgrading welfare services. They said Missouri has started an experimental program to determine how strengthened services might best operate.

INCENTIVE CITED

The Missouri officials reportedly took the position that an incentive provided under the pending legislation was sufficient to encourage the State to provide improved minimum services. The incentive is a provision for the Federal Government to pay 75 percent, rather than 50 percent, of the administrative costs of new State services emphasizing rehabilitation.

Carter said the penalty provision was unnecessary, Fike stated. The Missouri official warned that Missouri and other States might have to cut back present welfare services as a result of the penalty clause if their legislatures are unwilling to underwrite the cost of new services.

Amending the proposed Senate bill would open the way to revising an even more stringent measure already passed by the House. The House bill provides that States failing to comply with the proposed new minimum standards could lose all, not just half, of Federal funds furnished for administration.

They could lose all Federal funds provided for direct payments to welfare recipients. This is a much larger sum than the administrative payments. In the year ended June 30, 1961, Missouri received $86,746,000 in Federal money for direct payments, compared with less than $4 million for administrative purposes.

Missouri officials, who at first were unaware of the nature of the penalty contained in the House bill, told Fike that this approach could endanger the State's entire welfare assistance program.

MISSOURIANS' ONLY HOPE

Because the House has completed action on its measure, the only hope for the Missourians is to try to have the Senate eliminate any penalty provision from its measure. This would throw the legislation into a conference of the House and Senate, where an attempt could be made to eradicate the House penalty clause.

If Ribicoff and his advisers agree to the request for eliminating the penalty provision, Fike said an amendment to carry out this change would be offered on the floor of the Senate. The bill, which has been approved by the Senate Finance Committee, is expected to be considered by the Senate some time next week.

If the Department of Health, Education, and Welfare will not agree to the change, Fike said, a decision on whether an amendment would be offered would have to be considered further. Originally the Kennedy administration favored the approach represented by the House bill. An agreement to place the matter before Ribicoff was arranged by Senators SYMINGTON and LONG as a result of a protest expressed last week by Gov. John M. Dalton, of Missouri, over possible effects of any cut in Federal funds.

JUNE 25, 1962.

Hon. ABRAHAM RIBICOFF,
Secretary of Health, Education, and Welfare,
Washington, D.C.:

I appreciate the meeting in Washington last Friday arranged by Missouri Senators SYMINGTON and LONG between officials of the Missouri Welfare Department and the Department of Health, Education, and Welfare at which time discussion was held on a proposed Senate Finance Committee amendment to H.R. 10606, which could, under certain conditions, result in greatly reduced Federal funds for administration of welfare programs by the States. We in Missouri are completely in accord with the new approach to welfare problems reflected in this legislation which was sponsored by your Department. We intend to do everything possible to further self-help, self-care and rehabilitation among recipients of welfare. However, we do not believe that any State should be put in the position of losing administrative money if such State did not furnish certain services to welfare recipients as designated by the Secretary of Health, Education, and Welfare. We believe the provision for an increase in Federal administrative matching

from 50 to 75 percent would be sufficient incentive to States to provide welfare services consistent with the funds made available by the various State Legislatures. It is conceivable in some instances that the Legislatures may not see eye to eye with the Federal department and might not for one reason or another furnish services designated as essential by the Secretary. For such States to have their Federal administrative allotments sliced in half as a consequence would be entirely wrong in our opinion. Potentially, Missouri could lose as much as $2 million a year in Federal allotments if our Legislature did not appropriate money to add workers to furnish services to welfare recipients.

We were unaware that the House-passed bill carried even more penalties on the States. Nonetheless we are at this point trying to change the bill in the Senate so that no State would receive less than 50 percent Federal funds for administration as now provided by law. I sincerely hope that the Department will favor the elimination of the penalty provision in H.R. 10606 and that the bill will be enacted into law with such change.

JOHN M. DALTON,
Governor of Missouri.

Mr. LONG of Missouri. Mr. President, my distinguished colleague, the senior Senator from Missouri, has just presented a clear, persuasive argument for continuing the 50 percent matching fund basis for administrative costs even though the State does not provide the rehabilitation services prescribed by the Secretary of Health, Education, and Welfare.

The aim of the rehabilitation provisions of this bill to restore welfare recipients to useful citizenship, to strengthen family life and to further self-help and self-support among recipients is certainly commendable, and these provisions should become law. However, I have grave misgivings as to this sword of Damocles which the bill would hang over the heads of the States to obtain compliance. In my opinion, the 75 percent matching fund provision approved by the House and Senate Committee is a sufficient incentive to induce States to meet the requirements prescribed by the Secretary.

As my colleague has pointed out, this entire matter has been discussed and considered at length and I hope the Senate will take the appropriate action.

Mr. KUCHEL. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MANSFIELD. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. MUSKIE in the chair). Without objection, it is so ordered.

PUBLIC WELFARE AMENDMENTS OF 1962

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the Senate return to the consideration of the unfinished business.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. JAVITS. Mr. President, I wish to address myself to the bill itself, which I favor, and to a particular amendment which I have submitted. It deals with the question of judicial review, to which the States would be entitled under the plan of welfare payments or aid to the States in connection with welfare payments, which the bill provides.

The basis of my observations relate to the testimony of Miles B. Amend, chairman of the New York Board of Social Welfare, which appears in the hearings beginning at page 425.

As I have said, Mr. Amend is chairman of the New York State Board of Social Welfare, which is a board composed of 15 private citizens appointed by the Governor of New York with the consent of the State senate, one from each of the 11 judicial districts of the State and 4 at large.

He describes the board as being very diversified in terms of economic, professional, and other interests in the State. He describes the board as the policymaking head of the Department of Social Welfare of the State of New York.

The board endorsed the provisions of H.R. 10606, the bill now before the Senate, but he made some basic points, which I believe are extremely important. One of them is the basis for the amendment which I have submitted.

The recommendations made by Mr. Amend are twofold. First, he believes that there should be Federal court review of any proposed deduction or other penalty which flowed from the Federal Government to State plans and programs. Second, he believes that the best plan for Federal administration was for the Federal Government to require law on the part of the State to conform to Federal requirements, but that it should not break it down into the detail of the State's plan, which, he said, really resulted in a proliferation of technical and administrative detail.

If the general law of the State were in consonance with the requirement of the Federal Government, then the attitude of the Social Welfare Board of New York was that was adequate. Obviously, that deals with the whole scheme of legislation and was really testimony relating to a prewar policy on the part of some men. Therefore, in the proposed amendment to the bill, I have

picked up only the problem of judicial review.

I have not called up my amendment because in a matter of this nature it is always best, if possible, to come to agreement with the department which is concerned. So we are making every effort to agree with the Department of Health, Education and Welfare on a judicial review amendment which will be satisfactory to them and satisfactory to us.

There is one question in that regard which is open and which, I think, can easily be resolved. My amendment expressly provides that payments to the State under the statute shall not be stopped while judicial review is pending, while an appeal is taken from the determination of the Secretary. I think the Department would prefer to keep silent on that score, so that, first, would leave it a matter of administration; and second, would leave it to the injunctive power of the courts, which would always have the power to intercede in the situation once a judicial review was sought.

My present thought is to accede to that idea; that is, to leave the matter unprovided for specifically by the bill, and therefore in the hands of the normal administrative process plus the injunctive power of the courts.

The other question comes as to the type of court which should have jurisdiction. Normally, we think of the circuit court of appeals as the review court for determinations made by the Secretary. There is some feeling that because there is not a circuit court of appeals in every State, there may be involved, since this is uniquely a State matter, an element of inconvenience to require State authorities and officials to proceed to another State than their own State in which to ask for judicial review. It is a fact, though, that every State has a U.S. district court; so it may be, if it is satisfactory to the Department, that that could be a solution.

I shall explore all these points of view and shall do my utmost to develop an amendment which will provide for a proper kind of judicial review, with proper accommodation to the Department and to the States. However, I have not called up my amendment for the reasons which I have stated; and I think it is useful to announce that the subject is under negotiation, as it were, for determination, because other Senators may have received from their State welfare authorities the same request that I have received from the welfare authorities of the State of New York. Therefore, I wish to extend, both on the floor of the Senate and through the Record, an invitation to other Senators having similar problems to cooperate with me in their resolution to cosponsor an amendment, as we finally agree on one, if we can agree on one, so that the whole question of judicial review, which interests not only my State, but other States, as well, may be determined at one and the same time. I hope that other Senators who are interested will communicate with me, so that we may resolve this unit question at one time by one amendment.

Mr. WILLIAMS of New Jersey. Mr. President, I call up my amendments designated "6–29–62—F." I ask that in lieu of a reading of the amendments, the amendments be printed at this point in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments offered by Mr. WILLIAMS of New Jersey for himself and Mr. HUMPHREY, Mr. DOUGLAS, Mr. SMITH of Massachusetts, Mr. YARBOROUGH, Mr. CARROLL, Mr. HART, Mr. MORSE, Mr. JAVITS, Mr. BURDICK, Mr. MCCARTHY, Mr. METCALF, Mr. CLARK, Mr. HOLLAND, and Mr. SMATHERS are as follows:

On page 40, after line 5, insert the following:

"(e) Part 3 of title V of such Act (as amended by the preceding provisions of this section) is further amended by adding at the end thereof the following new section:

"'DAY-CARE FACILITIES FOR CHILDREN OF MIGRANT AGRICULTURAL WORKERS

"'SEC. 529. (a) For the purpose of enabling the United States, through the Secretary, to further cooperate with State public-welfare agencies which have included in their plans for child-welfare services provisions calling for the providing of day-care facilities for the children of migrant agricuitural workers, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1963, and for each succeeding fiscal year through the fiscal year ending June 30, 1965, the sum of $750,000, which shall be used exclusively for the establishment and operation of such day-care facilities.

"'(b) On October 1, 1962, and thereafter at the beginning of each fiscal year (commencing with the fiscal year ending June 30, 1964) the Secretary shall allot the sums appropriated pursuant to subsection (a) to States as follows: He shall allot to each State the plan of whose child-welfare agency calls for the providing of such day-care facilities an amount which bears the same ratio to the amount appropriated pursuant to subsection (a) of such year as the total number of children of migrant agricultural workers who were in such State during the preceding fiscal year (as determined by the Secretary on the basis of the best data available to him) bears to the total number of such children who were in all such States for such preceding year (as so determined).

"'(c) From the sums appropriated pursuant to subsection (a) and the allotments available under subsection (b), the Secretary shall from time to time pay to each State the public-welfare agency of which includes in its plan for child-welfare services provisions calling for the providing of day-care facilities for the children of migrant agricultural workers an amount equal to the Federal share (as determined under section 524) of such portion of the total sum expended under such plan (including the cost of administration of the plan) as is attributable to the providing of such day-care facilities. Such amounts shall be payable in the manner provided by section 523(b).

"'(d) The amount of any allotment to a State under subsection (b) for any fiscal year which the State certifies to the Secretary will not be required for carrying out the provisions of its State plan relating to the providing of day-care facilities for the children of migrant workers shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines (1) have need in carrying out the provisions of their State plan which call for the providing of such facilities for sums in excess of those previously allotted to them under such subsection and (2) will be able to use such excess amounts during such fiscal year in carrying out such provisions. Any amount so reallotted to a State shall be deemed part of its allotment under subsection (b).

"'(e) In no case shall a State receive Federal financial assistance with respect to the same expenditure under this section and the preceding sections of this part.

"'(f) For purposes of this section—

"'(1) The term "migrant agricultural worker" means an individual (A) whose primary employment is agriculture, as defined in section 3(f) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(f)), on performing agricultural labor, as defined in section 3121(g) of the Internal Revenue Code of 1954 (26 U.S.C. 3121(f)), on a seasonal or other temporary basis, and (B) who establishes with his family for the purpose of such employment a temporary residence;

"'(2) The term "child" means a child who makes his home with his parent or the individual who stands in loco parentis to the child; and

"'(3) The term "day-care facility" includes (A) day-care centers whether provided directly by the State (or any political subdivision thereof) or indirectly through a purchase of care or other basis, and (B) individualized care provided through foster home services.

"'(g) No funds appropriated under the authority of subsection (a) shall be payable to any State which imposes, as a condition of eligibility for day-care facilities, any residence, requirement which excludes any otherwise eligible child physically present in the State.'"

Amend the table of contents so as to add, at the end of the matter describing the contents of section 102 of the bill, the following:

"(e) Day-care facilities for children of migrant agricultural workers."

Mr. WILLIAMS of New Jersey. Mr. President, these amendments relate to a program of day care for the children of migrant farm families.

During the past few years I have made field trips to numerous States and have seen and learned of conditions that are almost unbelievable. Children were locked in the family's quarters or playing unsupervised in roadways, near irrigation ditches, in the fields near heavy machinery and trucks, or in camp lots littered with junk, broken glass, and garbage. Parents were often far out of earshot, picking fruits, vegetables, and fibers.

The number of children who live under these conditions is not so small that their needs can be easily overlooked. An estimated 100,000 to 150,000 young children accompany their parents in the migratory stream each year. We have reason to believe that far more than half of these children, perhaps as many as 70,000, are under 6 years of age.

The concern for this problem goes back four decades. According to a report—"Children in Migrant Families," prepared by Children's Bureau of Social Security Administration, U.S. Department of Health, Education, and Welfare, December 1960, submitted to Committee on Appropriations, U.S. Senate—of the Children's Bureau of the Department of Health, Education, and Welfare, a church group in 1921 opened an experimental day-care center in Maryland which filled a gaping need.

This was a beginning, and it has been augmented over the years by the additional efforts of other church and private groups.

I observe in the Chamber the distinguished senior Senator from Florida [Mr. HOLLAND], who has shown great interest

in this program. I have seen in his State some of the examples of a truly great humane work by church people and others who have brought day care to the children of migrant farmworkers.

Nonetheless, as we view the condition today, the program still amounts to no more than a beginning. Forty-one years later, there are still parents in this great Nation of ours who have no where to leave their children except in a wide-open field or an unkept, unprotected, unsanitary camp. In the entire Nation, there are only 24 day-care centers, licensed by State agencies, which primarily serve children of migrant families. The combined aggregate capacity of all 24 centers would probably serve less than 1,000 children.

Many States have rightfully become alarmed at the lack of daily supervision and have established day-care centers for migratory children on a pilot project basis. Regrettably, however, the financial resources of most States have not been sufficient to provide the stimulation needed for the establishment of these projects on a more general basis.

For the States which will expand initial projects and for the States which will start day-care centers, this amendment to H.R. 10606 would authorize an appropriation of $750,000 to provide matching grants to such States. A provision of the amendment assures that the grants will be channeled into those States having a substantial impact of migratory seasonal farmworkers each year and that residence requirements will not bar otherwise eligible children from the States' day-care services. The amount of Federal grants would be determined by the matching formula in the child welfare services section of the Social Security Act.

I want to emphasize, moreover, that this amendment is not intended to deny migratory children any welfare services and benefits currently available under the Social Security Act, or any amendment thereto.

This amendment to H.R. 10606 has been given the support of numerous church and social organizations concerned with alleviating the problems faced by migratory children. The administration, too, has given its support to this amendment. The Department of Health, Education, and Welfare, considers this amendment necessary and supports it. This amendment merely incorporates the provisions of our day-care bill, S. 1131, which had the express support of every administrative agency reporting on the bill.

I have given considerable time to the study of providing day-care services to our Nation's migrant children and am convinced that the proposed day-care amendment to H.R. 10606 will be of momentous assistance to these children. The enactment of this migrant day-care provision will announce the beginning of a safe, sanitary, and happy life for many young children whose only "happiness" has been the mere absence of hardship. Providing these many small children with positive joy and companionship is as needed as it is deserved by these neglected migrant children.

Mr. President, this amendment has been prepared and offered with the cooperation of the distinguished Senator from Oklahoma [Mr. KERR], who is in charge of H.R. 10606. The program of providing migrant children with day-care services has been arranged so as to begin in October of this year. It would be a continuing program and would phase out at the end of fiscal year 1964, the beginning of fiscal year 1965.

Mr. KERR. Mr. President, will the Senator yield?

Mr. WILLIAMS of New Jersey. I yield.

Mr. KERR. I believe the Senator from New Jersey intended to say that the program would terminate at the end of fiscal year 1965.

Mr. WILLIAMS of New Jersey. At the end of fiscal year 1965.

Mr. KERR. June 30, 1965.

Mr. WILLIAMS of New Jersey. The Senator is correct.

Mr. HOLLAND. Mr. President, will the Senator from New Jersey yield?

Mr. WILLIAMS of New Jersey. I am happy to yield to the Senator from Florida.

Mr. HOLLAND. Do I correctly understand that the amendments now offered to the more general bill are the same as S. 1131?

Mr. WILLIAMS of New Jersey. That is correct; with the exception that its time of life has been limited. It will end on June 30, 1965.

Mr. HOLLAND. In other words, the Senator's proposal sets up the same machinery and puts it on a trial basis, so far as time is concerned?

Mr. WILLIAMS of New Jersey. That is correct.

Mr. HOLLAND. I wish to voice my appreciation of the long, persevering, and even determined efforts of the distinguished junior Senator from New Jersey in this field. Sometimes his efforts have led into fields where I could not follow him; but in this particular effort I think every Senator will find it possible to follow the Senator from New Jersey, because there is not a doubt in the world that day-care schools for the children of migratory workers in the various States which have established them, including Florida, have shown their very great value. There is not a doubt in the world that the young children of the day-workers who migrate from place to place in the pursuit of their livelihood in serving our seasonal agricultural industries need this kind of service.

I am glad to join with the Senator from New Jersey in this effort. I hope that the gracious act of the Senator from Oklahoma [Mr. KERR], who is handling the bill, in accepting the amendments, means that this program is now safely on the track to becoming law in the near future.

I thank the Senator.

Mr. WILLIAMS of New Jersey. I thank the Senator from Florida; and I wish to state that without his guidance, his counsel, and his cooperation, this measure and two or three others would not be as advanced as they are.

Mr. JAVITS. Mr. President, will the Senator from New Jersey yield?

Mr. WILLIAMS of New Jersey. I yield.

Mr. JAVITS. I am very glad to be a cosponsor of this amendment; and I wish to say that in the Finance Committee the leadership of the Senator from New Jersey has added greatly to the development of these provisions. I am a member of the subcommittee on which the Senator has done such great work in dealing with migratory labor; and the provisions of this amendment are most important in connection with our work in this field.

This is a most humanitarian measure, and I think the Senator from New Jersey is to be congratulated on having this amendment worked out in so wise a way, in connection with this most important field.

I thank the Senator from New Jersey.

Mr. WILLIAMS of New Jersey. Mr. President, I wish to state how helpful and cooperative the senior Senator from New York has been. I also wish to state that the chairman of the Finance Committee has been most cooperative, both this year and last year, in trying to find a way to bring this measure to the floor of the Senate.

Mr. JAVITS. I thank the Senator from New Jersey.

Mr. CURTIS. Mr. President, will the Senator from New Jersey yield?

Mr. WILLIAMS of New Jersey. I yield.

Mr. CURTIS. Will the Senator point out the language in regard to termination?

Mr. WILLIAMS of New Jersey. The termination language is in the copy which is at the desk. This was worked out within the last hour.

Mr. CURTIS. So it is not in the printed copy?

Mr. WILLIAMS of New Jersey. No, but it is in the official copy which is at the desk.

Mr. CURTIS. And the proposal will end at that time?

Mr. WILLIAMS of New Jersey. Yes, in June of 1965.

Mr. CURTIS. Is it anticipated that the need for it will be over then; or is this suggested as more or less of a temporary trial run, so that it can be looked at again at that time?

Mr. WILLIAMS of New Jersey. It is difficult to say how many States will avail themselves of the program. Of course, it is a relatively low matching program, and the States will have to put in considerable amounts of their own resources. After making those investments, probably they will wish to continue the program, because it really involves a small investment in order to take care of the many day-care needs of these migratory children. So I hope the States will continue this with their own programs.

Mr. CURTIS. Does the Senator from New Jersey anticipate that it will or will not be continued after 1965?

Mr. WILLIAMS of New Jersey. I would not wish to be dogmatic about the matter, either one way or the other; but I certainly hope the States will devote their resources to the program; and once they do, I hope they will continue the program.

Mr. CURTIS. I thank the Senator from New Jersey.

Mr. KERR. Mr. President, on the basis of the changes in the amendment of the Senator from New Jersey, I recommend that the amendment be adopted.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from New Jersey.

The amendment was agreed to.

Mr. MOSS. Mr. President, on behalf of the Senator from Indiana [Mr. HARTKE], I call up the amendment identified as "5–24–62—H" and ask that it be stated.

The PRESIDING OFFICER. The amendment will be stated.

The LEGISLATIVE CLERK. On page 55, between lines 2 and 3, it is proposed to insert the following:

(e) The increase in the Federal share of public assistance payments provided for in this section shall be paid to the States only upon the condition that the money payments received by recipients of old-age assistance, aid to the blind, and aid to the permanently and totally disabled shall be increased by the full amount of the increase in the Federal share.

Mr. MOSS. Mr. President, the Senator from Indiana [Mr. HARTKE] is unable to bring up this amendment, since he is absent from the city, on official business. The amendment provides that the increase in Federal matching funds for the aged, blind, and disabled which is provided for by section 132 of the bill must be passed on to recipients, rather than be absorbed by the States.

The bill as reported provides for an increase of about $4 per recipient, plus continuing the $1 increase given on a temporary basis last year. This is a most modest increase, and one to which our needy, aged, blind, and disabled are certainly entitled. The national average payments in these three categories now are hardly enough to provide a bare level of existence—$76.35 for the blind, $72.08 for the aged, and $71.33 for the disabled.

At this income level, if 50 percent of the total amount of aid were allocated for food, which is about average, a blind aid recipient receiving $76.35 per month would have $38.17 per month for food. This is approximately $1.27 per day. In this age of high prices and rising cost of living, how can a person eat three meals a day on $1.27?

As H.R. 10606 is presently written, the language which provides for the increase in Federal matching funds for the aged, blind and disabled, contains no guarantee that this additional money going to the States will be passed on to the aid recipient. The State could, if they wished, use the increase in some other way, such as to meet the increased costs of new cases which are coming on the rolls.

Let me quote from a publication of the U.S. Department of Health, Education, and Welfare, Social Security Administration, entitled "State and Local Financing of Public Assistance, 1935–55." The third paragraph on page 18 reads:

While Congress intended to benefit individual recipients by the three amendments, the Federal matching formula is related to total State and local expenditures and not to individual payments. Thus a specified increase in the Federal share does not necessarily mean that each recipient receives an increase in his assistance payment equal to the Federal increase. When the Federal share is increased, States use the additional funds in one or more ways. Some use the full amount of the increase to raise payments to recipients of the special types of public assistance. If State funds are limited and caseloads are increasing, however, a State may use only part of the money (or perhaps none of it) to raise assistance payments and use the rest (or all) to meet the costs of the growing assistance rolls. Furthermore if a State is already meeting need for the special types of public assistance in full, as defined in the State's assistance standards, it may see no need or justification for increasing assistance payments and may reduce State and local spending when the Federal share goes up. The State may prefer to transfer State and local funds to another program—where perhaps need is being met less nearly adequately than in the federally aided programs.

In other words, the Federal matching formula is related to total State and local expenditures, and does not assure in any way that the $4 increase we are authorizing here today, along with the $1 increase we are making permanent, will reach the relief recipient. If any State does not see any justification for raising assistance payments in any category, that State may simply reduce State and local spending, and fill in the Federal amount to keep benefits at the same level; or the State can use for some other assistance area the increase intended for the needy blind.

I feel that when Congress passes a bill to give the needy blind, or the needy disabled, or needy aged, an increase—regardless how small—and when all of the newspapers and other news media carry the story, the people who have been led to believe they will get that increase should have it, in this instance as soon after October 1 as possible. The fact that this is the congressional intent has been made very clear. The Senate Finance Committee report on this bill—H.R. 10606—says, on page 9:

The committee expects, and, on the basis of experience after prior increases of this type, believes that the additional funds that would be available will be used by States to improve payments to persons who are receiving assistance under the programs of old-age assistance, aid to the blind, and aid to the permanently and totally disabled.

I realize that there are differences between the States in the extent of their need, and that if this amendment were passed it would force some States to make changes they may not want to make in their procedures. But we are only talking about a pitifully small increase of $4 a month for each recipient, and there is not a single State where our aged and our blind and our disabled could not put this to urgent use in a dozen different ways. Also, may I point out that this amendment relates only to the Federal contribution to these programs—not to State funds. It simply states that the amount the recipient is now receiving must be increased by $4—plus the $1 temporary increase voted in 1961. We are not dictating to the State what disposition it must make of State funds in this respect. Nor are we trying to dictate to the State what assistance standards it shall set.

The amendment I am offering is merely an attempt to assure that the intent of the Congress shall be carried out—and within a reasonable time.

I understand that the time between the effective date of the amendments and the date by which States raise payments by the entire Federal addition has tended to increase with successive amendments. After the 1948 amendments were passed, most of the States had raised payments to include the entire Federal addition by the end of 1948. But that in the case of later amendments it has taken 3 years for the majority of the States to reach the new levels provided, and in a few States, the full increase has never been reached.

I know that it is argued that eventually the vast majority of the States pass on the increases to relief recipients—in one form or another—but I feel this amendment should be passed to inform the States that the Congress wishes to have the full amount of the increase passed on directly to the recipient, as expeditiously as possible within the bounds of State administrative processes and laws.

Mr. CURTIS. Mr. President, will the Senator yield for a moment?

Mr. MOSS. I am happy to yield.

Mr. CURTIS. Has the amendment to which the Senator is speaking been printed?

Mr. MOSS. It has been printed; yes.

Mr. CURTIS. What is the number of it?

Mr. MOSS. It is identified as "6–28–62—H."

Mr. CURTIS. No copies seem to be available.

Mr. MOSS. I sent my only copy to the desk when I started.

Mr. CURTIS. I thank the Senator.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

Does the Senator from Utah yield the floor?

Mr. MOSS. Yes; I yield the floor for a discussion on the amendment.

Mr. CURTIS. Mr. President, may I inquire if it is the intention of the distinguished Senator from Utah to ask for a vote on his amendment this afternoon?

Mr. MOSS. Yes; I had expected to ask for a vote—not necessarily a yea and nay vote.

Mr. KERR. Mr. President, will the Senator yield?

Mr. CURTIS. I yield.

Mr. KERR. I may say to the Senator from Nebraska that the Senator from Oklahoma opposes the amendment, and I shall discuss my reasons for my opposition at some length, if that is the question the Senator from Nebraska had in mind.

Mr. CURTIS. It is not my purpose to speak to the merits or demerits of the amendment at this time. I am concerned about the procedure. Tomorrow is a holiday. I believe all Senators had an understanding that there would be no votes today. If a vote is pressed for on

any amendment that is not acceptable to the Committee on Finance, I shall insist on a live quorum.

I yield the floor.

Mr. MILLER. Mr. President, will the distinguished Senator from Utah yield so I may ask a question or two about this amendment?

Mr. MOSS. Certainly; I shall be happy to answer the Senator.

Mr. MILLER. As I understand the amendment, it is designed to prevent the Congress from passing legislation which has as its objective the improvement of the status of our old age and blind recipients in the States and having that objective frustrated by a State making a determination that the increase voted by Congress will not be passed on to the individual recipient. Is that the objective?

Mr. MOSS. The Senator is correct; that is the objective. There have been instances at times in the past where there has been an increase in the Federal contribution which has never reached the recipient, and which has caused a great deal of distress and misunderstanding.

Mr. MILLER. How is that possible where we have matching funds of the States and Federal Government involved?

Mr. MOSS. The Federal money, as I understand, has to be matched by State money, but it does not have to be applied to a specific program. The State may have several programs—dependent children, blind, disabled, general welfare—so, rather than apply the matching funds to a given program, the funds may be diverted to another welfare program, for example.

Mr. MILLER. Let us take as an example an old-age recipient receiving $100 a month in my State of Iowa. Because of increases in the cost of living, Congress reaches a determination that $100 a month is not adequate; it adopts a provision for $105 a month, for example. So the Congress, in order to meet that problem, makes an appropriation and amends the law to see to it that that old-age recipient gets $105 a month.

Mr. KERR. Mr. President, will the Senator yield on that point?

Mr. MILLER. I yield.

Mr. KERR. I would remind the Senator that the amendment referred to by the Senator from Utah does not operate on that basis. The Federal Government does not determine the amounts that meet the needs of the beneficiaries in the several States. That determination is made by the individual States. The amendments to which the Senator has referred have not been in the form of increases in payments from, for example, $100 to $105. They have been in the form of increasing the amount of money which the Federal Government would provide to the States in the event the States matched those funds, and would be added to whatever amount a particular State might be paying to its beneficiaries. As I understand, such amounts vary from somewhere in the average amount of $30 or $40 a month to $100 a month. So the amendment would not be in the form which the Senator from Iowa indicated as the basis for his question.

Mr. MILLER. I thank the Senator from Oklahoma. The Senator inferred that that was the specific way of doing it. What I was trying to get at was the intention of Congress in this legislation. I assume that in working up this particular proposal the committee staffs had come to the conclusion that some additional benefits are needed by aged and blind recipients, and in order to reach a conclusion on how much should be appropriated, they have tried to hit upon some kind of a standard, and there is a determination on the part of the committee that benefits should be increased by $5 a person.

In the State of Iowa, for example, the payment might be increased from $100 to $105. In the State of Utah, which might have a lower base, it might mean an increase from $65 to $70. The intention of the specific proposed legislation is to improve the status of the recipients by an average of $5 per person.

With that as a background, as an objective, do I correctly understand that some of the States have frustrated that objective by working out an allocation formula of some kind which does not increase the payment from $65 to $70, perhaps, in the State of Utah, or from $100 to $105, perhaps, in the State of Iowa.

Is this the background for the amendment?

Mr. MOSS. Yes. That is the problem to which the amendment is directed.

As I pointed out in my discussion, although usually the increases have been passed on, there have been increasing periods of delay, sometimes requiring 3 years before there is an increase to the recipient. In some States the increase has never been effective when it has been granted by the Federal Government.

The amendment is designed for the simple purpose of requiring States which receive added amounts from the Federal Government to pass those amounts on, to get them to the recipients so that the recipients will have the benefits from them.

When the Congress makes the decision that there is a need for additional money, it does not wish to have the program short-circuited, to have the money sent elsewhere or used for a purpose other than giving aid to the recipient.

Mr. MILLER. May I ask the Senator whether he has any statistics in regard to the history of this type of legislation, on the basis of which he feels that the amendment is desirable?

Mr. MOSS. I quoted rather extensively from the report from the Department of Health, Education, and Welfare, which indicated that this had happened before. I quote now from a document called "State and Local Financing of Public Assistance, 1935–55." It is dated in August of 1956.

I begin reading on page 18, the second paragraph:

> The congressional intent in passing the 1946, 1948, and 1952 amendments was primarily to benefit recipients of the special types of public assistance rather than to decrease State and local spending for public assistance. Because of this intent and because of the effect the amendments had on Federal spending compared with State and local spending and fiscal effort, a closer look at public assistance in the period 1946–55 seems worth while in appraising the Federal and State-local financial roles.
>
> While Congress intended to benefit individual recipients by the three amendments, the Federal matching formula is related to total State and local expenditures and not to individual payments. Thus a specified increase in the Federal share does not necessarily mean that each recipient receives an increase in his assistance payment equal to the Federal increase. When the Federal share is increased, States use the additional funds in one or more ways. Some use the full amount of the increase to raise payments to recipients of the special types of public assistance. If State funds are limited and caseloads are increasing, however, a State may use only part of the money (or perhaps none of it) to raise assistance payments and use the rest (or all) to meet the costs of the growing assistance rolls. Furthermore if a State is already meeting need for the special types of public assistance in full, as defined in the State's assistance standards, it may see no need or justification for increasing assistance payments and may reduce State and local spending when the Federal share goes up. The State may prefer to transfer State and local funds to another program—for example, general assistance—where perhaps need is being met less nearly adequately than in the federally aided programs.

That is the basis for the amendment. The purpose is to prevent the increase from being cut off, as it were, between the Federal Government and the recipient.

Mr. MILLER. I thank the Senator from Utah. While I wish to hear both sides of the argument on this particular amendment, and I look forward to hearing the rebuttal by the distinguished Senator from Oklahoma, I want the Senator from Utah to know that I have observed this type of problem in previous years in my own State, and I am favorably inclined toward his amendment.

Mr. MOSS. I thank the Senator from Iowa.

Mr. CURTIS. Mr. President, will the distinguished Senator yield?

Mr. MOSS. I yield.

Mr. CURTIS. Is the amendment the Senator has offered an amendment to H.R. 10606?

Mr. MOSS. The Senator is correct.

Mr. CURTIS. I hold in my hand a print of that bill, Calendar No. 1549. Can the Senator inform the Senate as to where in the bill the amendment would appear?

Mr. MOSS. I am unable to indicate the exact location in the bill, since the amendment was printed before this particular printing of the bill was completed. It would have to be printed at an appropriate point. I do not have that information readily at hand. It is a general provision, however, and it would appear somewhere near the end of the bill.

Mr. CURTIS. The amendment refers to page 55. There are 102 pages in the bill.

Mr. MOSS. Unfortunately, I have given out all the printed copies of the amendment I had. I no longer have one at my desk.

Mr. CURTIS. I have one which I ask the page to take to the Senator.

Mr. MOSS. I thank the Senator.

Obviously, the reference to the line and the page does not coincide with the printing of the bill as it is now numbered and divided. This is a committee print. Many things have been stricken out, and new language has been written in.

Mr. CURTIS. Mr. President, will the distinguished Senator yield further?

Mr. MOSS. I yield.

Mr. CURTIS. The amendment says, "The increase in the Federal share of public assistance payments provided for in this section," and so on.

Is the Senator referring to the increases carried in this proposal now before the Senate or to all the increases which have been enacted by law in the past to the original section?

The intention is to include under the amendment the increases proposed by the bill which amount, as I understand, to $4 per person in the three categories of disabled, blind, and dependent children, and also the $1 increase which was temporarily granted last year but under the bill would be made permanent, resulting in a total of $5 per welfare recipient.

Mr. CURTIS. In other words, if the amendment is agreed to, it would apply to the increases included in the pending proposal and not to prior measures?

Mr. MOSS. The Senator is correct.

Mr. CURTIS. I thank the Senator.

The PRESIDING OFFICER. The question is on agreeing to the amendment offered by the Senator from Utah [Mr. Moss].

Mr. CURTIS. Mr. President, unless the amendment is acceptable to the Committee on Finance, it is my intention to insist upon a "live" quorum.

Mr. KERR. Mr. President, the amendment was considered by the committee at great length. As I understand, an amendment in one form or another which would achieve the object of the amendment of the Senator from Utah has been considered by the Committee on Finance many times. No such amendment has ever been adopted, for many reasons. The committee, both in connection with its own deliberation and based upon advice and information received from representatives of the Department of Health, Education, and Welfare, has found that it is very difficult to develop a workable provision because of complex administrative and fiscal problems involved. Various factors in individual State programs and circumstances make the effect of such requirement difficult to predict. Caseloads may be rising or declining. State and local funds may become more limited, or additional funds may become available.

The provision would require elaborate bookkeeping and auditing devices to determine whether the proportionate increases in money payments to recipients were properly made.

States claim Federal matching on estimates of future expenditures and cannot make those with exact accuracy. Thus, a State intending to meet the condition for receiving the increase in Federal funds could fail unless, to be safe, it raised money payments well above the amount needed to meet the condition.

The distinguished Senator from Utah made very clear that the increases provided by the Federal Government in past years have in effect, in most instances been passed on. The record of the Department of Health, Education, and Welfare indicates that increases to the extent of 95 percent have been passed on to the recipients either shortly after the increase was provided or within varying lengths of time. In all cases it was within a limited time.

I think the amendment in the form presented not only would be unworkable on the basis of any formula or specifications of administration thus far developed by the Department of Health, Education, and Welfare, but also could result in extreme discriminations and unjust results as between States.

For example, let us suppose a situation involving two States, one of which has recently gone through the process of increasing payments to its beneficiaries. Perhaps in that State local taxes have been increased in order to bring funds or revenue into the welfare fund out of which increases could be paid to the beneficiaries. Perhaps such State has recently passed through such an experience, and at the time of the passage of the bill it might be really straining its financial resources to carry out the provisions of an increase that had just been provided.

It might well be that another State had been lagging behind and had not provided, updated, or improved its program to move in order to more adequately meet the needs of the beneficiaries in that State.

Perhaps the first State could not take advantage of the proposed increase, having strained its financial resources in order to provide increases on the basis of matching funds already available. Under those provisions of the bill of that State, for the time being and until its resources or revenues increased or reached a more favorable posture, could be penalized, though it had already gone far beyond what many other States had been doing to meet the needs of its people.

At the same time, a State which had been slow in moving forward, but which had funds available, could take advantage of the proposal at very little, if any, cost to itself.

One of the basic principles of our assistance program is that it shall be participated in by the States on the basis of budgeted needs arrived at by the States which, as Senators know, are different in all of the States. I know of no two States that have exactly the same specifications and the same budgetary formula.

Therefore, as I see it, in the first place, the amendment would be unworkable. That has been the evidence submitted by the Department of Health, Education, and Welfare representatives before our committee every time the question has been brought before us. It would result in injustice as between the States. It would interfere with the operation of the programs by the States.

For those reasons the Senator from Oklahoma, stating a position consistent with that which the Committee on Finance has taken without exception, urges that the amendment be rejected.

Mr. MOSS. Because of the opposition on this question and the necessity of taking it to a vote, and because of the obvious fact that a considerable number of Senators are unable to be present today because of other commitments, although I am perfectly willing to discuss the amendment further, if there is further discussion, I announce that I intend to withdraw the amendment at this time and call it up again on Thursday, or whenever the Senate returns to the discussion of the bill, when it is possible to have a representative vote on it. If there is any further discussion I shall not withdraw it at this point, but I will withdraw it when the discussion has been completed.

Mr. MILLER. Mr. President, will the Senator yield?

Mr. MOSS. I am glad to yield to the Senator from Iowa.

Mr. MILLER. Mr. President, I should like to ask the Senator from Utah a question. Earlier in the colloquy he read from the report with respect to the intention of Congress in connection with previous increases by Congress. Is there anything in the report of the Committee on Finance with respect to the bill or anything else in the legislative history regarding the bill that we can point to as evidencing the intention of the Congress that this additional money be passed on to the individuals we have been discussing, so that we can relate this amendment clearly to the intention of Congress?

Mr. MOSS. There is a statement in the committee report on the bill.

Mr. MILLER. Will the Senator please indicate the page number from which he is reading?

Mr. MOSS. This is at page 9 of the committee report. It reads:

> The committee expects and, on the basis of experience after prior increases of this type, believes that the additional Federal funds that would be available will be used by States to improve payments to persons who are receiving assistance under the programs of old-age assistance, aid to the blind, and aid to the permanently and totally disabled.

That language expresses the committee's hope and belief. However, this is still limited somewhat by the statement that it is expected that this will improve the payments to persons. The committee does not go so far as to say that the amount of the increase will be passed on.

Mr. MILLER. Of course this is what the Senator's amendment is designed to make sure of. Is that correct?

Mr. MOSS. To pin it down to the amount; yes.

Mr. MILLER. I thank the Senator.

Mr. MOSS. At this point I withdraw my amendment, but I give notice that I expect to call it up again when the debate is resumed on another day.

The PRESIDING OFFICER. Without objection, the Senator withdraws his amendment.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. McCARTHY. Mr. President, I call up my amendment designated "6–29–62—C," now at the desk.

Mr. DIRKSEN. Mr. President, will the Senator yield to me so that I may suggest the absence of a quorum?

Mr. McCARTHY. I yield.

Mr. DIRKSEN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. McCARTHY. Mr. President, I withdraw my amendment. I intend to offer it later.

The PRESIDING OFFICER. The amendment of the Senator from Minnesota is withdrawn.

Mr. McCARTHY. Mr. President, by way of explanation of the amendment which I intend to offer later in the course of the debate, I should like to make a brief statement. I intend to offer the amendment on behalf of myself, the senior Senator from Minnesota [Mr. HUMPHREY], the Senator from Illinois [Mr. DOUGLAS], the Senator from Michigan [Mr. HART], the Senators from New York [Mr. JAVITS and Mr. KEATING], and the Senator from Pennsylvania [Mr. SCOTT].

The Senator from Louisiana [Mr. LONG] announced his support of the amendment and agreed to cosponsor it. The Senator could not be reached until after the amendment was ordered to be printed and consequently, his name does not appear on the amendment.

The amendment, designated "6–29–62–C," if agreed to, would restore to the public welfare measure a provision which has been recommended by the administration and which has already been approved by the House of Representatives in its version of H.R. 10606.

The provision was eliminated by the Committee on Finance, although, so far as I know, I do not believe any witnesses appearing before the committee at hearings stated opposition to the proposal.

Under the aid-to-dependent-children program at the present time the Federal Government participates in an extensive program to assist children living in their own homes or in the home of a close relative. In April of this year more than 2.8 million children were receiving benefits under the program.

However, the State and local governments, along with voluntary agencies, provide almost the entire expense of maintaining children in foster family homes and child care institutions. The most recent data, that for 1960, showed that State and local public welfare agencies were providing funds for 157,989 children in foster family homes and for another 40,736 in child-care institutions. The cost of the foster care programs was $147 million, of which the States supplied about $76 million, the local communities about $70 million and the Federal Government only $1.5 million. About $81.7 million of these funds were used to support children in foster family homes supervised by public welfare agencies and another $65 million for children in foster family homes and child-care institutions which are supervised or administered by voluntary agencies. A majority of States have contracts with private nonprofit groups and use their services in meeting their child-care problems.

The statistical records on the efforts of voluntary agencies indicate that these groups also make an important contribution to the welfare of needy children. For 1961 it is estimated that there were 125,000 children receiving foster care in which the primary responsibility was that of private agencies. Of these some 83,000 were placed in foster family homes and about 42,000 in child-care institutions. Probably about half of these 125,000 children, who were the primary responsibility of voluntary agencies, also received some aid from public funds, but the cost of supporting about 60,000 children was carried by the voluntary agencies alone.

Last year the Congress adopted a temporary measure to provide Federal participation for a very small percentage of children in foster homes—for those children removed from their homes by court order and placed in a foster family home. This legislation gave the States an alternative to leaving children in unsuitable homes—but where they would be eligible for Federal aid-to-dependent-children payments—and permitted the States under limited circumstances to place them in foster family homes and still be eligible for payments. Both the bill approved by the House and the Finance Committee bill now propose to make this temporary measure a permanent provision.

However, in limiting the placement by the court to foster family homes the present act restricts the opportunity for the court to improve conditions for many unfortunate children, in that the changes made by the Committee on Finance would not permit any contribution by the Federal Government if by court order the child were placed in a child-care institution rather than in a foster family home.

In April of this year the present program of aid-to-dependent-children payments for children removed under court order provided for only 1,220 children in 13 States. Altogether 14 States have the program in effect and action has been authorized in an additional 5 States.

It is my understanding that the need is far greater and that a major impediment has been that foster family homes cannot supply all the needs of the children. The conditions which make it necessary to remove such children from unsuitable homes often result in needs for special pychiatric and medical care of the children. While foster family homes cannot ordinarily meet these needs, many child care institutions have such facilities and services.

Most of the child-care institutions at the present time are conducted by private nonprofit groups often associated with a religious denomination. In 1960 there were about 1,200 private child-care institutions in the United States; in addition about 125 institutions are under wholly public auspices.

A second factor which limits the courts under the present law is that of the difficulty—and apparently in many cases the impossibility—of finding foster family homes for children under these circumstances. These are the most underprivileged children and often have special problems. When they come from minority group families, the difficulty is increased because the general crowded housing of these groups cuts down on the opportunity for finding suitable foster homes. In effect, then, the present legislation puts the States and the courts under pressure not to act in attempting to find better living conditions for these underprivileged and unfortunate children. They cannot find foster family homes, and if they place the child in a child-care institution, it has to be at State expense without Federal participation. I should add, of course, that while this is a most difficult problem, it involves only a small percentage of children. The Children's Bureau has estimated that only about 1 percent of the aid to dependent children would require removal under court order for foster care.

Mr. President, I believe that in judging this recommendation of the Department of Health, Education, and Welfare, we should keep in mind two principles.

The first consideration is the welfare of the child. The evidence under the limited provision of last year and the statements of authorities indicate that limiting the program only to those children which are placed in foster family homes is too rigid. The small percentage of aid to dependent children who can be helped within the terms of this measure are among the most unfortunate in the Nation. Children in homes where parents suffer from poverty, sickness and unemployment have their own handicaps, but they retain the strength of family unity in spite of adversity. This provision relates to the unfortunate situation where the court finds the parent and the home unsuitable for the welfare of the child.

The issue is whether the Federal Government is going to place restrictions on programs which limit the courts from making a placement in the best interest of the child forcing it to remain in a home which has been determined as an unsuitable place.

This amendment—and the House approved provision—opens the way for the courts to make a determination in the best interest of the child.

I do not believe we should be less concerned about the welfare of these children who must be removed from an unsuitable home than we are about needy children who have the advantage of remaining with their own families. I do not believe we want to extend Federal participation to the child whose home is unsuitable only if he is placed in a foster family home and deny it when the court determines it is in his best interest to be transferred to a child-care institution.

A second principle involved is that of State rights. The public welfare programs are primarily the responsibility of the States and local communities. The Federal Government participates, but on the whole, the States develop the programs, supply the personnel, and make the primary and principal determinations as to how these children should be treated.

The States have traditionally used private child-care institutions to help meet their problems, and a majority of States today have contracts with private nonprofit child-care institutions to provide foster care. To adopt this amendment is not to give an open-end approval to the States, under which abuses could develop.

On the contrary, it authorizes action for a group who more than any other group under the social security program or welfare program come under close scrutiny and a most careful weighing of evidence.

It involves a court determination that the child should be removed from his unsuitable home. This is not a decision which judges make lightly.

I believe the Congress should approve minimum Federal standards which are placed in the law either to prevent misuse of Federal funds or to prevent discrimination against the needy. That is quite a different proposition from the restriction in the committee bill which excludes the most needy children from benefits which the court holds to be in their best interest.

I should like to read at this point an excerpt from the testimony of Mr. William R. MacDougall at the hearings on this bill conducted by the Committee on Finance. Mr. MacDougall is Secretary of the Welfare Committee of the National Association of County Officials and general counsel of the County Supervisors Association of California. He stated:

> We give the highest priority to Federal participation to aid needy children in foster home and institutions. Secretary Ribicoff himself has stated that Congress in enacting and amending our Social Security Act had repeatedly demonstrated its deep concern that no child, wherever he may live, shall go without food, clothing, shelter, or other essential needs.
>
> There is one glaring exception. Until last year all children in foster homes could truly be classified as American "forgotten children" with respect to Federal programs.
>
> Children in foster homes were not eligible for Federal participation under the aid-to-dependent-children program.
>
> In some States, children were being retained in unsuitable homes to qualify for Federal participation rather than being placed in a healthier atmosphere of a foster family because the local authorities were aware that there were not sufficient funds available to place the child in a foster home.
>
> We are pleased that H.R. 10606 would make permanent the change of last year, which provided for Federal participation for ADC payments to children in foster homes who had been placed there by a court order and were receiving ADC aid at the time they were moved to a foster home.
>
> We heartily endorse the new provision of H.R. 10606, which expands the program to include care in child-care institutions, as well as private foster homes.

Mr. JAVITS. Mr. President, will the Senator yield?

Mr. McCARTHY. I yield.

Mr. JAVITS. I believe that the Senator's amendment will materially benefit the people who are intended to be benefited by the pending measure, as well as the Nation generally. When the amendment is called up I hope to have the privilege of giving it all the support I possibly can.

Mr. McCARTHY. I thank the Senator from New York for his support. I hope the Senate will see fit to restore the House language. As I recall it was supported by every witness who testified about this provision and opposed by none. At the appropriate time when the amendment is offered, I will join the Senator from New York in making the case again in the Senate.

Mr. President, I wish to make an additional comment on some court decisions that relate to what might possibly be the only argument that could be made against the inclusion of these children in the pending bill.

The question of the right of States to place children in private agencies, even when conducted under the auspices of religious denominations, has been tested in court and the precedents uphold the right of the State to make such placements in the best interest of the child. The latest decision on the subject is that of *Schade* v. *Allegeny County Institution District* (126 A. 2d 911), decided by the Supreme Court of Pennsylvania in 1956. Here it was urged that reimbursement of sectarian orphanages violates the State constitution and the principles of the first amendment as applied to State action by the 14th amendment. The court stated:

> The appellant argues that the institution district's payments to the denominational or sectarian defendants tend toward governmental establishment of religion and, consequently, are violative of the 14th amendment. It is unnecessary to devote much time to this contention. The supreme court has, in principle, settled it adversely to the appellant's position. See *Everson* v. *Board of Education, supra,* where it was held that a State's use of public tax funds for the transportation of pupils to and from sectarian schools did not serve to promote the establishment of religion.

Another important decision on this subject is that of *Murrow Indian Orphans Home* v. *Childers* (171 P 2d 600, (1945)). This case involved the constitutionality of contracts between the State board of affairs for Oklahoma and a Baptist child-caring institution for the support of certain dependent orphans. The facts disclosed that the home is sectarian in character. After reviewing all of the pertinent legal authorities, the Supreme Court of Oklahoma declared:

> The legislature of the people have a discretion in this matter and may care for needy children through any scheme that seems appropriate to them, omitting, of course, to offend other constitutional provisions. Such a scheme may involve State given institutional care, or placement in the homes of private citizens, or contracting with eleemosynary institutions, or by grants of money, or combinations of these.

A quasi-official document was filed by the National Probation and Parole Association as an amicus curiae in the Pennsylvania case of Schade against Allegeny County Institution District. The brief indicates that a survey was made to determine the extent of the use of private sectarian facilities for the care of delinquent, neglected, and dependent children. On the basis of the returns of this questionnaire, the association asserted:

> It is clear that in the States represented, substantial use is made of private agencies in the placement of delinquent, neglected, and dependent children by juvenile courts and among these agencies a majority of the children are placed in sectarian or denominational agencies.

The brief also asserts:

> The overwhelming majority of the replies were to the effect that if the use of sectarian institutions were withdrawn from the facilities available to the juvenile courts, there would result a critical loss of much needed facilities.

A particularly interesting reply is that made by the court in Alameda County, Calif. The court stated:

> We would be virtually restricted to the use of State schools, which are geared to the handling of much more severely disturbed children than those customarily placed in private, sectarian institutions.

The juvenile authorities of Richmond, Va., replied in the following manner:

> If the use of sectarian institutions were withdrawn, our welfare department would have to locate more foster homes and the cost would be borne by the taxpayer.

Mr. JAVITS. Mr. President, as we shall be entering into the debate on the amendments to the pending bill which relate to medical care for our aging citizens probably on or close to Thursday, and as Members of the Senate may be studying the RECORD over the Fourth of July, I should like briefly to make some observations on what has been accomplished in the amendments offered by the Senator from New Mexico [Mr. ANDERSON] and myself and other Senators on this side of th eaisle as well as on the other side of the aisle in support of the amendments; and also to outline the area of our difference, as it still exists, though I hope very much that there will not be differences when we finally complete our work and are ready

in a final way to call up the amendments.

The group of Senators on this side of the aisle who have worked with me and the Senator from New Mexico and his colleagues, in an effort to merge our ideas on medical care for the aging, have made substantial gains, which will be of great benefit to the program.

One of the most gratifying things that the Senator from New Mexico said in presenting the amendments last Friday, was the fact that he felt there had been an affirmative contribution.

Let us first see what has been agreed upon, and then at what still remains open and subject to an agreement that we can attain.

First and very important, a real historical step forward has been taken in coverage. The Senator from New Mexico estimated that 2½ million of the uninsured people affected by the proposal not previously included would be included in the bill. These are the people over 65 who are not eligible for social security benefits. Very clearly all of those who are 65 on January 16, 1964, when this plan would take effect, will be blanketed in under the law, and would then be included, as the Senator from New Mexico described it, over a period of time up to 1971. All of these people would be blanketed into the social security system. With the incentive which will be given to get under the system, by the fact that greater benefits will be available, we have no doubt that for all practical purposes, estimating in the area of 85 percent to 90 percent, all of those over 65, whether or not now eligible for social security, and whether or not eligible for social security as time goes on up to the 1971 date—that a very large proportion will be blanketed in and included in the medical care benefits.

So for all substantial purposes, the overwhelming majority of those 65 and over not covered by the King-Anderson bill will come in under the benefits of the bill as it is now amended, following the discussions which we had in such an auspicious way with the Senator from New Mexico [Mr. ANDERSON]. That is the first point.

Mr. CURTIS. Mr. President, will the distinguished Senator from New York yield?

Mr. JAVITS. I yield to the Senator from Nebraska.

Mr. CURTIS. When will the act become effective?

Mr. JAVITS. January 1, 1964.

Mr. CURTIS. As I understand the amendment, all persons now eligible for title II benefits, which are the old age and survivor disability benefits, or who will become eligible by January 1, 1964, will be eligible for hospital benefits.

Mr. JAVITS. The Senator is correct.

Mr. CURTIS. They will be paid out of the social security fund, will they not?

Mr. JAVITS. No; they will be paid out of the special medical trust fund. That was the next point to which I wished to speak.

Mr. CURTIS. How much will persons already eligible, or who will become eligible by 1964, have paid into that trust fund?

Mr. JAVITS. Of course, persons who are eligible on January 1, 1964, will have paid whatever their social security tax was in the intervening year and a half.

Mr. CURTIS. When will the tax go into effect?

Mr. JAVITS. The tax will become effective a little earlier. I do not have the precise figures before me.

Mr. CURTIS. How much will persons who are now retired and who are eligible for social security have paid into the hospital benefits trust fund?

Mr. JAVITS. Those persons who are now retired and are not working, in the sense of still paying social security tax, will not have paid anything.

Mr. CURTIS. Why will their benefits be paid out of the social security fund, and the benefits of the 3 million aged who are not eligible for benefits not be paid from the fund, but directly from general revenues?

Mr. JAVITS. The reason is that the payers of social security will be paying into the fund, so the fund will have taxation money arising out of social security payments, although not paid by those who will be getting the benefits.

The Senator from Nebraska may recall that this was one of the great problems I had with the idea of social security financing, and why I called it regressive. But I pointed out the other day—and I am very glad to do so again at this moment—that I have felt, and I have ascertained to my own satisfaction over the course of the last 2 years, in round figures, that the younger people, those under 65, who would be paying, as it were, for those over 65, who have not paid anything on this particular account, are willing, from my observation, to do so, and want to do so. It seems to me there is a very strong sentiment—not unanimous, by any means; but this is my own judgment, and all of us in public life have to have some instinct about these matters—to pay the social security tax for health benefits, and even to begin to pay it now, although the health benefits for most social security payors will be long deferred.

So the answer to the Senator from Nebraska is: Yes. What the Senator has said is perfectly true. The beneficiaries will not have paid. But I feel—and I am speaking unilaterally—that those who will be paying into the trust fund will be willing to do so in the expectation of the future benefits that will flow to them.

Mr. CURTIS. But there will be two classes who will receive benefits. The first will receive benefits from the social security taxes paid by present workers, and one group will be paid from the general revenues. Why the distinction?

Mr. JAVITS. The distinction is that these are persons who are covered by the King-Anderson bill now, and those who are not eligible for social security are being brought in on a basis upon which they will gradually be blanketed into the system by the amendment which we prepared with the Senator from New Mexico. There is no distinction now. There was a distinction before. There is a distinction in the method of financing.

I have pointed out that those who are paying social security taxes, although they are not paying them for the benefits they will get right now, are nonetheless entirely willing to pay in order to receive that benefit conferred upon those who are members of the system, as it were.

Mr. CURTIS. Why are they willing to pay it for the members of the system who pay nothing, and not be willing to pay it for other aged who pay nothing?

Mr. JAVITS. I think there is some justification, because those persons are themselves persons who have paid into the system as a result of helping to build up the system.

Mr. CURTIS. In what way?

Mr. JAVITS. They have made their own social security payments before they reached the age 65. Hence, they are members of the system.

Mr. CURTIS. They are members of a very exclusive club, I agree, because a man who retired at age 65 5 years ago had a life expectancy of 12 years. His wife had a life expectancy of 14 years. I daresay that in the average case, where he has paid the maximum all through the years, in about a year he and his wife have drawn out everything they put into the fund.

Now a new fund will be started, to which he will not contribute but from which he will draw benefits; and there are other aged who have never received any social security benefits, who will now receive benefits. I agree to that part, but they will have financing from the General Treasury. They will be dependent upon appropriations. Is not that correct?

Mr. JAVITS. That is correct.

Mr. CURTIS. Why the distinctions?

Mr. JAVITS. The distinction is the one I made before: That the background of those who are eligible for social security is that they are members of a particular group. They are in the fund. They are insured. This is an extension of their insurance, as it were.

As I said to the Senator a moment ago, we had hoped this afternoon only to map out our basic ground.

Mr. CURTIS. We shall continue the discussion at another time.

Mr. JAVITS. I deeply appreciate the Senator's understanding.

Taxes will begin for the taxable years starting after December 31, 1962.

Also, we separate the trust fund. There will be a separate Federal medical trust fund, which will enable us to see precisely the viability of the whole enterprise, which is important.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD an analysis of that provision made by the Senator from New Mexico [Mr. ANDERSON] and myself.

There being no objection, the analysis was ordered to be printed in the RECORD, as follows:

SEPARATE TRUST FUND

Under the bill I introduced last year, there would have been a health insurance account in the Federal social insurance trust fund. The trust fund would also have included special accounts for old-age and survivors insurance and for disability insurance. While I believe this arrangement would have been fully effective in segregating the monies

for the various benefits provided under social security, in the proposed amendment we have substituted provisions for a separate health insurance trust fund. We have made this change because some people believe that there would be merit in a separate trust fund for health insurance, and that there would be less danger of misunderstanding.

Of course, the payments for health services that would be made on behalf of those people who qualify for protection through the provisions for the uninsured would be made from general revenues. The trust fund and the rights of the social insurance beneficiaries would in no way be affected by these expenditures.

Mr. JAVITS. Mr. President, third—and this is very important, so far as we are concerned—is the whole scheme by which hospitals may be accredited, by which hospitals may join in allowing themselves to be represented by an organization like Blue Cross in their relationship to the Federal Government program; and providing also for some State administration.

All these factors are incorporated in this amendment and represent steps forward, taken as a result of merging the views of the Senator from New Mexico and his group and the group on this side of the aisle.

Finally, and most important—and this is the critical point of distinction—we have always made a big point of the fact that there should be an opportunity for private enterprise, whether cooperatives, group plans, or private insurance carriers, which would give, in value terms, very much the same thing as was given in the King-Anderson bill, to be compensated for so doing, helped by a premium payment from the Federal Government.

It is this fundamental option principle—also, incidentally, an option principle espoused by Governor Rockefeller, of New York—which has been one of the two big factors, the other being complete coverage, which is now being attained for all persons over 65, whether or not they are under social security.

What has happened with respect to the option is that we have adopted a basic principle with the Senator from New Mexico by which a private carrier may be reimbursed for benefits which it confers, if the benefits are the same as those in the Federal system after the bill has become law. Therefore, a private carrier may frame an insurance policy or coverage upon that base.

We have not worked out any way in which there would be premium reimbursements—which is a very different thing. It is one thing to reimburse benefits actually paid by the insurance carrier or the other carrier; it is quite another thing to reimburse for premiums. The Anderson amendments, in which we joined because they took us to where we were at that moment, carry the concept of reimbursement of the carrier for benefits paid.

So, Mr. President, I ask unanimous consent to have printed in the RECORD Senator ANDERSON's analysis of those provisions, which we have, in a sense, introduced, bid, and asked, to use a colloqual term. We on this side—the Senator from Kentucky [Mr. COOPER], my colleague [Mr. KEATING] and I—have joined in the concept of having the Federal Government pay such part of its own total fund as will represent the allocated actuarial risk to the particular person who chooses to have a private plan, instead of the governmental plan. It is on this that we are trying to have a complete meeting of the minds.

There being no objection, the analysis was ordered to be printed in the RECORD, as follows:

PROTECTION FOR THE UNINSURED

Our proposed amendment provides to the residual group of 2½ million elderly people the same benefit protection that is provided those insured under the social security program and finances the protection for this group through general revenues. People who reach age 65 before 1967 and who do not meet the regular insured status requirements of the social security system would be deemed insured. Uninsured people who will reach age 65 in 1967 would be deemed to be insured for social security health benefits if they had earned as few as 6 quarters of coverage in covered work at any time—9 fewer quarters of coverage than men of this age need to qualify for social security retirement benefits and 6 fewer quarters of coverage than women of this age need to qualify for social security retirement benefits.

For people who reach age 65 in each of the succeeding years, the number of quarters of coverage needed to be insured for health insurance protection increases by 3 each year, thus, people reaching age 65 in 1968 would need 9 quarters of coverage, people reaching 65 in 1969 would need 12 quarters of coverage, and so on. For persons who attain age 65 after 1971 the special insurance status provisions for health insurance will require as many, or more, quarters of coverage as the regular insured status provisions for other social security benefits, so that for both men and women the new insured status provision will soon "wash out."

Under this special provision, people who are uninsured under the regular social security program and who become 65 after 1966 will be able to qualify for health benefits only if they have had reasonably substantial work under social security. This would be consistent with the work-related and contributory principles of the social security system.

It might be noted that one-half of the 2½ million uninsured people who will be affected by this proposal are receiving cash assistance under the Federal-State assistance program. Of course, some of these assistance recipients will be receiving health care through the Federal-State assistance program when our proposed health benefit program goes into effect. In their case the benefits of our amendment would sometimes be in the nature of a partial substitute for the aid they would be getting. Thus the cost of providing the new insured status provision will be offset in part by reductions in current expenditures. In other cases, however, the Federal-State assistance program does not give protection comparable to the benefits I am proposing, and in those instances the result would be a net increase in medical care for the assistance recipients.

I might also point out that in the uninsured group which would receive protection paid for by the general Treasury, there are some who have had the opportunity to come under social security but have declined to do so. For example, there are ministers and certain employees of nonprofit organizations who elected not to be covered and some employees of State and local governments who voted not to be covered. Of course, the uninsured group also includes doctors and their wives and widows who have not been included under social security solely because the American Medical Association has opposed such coverage. For purposes of administrative simplicity, no attempt has been made to exclude these groups.

COST OF HEALTH BENEFITS FOR THE NONINSURED

As I indicated, the cost of the proposed health benefits for the 2½ million noninsured would be met out of general revenues. The gross cost of the provision would be $250 million in 1964, the year the health benefits program would go into effect. This calendar year cost would be offset by savings in Federal medical care expenditures in 1964 that except for the passage of our amendment would be made under public assistance and the veterans' programs. These savings would be about $200 million, leaving a net cost to general revenues of about $50 million in 1964. Federal expenditures for the noninsured would decline over the years and eventually would wash out altogether.

SIGNIFICANT ADMINISTRATIVE ROLE FOR PRIVATE ORGANIZATIONS

Under the proposed amendment the Secretary of Health, Education, and Welfare would be given specific statutory authority to delegate some of the more sensitive administrative functions to Blue Cross or to other similar voluntary organizations that are experienced in dealing with hospitals and other providers of health services. Any group of hospitals (or group of other providers of health services) could designate a private organization of their own choice to receive their bills for services and to pay these bills. Advantageous additional administrative functions could be included in the contract between the Government and the organization. These administrative functions would include reviewing hospital fiscal records as a part of the determination of the cost of services, and acting as a center for communicating and interpreting payment procedures to hospitals.

I should point out that representatives of the American Hospital Association appearing before the Committee on Ways and Means last summer urged an approach that would utilize the services of voluntary organizations if a bill of this type were to be enacted, and I am convinced from numerous conversations with individuals in the field of hospital administration that the provisions I am now outlining will prove to be eminently satisfactory to them. The principal advantage hospitals and other providers of services would find in this arrangement would be that policies and procedures of the Federal program would be applied by the same organization which administers the private, voluntary benefit program with which most of them now deal.

The participation of Blue Cross plans and similar expert organizations in carrying out the provisions of our proposed amendment would have advantages that go beyond the benefits that would be derived from their experience in dealing with hospitals and the well-established working relationships that exist. With such organizations serving as intermediaries between the Government and the providers of services, those who are concerned that Government might try to intervene in hospital affairs would feel much more confortable.

ROLE OF STATE AGENCIES

Under our proposal the Federal Government would use State agencies to determine whether hospitals which are not accredited by the Joint Commission on the Accreditation of Hospitals are qualified to participate in the program. State agences would make these determinations also in the case of skilled nursing facilities and other providers of health services. The conditions of participation for such providers are spelled out

in the amendment. State agencies would determine whether they are met. I am confident that all States would be willing and able to enter into agreements to assume these responsibilities, just as they have participated in the administration of the disability portion of the OASDI program.

State health departments or other appropriate agencies designated by each State would also give professional consultation to providers of health services to assist them in meeting the conditions for participation and in establishing and maintaining necessary fiscal records and providing information necessary to derive operating costs which are the basis for payment for their services. State agencies would be reimbursed for the costs of activities they perform in the health insurance benefits program, including Federal sharing in the costs of coordinating these activities with other State activities related to health and medical services.

What is contemplated is a Federal-State relationship under which each governmental entity performs those functions for which it is best equipped and most appropriately suited. State governments license health facilities and State public health authorities generally supervise these facilities. In addition, State programs purchase care from providers of health services. On the basis of experience and function, State agencies should assist the Federal Government in determining which providers of health services conform to prescribed conditions. Furthermore, where an institution or organization that has not yet qualified needs consultative services in order to determine what steps may be appropriately taken to permit qualification, such consultative services should be furnished by the State health or other appropriate State agency. These types of consultative services are related to State programs and requirements and should logically be provided by, or coordinated in, the State agency.

PRIVATE INSURANCE

The final revision which added as a result of many conferences provides an option to beneficiaries to continue private health insurance protection in order to encourage private health insurance supplementation. The plan is as follows:

1. At the time of first eligibility for social security, beneficiaries who for a period of time had private insurance protection under plans which include the same benefits as provided under social security would be able to choose between having the statutory benefit paid for directly by social security or, if they wish to continue the private plan, they could have the statutory benefits paid for through the private carrier.

(Of course, those who did not elect to continue such a private plan could buy private policies completely separate from but supplementary to social security protection.)

2. Carriers would be reimbursed for the statutory benefits they paid for and for their administrative costs.

3. The beneficiaries could elect to have their benefits paid by a private carrier only if they have had the required plan in effect for a period before they become entitled to health benefits under social security. The required period of prior insurance would be brief at first, to allow for a change in private plans and then gradually lengthen until 5 years of previous membership is ultimately required. The required period of membership would be 3 months for persons entitled when the plan goes into effect on January 1, 1964, and would remain at 3 months until the end of March 1964. From then until the end of 1968 it would require continuous membership from January 1, 1964, until entitlement. After 1968, 5 years would be required.

4. Any carrier would be approved to participate for its group health insurance plans and all nonprofit plans would be approved. To participate for individual policies a commercial carrier would need to be licensed in all States and doing 1 percent of the health insurance business throughout the Nation, or is found by the Secretary to be national in scope. As an alternative it could be approved for a particular State if it did 10 percent of the business in that State.

Mr. JAVITS. Mr. President, in this connection I ask unanimous consent to have printed in the RECORD an analysis of our amendment, so that Senators will be able to see at a glance the option provided by Senator ANDERSON'S amendments—in which we have joined, for the reasons I have stated—which were filed last Friday. Thus, Senators will be able to see what we have in mind. I believe that will be taken as more than merely an idle statement, because I think the Senator from New Mexico [Mr. ANDERSON] and the Senators on our side who have joined with him have gone a long way toward reaching complete agreement; and I am very hopeful that by the time the measure is called up, we shall find ourselves completely in accord as to our views on the option, and thus I hope very much that it will not be necessary actually to press for adoption of the amendment which we have submitted for the purposes I have outlined.

There being no objection, the analysis was ordered to be printed in the RECORD, as follows:

For those eligible individuals who have private health care plans for at least 1 year preceding age 65 and want to continue them, this option would provide a cash payment to an insurance carrier of premiums on a guaranteed renewable health insurance policy up to $100 per calendar year. The policy, which may be individual or group, shall provide benefits which the Secretary of Health, Education, and Welfare determines are equivalents of the value of the health insurance benefits provided in other sections of this bill. The carrier is also required to notify the Secretary in the event of a lapse in payment of premiums.

Mr. KEATING. Mr. President, will my colleague yield to me?

Mr. JAVITS. I yield.

Mr. KEATING. I think it is very helpful to have this amendment, so that Members can become acquainted with what we are trying to accomplish.

In the analysis my colleague has made this afternoon, I am not sure that one point was made entirely clear. It is my understanding that under the option contained in the revised Anderson amendments, the insured person can, if he wishes, bring into the plan, at age 65, a private policy, and that private policy need not be in terms of the benefits set forth in this act; it may be much broader, and many might wish to have a broader coverage. But if at age 65 such a person so covered was taken to the hospital and had benefits coming to him from the insurance company, the insurance company would be reimbursed to the extent that those benefits fell within the confines of those set forth in the bill. But for other benefits, beyond those, the insurance company would not be reimbursed. Is that correct?

Mr. JAVITS. That is exactly correct; and that would be covered by such remaining premium as the insurance company charged the insured.

Mr. KEATING. It is my hope, and I think it is the hope of all of us, that that might encourage the insurance companies to write broader coverage, because all of us recognize that the medical care envisioned by this bill is not by any means complete medical care. So this would encourage them to write a broader coverage at, we hope, a rather modest premium, inasmuch as the insurance company would be underwritten for the benefits set forth in the Anderson amendments.

Mr. JAVITS. That is exactly correct; and it is also accurate to add that the Anderson amendments benefits are calculated, at the best, to cover one-third of the total medical expenses, or perhaps even as high as 40 percent, but no more. So there is an enormous range for other benefits to be insured by insurance companies or cooperatives or group units of various kinds; and we hope that as we finally finish our discussions, we shall be able to present them—regardless of whether the insurance companies agree with us or do not agree with us; and right now they do not agree with us, any more than does the American Medical Association—with an opportunity which they will not forego.

Mr. KEATING. Yes.

Mr. President, I appreciate very much my colleague's comments on these matters.

Mr. ANDERSON. Mr. President, two newspapers of national standing have come out over the weekend in strong support of the bipartisan proposal for a program of health care for the aged. I ask unanimous consent that an editorial from the New York Times and an editorial from the Washington Post of Sunday, be printed in the RECORD at this point.

There being no objection, the editorials were ordered to be printed in the RECORD, as follows:

[From the New York Times, July 1, 1962]

COMPROMISE ON MEDICAL CARE

The success of Senate Democrats and Republicans in arriving at a compromise formula on medical care for the aged is a fresh demonstration of bipartisan responsibility in meeting urgent national problems. The extent to which the health issue has become enmeshed in party politics on both sides makes this in some ways an even more significant triumph for cooperation than the support the Trade Expansion Act was given in its passage by the House.

The new bill retains the sound insurance principles of social security as the bedrock of its financing, but it extends the plan's protection to the great bulk of the 3 million elderly citizens outside the Federal system. It also provides additional reassurance for those who fear the program might undermine the independence of the medical profession and it opens the way for an option to allow freedom of choice to persons preferring private health insurance. Senator ANDERSON, of New Mexico, and Senator JAVITS, of New York, chief engineers of the compromise, deserve special credit. The Nation's

structure of social insurance will be better geared to meeting the needs of our aged citizens if their bill wins congressional approval.

[From the Washington Post, July 1, 1962]

MEDICAL BREAKTHROUGH

There is room for qualified rejoicing over the new bill to provide medical care for the aged introduced in the Senate on Friday by 23 sponsors. It does the bill a disservice to call it a compromise; it is an improvement on the old version. And there is something really hopeful in the fact that it has the support not only of administration leaders but of five distinguished Republican Senators as well.

The Republican support comes from THOMAS KUCHEL, the Republican whip, and Senators JAVITS, KEATING, CASE; and COOPER. Although these men are progressive Republicans, who have already accepted the principle of social security financing for the medical care program, they are also men who have been articulately critical of the administration measure. That they and the Democratic sponsors of the program were able to adjust differences and join hands in a common proposal reflects the best sort of legislative accommodation and suggests a real determination on both sides to eschew political jockeying and find a practical solution for an urgent national problem.

The changes in the bill are all commendable. It will now include persons over 65 who are not covered by social security; it would be unwise as well as unjust to leave them out of the program. It provides that accreditation of hospitals furnishing services under the program be determined by the American Hospital Association and the American Medical Association; this should insure high standards, and perhaps it will in some measure mitigate the hostility of doctors. It will allow Blue Cross or other private insurance plans to deal with the hospitals in supervising administration of the program and it will give beneficiaries an option to continue private health insurance protection. In addition, it will adopt Gov. Nelson Rockefeller's idea of creating a separate health insurance trust fund instead of lumping medical care money in with other social security accounts. We see no harm in these changes.

The Senate is to debate the medical care program this week. We hope it will be an enlightening debate which will set at rest some of the hobgoblins raised by the American Medical Association. If the Senate passes the bill, it must go to the House where hopes for its adoption are far from high. Representative WILBUR MILLS, the redoubtable chairman of the House Ways and Means Committee, is against it and so there is little hope that it will be reported out by that body. If senatorial strategists try tacking it on to the general welfare reform bill as an amendment, it will have to go to the House Rules Committee where its chances do not seem much brighter. Nevertheless, let rejoice that it is on its way.

Mr. ANDERSON. Mr. President, the proposed welfare legislation embodied in H.R. 10606 is certainly of great importance. These proposals look to considerable betterment in the provision of public assistance and would make for a brighter future for those who cannot provide for themselves. I personally have strong feelings that there is need for this measure, and I particularly favor the greatly increased emphasis that it would place on rehabilitation of people now on relief.

I suggest, however, that we shall be remiss in fulfilling our obligation to the people of this country if we limit ourselves to taking action to improve the lot of people who have fallen into poverty but simultaneously take no action to remove the grave threat that faces the great majority of older Americans—average people who have always paid their own way and think of public assistance with its means test only as a last resort when all else has failed. The threat that they face, of course, is the possibility—even likelihood—that serious illness and a long hospital stay will wipe out their lifetime savings and leave them with the dreadful prospect of living out their later years in poverty.

Our obligation can be fulfilled only if legislation that would provide an effective program of health insurance for the elderly is enacted without delay. We must face facts. Giving assistance to people who are already reduced to poverty is necessary, but the prevention of dependency before it occurs is certainly more in line with the American tradition of self-reliance and the wishes and aspirations of the American people. I cannot stand by in silence and watch us try to pick up the pieces of lives that have been broken and not take the sensible, logical step of removing the haunting fear that faces almost all of our older people—the fear that costly illness will bankrupt them after many years of independence and force them to seek help from public or private charity or from already overburdened relatives.

Unless favorable action is taken now, health insurance for the aged is likely to be a major issue in the fall elections and next year a bill will be passed. But the problem that confronts our aged people is so pressing that I hope we will not delay a solution for another year.

GROUNDS FOR GENERAL AGREEMENT

For these reasons, a bipartisan group now proposes an amendment to H.R. 10606 to provide health insurance for people aged 65 and over. The amendment we would add to the welfare bill is a considerably improved version of S. 909, the bill I introduced last year. S. 909 is identical to Representative KING'S bill, H.R. 4222, which has been under consideration by the House Ways and Means Committee for some time.

In offering this amendment on the floor of the Senate, I recognize that the proposed health insurance for the aged measure is still under consideration by the House Committee on Ways and Means. My thought and purpose in proposing our amendment at this time is that the great importance of the proposal and the tremendous need for action justify immediate consideration by this body, thus facilitating early action by the Congress as a whole. We offer the proposed amendment as a clear and unequivocal demonstration that we in the Senate who agree, in principle, that the social security mechanism offers the only effective means of helping to finance the intolerable burden of health costs in old age are ready to resolve our differences of opinion and offer a proposal that can be enacted this year.

The amendment we offer proposes a program on which I am sure a majority of Senators can agree. It has been developed over a period of months after a painstaking evaluation of alternatives sponsored by my colleagues and thorough study of criticisms that have been raised against S. 909 and the points on which it has been misunderstood or misinterpreted. Our proposed amendment incorporates important features similar to those proposed by some of my colleagues but with decided improvements. I have welcomed suggestions from a number of other interested people and organizations and have improved a number of provisions of S. 909 in accordance with their ideas.

The proposed amendment offers what I can assure you is a conscientious effort to develop a plan distinctly superior to S. 909 while at the same time preserving its essential points—health insurance benefits for aged social security beneficiaries and railroad retirement annuitants without a means test and financed through the contributory social security system.

On these essential social security features I cannot compromise. Our proposed amendment would utilize social security financing, for through this mechanism the health insurance needs of our people in their later years can be met by payments made during their working years. Health insurance will go far to make retirement protection under social security truly adequate in a way that increased cash monthly payments can never achieve. Health costs of the aged are not evenly distributed from month to month or even from year to year. A person over 65 may have no appreciable health costs for several years and then in a short time have health costs running into thousands of dollars. It is not possible to increase the cash benefits under OASI sufficiently to cover such large expenses. The obvious solution is to even out this expense over a span of years and over millions of the aged through insurance. The health insurance to which the elderly would be entitled would be provided as an earned right through the social security system which they have helped support by their contributions during their working years. Beneficiaries could apply for and receive the health insurance benefits of the program with dignity, and let us not forget that the dignity associated with the social security program has been a major factor in its widespread acceptance by the American people.

Similarly, the amendment we offer would follow the same threefold attack on dependency in old age as that carried out by the present social security program. First, basic health insurance protection against hospital costs and certain alternatives to hospitalization would be afforded the elderly through social security; second, the existence of a program of basic protection would encourage the development of additional private protection which the individual could purchase by his own means; third, all the States would be placed in a far better financial position to provide adequate medical assistance to help the relatively small group whose special needs and circumstance make it impossible for them to meet health costs that exceed those covered by this bill.

The proposed program would be financed on the same fiscally sound basis as the present social security program. Its cost over the longrun future has been carefully calculated, and sufficient income to meet both short-term and longrun program obligations is provided for.

MAJOR IMPROVEMENTS MADE IN S. 909

Some of the objections to S. 909, the bill I introduced last year, as we all know, have not been based on anything associated with my bill. The American Medical Association has made clear it opposes the British National Health Service as a form of protection against medical costs. This is an interesting point, but it has nothing to do with my bill. Some doctors have said they would not participate—apparently they would not accept payment under social security. This is an interesting point, too, but my bill never proposed to make payments to doctors. While the American Medical Association has lately given lip service to compromise, it is quite clear that its only purpose is to delay action on constructive legislation in this area. The American Medical Association has stated its opposition to any program without a means test and to any program which uses social security financing. Its opposition and its statements cannot turn social security financing and protection given as a right, without a means test, into something that the American people regard as undesirable.

But I am speaking now of the objections raised by those who honestly want to see a health insurance bill passed. I have gone to great lengths to examine and study these objections and the reasoning behind them. I have made changes that I believe will be agreeable to all who really want a bill to be passed. It is with the sincere hope that efforts to work out satisfactory alternatives to some of the provisions in my bill will lead to the early availability of health insurance for the aged that I offer with other Senators our proposed amendment.

First, let me mention very briefly the general nature of the major changes embodied in our amendment. The amendment extends to aged persons who are not protected by the social security system the same health benefits that would be provided for aged social security beneficiaries and railroad retirement annuitants. Our proposal includes a number of new and explicit provisions that will make it crystal clear that the Federal Government will not be able to interfere with the practice of medicine or inject itself into the operation of hospitals. Specific provision is made so that hospitals may choose organizations, such as Blue Cross, to perform certain administrative functions that the Secretary of Health, Education, and Welfare could delegate to them. In addition, my proposal includes a provision for an option under which beneficiaries could get the health benefits through private insurance, group practice, and other voluntary plans instead of the Government plan.

Now, I should like to discuss the amendment, and the considerations that prompted the new provisions, in some detail.

THE UNINSURED AGED

When I introduced S. 909 early last year, there were many assertions that the great majority of the low-income older people who are not insured under social security would get help through Kerr-Mills programs of medical assistance for the aged. But there has been little of the hoped-for progress in this direction. The Kerr-Mills provisions clearly do not and cannot assure that people who need help with the payment of their hospital bills will get it. This is particularly true in the poorer States, which have not been able to muster the resources to match the Federal grants that are provided by the Kerr-Mills legislation. It is now obvious that if the basic health benefit needs of many of those who are not eligible under social security are not met through a Federal program tied in with social security, these needs will not be met in any satisfactory manner, if at all.

It is estimated that by January 1964—the effective date of our proposed amendment—the total population aged 65 and over in the United States will be 17,877,000. Of this number, about 400,000, though not eligible for social security or railroad retirement protection, would have their health needs taken care of under various other governmental programs. This 400,000 includes retired Federal employees who have Government programs of health benefit protection available to them, and people who are cared for in public tuberculosis and mental institutions at public expense. This leaves approximately 17½ million people who are 65 and over, of which about 15 million would be eligible for health insurance under either the social security or railroad retirement program. Our proposal would provide coverage for the residual group of 2½ million, which includes uninsured persons on old-age assistance and other public welfare programs, widows whose husbands died before becoming insured, and persons who are without health insurance protection under other public programs.

PROTECTION FOR THE UNINSURED

Our proposed amendment provides to the residual group of 2½ million elderly people the same benefit protection that is provided those insured under the social security program and finances the protection for this group through general revenues. People who reach age 65 before 1967 and who do not meet the regular insured status requirements of the social security system would be deemed insured. Uninsured people who will reach age 65 in 1967 would be deemed to be insured for social security health benefits if they had earned as few as six quarters of coverage in covered work at any time—nine fewer quarters of coverage than men of this age need to qualify for social security retirement benefits and six fewer quarters of coverage than women of this age need to qualify for social security retirement benefits.

For people who reach age 65 in each of the succeeding years, the number of quarters of coverage needed to be insured for health insurance protection increases by 3 each year, thus, people reaching age 65 in 1968 would need 9 quarters of coverage, people reaching 65 in 1969 would need 12 quarters of coverage, and so on. For persons who attain age 65 after 1971 the special insurance status provisions for health insurance will require as many, or more, quarters of coverage as the regular insured status provisions for other social security benefits, so that for both men and women the new insured status provision will soon "wash out."

Under this special provision, people who are uninsured under the regular social secuirty program and who become 65 after 1966 will be able to qualify for health benefits only if they have had reasonably substantial work under social security. This would be consistent with the work-related and contributory principles of the social security system.

It might be noted that one-half of the 2½ million uninsured people who will be affected by this proposal are receiving cash assistance under the Federal-State assistance program. Of course, some of these assistance recipients will be receiving health care through the Federal-State assistance program when our proposed health benefit program goes into effect. In their case the benefits of our amendment would sometimes be in the nature of a partial substitute for the aid they would be getting. Thus the cost of providing the new insured status provision will be offset in part by reductions in current expenditures. In other cases, however, the Federal-State assistance program does not give protection comparable to the benefits I am proposing, and in those instances the result would be a net increase in medical care for the assistance recipients.

I might also point out that in the uninsured group which would receive protection paid for by the General Treasury, there are some who have had the opportunity to come under social security but have declined to do so. For example, there are ministers and certain employees of nonprofit organizations who elected not to be covered and some employees of State and local governments who voted not to be covered. Of course, the uninsured group also includes doctors and their wives and widows who have not been included under social security solely because the American Medical Association has opposed such coverage. For purposes of administrative simplicity, no attempt has been made to exclude these groups.

COST OF HEALTH BENEFITS FOR THE NONINSURED

As I indicated, the cost of the proposed health benefits for the 2½ million noninsured would be met out of general revenues. The gross cost of the provision would be $250 million in 1964, the year the health benefits program would go into effect. This calendar year cost would be offset by savings in Federal medical care expenditures in 1964 that except for the passage of our amendment would be made under public assistance and the veterans' programs. These

savings would be about $200 million, leaving a net cost of general revenues of about $50 million in 1964. Federal expenditures for the noninsured would decline over the years and eventually would wash out altogether.

SIGNIFICANT ADMINISTRATIVE ROLE FOR PRIVATE ORGANIZATIONS

Under the proposed amendment the Secretary of Health, Education, and Welfare would be given specific statutory authority to delegate some of the more sensitive administrative functions to Blue Cross or to other similar voluntary organizations that are experienced in dealing with hospitals and other providers of health services. Any group of hospitals—or group of other providers of health services—could designate a private organization of their own choice to receive their bills for services and to pay these bills. Advantageous additional administrative functions could be included in the contract between the Government and the organization. These administrative functions would include reviewing hospital fiscal records as a part of the determination of the cost of services, and acting as a center for communicating and interpreting payment procedures to hospitals.

I should point out that the representatives of the American Hospital Association appearing before the Committee on Ways and Means last summer urged an approach that would utilize the services of voluntary organizations if a bill of this type were to be enacted, and I am convinced from numerous conversations with individuals in the field of hospital administration that the provisions I am now outlining will prove to be eminently satisfactory to them. The principal advantage hospitals and other providers of services would find in this arrangement would be that policies and procedures of the Federal program would be applied by the same organization which administers the private, voluntary benefit program with which most of them now deal.

The participation of Blue Cross plans and similar expert organizations in carrying out the provisions of our proposed amendment would have advantages that go beyond the benefits that would be derived from their experience in dealing with hospitals and the well-established working relationships that exist. With such organizations serving as intermediaries between the Government and the prviders of services, those who are concerned that Government might try to intervene in hospital affairs would feel much more comfortable.

ROLE OF STATE AGENCIES

Under our proposal the Federal Government would use State agencies to determine whether hospitals which are not accredited by the Joint Commission on the Accreditation of Hospitals are qualified to participate in the program. State agencies would make these determinations also in the case of skilled nursing facilities and other providers of health services. The conditions of participation for such providers are spelled out in the amendment. State agencies would determine whether they are met. I am confident that all States would be willing and able to enter into agreements to assume these responsiiblities, just as they have participated in the administration of the disability portion of the OASDI program.

State health departments or other appropriate agencies designated by each State would also give professional consultation to providers of health services to assist them in meeting the conditions for participation and in establishing and maintaining necessary fiscal records and providing information necessary to derive operating costs which are the basis for payment for their services. State agencies would be reimbursed for the costs of activities they perform in the health insurance benefits program, including Federal sharing in the costs of coordinating these activities with other State activities related to health and medical services.

What is contemplated is a Federal-State relationship under which each governmental entity performs those functions for which it is best equipped and most appropriately suited. State governments license health facilities and State public health authorities generally supervise these facilities. In addition, State programs purchase care from providers of health services. On the basis of experience and function, State agencies should assist the Federal Government in determining which providers of health services conform to prescribed conditions. Furthermore, where an institution or organization that has not yet qualified needs consultative services in order to determine what steps may be appropriately taken to permit qualification, such consultative services should be furnished by the State health or other appropriate State agency. These types of consultative services are related to State programs and requirements and should logically be provided by, or coordinated in, the State agency.

CONDITIONS FOR PARTICIPATION

Many people in the health field, including public health officials of the States, hospital administrators and many physicians have applauded the intention—clearly reflected in S. 909—to be specific about any conditions that hospitals or other organizations would have to meet before they could participate in the proposed program. To make sure that the new program would not in any way undercut the efforts of the health professions and would not permit payment to obviously substandard institutions, the participation requirements of S. 909 were intended to parallel requirements of the health professions as they define and accredit institutions. The provision has been interpreted as possibly implying an authority to impose additional requirements beyond those necessary for accreditation. The amendment we are offering makes very explicit that such authority is not provided. The amendment limits requirements for participation so that they may not go beyond the professionally set and professionally accepted standards established for hospitals save for the requirement of a review committee, which I shall discuss further. The original bill clearly anticipated heavy reliance on agencies like the Joint Commission on the Accreditation of Hospitals. Now the amendment goes so far as to name the Commission and require use of its provisions and findings. The Joint Commission is composed of representatives of the American Medical Association, the American Hospital Association, the American College of Surgeons and the American College of Physicians. There is a provision in the proposed amendment that specifically provides that, with the one exception of the review committee, a hospital that is accredited by the Joint Commission would be conclusively presumed to meet the conditions for participation in the proposed social security health insurance plan. About 84 percent of the hospital beds in the country are in hospitals that are accredited by the Joint Commission.

REVIEW COMMITTEE

The unconditional opportunity to participate that is assured to accredited hospitals is subject to only one exception. This exception is that all hospitals would also have to maintain some mechanism of their own for reviewing whether patients who are beneficiaries are in need of hospital services. The thought behind the bill was that the hospital's medical staff should keep an eye on long-stay cases. When S. 909 was drafted, the Joint Commission was considering adding to its standards for accreditation the requirement that hospitals maintain a formal hospital committee to conduct such reviews; S. 909 was drafted to require that hospitals maintain such committees. It is not now clear that a review requirement added to accreditation standards would take this exact form. Therefore, a utilization review requirement has been developed in the proposed amendment that would be acceptable to the Joint Commission no matter what form of review is decided upon by that organization. When the Joint Commission decides on what form the utilization review mechanism should take in order to qualify a hospital as an accredited hospital, that same requirement could be accepted in the proposed program.

MAINTAIN CLINICAL RECORDS

Another requirement that S. 909 provided as a condition for participating in the proposed health insurance program was that hospitals maintain adequate medical records. There has been some misapprehension that this provision would give the Federal Government authority to decide what was adequate. Of course, what was intended was a requirement that would merely follow accepted practices—in other words, a requirement that would go no further than the practices that any good hospital would have in effect anyway. Nevertheless, to preclude any misapprehensions, the new language in the amendment we are offering would require merely that hospitals maintain clinical records for their inpatients. This is parallel to a requirement of the American Hospital Association that institutions satisfy before they can be recognized as hospitals by that association.

LIMITATIONS ON REQUIREMENTS TO BE SET BY SECRETARY

There has also been some misunderstanding of the provision of S. 909 that authorizes the Secretary of Health, Education, and Welfare to prescribe such additional conditions of participation as he may find necessary in the interests of health and safety. It has been said that this authority to prescribe conditions of health and safety would lead to Government control. The fact that the intent of the bill was that the Secretary would lean heavily on the Advisory Council, State agencies, and accrediting bodies like the Joint Commission on Accreditation of Hospitals, and that this intent was clearly expressed in the bill, was apparently not enough to overcome all fear of Government control. To clear up any doubts, the amendment contains explicit limits on the Secretary's authority. First, as I mentioned previously, accredited hospitals would be conclusively presumed to satisfy the conditions that the Secretary would prescribe in the interests of health and safety of patients. Insofar as unaccredited hospitals are concerned, my amendment would specifically provide that the Secretary's health and safety requirements could not exceed those prescribed by the Joint Commission on the Accreditation of Hospitals.

Some of my colleagues may have wondered why the professionally accepted standards for adequate hospital operations are not used exclusively, and why the Secretary is given any authority in this area. Of course, the reason for this authority is not that the administration—or anyone else for that matter—wants to impose new standards of adequacy on hospitals and take over the health profession's responsibilities. The reason that the proposed health insurance plan cannot rely solely on the professional standards is that they are set too high for some hospitals and some parts of the country. Absolute adherence to the accreditation standards would unreasonably deprive the residents of some localities of protection under the proposed program.

MAINTAINING QUALITY OF CARE

On the other hand, if the proposed health insurance plan were to operate without any standards at all, or with only token standards of eligibility, the health insurance payments that would be made could damage the continuing efforts of the health professions to improve the quality of hospital care available throughout the country. Even more significant is the need for quality protection in the case of nursing homes. It would be regrettable if poor quality care in nursing homes were to be sponsored by paying for health care in institutions whose environment is truly a threat to the lives of their patients.

Our amendment would strengthen the assurance that nursing home services covered by the proposal are of high quality. It would do this by requiring that nursing facilities may participate in the program only if they are affiliated with hospitals.

MANNER OF PAYMENTS

There is another important area where a health insurance program under social security can back up the efforts of the health professions to improve hospital care. There is no better way to lower a hospital's ability to give quality care than to put patients there and then not pay the hospital fully for the services they receive. And this is just exactly what is happening under our public assistance programs in various parts of the country. I am not surprised that a good many people are genuinely concerned that the same thing not be allowed to happen under the proposed health insurance program.

No question has been studied more intensively than the matter of reimbursing hospitals under a social security health insurance program. Our amendment would absolutely assure that, under the proposed health insurance plan, payment would be made for the full and reasonable cost of the services the bill would cover. In addition to the assurances given by the reimbursement provisions of S. 909, the proposed amendment would include a specific reference to the guides to be used to assure that reimbursement would be made for all the various items of cost, including indirect costs, of the services covered under the proposal. The amendment states specifically that the reimbursement policy to be followed in paying hospitals would be oriented to the principles of reimbursement by third parties laid down by the American Hospital Association.

DRUGS

In addition to the modifications I have mentioned, the amendment we are offering makes a technical change that would make doubly sure that the bill would not discourage the use of any drugs of therapeutic value. Under S. 909, hospital payments would have been made for any drug or biological that is listed on any one of the three major U.S. drug listings that have been developed by the drug industry and the medical profession. Since these drug listings are entirely under the control of the medical profession, and since new drugs and therapeutic value can be added to the listings at will, I do not see how Government reliance on these compendia would involve Government supervision or restriction of physicians' choice of drugs. Nevertheless, the proposed amendment will clear up any misunderstandings by providing that payment would be made under the proposed program for any drug not listed on one of the professional drug listings if the drug is acceptable to the drug or pharmacy committee of the hospital in which the drug is used.

MEDICAL TEACHING PROGRAMS

Another charge made against S. 909 is that under it the Secretary might make use of decisions of organizations unacceptable to the American Medical Association in determining whether an intern and resident is a student doctor and not a full-fledged staff member. I have modified the provision in question to state specifically that a hospital intern or resident who is a member of a teaching program that is approved by the Council on Medical Education and Hospitals of the American Medical Association would be officially determined to be a student for whom payment could be made under the amendment. Obviously this was the intent of S. 909.

In making the language abundantly clear, in a bill already characterized by a full spelling out of provisions, I believe that the proposed amendment will put an end to any real concern that the Blue Cross type insurance program we are proposing—for less than 10 percent of our population—will somehow lead to a program of socialized medicine. It will not—and the American Medical Association should stop worrying.

SERVICES COVERED

The basic insurance protection provided under our amendment—as under my bill, S. 909—includes four major benefits:

First. Payment would be made for inpatient hospital services for as many as 90 days of care during any single period of illness. The patient would be required to pay $10 a day of the cost of inpatient hospital care for up to 9 days during each benefit period, with the minimum payment being $20.

Second. Payment would be made for up to 180 days of skilled nursing home services for patients who transfer to a hospital-affiliated nursing home from a hospital.

Third. Home health services would be paid for when furnished by, or through, public or nonprofit agencies under a plan prescribed by a physician. Up to 240 home health services visits could be paid for during a calendar year. These services would include nursing care, physical, occupational, and speech therapy, medical supplies—other than drugs—appliances for temporary use, and certain part-time or intermittent homemaker services.

Fourth. Payments would be made for outpatient hospital diagnostic services of the kind customarily furnished by or through a hospital to its outpatients, with the patient being required to pay the first $20 of the cost of each diagnostic study.

DOCTORS' BILLS NOT COVERED

I want to emphasize that physicians' services would not be covered except for services of interns and residents-in-training under an approved teaching program, and except for hospital services provided by physicians in the fields of pathology, radiology, physical medicine, and anesthesiology where such physicians are in the employ of, or work under an arrangement with, the hospital.

HOSPITAL ORIENTED

Our proposal is focused on hospital services because an illness that necessitates hospitalization is usually the most costly. The medical expenses for aged people who are hospitalized are about five times greater than the medical bills of aged people who are not hospitalized. Furthermore, among the aged, hospitalization is very likely to occur. It is esti-

mated that 9 out of every 10 persons who reach age 65 will be hospitalized at least once before they die; 7 out of 10 will be hospitalized at least 2 times; and almost 4 out of 10 will be hospitalized at least 3 times. The aged group spend at least twice as many days per capita in general hospitals as the population as a whole.

One of the most significant features of the proposal is that it provides alternatives to inpatient hospital care. Provision has been made for payment for skilled nursing home care, home health care, and outpatient diagnostic studies in order to promote the most efficient and economical use of existing health care facilities. In providing for payment for these alternative services, the proposed program would reinforce the efforts of the health professions to reserve hospital beds for acute illnesses requiring intensive treatment that can be provided only in a hospital.

As already noted, our proposal would not cover surgical services and other physicians' services. I believe that protection against costs of doctors' fees should not be included in the Government-sponsored program. Payment of doctors' fees requires financial arrangements to which physicians are adamantly opposed. Moreover, since the financial base of our proposed program is, like the entire proposal, intentionally modest and conservative, it seems better to concentrate the funds on hospital costs rather than doctors' fees, which by tradition are adjusted to the means of the patient. Since only basic health insurance protection would be provided under the amendment, aged people can be expected to purchase private, supplementary insurance against the cost of surgical and other physicians' services.

FINANCING OF THE PROGRAM

The chief actuary of the Social Security Administration has assured me that the benefits of the proposal would be financed on a sound actuarial basis with cost calculations based on assumptions and methodology consistent with those used for the other elements of the OASDI program. The financing of both the cash benefits, including the higher ones that would result from raising the earnings base, and the new health benefits, would be accomplished by raising the maximum taxable earnings base to $5,200 per year and by an additional combined employer-employee tax of one-half of 1 percent.

The proposed health benefits would be financed by an allocation to the health insurance trust fund from the total social security tax receipts—an allocation equal to what a combined employer-employee tax of .68 percent would yield. Part of this—.50 percent—comes from the increase in the scheduled contribution rates in all future years. The remainder comes from the net gain resulting in the cash-benefits portion of the system from raising the earnings base from $4,800 to $5,200.

SEPARATE TRUST FUND

Under the bill I introduced last year, there would have been a health insurance account in the Federal social insurance trust fund. The trust fund would also have included special accounts for old-age and survivors insurance and for disability insurance. While I believe this arrangement would have been fully effective in segregating the moneys for the various benefits provided under social security, in the proposed amendment we have substituted provisions for a separate health insurance trust fund. We have made this change because some people believe that there would be merit in a separate trust fund for health insurance, and that there would be less danger of misunderstanding.

Of course, the payments for health services that would be made on behalf of those people who qualify for protection through the provisions for the uninsured would be made from general revenues. The trust fund and the rights of the social insurance beneficiaries would in no way be affected by these expenditures.

ROLE OF PRIVATE INSURANCE

I want to emphasize that under this proposal the role of private insurance would be an important one. The proposal is designed to meet only the most pressing health care costs of the aged, and, as in the case of the present program of old-age and survivors insurance benefits, beneficiaries can be expected to build on the basic health insurance protection. I think we have every right to expect that at least some of the money the aged now spend to meet hospital costs, through insurance, and otherwise, would be used to purchase insurance against the costs of the services of physicians and dentists, drugs, and the other health services and supplies not covered under the proposal. Also, I would expect that many aged people who now go without any health insurance protection because they cannot afford to safeguard themselves against the financial catastrophe of a serious illness would also obtain supplemental coverage from private sources once real security becomes possible. Certainly, with basic protection furnished under the Government program, employers will be encouraged to carry supplemental protection for their retired employees just as they have provided supplementary pensions. Private financing alone cannot do the job but it can do much to make retirement and health insurance protection in old age adequate when basic protection under social security is available. Our amendment makes clear the intention to encourage and facilitate supplementation by States, private insurance, or other methods.

So the administration is indeed proposing that Government and private insurance play complementary roles in meeting the need. The role of Government in the health insurance area, just as it is in the area of retirement income, would be to provide a guarantee of basic protection for the aged through the Nation's social insurance system, while the role of private insurance would be to build supplementary protection on this base. By working together—and not by competing with each other—Government and private insurance can make comprehensive and adequate protection a realistic possibility for all of the aged.

SUMMARY

Mr. President, I am convinced that the amendment we are offering for the consideration of the Senate offers a reasonable basis for agreement. The amendment would embody all of the great merit of the social security approach and at the same time provide meaningful assistance for the relatively few older people who are not now protected by the social insurance system. The proposal has strong safeguards against any possibility that Government would exert control over providers of services and established medical practices.

I take great pride in pointing to the large area of agreement that has been reached by those of us who sincerely seek a way by which much-needed protection against the cost of serious illness can be provided for our senior citizens. We believe we have demonstrated that we have offered a workable and satisfactory plan that will meet with widespread public approval. I urge all Senators who are seeking a way by which much-needed protection against the cost of serious illness can be provided for the aged to join in support of our proposal. If we are truly of goodwill, we can meet objections with fair and workable solutions; we can demonstrate to the American people our sincerity and good faith. There is no justification for further delay; we must not wait longer to provide an effective program of protection for the Nation's elderly people.

The final revision which was added as a result of many conferences provides an option to beneficiaries to continue private health insurance protection in order to encourage private health insurance supplementation. The plan is as follows:

First. At the time of first eligibility for social security, beneficiaries who for a period of time had private insurance protection under plans which include the same benefits as provided under social security would be able to choose between having the statutory benefit paid for directly by social security or, if they wish to continue the private plan, they could have the statutory benefits paid for through the private carrier.

Of course, those who did not elect to continue such a private plan could buy private policies completely separate from but supplementary to social security protection.

Second. Carriers would be reimbursed for the statutory benefits they paid for and for their administrative costs.

Third. The beneficiaries could elect to have their benefits paid by a private carrier only if they have had the required plan in effect for a period before they become entitled to health benefits under social security. The required period of prior insurance would be brief at first, to allow for a change in private plans and then gradually lengthen until 5 years of previous membership is ultimately required. The required period of membership would be 3 months for persons entitled when the plan goes into effect on January 1, 1964, and would remain at 3 months until the end of March 1964. From then until the end of 1968 it would

require continuous membership from January 1, 1964, until entitlement. After 1968, 5 years would be required.

Fourth. Any carrier would be approved to participate for its group health insurance plans and all nonprofit plans would be approved. To participate for individual policies a commercial carrier would need to be licensed in all States and doing 1 percent of the health insurance business throughout the Nation, or is found by the Secretary to be national in scope. As an alternative it could be approved for a particular State if it did 10 percent of the business in that State.

That, I feel, makes the package complete and strengthens my hope that the Senate will take the forward step of approving this amendment.

Finally, I compliment the Secretary of Health, Education, and Welfare, Mr. Ribicoff, for the amount of time he has personally devoted to working out a satisfactory solution to some of our problems. Solutions were not easy to accomplish. A great deal of work was required to make sure that the proposals could be properly administered under the law. I wish to compliment Mr. Ribicoff for the fine job he has done.

Mr. McNAMARA. Mr. President, I ask unanimous consent that all staff members of the Committee on Aging be permitted access to the floor until the Senate has concluded its deliberations concerning H.R. 10606.

The PRESIDING OFFICER. Without objection, it is so ordered.

PUBLIC WELFARE AMENDMENTS OF 1962

Mr. METCALF. Mr. President, I ask that the Chair lay before the Senate the unfinished business.

The PRESIDING OFFICER. The Chair lays before the Senate the unfinished business, which will be stated by title.

The LEGISLATIVE CLERK. A bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

The PRESIDING OFFICER. The bill is open to amendment.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. MOSS. Mr. President, on Tuesday of this week, I proposed an amendment to this bill, and the amendment was debated at some length. Because of factors which then existed, I agreed to withdraw my amendment then, and reserved the right to call it up today.

I ask that my amendment, which was discussed at some length on Tuesday, now be called up and read.

The PRESIDING OFFICER. The amendment will be read.

The LEGISLATIVE CLERK. On page 70, between lines 17 and 18, it is proposed to insert the following:

(f) The increase in the Federal share of public assistance payments provided for in this section shall be paid to the States only upon the condition that the money payments received by recipients of old-age assistance, aid to the blind, and aid to the permanently and totally disabled shall be increased by the full amount of the increase in the Federal share.

Mr. MANSFIELD. Mr. President, if the Senator from Utah will yield, I should like to suggest the absence of a quorum.

Mr. MOSS. I yield for that purpose.

Mr. MANSFIELD. Then, Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MOSS. Mr. President, at page 11792 of the RECORD of the Senate proceedings for Tuesday, July 3, appears the brief wording of the amendment which we are now considering, together with the remarks I made at that time.

There was a colloquy among Senators at that time, including a discussion of the amendment by the senior Senator from Oklahoma [Mr. KERR], who is handling the bill on the floor. At that time the Senator from Oklahoma was in opposition to the amendment, and I think stated fully the reasons for his opposition. I stated my reasons fully at that time.

This amendment simply provides that any increase in the amount of Federal money granted for welfare in the classes of blind and disabled persons shall be passed on to the recipient at the end of the line, rather than be deflected or diverted or absorbed in any way by the State.

I think such a provision is of considerable importance because of the feeling of the people who are receiving this sort of aid that they have been betrayed when such benefits have not been passed on to them. I think when there has been a reason for Federal action increasing the amount of such support, certainly it should go to the recipient.

I have no reason to discuss the amendment in any more detail at the present time, and I ask for a vote on my amendment.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Utah.

The amendment was rejected.

Mr. MOSS. Mr. President, I send to the desk amendments which I call up at this time and ask to have stated. They are the same as the amendment the Senator from Indiana [Mr. HARTKE] had prepared. However, the measure has been slightly amended to refer to the proper page and paragraph designations.

The PRESIDING OFFICER. The amendments offered by the Senator from Utah will be stated.

The CHIEF CLERK. It is proposed, on page 78, line 9, to strike out "and".

On page 78, line 13, to insert ", and (C) the ability of such individual's family or relatives to provide for his support" after "plan".

On page 100, between lines 15 and 16, to insert the following:

ABILITY OF FAMILY OR RELATIVES TO PROVIDE SUPPORT TO BE DISREGARDED IN DETERMINING NEED OF INDIVIDUAL FOR AID TO THE BLIND

SEC. 156. Effective July 1, 1963, section 1002(a)(8) of the Social Security Act is amended to read as follows: "(8) provide that the State agency shall, in determining need, take into consideration any other income and resources of the individual claiming aid to the blind as well as any expenses reasonably attributable to the earning of such income; except that, in making such determination, the State agency shall disregard (A) the first $85 per month of earned income plus one-half of earned income in excess of $85 per month, and (B) the ability of such individual's family or relatives to provide for his support;".

Mr. MOSS. Mr. President, my amendment would amend H.R. 10606 to abolish the legally enforceable obligation of a relative to contribute to the support of a person who is blind. This amendment is strongly desired by the National Federation for the Blind.

At present, State laws require, under the penalty of legal action, that family members must contribute to the support of a needy blind person. A blind person's family is fully investigated, and a decision is made as to how much the family can afford to contribute to his support. This amount is then deducted from the benefits the blind person receives under the program in his State, and he becomes a dependent ward of his family, living with them.

The average payment to a needy blind recipient in this country is $76.35. Therefore, should it be found that a family can contribute $20 toward the support of a blind member in a State where the payment is about average, the payment the blind person would receive would be about $55.

Now on the face of it this seems fair. But in many families where the blind can be classified as needy, the family itself is on the narrow edge of need. To pull out of their meager resources enough money to support the blind member of the family—a perpetually nonproducing member—is not only a genuine hardship, but sooner or later begins to cause resentment. The blind member feeling and hearing the resentment he cannot see, knows he is a burden and a drain on family finances needed for others who do have a future.

If a family is unwilling to take on a measure of support for the blind member, and has been forced to do so, the strain is even greater. The blind member feels he is not only a burden, but unwanted.

In either instance, an atmosphere of bitterness and strife often develops—bitterness which deeply affects a person made more sensitive than most because of his affliction.

Today, every effort is being made to encourage the blind to rehabilitate themselves. We have developed splendid programs to help them. We have all been touched and inspired by the sight of a blind person making his own way about town, going to a place of business, doing a job. We all know that the blind, with resolution and proper training, can learn to take care of themselves and can take their place in society.

To do so, however—to make the break from their world of darkness and dependency—the blind need an atmosphere of harmony and encouragement. To rehabilitate himself, the blind person must put forth intense personal effort. He must have incentive and understanding. He must have peace of mind and harmony about him. This he cannot find in a household filled with resentment against him, and with strife and bitterness over his plight.

We are told that many of the more than 100,000 needy blind covered by the provisions of this bill are eager to rehabilitate themselves. They have the initiative and ability—they need only the independence the passage of this amendment would give them to start them down the path toward rehabilitation and self-support. It is evident that the federally supported programs we have established are hindering as well as helping them—I feel they must be adjusted so they are as modern and progressive as the blind themselves.

The amendment I am offering is in character with the trend in welfare legislation. In 1956, for example, the purpose of the amendments the Congress added to the public assistance sections of the Social Security Act was stated as follows:

To promote the well-being of the Nation by encouraging the States to place greater emphasis on helping to strengthen family life and helping needy families and individuals attain the maximum economic and personal independence of which they are capable.

In the bill before us, both the House and Senate reports state similar objectives. The House bill states:

The new approach embodied in the bill places emphasis on the provisions of service to help families become self-supporting rather than dependent on welfare checks. The bill would make it possible for the States to provide incentives to the recipients of public assistance to improve their condition so as to render continued public assistance for such persons unnecessary. This approach accords due recognition to rehabilitation of recipients so as to restore them as useful, productive individuals, and assist them to become self-supporting, independent and able to take care of themselves.

The Senate report has similar language.

I realize that many people feel very strongly about filial and family responsibility and I anticipate that some of the Members of this body may hesitate to write it off even in the case of the blind. The Department of Health, Education, and Welfare has issued a very interesting study on "Filial Responsibility in the Modern American Family." Though it deals primarily with the responsibility of adult children to their aged parents, many of its conclusions are applicable to the situation we are discussing today.

It shows that filial support policies vary from State to State, both in rigor and in methods of application. Some States require a contribution by law or policy, but do not make assistance contingent on contribution. In general, children living outside a State are not obliged to contribute to their parents, but they are encouraged to support them. Various scales of support are used in various States.

Now let me quote some pertinent comments from the study:

Most administrators agree, regardless of their position on requiring filial support, that it is difficult and painful to administer * * * (and that) many parents resist the requirement and adult children resent it. The legislator enacting filial responsibility envisions a wealthy son whose father ekes out a desperate living on old-age assistance. But caseworkers and administrators see a different picture. Though income scales help to achieve a degree of equality, their application in varying situations and to families whose filial feeling may range from love to hatred may easily seem unjust to parent or child, client or caseworker. If in the end the agency must have recourse to the courts, prosecutors and judges are reluctant to bring these cases to trial. Even then, it frequently turns out that the child does not contribute the specified sum and the entire procedure begins again.

I would point out that such procedures are not unknown in the case of a family which is reluctant to contribute to the support of a blind person, either because of the strain on finances, or because of lack of a feeling of responsibility. What is the impact on the blind person?

This is brought out in another paragraph dealing again with filial responsibility to parents, but applicable in the case we are discussing:

We are left with the question of the effects of filial requirements on families. In a sense, this is the crucial question. At come expense of equity and of feelings, both clients and administrators, there is a net savings in enforcing filial support; opinions divide on whether it is worth while. The question that remains is, "what is the human cost of the saving?" * * *(There are) three kinds of human cost: The perpetuation of poverty, the substitution of enforcement for incentive, and the domination of family arrangements by considerations that are secondary, and often inimical to family cohesion.

Another question which undoubtedly would be raised is that of the saving of tax funds by requiring a family to assume either in full or part the care of a member who cannot support himself.

Again, I quote from the HEW study:

If one examines the caseloads of the States that require filial support, they turn out to be markedly lower than the States that do not. As these tend to be the wealthier States that would in any case have lower caseloads, however, the savings is only in part a result of filial support. Among people receiving assistance, through exploration of filial support does not usually, in agency experience, produce a great deal more than is already being contributed. It appears that the savings might be balanced by the cost of administration.

This would apply, perhaps in a lesser degree, to the investigations necessary to decide whether the family of a blind person can contribute to his support, and how much.

I could continue to quote at length from the HEW study, but the gist of the discussion seems to be that there are some serious doubts among welfare administrators and social workers about the wisdom and effectiveness of forcing filial or family support, and also about the extent to which tax funds are saved in the process. I certainly do not want to indicate here that I feel families who are able should not shoulder responsibilities they can well carry, nor do I want to indicate that I do not believe children should care for their aged parents, nor that families with blind members should care for them if they are able, and care for them with good will and understanding. But I feel we must recognize the fact that when such care is forced on those who feel they are not able to shoulder it, or who are unwilling to shoulder it, the recipient of the aid can be made to suffer cruelly.

Mr. President, I believe that in the case of the blind we should consider them first—consider them before we consider welfare policies and tax loads.

I feel we must not doom the blind person by laws which force him to be dependent on his relatives and his family. Rehabilitation starts not with skilled personnel, not with training facilities—but it starts with the person himself. He must believe in himself, and he must have help in gaining in this belief. If he cannot get the inspiration he needs from his family, then he must be freed from dependence on that family so he can go where he can get inspiration and help. With independence, he may succeed in rehabilitating himself; without it he may sit, helpless and crushed, in a chair for the rest of his life.

I ask that the amendment be agreed to.

Mr. RANDOLPH. Mr. President, will my colleague yield?

Mr. MOSS. I am happy to yield to my colleague from West Virginia.

Mr. RANDOLPH. I shall not discuss the amendment which has been offered. It has had, and will have, discussion by proponents and opponents. I followed the RECORD earlier this week in connection with this subject matter. My support will be given to the amendment as offered by the Senator from Utah. It was my privilege to join with Senator HARTKE early in the first session of this Congress and sponsor a measure to amend title X of the Social Security Act. It provided that consideration with respect to the ability of the family or relatives of a blind individual to provide for his support shall be disregarded in determining his need for aid to the blind under State programs established pursuant to such title.

When we consider the independence of this group of our citizens, it is important to realize that there are approximately 400,000 blind persons in the United States of America. From this reservoir of blind people have come those individuals who have had not only the aptitudes but also the attitudes which have been very important in regard to certain work programs. This has been true particularly with respect to one notable effort to which I invite our attention.

The Vending Stand Act of 1936 provided the way, as it were, for blind persons who could meet certain requirements, who could be trained. The act provided for operation of those small business units.

In fiscal year 1961 there were 2,332 blind persons who were conducting these small business units in Federal and non-Federal buildings, as well as parks and forest throughout the United States.

In the fiscal year 1961 those men and women did a gross business of more than $42 million. They netted to themselves in excess of $8 million. I mention that program, which was enacted in 1936, as one of the very intelligent activities by which the blind of the United States have been able to reach a status of independence, dignity, and ability to contribute to personal and community responsibilities rather than to be recipients of charity. I express my appreciation to that segment of blind people in the United States. For the benefit of the 400,000 blind citizens in our country, we need to develop, at this time, additional programs of the type which I have mentioned.

Mr. MOSS. I thank the distinguished Senator from West Virginia for his timely comments. Certainly much has been done in that area. I think we have all been inspired to see the blind obtain a degree of initiative in providing for themselves. It has been inspiring to see the self-respect that their work brings to them, in strong contrast to sitting as a defeated burden upon family or friends. The blind person who has initiative may move out and grow for himself. He thereby grows in his own self-respect and the respect of the members of the community.

The amendment about which we are speaking would merely eliminate the condition that may arise, and sometimes does arise, in which a deep internal conflict develops within a family group because of the requirement of the law for a contribution in cases in which the family, for one reason or another, justified or not, does not feel that it should be imposed upon by the person who is handicapped by blindness.

The amendment would require that the family not be required by law to make a contribution to a person, or that his blind aid be decreased by any amount that legally should be contributed by the family. The amendment would give a blind person a sense of independence.

I repeat that I do not at all negate the idea that family responsibility should voluntarily motivate a family to want to help any member of the family. That should be done, and will be done in a great many cases, regardless of what the law is. I am thinking of cases in which, for one reason or another, that feeling of responsibility does not exist. In such cases the entire weight of oppression falls on the shoulders of the blind person, who is already handicapped and working against a very great handicap. That oppression should not be inflicted upon him. The amount about which we are talking is not great. Therefore I hope that the amendment will be agreed to.

Mr. KERR. Mr. President, will the Senator yield?

Mr. MOSS. I am happy to yield.

Mr. KERR. Does the Senator know the extent to which his amendment would change the present law?

Mr. MOSS. It would change the existing law only to the degree that an immediate member of the family would not be required to support a blind person who is receiving financial aid.

Mr. KERR. Is there any such Federal law at present?

Mr. MOSS. I am not sure of the extent to which there is a Federal law. I know that many States have such a law. We are talking about the money contributed.

Mr. KERR. Will the Senator advise the Senator from Oklahoma which State has a law that requires a relative of a blind person to support the blind person?

Mr. MOSS. I am not sure that I have that information available. I do not have the reference, except that, from my acquaintance with the welfare laws of my own State, I know that there is a requirement of a family contribution. I have been informed that such is also true in a great many other States.

Mr. KERR. In the knowledge of the Senator from Oklahoma, such is not the case. There are States which have laws that declare that the ability of sons and daughters to support the blind shall be taken into consideration in determining aid to the blind. If I correctly understand the amendment of the Senator from Utah, it is intended to prevent States from requiring that a relative of a blind person should support that blind person. If I correctly understand the Senator's amendment, it would say to a State, "You cannot, by your own State law, have a program which would take into account the ability of a relative to support a blind person."

As I understand the Senator's amendment, it would prevent a State from exercising its right to require a person to support a blind relative. The Senator's amendment would deny to a State the right, under its laws, to take into account the ability of a relative of a blind person to support that person.

Mr. MOSS. In general the Senator is correct.

Mr. KERR. The Senator has said that my statement is correct in general. Will he specify in what manner it is not correct?

Mr. MOSS. Under the Federal funds made available in the bill to a State it would not be permissible to decrease the allocation of the amount a blind person would receive based upon any study of the State or any finding of the State that the family, or some relative, could contribute in part.

In other words, the benefit would not go in different amounts to different people based upon the family circumstances and relief. There are areas of friction in which a family feels it has been imposed upon, and therefore makes the blind person feel that he is a drain and a burden upon the family. The amendment would be an attempt to restore the self-confidence of that blind person.

Mr. KERR. The amendment of the Senator from Utah would go far beyond that point. His amendment would compel a State to disregard the fact that the blind person had a relative who wanted to help to support him and was doing so.

Mr. MOSS. I do not think the amendment would go that far.

Mr. KERR. The Senator should read his own amendment.

Mr. MOSS. No relative would ever be inhibited in helping in a case in which he wanted to help. But the State would be inhibited from taking that fact into consideration and thereby decreasing the amount that would otherwise come to a blind person.

Mr. KERR. The Senator is entirely correct in his last statement. Even though a relative might be very wealthy and was making abundant provision for a blind relative, the Senator's amendment would require the same payments to that blind person as he would receive if he had no relative making independent arrangements for his support.

Mr. MOSS. That is quite true. It would be available for him.

Mr. KERR. I do not believe the Senator would wish to urge that amendment.

Mr. MOSS. I certainly do urge the amendment.

Mr. KERR. As the Senator sets forth in his amendment, the law with reference to aid to the blind is the most liberal of any assistance program we now have. The law now is that the first $85 a month of earned income is disregarded, in determining how much assistance shall be given to a blind person.

The law now requires that one-half of what a blind person earns above $85 a month be not taken into account in determining how much he shall receive from the State program. The Senator would provide that even though the blind person himself were making $85 a month, which is disregarded, and another $100 a month, being one-half of another $200 a month, which is also disregarded, would compel the State to disregard the fact that an independent, wealthy relative of the blind person was making a provision for the blind person in addition to what he was earning himself; and to contribute to him as though he were not receiving such contribution from his well-to-do or wealthy relative.

Mr. MOSS. I quote again, as I did before, from the report of the Department of Health, Education, and Welfare:

> The legislator enacting filial responsibility envisions a wealthy son whose father ekes out a desperate living on old-age assistance. But caseworkers and administrators see a different picture, as we shall observe.

Then it discusses that situation. Of course, there may be a situation of the kind the Senator points out. It might be that a wealthy family had a blind member. Nevertheless, a large number of these cases fall into the marginal area, where the administrator may have reason to say that the family can give a certain amount of support and where the family does not believe it can. In that way we get into an area where a blind person is made to feel the brunt of the conflict, and to feel the depressing effect of the situation, in that he feels as though he is a complete burden on the family and is unwanted, and, as a result, does not have the stimulus that we say we want to give blind people.

Mr. KERR. As the Senator knows, there is another amendment in the bill which provides:

In determining need for aid to the blind, a State shall, in addition to presented exempted amounts ($85 a month in earnings plus one-half of the balance) exempt such other amounts of income or resources as may be necessary to fulfill a State-approved rehabilitation plan for a blind individual.

In other words, the bill contains an amendment which directs the State to disregard any income, just as the Senator would say, with reference to a wealthy or poor relative that may be necessary to make the blind person completely self-sustaining under a plan approved by his State.

Mr. MOSS. That is a very salutary provision. However, this would apply not only to the blind person who has an income but also to one who has an income and receives aid. In other words he would receive aid, and there could be no writeoff against the family.

I ask for a vote on the amendment.

The PRESIDING OFFICER. The question is on agreeing to the amendment offered by the Senator from Utah [Mr. Moss].

The amendment was rejected.

Mr. KERR. Mr. President, I move that the Senate reconsider the vote by which the amendment was rejected.

Mr. DIRKSEN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

PROPOSED UNANIMOUS-CONSENT AGREEMENT

Mr. MANSFIELD. Mr. President, I send to the desk a unanimous-consent request and ask that it be considered.

The PRESIDING OFFICER. The proposed unanimous-consent agreement will be read.

The legislative clerk read the proposed unanimous-consent agreement as follows:

Ordered immediately, That, during the further consideration of H.R. 10606, the public assistance and welfare bill, with the exception of the so-called Anderson and other Senators' amendments, hereinafter referred to, debate on any amendment, motion, or appeal, except a motion to lay on the table, shall be limited to one hour, to be equally divided and controlled by the mover of any such amendment and the majority leader: *Provided,* That in the event the majority leader is in favor of such amendment the time in opposition thereto shall be controlled by the minority leader.

Provided; That on the Anderson and other Senators' amendment to the said bill, debate on any amendment, motion, or appeal relating thereto, shall be limited to six hours, to be equally divided and controlled as above indicated: *Provided,* That on any amendment proposed thereto or motion relating thereto, debate shall be limited to one hour equally divided and controlled by the mover of any such amendment and Mr. Anderson, if he is opposed to any such amendment or motion, and that in the event he is favorable to such motion or amendment, debate in opposition thereto shall be controlled by the minority leader: *Provided further,* That no amendment that is not germane to the provisions of the bill or the Anderson and other Senators' amendment shall be received.

Ordered further, That on the question of the final passage of the said bill debate shall be limited to six hours, to be equally divided and controlled, respectively, by the majority and minority leaders: *Provided,* That the said leaders, or either of them, may, from the time under their control on the passage of the said bill, allot additional time to any Senator during the consideration of any amendment, motion, or appeal.

The PRESIDING OFFICER. Is there objection?

Mr. MANSFIELD. It had been anticipated by the majority leader that the unanimous-consent request would be made prior to the final disposal of the honeybee bill. I hope there will be no objection to the proposal at this time, so that we may be in a position of assuring Members of what the status of the bill and amendments thereto will be for the rest of the week and possibly next week.

Mr. DIRKSEN. Mr. President, the majority leader has always been so obliging and he has always been so reasonable in his requests, that I often find it difficult to object.

However, I point out that we will be considering here a matter that has not been considered by the Finance Committee, which ordinarily would have jurisdiction in the matter; that we are considering a matter of such great import to the country and so permanent in its impact, and of a dimension that is scarcely appreciated by the membership at the moment, that I feel a maximum amount of discussion must develop on the Senate floor in every aspect of the proposal. Therefore, reluctant as I am, I feel constrained to and I must object.

The PRESIDING OFFICER. Objection is heard.

SOCIAL SECURITY FINANCING OF HEALTH COSTS

Mr. LONG of Hawaii. Mr. President, while we are hammering out a bill to provide health benefits for the aged which will be acceptable to the House as well as to the Senate, we will undoubtedly be faced with a variety of proposals all necessarily complex in their technical details. Because this is a complex and technical piece of legislation, the basic differences in philosophy of the alternatives proposed may not be immediately clear. I would like, therefore, to share my philosophy—the yardstick I shall use in determining whether a specific proposal measures up to my requirements of a program of health benefits financed through social security.

During this past year of serious debate over the issue of health care for the aged, one significant fact has emerged: There is now almost unanimous agreement that the problem is of such dimensions that only social security financing can provide the solution.

The AMA remains almost the lone holdout, still fighting a desperate rear guard attack, confusing the issue with indiscriminate labels of "too much" and "too little." Some of its members warn of strikes against the patient who uses social security benefits to pay for his hospital bills and of reprisals for any doctors who deviate from the official line.

First, the AMA objected to the King-Anderson bill because it excluded 3 million people—including the most needy—from coverage. Now we are considering legislation which will bring those 3 million under the program. They are now saying: "It's just an expanded version of King-Anderson." Many members of this body question the sincerity of the AMA. "We're damned if we do, and damned if we don't."

The first 6 months of 1962 have witnessed a number of impressive conversions to the principle of social security financing—conversions that give hope that the breakthrough of legislative action is near.

The year 1962 was barely underway before important developments took place. On January 4, Blue Cross Association and the American Hospital Association announced they would work out a national Blue Cross program for the aged, which involved governmental financial assistance, and that the method to be used by the Government in financing this program was "of secondary importance"—in other words, the social security financing mechanism could be used provided the plan was administered by Blue Cross. Significantly, the social security financing method, although long and vehemently opposed by organized medicine, had suddenly become acceptable to the one group directly involved in the administration's health insurance proposal—the hospitals.

On January 11, Senator JAVITS introduced his compromise bill to provide health insurance for the aged through social security financing, a radical departure from his earlier proposals based on general revenue financing.

Still another significant convert to the social security method was Representative KEITH, Republican, of Massachusetts, who said "from the viewpoint of a professional insurance underwriter and a proven conservative," called the social security financing "the true conservative approach to a problem we can no longer ignore."

And to list one more—Senator BUSH on June 27 introduced a bill, based on his dual conclusions that "there is a need for Federal action in this field which extends beyond the Kerr-Mills legislation," and that the "social security system provides an acceptable method of financing such a Federal program."

On June 20 Senator PAT MCNAMARA, chairman of the Senate Special Committee on Aging, released a staff report that assembles an impressive array of evidence leading inevitably to the finding that Kerr-Mills—by itself—cannot be expected to meet the medical requirements of America's elderly people "either now or in the years to come," and that a program of hospital and related insurance benefits under social security is also needed to "provide the broad base of financial assistance that would help assure older Americans independence, dignity, and security in their retirement."

These are some of the developments of recent months that indicate the spreading conviction that use of the social security financing method is an absolute necessity in handling this problem.

But there is less conviction—in fact, there is still considerable confusion—about the obligations to the contributors that accompany the use of this financing method—the guarantees of benefits that are essential when we use the social se-

curity mechanism to collect a compulsory payroll tax in return for a future promise of benefits.

As a longtime and wholehearted advocate of the social security financing principle, I believe strongly that use of this financing method involves certain commitments to beneficiaries, now and in the future. There are four commitments basic in measuring the appropriateness of the specifications of any legislative proposal which is based on the social security principle.

First—and I think this is almost too obvious to need saying—there must be no needs test or income test for persons who are beneficiaries under social security. Such a test, no matter how liberal, is irreconcilable with the principle that social insurance benefits are an earned right. Why should workers help to finance, through their social security taxes, a benefit for which they will be ineligible if their retirement income exceeds some limit? Why should they accumulate other sources of retirement income if this would make them ineligible for the health benefits?

Because I believe so strongly that an income test is incompatible with the social security financing method, I was delighted to see that Senator JAVITS amended his earlier proposal, initially introduced in January, to eliminate the income test for those eligible for social security benefits.

Second. The health benefits must be available to everyone who meets the tests of eligibility whether these are tests of insured status under the social security system or whether the tests go beyond—as I believe they should—to encompass other aged persons. This means that there must be a Government plan to guarantee the benefits. There must be no chance that anyone, no matter how poor his health, is excluded from the benefits completely, or that there are exclusions of preexisting conditions. No one should be ruled ineligible on the basis of a technicality or failure to comply with some routine regulation. Attainment of this objective requires a Government plan which excludes no one—no matter how bad a risk. And in order that the Government plan should not be left with all the bad risks while private insurance "creams off" the better risks, the Government plan would have to be an exclusive plan, or at the minimum, protected through carefully drawn safeguards.

This yardstick would, of course, rule out completely proposals which leave the entire job to private insurance, such as those put forth by Senator BUSH and by Congressman BOW and the sponsors of similar bills.

In this connection, I would call attention to the fact that Senator BUSH, in introducing his proposal, stated that it was estimated that 12.2 million persons "would take advantage" of the proposal in 1963. There would be at least 14½ million people who would meet the eligibility qualifications of his proposal in 1963—that is, who would be 65 or over and eligible for social security or railroad retirement benefits. It is hard to conceive of anyone eligible who would not wish to take the offer of $108 toward the purchase of health insurance. Does this mean then that the other 2⅓ million persons would be unacceptable to the insurance carriers? Is this what is meant by not "taking advantage" of the proposal?

Any proposal that collects compulsory contributions over the working years and leaves to the small print of a health insurance policy the determination of whether the individual is eligible at all—or for what he is eligible—is completely unacceptable under my standards.

Third, the plan should provide a guarantee of specified services—a meaningful guarantee based on assurance of payment in full for the services included.

Only in this way can the health benefits be truly paid up in advance of old age. This rules out all plans that merely offer the meaningless promise of cash indemnity toward unspecified, uncertain, and constantly rising fees and charges—fees and charges that can, in fact, be expected to rise ever higher since the providers of medical services are left free to increase their costs because of the existence of the insurance.

It is completely unreasonable to expect the worker to pay contributions over his working lifetime—perhaps as long as 30 or 40 years—only to find that the cash indemnity health insurance policy he has been purchasing is virtually worthless when he is ready to collect.

In specifying that service benefits are an essential element of a health insurance program financed through social security, I recognize that I lay myself open to the counterargument that the cash benefits to be paid on retirement after 30 or 40 years of contributions may also be depreciated in value. I would only point out parenthetically that these benefits are related to wage levels and the problem is not the same.

Fourth, social security contributions should not be used to pay profits to private insurance companies, thus spending large amounts which have been collected compulsorily without buying protection. During 1960, commercial insurance companies returned only 53 cents on benefits for every dollar they collected for individual health policies.

The social security mechanism provides an economical method of collecting contributions for health benefits on a group basis. These contributions should not be squandered on health insurance premiums, heavily weighted by profits and overhead and determined on an individual rather than a group basis.

These are the four criteria—the four yardsticks—I would use in assessing the acceptability of any proposal for health benefits based on the principle of financing through the social security system.

I firmly believe that the social security system is the only method through which older people can be relieved of the burden—and the fear—of rising and unpredictable health costs. It is only through our social security system that workers can provide for themselves, as a group and at a rate they can afford to pay, health insurance that is paid up prior to old age.

Fortunately, we have now reached a point in our history where these beliefs—these convictions—are widely shared. It is time now to move on to put our principles into operation—to expand our social security program by providing protection against the most essential health costs of the aged. In so doing, let us be ever mindful of the obligations placed upon us when we use the social security mechanism of financing. Let there be no dilution of our commitments to future beneficiaries, no deviation from our basic principles.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. McNAMARA. Mr. President, the amendment for health insurance for the elderly now before the Senate has been referred to as a compromise.

However, I am pleased to note that the new proposal is in many respects a significant improvement over the original King-Anderson bill.

I had supported that bill as a reasonable base on which to start building adequate protection for our older citizens against the heavy medical costs of their later years.

With one major exception, I am even more pleased to support this new proposal.

Particularly gratfiying is that a number of the improvements bring the proposal closer to my own bill —S. 65— which was introduce on January 4, 1961.

I say this not out of any pride of authorship, but because S. 65 had been carefully worked out to meet the basic needs of the elderly and to meet some of the arguments that have since plagued the King-Anderson bill.

Both bills provided for health insurance coverage for those eligible for social security to be financed through social security contributions.

However, we went further in S. 65 to include also the several million elderly individuals who did not have social security protection.

The new Anderson proposal now before the Senate, I am happy to note, would include those persons not now eligible for social security.

This is a most significant step forward, not only because this group includes many of the people most in need of health protection, but also because it meets one of the most telling objections to the King-Anderson bill which has been raised by the AMA and other opponents.

I sometimes feel that this argument, when raised by the AMA, somehow lacked the full ring of sincerity. Nevertheless, it was an argument that even many of the proponents felt was legitimate.

As in my bill, the costs of providing the protection for persons not eligible through social security would be met through general revenues. There would be no means test.

The inclusion of the noninsured aged is, I believe, the only way in which the States can be relieved of the almost intolerable financial burden of providing public assistance medical care for large numbers of needy aged persons.

Relieved of this burden, the States should be able to move ahead rapidly and on a sound financial basis to provide adequate medical care for those of the needy aged who may have medical costs beyond those met by the new program.

Recently the Senate Special Committee on Aging received a staff report entitled: "Performance of the States—18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program."

In the introduction to that report, I stated:

> A program of hospital and related insurance benefits under social security should make it financially feasible for all the States to implement the Kerr-Mills MAA program. The two programs together would provide the broad base of financial assistance that would help assure older Americans independence, dignity, and security in their retirement.

I am pleased to see that the Anderson amendment also incorporates provisions like those in my bill for a separate trust fund for the health benefits and for the use of public agencies and nonprofit organizations for appropriate tasks.

Mr. MORSE. Mr. President, will the Senator from Michigan yield?

Mr. McNAMARA. I yield to the Senator from Oregon.

Mr. MORSE. I should like to emphasize that it was the distinguished senior Senator from Michigan who took the lead—and many of us were pleased and proud to support him—in proposing that these funds should be set up as a separate health trust fund, separate and distinct from the rest of the social security funds. I think that is a very important improvement in the bill.

Mr. McNAMARA. I think the Senator from Oregon for his generous remark.

The new Anderson proposal before the Senate does continue a feature of the King-Anderson bill which is not included in S. 65 and which I still find objectionable.

This is the so-called deductible feature, under which the individual must first make some basic payments for health care provided before he is entitled to benefits under the proposed law.

While I can appreciate the reasons why this feature is included, I hope that in the years ahead it will be possible further to improve the basic program by eliminating such features.

Mr. MORSE. Mr. President, will the Senator from Michigan yield?

Mr. McNAMARA. I yield.

Mr. MORSE. I join with the Senator from Michigan in his criticism of the provision of the King-Anderson bill which requires an initial $90 payment to be made by the recipient. I shall offer an amendment to the bill during the course of the debate which will seek to eliminate the $90 payment. I think we ought to start to make our fight against that provision this year. I hope that my amendment will be adopted. In my judgment, this provision of the bill is not justifiable. A sound social security principle or policy ought to be adopted in connection with the medicare bill. I think the total cost should be paid out of the insurance fund, not out of the pockets of the aged.

It is said by some persons that the $90 initial payment will not be a great handicap to those who need medical care, but, in my judgment, it will be a serious handicap to thousands of persons. It will cause many aged persons to postpone, postpone, and postpone even getting a diagnosis. In my judgment, such a requirement will result in great injustice to the aged having very limited means.

I know of no really good reason why we should not start at the beginning to put this plan on a complete insurance basis, with the understanding that the entire cost, to the extent that the bill covers health expenses, will be paid out of insurance funds, and not out of the pocket of the patient.

I recognize that this is considered a workable compromise between the unconscionable means test of the Kerr-Mills Act and the desirability of having some legislation passed at this session of Congress. But I am always interested in the question: What is the right thing to do? In my judgment, the right thing to do in this instance is to put this proposal on a strict insurance basis to begin with, and to eliminate the initial payment on the part of the patient. I shall offer an amendment in due course of time which will propose to do just that.

Mr. McNAMARA. I thank the Senator from Oregon.

Mr. ANDERSON. Mr. President, will the Senator from Michigan yield?

Mr. McNAMARA. I yield.

Mr. ANDERSON. I was interested in the closing remarks of the Senator from Oregon about putting the proposal on a straight insurance basis. That is precisely what was attempted. A sound insurance basis includes recognition of the fact that numerous nuisance claims are filed. It is necessary to have a valid claim.

For example, automobile companies provide collision insurance. In the days when they provided full collision insurance, it became too expensive; practically no one would carry it. Therefore, the insurance companies adopted a provision for $50 or $100 deductible, the idea being that if a person did not have a serious accident or a serious involvement with an automobile, he would not have his car repaired. If he had full collision insurance, he would immediately have every dent or scratch removed, or even replaced a damaged fender at a cost of $60, or whatever the price might be.

The same principle of deductibility has been carried into this bill. I do not say it is the wisest thing in the world; but otherwise, too many persons having slight illness would claim benefits.

Also, this provision is similar to provisions in all types of commercial insurance, particulary health insurance. It follows the provisions of the workmen's compensation laws in every State of the

Union, laws which require that a person must be incapacitated for a limited number of days before he may institute a claim.

From what little experience I have had in the insurance business, I think this is a good provision. It might be desirable to suggest that people should be paid for the first day; and there may be possibilities that welfare funds will cover this medium later if a change is found to be desirable.

We must always bear in mind that we are looking for an actuarial principle when we provide within a reasonable fee the amount of coverage which will be provided. This was hastily done, but it involved what I thought was an insurance principle.

Mr. McNAMARA. Ninety dollars is the maximum.

Mr. ANDERSON. Yes, it is the maximum. But the important point is that we are trying to see to it that devastatingly large bills do not descend upon those who are unable to pay them.

Today I received a letter from a woman who said she is 45 or 48 years old, as I recall; but the point is that she has a son, she is the sole support of the family, and she has worked a lifetime to save for his education. But just as he is about to enter college, she has been stricken with cancer. She says the doctors' bills not only are using up all her funds, but they also are making it absolutely impossible for her son to obtain a college education. In other words, even if the first $90 of the bills would not do that, the remainder would.

Mr. MORSE. Mr. President, will the Senator from Michigan yield?

The PRESIDING OFFICER (Mr. PELL in the chair). Does the Senator from Michigan yield to the Senator from Oregon?

Mr. McNAMARA. I yield.

Mr. MORSE. What I wish to say at this point will not be directed in any way to the amendment of the Senator from Michigan. I desire to state that when I offered my amendment, I wished to discuss at some length the amendment of the Senator from New Mexico.

However, at this time I merely state that I do not think it is sound, in connection with this matter, to make a comparison with the deduction made in connection with automobile insurance. It is quite different to be dealing with the question of whether, in connection with such a deduction, a claim for an entire new fender is legitimate, even though only a small dent was put in the original fender. I think there is no comparison between that situation and the case of an elderly person who should have a diagnosis, and perhaps has a latent cancer or some other ailment, but simply does not have the $90, or whatever the amount which will be required for the first few days in the hospital.

In this case we have an effective check: the doctor is the check. If in a given case the doctor finds that the patient should receive some hospital attention, in my judgment we should take the doctor's word for it, and he should have the authority to send the patient to the hospital to get the necessary treatment; and the patient should not have to pay the $90 maximum amount called for in this bill. It should be paid out of the insurance fund, because we are seeking to set up a great humanitarian program which will provide the necessary health attention at the time when it should first be given to the elderly person.

I have talked to a considerable number of doctors about this matter; and Senators will be surprised to find how many of them—a considerable number—are of the opinion that in dealing with the problem of the elderly who should have some health insurance, the doctors should be the ones to decide whether the patient should go to the hospital for treatment.

So the doctors will be the ones who will provide the check; and thus it will not be necessary to worry about possible malingerers, as contrasted with those who really need such attention, if we provide, as I propose, that the check shall be made by the doctor.

Mr. McNAMARA. Mr. President, one provision of the new amendment, however, gives me deep concern. That is the provision of section 1716 for an option to continue private health insurance protection.

I would be remiss in my responsibility as chairman of the Senate's Special Committee on Aging if I let this provision pass without protest.

During the years when I have had the privilege of serving as chairman of this subcommittee and its predecessor—the Subcommittee on Problems of the Aged and Aging, of the Senate Labor and Public Welfare Committee—I have had the opportunity to listen to our elder citizens and to carefully investigate their problems and possible solutions.

As a result, I question whether section 1716 properly protects the interests of our aged people, as the consumers who would purchase the private health insurance promoted through this option.

Personally, I oppose as unnecessary and potentially wasteful of tax funds any option which would go into private profits, rather than benefits.

Without question, however, the Anderson proposal is an improvement over other proposals for private health insurance options.

It is not a free option allowing beneficiaries a premium which they can apply to any private plan, regardless of the benefits that will be forthcoming. It is, instead, a provision which would reimburse a private plan only for the benefits covered by the Government plan which are actually used.

The formula of reimbursing the carrier, in terms of costs of service, plus reasonable administrative costs, assures the same level of benefits for the recipient. It virtually eliminates the effects of adverse selection found in the other proposals. This reimbursement formula is an assurance that the trust fund dollars will go primarily for benefits, not for excessive profits and costs.

The option provision is, nevertheless, deficient in the following respects:

First. The reimbursement to the carriers relieves them of the cost of the risk, but does not assure that this relief will result in correspondingly lower premium rates for the package the individual is purchasing, or in increased benefits.

A direct reimbursement without some form of review and regulation could result in creating a situation in which the carriers could make high profits for supplementary coverage.

Second. The tie-in of Government-financed benefits with private health insurance supplementary coverage would provide the industry with an opportunity to "milk" the aged consumer.

The consumer, already confused by the various diverse forms of policies, could easily be approached for the sale of overpriced coverage. Not realizing how much of his risk is assumed by the Government plan, rather than by the insurance company, he might pay premiums far beyond the value of his supplementary coverage. The lack of Federal regulation, combined with the diverse laws and regulations of States, would be an almost irresistible temptation to sell tie-in, lost-leader insurance.

Third. The option would result in payment of unnecessary administrative costs to private carriers. Under a straight Government plan, these administrative costs could easily be absorbed by the social security administrative structure already in existence.

Fourth. The original King-Anderson bill would not have prevented carriers from selling supplementary coverage in an open market to the recipient.

Spokesmen for the industry have admitted that under the King-Anderson bill there is room for the expansion of sales of supplementary coverage, and that potentially there is an ever-increasing market among the older citizens for these sales.

The option of the new Anderson amendment, however, would assure the carriers a Government-approved—indeed, a Government-financed—sales pitch.

My objection to the option in the Anderson amendment, then, is primarily because of its failure to protect the aged consumer who might be putting his scarce dollars into supplementary protection that would be overpriced but would appear attractive primarily because of the Government-financed portion of the package.

Let me make clear that the Anderson option is infinitely preferable to other options that have been proposed. It at least protects the health insurance trust fund, and thus the contributor, by assuring that the carrier will not collect from the Government for benefits that are never paid.

I would suggest that the operation of such an option be given continuous scrutiny if it is enacted into law.

In saying that the option included in the Anderson amendment is less objectionable than other options that are under serious consideration, let me explain through specific reference to the Javits amendment.

I am very happy to see that the Senator from New York [Mr. JAVITS] is present on the floor. I know he has given a great deal of attention to this amendment, and I am sure that any Senator

who has had even a passing interest in this subject has had an opportunity to hear from the Senator from New York on it.

Mr. JAVITS. Mr. President, will the Senator yield only on a question of fact?

Mr. McNAMARA. I am happy to yield.

Mr. JAVITS. I think it is fair to say—and the distinguished Senator from New Mexico [Mr. ANDERSON] is present—that what the Senator from Michigan called the Anderson option contained in the Anderson amendment is also the product of our joint work. I wanted to make that point factually clear.

Mr. McNAMARA. I am glad the Senator from New York has joined the Senator from New Mexico in this proposal. It makes it much better, so far as I am concerned.

This amendment proposes the payment of a sum, up to $100, to a private insurance carrier as partial premium on a policy that is "guaranteed renewable," and which provides benefits at least equal to the value of the benefits under the Government plan.

This proposal is inadequate in the following areas:

First. The so-called guaranteed renewable contract is not noncancellable—contrary to the common public impression.

It reserves to the company the right to increase premiums for classes of insured persons, or to terminate the policy for all who are insured.

The beneficiary, therefore, has no guarantee that he will receive benefits at a constant premium.

In fact, because medical costs are rising faster than other services, his benefit dollar will unquestionably provide less as time progresses.

In contrast, the social security approach assures the beneficiary benefits in terms of service for the rest of his life—a guarantee he can rely on without fear in his remaining years.

Second. The failure to prevent indiscriminate switching from the Government plan to private insurance, combined with the underwriting practices of the carriers which restrict enrollments, excludes undesirable risks and reserves to the carrier the right to terminate the policy, would result in an overloading of the Government plan with bad risks.

This lack of safeguards against adverse selection would defeat the economy and low cost of the social security plan which is based on spreading the risk over the greatest number of people—good and bad risks alike—in order to provide benefits at low cost.

Third. The option would result in payment of trust-fund dollars in profits to a loosely regulated industry.

Regulations vary widely in each State, and most State insurance departments are understaffed and underpaid and generally no match for the industry.

Unlike other forms of insurance, there is no specific rate regulation. The Javits amendment provides for no rate control.

The Secretary, charged with responsibility for proper use of social security contributors' dollars, would be forced to pay them out with no control over their disposition. This is an abdication of Federal responsibility not existent to this date.

Fourth. The Secretary, who is powerless to regulate rates or to bargain as do employers—including the Federal Government—for the advantages of group benefits, is compelled to pay dollars contributed by the Nation's workers to carriers who, on an average for individual policies, pay back little more than half of premiums received in benefits.

Almost half of these moneys may go for profits and costs, not benefits.

A situation like this is not tolerated in the administration of private trust plans. Far from fulfilling a commitment to the needs of the aged, this would be a gift of vast sums to insurance carriers.

Fifth. Commercial private individual health insurance policies today provide only limited dollar indemnities.

The beneficiary is not assured that these dollars will buy the same benefits next year or in the years thereafter, nor that they will buy the same benefits from one State to another.

The original King-Anderson bill provides coverage in terms of service, the same for every beneficiary, no matter where he lives.

He will know what he is getting and if he can afford to purchase supplementary coverage.

We can wait no longer to enact the proposed program of hospitalization and related health benefits for the aged through social security.

Each year that we delay means untold hardship for millions of older people.

One in every six people 65 and over go to the hospital each year.

But even more significantly, no one can predict whether he will be that one in six; all must be prepared for the eventuality.

No one is free from the worry that he will have a hospitalized illness, with all the heavy medical costs that go along with such illness.

During the past year, our Special Committee on Aging has held hearings in more than 30 cities throughout the length and breadth of the land, in rural areas as well as in large cities.

No one who had the opportunity to participate in these hearings, or who has read the printed records, can have the slightest doubt that the No. 1 problem facing the older people of this country is the problem of financing health costs during their later years, when incomes are at their lowest.

Our Committee on Aging has been the source of numerous studies and reports on the subject of the health and economic status of the aged.

All of these, including the 7,970 pages of State background studies for the White House Conference on Aging which we reprinted as a public service, make all too clear that the financing of health costs is an extremely serious problem for our older people.

They provide the factual proof of the existence and dimensions of the problem.

The hearings we have held added a new dimension to our knowledge—a perspective in depth. These hearings provided the voices and faces to go with our statistics.

We hear considerable talk nowadays of the importance of translating the problems of aging into the challenges of aging, of emphasizing the positive aspects of aging rather than the problems.

In simple fact, how is this possible, if our older people do not have the money for the basic essentials of everyday living, to say nothing of the heavy costs of medical care? How can they participate actively in community affairs if their lives are dominated by worry about failing health and heavy medical bills?

We must move ahead immediately to strengthen the economic security of our older population by providing basic protection against health costs.

This is the No. 1 step, which holds highest priority and urgency in our efforts to translate the problems of aging into the challenges of aging.

Mr. JAVITS. Mr. President, will the Senator yield?

Mr. McNAMARA. I am happy to yield.

Mr. JAVITS. In the first place, let me say I need not protest my respect and my personal affection for the Senator from Michigan, because he is well aware of them. Also, I have been designated by the Republican side to be a member of the Subcommittee on Aging. I am much pleased, knowing the strong feelings the Senator has on medical care, that he has taken a wait-and-see attitude on the option contained in the Anderson bill. It is with that in mind, and not in a contentious spirit, that I would like to call a few matters to the Senator's attention.

I think, as the Senator views the option concept, it is very important to note that it does not apply only to insurance companies. I think it is important to emphasize that fact for the country.

There are many cooperatives, many group practice organizations, and indeed pension and welfare funds—perhaps the most prominent is the Kaiser plan—which could fit into this concept which is called the option in the amendment.

There is another point I should like to suggest for a further study by the Senator. It is true that we wish to provide benefits for the aged. That is the fundamental point. It is also true, however, it is almost impossible for anybody to protect people against themselves. The people of whom we are speaking are fairly intelligent, older people. It has always been contemplated, as I have understood the bill, that there would be some kind of supplementary coverage. Indeed, the supplementary coverage which is called for by the bill itself is evidenced by the fact that the estimates generally proceed on the assumption that about one-third—up to not to exceed 40 percent—of the medical costs would be covered by the King-Anderson package. That is generally assumed to be the case, and I think the Senator himself has been a party to those estimates.

If there are to be supplementary benefits, and if the Secretary of Health, Education, and Welfare is to keep a rather tight rein on this whole situation, as I am confident he will, then under my amendment—even the one of which the Senator was rather critical, to which I will come in a minute—would it not be a fact that if we provided supplemental coverage, to be built efficiently upon the basic governmental coverage as contained in the bill, there would be a good chance to give to the person who seeks supplementary coverage more for his money? That was really the essence of the feeling of the Senator from New Mexico [Mr. ANDERSON], I believe.

I say "a chance." I am not trying to debate the Senator now, in view of the Senator's feeling that he would like to look into it further, with an open mind. Rather, I suggest areas of investigation, because the committee has a splendid staff which I think could be very helpful in looking into the implications of what we seek to do in regard to the totality of the Anderson proposal.

Mr. McNAMARA. I appreciate the remarks of the distinguished Senator from New York very much. I assure the Senator that what he has said concerning other organizations, as well as insurance companies, was included in my definite understanding. I hope there is nothing in what I have said which would indicate otherwise. I am happy to find out that we are as close together as this. I am moving, as the Senator has moved, considerably. Basically we are certainly on the same side, trying to get something done.

Mr. JAVITS. I agree that we are trying to get something done. I expressed the hope before that by the time this question gets to the voting stage there will be a single amendment, and that my amendment with respect to the option will not even be pending. I am hopeful that will occur.

There is one other thing which I would like to bring to the attention of the Senator.

I should like to bring to the attention of my colleague one other fact, because he did make some comment about it. The amendment which I filed—we kind of filed a "bid and asked amendment," to use a stock exchange term—went as far as we could in regard to the problem, since we did not wish to stand in the way of the filing of the amendment which the Senator from New Mexico [Mr. ANDERSON] worked out with us.

I say to my colleague—and I am sure he will agree, because this was in his own bill—to my mind, aside from the trust fund, there were two very important points to consider.

First, there was the generalized coverage for all of those who are over 65 years of age. That was in the McNamara bill, as it was in my bill, from the very start. That will be accomplished, I am sure. I know the Senator takes great satisfaction from that.

Mr. McNAMARA. Certainly.

Mr. JAVITS. Second, there was the question of the option.

Even in the amendment which I filed, in the first place, the standards for insurance or other coverage were to be set by the Secretary.

In the second place, the policy was not to be a cancellable policy. There was to be a guaranteed renewal at the option of the insured.

In the third place, at all times—and I think this is important, as bearing upon our good will in the matter, at least—the value of the benefits to be contained in the coverage must be not less than the value of the benefits to be provided by the King-Anderson proposal.

Finally, at no time would an older person be without coverage. We have provided even in our amendment—and, as I say, I hope that will be washed out—that the minute the policy lapses or is canceled for any reason, even for nonpayment of premiums, the Government coverage will immediately take effect.

I point that out to my colleague, because I think it is fair to those of us who have taken this position.

Finally, I should like to ask my colleague one other question. I assume that his view of the option turns upon the fulcrum of the discussions; that is, is the option to be for a premium payment or is the option to be for a reimbursement of benefits actually conferred? That goes directly to the solution of the so-called selectivity of risks argument, the traditional trade union argument, with which I know the Senator is very familiar.

May I have the Senator's reaction?

Mr. McNAMARA. I think that is true. My basic concern was not that part of the question, but the fact that the proposal involved such a potential drain on the trust fund. The potentiality of the drain on the fund on the first proposal of the Senator from New York was so great that I did not wish to run the risk of that drain. That was my primary objection.

Mr. JAVITS. I am very grateful to my colleague for this exchange of views.

Mr. ANDERSON. Mr. President, I call up my amendments No. "6-29-62—A."

The PRESIDING OFFICER. The amendments will be identified for the information of the Senate.

The LEGISLATIVE CLERK. The Senator from New Mexico [Mr. ANDERSON], for himself and other Senators, proposes amendments to H.R. 10606 identified as "6-29-62—A."

The amendments are as follows:

On page 1, line 4, strike out "Public Welfare Amendments of 1962" and insert in lieu thereof "Public Welfare and Health Insurance Amendments of 1962".

On page 100, line 16, strike out "II" and insert in lieu thereof "III".

On page 100, line 18, strike out "201" and insert in lieu thereof "301".

On page 100, line 23, strike out "202" and insert in lieu thereof "302".

On page 100, between lines 15 and 16, insert the following:

"TITLE II—HEALTH BENEFITS

"Findings and declaration of purpose

"SEC. 200. (a) The Congress hereby finds that (1) the heavy costs of hospital care and related health care are a grave threat to the security of aged individuals, (2) most of them are not able to qualify for and to afford private insurance adequately protecting them against such costs, (3) many of them are accordingly forced to apply for private or public aid, accentuating the financial difficulties of hospitals and private or public welfare agencies and the burdens on the general revenues, and (4) it is in the interest of the general welfare for financial burdens resulting from hospital services and related services required by these individuals to be met primarily through social insurance.

"(b) The purposes of this Act are (1) to provide aged individuals entitled to benefits under the old-age, survivors, and disability insurance system or the railroad retirement system with basic protection against the costs of inpatient hospital services, and to provide, in addition, as an alternative to inpatient hospital care, protection against the costs of certain skilled nursing facility services, home health services, and outpatient hospital diagnostic services; to utilize social insurance for financing the protection so provided; to encourage, and make it possible for, such individuals to purchase protection against other health costs by providing in such basic social insurance protection a set of benefits which can easily be supplemented by a State, private insurance, or other methods; to assure adequate and prompt payment on behalf of these individuals to the providers of these services; and to do these things in a manner consistent with the dignity and self-respect of each individual, without interfering in any way with the free choice of physicians or other health personnel or facilities by the individual, and without the exercise of any Federal supervision or control over the practice of medicine by any doctor or over the manner in which medical services are provided by any hospital; and (2) to provide such basic protection, financed from general revenues, to those persons who are now age 65 or over or who will reach age 65 within the next several years and who are not eligible for benefits under the old-age, survivors, and disability insurance or railroad retirement systems.

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

"Part A.—Health insurance benefits for the aged

"Benefits

"SEC. 201. The Social Security Act is amended by adding after title XVI the following new title:

"'TITLE XVII—HEALTH INSURANCE BENEFITS FOR THE AGED

"'Prohibition against interference

"'SEC. 1701. (a) Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any hospital, skilled nursing facility, or home health agency; or to exercise any supervision or control over the administration or operation of any such hospital, facility, or agency.

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

"'*Free choice by patient*

"'SEC. 1702. Any individual entitled to have payment made under this title for services furnished him may obtain inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services from any provider of services with which an agreement is in effect under this title and which undertakes to provide him such services.

"'*Description of services*

"'SEC. 1703. For purposes of this title—

"'Inpatient Hospital Services

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

"'(1) bed and board (subject, however, to the limitations in section 1709 (c) and (d) on the amount which is payable with respect to certain accommodations),

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

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

excluding, however—

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

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

"'Skilled Nursing Facility Services

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

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

"'(2) bed and board in connection with the furnishing of such nursing care (subject, however, to the limitations in section 1709 (c) and (d) on the amount which is payable with respect to certain accommodations),

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

"'(4) medical social services,

"'(5) drugs, biologicals, supplies, appliances, and equipment which are furnished for use in such skilled nursing facility,

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

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

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

"'Home Health Services

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

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

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

"'(3) medical social services,

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

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

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

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

"'Outpatient Hospital Diagnostic Services

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

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

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

excluding, however—

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

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

"'Drug and Biological

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

"'Arrangements for Certain Services

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

"'*Deductible; duration of services*

"'Deductible

"'SEC. 1704. (a)(1) Payment for inpatient hospital services furnished an individual during any benefit period shall be reduced by a deduction equal to $20, or if greater, $10 multiplied by the number of days, not exceeding nine, for which he received such services in such period.

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

"'Duration of Services

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

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

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

Payment under this title for inpatient hospital services or skilled nursing facility services furnished an individual during a benefit period may also not be made for any such services after one hundred and fifty units of services have been furnished to him in such period; and, for purposes of this sentence—

"'(3) a "unit of service" shall be equal to one day of inpatient hospital services or two days of skilled nursing facility services, and

"'(4) there shall not be counted any inpatient hospital services furnished in a benefit period for any days in excess of ninety days or any skilled nursing facility services furnished in a benefit period for any days in excess of one hundred and eighty.

For purposes of the preceding provisions of this subsection, inpatient hospital services or skilled nursing facility services shall be counted only if payment is or would, except for this subsection and except for the failure to comply with the procedural and other requirements of or under section 1709(a)(1), be made with respect to such services under this title. Payment under this title for home health services furnished an individual during a calendar year may not be made for any such services after such services have been furnished him during two hundred and forty visits in such year.

"'Benefit Period

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

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

"'(2) ending with the last day of the first ninety-day period thereafter during each day of which he is neither an inpatient in a hospital nor an inpatient in a skilled nursing facility.

"'Day

"'(d) For the purposes of this section, a "day" on or for which inpatient hospital services or skilled nursing facility services are furnished shall have the meaning customarily assigned to it by the hospital or skilled nursing facility furnishing such services, but in no event shall it be less than twenty-four hours (except the day on which such individual is admitted to, or discharged from, such hospital or such skilled nursing facility).

"'*Entitlement to benefits*

"'SEC. 1705. (a) Every individual who—

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

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

shall be entitled to health insurance benefits for each month for which he is entitled to such benefits under section 202, beginning with the first month with respect to which he meets the conditions specified in paragraphs (1) and (2). Notwithstanding the preceding provisions of this subsection, no payments may be made under this title for inpatient hospital services, outpatient hospital diagnostic services, or home health services furnished an individual prior to January 1, 1964, or for skilled nursing facility services furnished him prior to July 1, 1964.

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

"'(1) entitlement of an individual to health insurance benefits under this title for a month shall consist of entitlement to have payment made under, and subject to the limitations in, this title on his behalf for inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services furnished him in the United States (as defined in section 210(i)) during such month; and

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

"'*Definitions of providers of services*

"'SEC. 1706. For purposes of this title—

"'Hospital

"'(a) The term "hospital" (except for purposes of section 1704(c)(2), section 1709(f), paragraph (6) of this subsection, and so much of section 1703(b) as precedes paragraph (1) thereof) means an institution which—

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

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

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

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

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

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

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

For purposes of section 1704(c)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of section 1709(f) (including determination of whether an individual received inpatient hospital services for purposes of such section 1709(f)), and so much of section 1703(b) as precedes paragraph (1) thereof, such term includes any institution which meets the requirements of paragraphs (1), (2), (4), and (6) of this subsection. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of section 1704(c)(2), include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients.

"'Skilled Nursing Facility

"'(b) The term "skilled nursing facility" means (except for purposes of section 1704(c)(2)) an institution (or a distinct part of an institution) which is affiliated or under common control with a hospital having an agreement in effect under section 1710 and which—

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

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

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

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

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

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

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

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

except that such term shall not (other than for purposes of section 1704(c)(2)) include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients. For purposes of section 1704(c)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.

"'Home Health Agency

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

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

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

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

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

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

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

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

"'Physician

"'(d) The term "physician" means an individual (including a physician within the meaning of section 1101(a)(7)) legally authorized to practice surgery or medicine by the State in which he performs the functions referred to in this title.

"'Utilization Review

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

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

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

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

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

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

"'Provider of Services

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

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

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

"'(1) the facility will be operated under standards, with respect to—

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

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

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

which are developed jointly by or are agreed to by the two institutions;

"'(2) timely transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate, and provision is made for the transfer or the joint use (to the ex-

tent practicable) of clinical records of the two institutions; and

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

"'*Use of State agencies and other organizations to develop conditions of participation for providers of service*

"'SEC. 1707. In carrying out his functions, relating to determination of conditions of participation by providers of services, under section 1706(a)(7), section 1706(b)(8), or section 1706(c)(6), the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1712, appropriate State agencies, and recognized national listing or accrediting bodies. Such conditions prescribed under any of such sections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide (subject to the limitation provided in section 1706(a)(7)) higher requirements for such State than for other States.

"'*Use of State agencies and other organizations to determine compliance by providers of services with conditions of participation*

"'SEC. 1708. (a) The Secretary may, pursuant to agreement, utilize the services of State health agencies or other appropriate State agencies for the purposes of (1) determining whether an institution is a hospital or skilled nursing facility, or whether an agency is a home health agency, or (2) providing consultative services to institutions or agencies to assist them (A) to qualify as hospitals, skilled nursing facilities, or home health agencies, (B) to establish and maintain fiscal records necessary for purposes of this title, and (C) to provide information which may be necessary to permit determination under this title as to whether payments are due and the amounts thereof. To the extent that the Secretary finds it appropriate, an institution or agency which such a State agency certifies is a hospital, skilled nursing facility, or home health agency may be treated as such by the Secretary. The Secretary shall pay any such State agency, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in the first sentence of this subsection, and for the fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under this title, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

"'(b)(1) An institution shall be deemed to meet the conditions of participation under section 1706(a) (except paragraph (5) thereof) if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals. If such Commission hereafter required a utilization review plan, or imposes another requirement which serves substantially the same purpose, as a condition for accreditation of a hospital, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1706(a)(5).

"'(2) If the Secretary finds that accreditation of an institution by a national accreditation body, other than the Joint Commission on the Accreditation of Hospitals, provides reasonable assurance that any or all of the conditions of section 1706(a), (b), or (c), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution as meeting the condition or conditions with respect to which he made such finding.

"'*Conditions of and limitations on payment for services*

"'Requirement of Requests and Certifications

"'SEC. 1709. (a) Except as provided in subsection (f), payment for services furnished an individual may be made only to eligible providers of services and only if—

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

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

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

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

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

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

"'(3) with respect to inpatient hospital services or skilled nursing facility services furnished such individual after the twenty-first day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hopsital, a decision under section 1710(e) (based on a finding that timely utilization review of long-stay cases is not being made in such hospital or facility);

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

"'Determination of Costs of Services

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

"'Amount of Payment for More Expensive Services

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

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

"'Amount of Payment Where Less Expensive Services Furnished

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

"'No Payments to Federal Providers of Services

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

"'Payment for Emergency Inpatient Hospital Services

"'(f) Payments shall also be made to any hospital for inpatient hospital services or outpatient hospital diagnostic services furnished, by the hospital or under arrangements (as defined in section 1703(e)) with it, to an individual entitled to health insur-

ance benefits under this title even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payment shall be made only in amounts determined as provided in subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1710(a).

"'Payment for Services Prior to Notification of Noneligibility

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

"'Agreements with providers of services

"'SEC. 1710. (a) Any provider of services shall be eligible for payments under this title if it files with the Secretary an agreement not to charge any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1709(g)), and to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, except that such provider of services may charge such individual or other person the amount of any deduction imposed pursuant to section 1704(a) with respect to such services (not in excess of the amount customarily charged for such services by such provider) and, where the provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider may also charge such individual or other person for such more expensive items or services but not more than the difference between the amount customarily charged by it for the items or services furnished at such request and the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

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

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

"'(2) by the Secretary at such time and upon such notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined, and has given such provider notification thereof, (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider no longer substantially meets the applicable provisions of section 1706, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information.

Any termination shall be applicable—

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

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

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

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

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

"'(e) If the Secretary finds that timely review in accordance with section 1706(e) of long-stay cases in a hospital or skilled nursing facility is not being made with reasonable regularity, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or skilled nursing facility after a date specified by him, no payment shall be made for inpatient hospital services or skilled nursing facility services after the twenty-first day of a continuous period of such services. Such decision may be made only after such notice to the hospital, or (in the case of a skilled nursing facility) to the hospital and the facility, and to the public as may be prescribed by regulations, and its effectiveness shall be rescinded when the Secretary finds that the reason therefor has been removed and there is reasonable assurance that it will not recur.

"'Payment to providers of services

"'SEC. 1711. The Secretary shall periodically determine the amount which should be paid to each provider of services under this title with respect to the services furnished by it, and the provider shall be paid, at such time or times as the Secretary believes appropriate and prior to audit or settlement by the General Accounting Office, from the Federal Health Insurance Trust Fund the amounts so determined; except that such amounts may be reduced or increased, as the case may be, by any sum by which the Secretary finds that the amount paid to such provider of services for any prior period was greater or less than the amount which should have been paid to it for such period.

"'Health Insurance Benefits Advisory Council

"'SEC. 1712. For the purpose of advising the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, there is hereby created a Health Insurance Benefits Advisory Council which shall consist of fourteen persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as Chairman. Not less than four of the appointed members shall be persons who are outstanding in the fields pertaining to hospitals and health activities. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, three at the end of the first year, four at the end of the second year, three at the end of the third year, and four at the end of the fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms. The Secretary may, at the request of the Council, appoint such special advisory or technical committees as may be useful in carrying out its functions. Appointed members of the Advisory Council and members of its advisory or technical committees, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such a committee, or committees, shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of four or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.

"'Review of determinations

"'SEC. 1713. Any individual dissatisfied with any determination made by the Secretary that he is not entitled to health insurance benefits under this title or that he is not entitled to have payment made under this title with respect to any class of services furnished him, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"'Overpayments to individuals

"'SEC. 1714. (a) Any payment under this title to any provider of services with respect to inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services, furnished any individual shall be regarded as a payment to such individual.

"'(b) Where—

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

"'(2) any payment has been made under section 1709(g) to a provider of services for services furnished an individual,

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

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

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

"'(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1709(g)) for services furnished to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience.

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

"'Use of private organizations to facilitate payment to providers of service

"'SEC. 1715. (a) The Secretary is authorized to enter into an agreement with any organization, which has been designated by any group of providers of services, or by an association of such providers on behalf of its members, to receive payments under section 1711 on behalf of such providers, providing for the determination by such organization (subject to such review by the Secretary as may be provided for in the agreement) of the amount of payments required pursuant to this title to be made to such providers, and for making such payments. The Secretary shall not enter into an agreement with any organization under this section unless he finds it consistent with effective and efficient administration of this title.

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

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

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

"'(3) assist in the application of safeguards against unnecessary utilization of services furnished by providers to individuals entitled to have payment made under section 1711;

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

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

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

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

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

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

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

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

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

"'Option to beneficiaries to continue private health insurance protection

"'SEC. 1716. (a) In lieu of paying a provider of services under an agreement under this title, payments may be made to an eligible carrier under an approved plan with respect to services which are furnished by such provider of services to any individual entitled to health insurance benefits (hereinafter in this section referred to as an "eligible individual") and for which payment would otherwise be made under the preceding provisions of this title (hereinafter in this section referred to as "reimbursable health services"), if such individual elects to have payment for such services made to such carrier.

"'(b) (1) An individual may make an election under subsection (a) with respect to the plan of an eligible carrier only if he was covered by a plan of such carrier (or an affiliate thereof), providing or paying for the costs of inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services which are subject to no greater limitations and deductibles than are provided in section 1704, and providing or paying for the costs of some additional health services, continuously during whichever of the following periods is the shorter—

"'(A) a period of not less than five years ending with the close of the month in which such individual becomes entitled, to health insurance benefits, or

"'(B) (i) if the month in which such individual becomes entitled to health insurance benefits is January, February, or March of 1964, a period of not less than ninety days ending with the close of the month before such month, or (ii) if the month in which he becomes so entitled is April 1964 or a subsequent month, the period beginning January 1, 1964, and ending with the close of the month before such month in which he becomes so entitled.

"'(2) An election may be made under subsection (a) in such manner and within such period after an individual becomes entitled to health insurance benefits, but in no event more than three months after the month in which he becomes so entitled, as the Secretary may prescribe; and an individual shall be permitted only one such election. An election so made may be revoked at such time or times and in such manner as may be so prescribed.

"'(c) To be approved with respect to any eligible individual, a plan must—

"'(1) include (A) provision of all reimbursable health services or payment to providers of services for the cost of all reimbursable health services furnished by them (as provided in subsection (d)(3)), and (B) provision of or payment for the cost of some additional health services; and

"'(2) provide for adequate notice to the Secretary and to such individual of termination of such individual's coverage under such plan.

"'(d) A carrier shall be eligible for purposes of this section if it—

"'(1) (A) is exempt from income tax under section 501(c) of the Internal Revenue Code of 1954, and is licensed in the State with respect to which it requests approval hereunder to provide or pay for the costs of reimbursable health services, or

"'(B) (i) is licensed in the fifty States and the District of Columbia to issue health insurance and, in the most recent year for which data are available, has made health insurance benefit payments aggregating at least 1 percent of all such payments in the fifty States and the District of Columbia, or (ii) is determined by the Secretary to be national in scope, or

"'(C) is licensed to issue health insurance in the State with respect to which it requests approval hereunder and, in the most recent year for which data are available, has made health insurance benefit payments aggregating at least 10 percent of such payments in such State, or

"'(D) in the case of a carrier which is not included in subparagraph (A), (B), or (C), is licensed to issue group health insurance in the State with respect to which it requests approval hereunder (but in such case it shall be eligible only with respect to such group health insurance);

"'(2) agrees to provide the Secretary, on request, such reports as may reasonably be necessary to enable him to determine the amounts due, under any plan with respect to which an election has been made under this section, on account of reimbursable health services and the administrative expenses of the carrier in connection therewith, and to permit such access by the Secretary to the records on which such reports are based as may be necessary to enable him to determine the accuracy of such reports; and

"'(3) agrees to make payments for reimbursable health services to providers of services in the same amounts, under the same conditions, and subject to the same limitations as are applicable in the case of such services for which payments are made under the preceding sections of this title.

"'(e) An eligible carrier shall be paid from time to time amounts equal to the payments made or the costs of services provided by it under approved plans for reimbursable health services and, in addition, such amounts as the Secretary finds to be the administrative costs of such carrier reasonably necessary to the provision of or payment for the cost of reimbursable health services under an approved plan for eligible individuals.

"'*Regulations*

"'SEC. 1717. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

"'*Application of certain provisions of title II*

"'SEC. 1718. The provisions of sections 206, 208, and 216(j), and of subsections (a), (d), (e), (f), and (h) of section 205 shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

"'*Designation of organization or publication by name*

"'SEC. 1719. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.'

"Federal Health Insurance Trust Fund

"SEC. 202. (a) Section 201 of the Social Security Act is amended by redesignating subsections (c), (d), (e), (f), (g), and (h) as subsections (d), (e), (f), (g), (h), and (i), respectively, and by adding after subsection (b) the following new subsection:

"'(c) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Health Insurance Trust Fund". The Federal Health Insurance Trust Fund shall consist of such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Health Insurance Trust Fund for the fiscal year ending June 30, 1963, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

"'(1)(A) 0.18 of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1962, and before January 1, 1964, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

"'(B) 0.68 of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1963, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

"'(2)(A) 0.135 of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1962, and before January 1, 1964, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns; and

"'(B) 0.51 of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1963, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.'

"(b) The first sentence of the subsection of such section 201 herein redesignated as subsection (d) is amended by striking out 'and the Federal Disability Insurance Trust Fund' and inserting in lieu thereof ', the Federal Disability Insurance Trust Fund, and the Federal Health Insurance Trust Fund'.

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

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

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

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

"(g) Section 221(e) of such Act is amended—

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

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

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

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

"Increase in Earnings Base

"Definition of wages

"SEC. 203. (a)(1) Paragraph (3) of section 209(a) of the Social Security Act is amended by inserting 'and prior to 1963' after '1958'.

"(2) Such section 209(a) is further amended by adding at the end thereof the following new paragraph:

"'(4) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $5,200 with respect to employment has been paid to an individual during any calendar year after 1962, is paid to such individual during such calendar year;'.

"Definition of self-employment income

"(b)(1) Subparagraph (C) of section 211(b)(1) of such Act is amended by inserting 'and prior to 1963' after '1958'; and by striking out '; or' and inserting in lieu thereof '; and'.

"(2) Such section 211(b)(1) is further amended by adding at the end thereof the following new subparagraph:

"'(D) For any taxable year ending after 1962, (i) $5,200, minus (ii) the amount of wages paid to such individual during the taxable year; or'.

"Definitions of quarter and quarter of coverage

"(c)(1) Clause (ii) of section 213(a)(2) of such Act is amended by striking out '1958' and inserting in lieu thereof '1958 and before 1963, or $5,200 in the case of a calendar year after 1962'.

"(2) Clause (iii) of section 213(a)(2) of such Act is amended by striking out '1958' and inserting in lieu thereof '1958 and before 1963, or $5,200 in the case of a taxable year ending after 1962'.

"Table for determining primary insurance amount

"(d)(1) The table in section 215(a) of such Act is amended by striking out all the figures in columns II, III, IV, and V beginning with the line which reads

"'105.50 102.30 315 319 109 254.00'

and down through the line which reads

"'399 400 127 254.00'

and inserting in lieu thereof the following:

"'101.50	102.30	315	319	109	255.20
102.40	103.20	320	323	110	258.40
103.30	104.20	324	328	111	262.40
104.30	105.10	329	333	112	266.40
105.20	106.00	334	337	113	268.00
106.10	107.00	338	342	114	268.00
107.10	107.90	343	347	115	268.00
108.00	108.50	348	351	116	268.00
		352	356	117	268.00
		357	361	118	268.00
		362	365	119	268.00
		366	370	120	268.00
		371	375	121	268.00
		376	379	122	268.00
		380	384	123	268.00
		385	389	124	268.00
		390	393	125	268.00
		394	398	126	268.00
		399	403	127	268.00
		404	407	128	268.00
		408	412	129	268.00
		413	417	130	268.00
		418	421	131	268.00
		422	426	132	268.00
		427	431	133	268.00
		432	433	134	268.00'.

"(2) The amendment made by paragraph (1) shall be applicable with respect to monthly insurance benefits under title II of such Act for months after December 1962 and with respect to lump-sum death payments in the case of deaths after December 1962.

"Average monthly wage

"(e) Paragraph (1) of section 215(e) of such Act is amended by striking out 'and the excess over $4,800 in the case of any calendar year after 1958' and inserting in lieu thereof 'the excess over $4,800 in the case of any calendar year after 1958 and before 1963, and the excess over $5,200 in the case of a calendar year after 1962'.

"Technical Amendments

"Suspension in case of aliens

"SEC. 204. (a) Subsection (t) of section 202 of such Act is amended by adding at the end thereof the following new paragraph:

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

"Persons convicted of subversive activities

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

individual is entitled to health insurance benefits under title XVII for any such month,'.

"Advisory Council on Social Security Financing

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

"(2) Subsection (d) of such section is amended by striking out 'and the Federal Disability Insurance Trust Fund' and inserting in lieu thereof ', the Federal Disability Insurance Trust Fund, and the Federal Health Insurance Trust Fund'.

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

"Part B—Amendments to the Internal Revenue Code of 1954

"Changes in Tax Schedules

"Self-employment income tax

"SEC. 211. (a) Section 1401 of the Internal Revenue Code of 1954 (relating to the rate of tax on self-employment income) is amended to read as follows:

" 'SEC. 1401. RATE OF TAX.

" 'In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows—

" '(1) in the case of any taxable year beginning after December 31, 1962, and before January 1, 1964, the tax shall be equal to 5.4 percent of the amount of the self-employment income for such taxable year;

" '(2) in the case of any taxable year beginning after December 31, 1963, and before January 1, 1966, the tax shall be equal to 5.8 percent of the amount of the self-employment income for such taxable year;

" '(3) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1968, the tax shall be equal to 6.6 percent of the amount of the self-employment income for such taxable year; and

" '(4) in the case of any taxable year beginning after December 31, 1967, the tax shall be equal to 7.3 percent of the amount of the self-employment income for such taxable year.'

"Tax on employees

"(b) Section 3101 of such Code (relating to rate of tax on employees under the Federal Insurance Contributions Act) is amended to read as follows:

" 'SEC. 3101. RATE OF TAX.

" 'In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

" '(1) with respect to wages received during the calendar year 1963, the rate shall be 3⅝ percent;

" '(2) with respect to wages received during the calendar years 1964 and 1965, the rate shall be 3⅞ percent;

" '(3) with respect to wages reecived during the calendar years 1966 and 1967, the rate shall be 4⅜ percent; and

" '(4) with respect to wages received after December 31, 1967, the rate shall be 4⅞ percent.'

"Tax on employers

"(c) Section 3111 of such Code (relating to rate of tax on employers under the Federal Insurance Contributions Act) is amended to read as follows:

" 'SEC. 3111. RATE OF TAX.

" 'In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

" '(1) with respect to wages paid during the calendar year 1963, the rate shall be 3⅝ percent;

" '(2) with respect to wages paid during the calendar years 1964 and 1965, the rate shall be 3⅞ percent;

" '(3) with respect to wages paid during the calendar years 1966 and 1967, the rate shall be 4⅜ percent; and

" '(4) with respect to wages paid after December 31, 1967, the rate shall be 4⅞ percent.'

"Effective dates

"(d) The amendment made by subsection (a) shall apply with respect to taxable years beginning after December 31, 1962. The amendments made by subsections (b) and (c) shall apply with respect to remuneration paid after December 31, 1962.

"Increase in Tax Base

"Definition of self-employment income

"SEC. 212. (a)(1) Subparagraph (C) of section 1402(b)(1) of the Internal Revenue Code of 1954 is amended by adding 'and before 1963' after '1958'; and by striking out 'or' and inserting in lieu thereof 'and'.

"(2) Such section 1402(b)(1) is further amended by adding at the end thereof the following new subparagraph:

" '(D) for any taxable year ending after 1962, (i) $5,200, minus (ii) the amount of the wages paid to such individual during the taxable year; or'.

"Definition of wages

"(b) Section 3121(a)(1) of such Code is amended by striking out '$4,800' wherever it appears and inserting in lieu thereof '$5,200'.

"Federal service

"(c) Section 3122 of such Code is amended by striking out '$4,800' and inserting in lieu thereof '$5,200'.

"Returns in the case of governmental employees in Guam and American Samoa

"(d) Section 3125 of such Code is amended by striking out '$4,800' wherever it appears and inserting in lieu thereof '$5,200'.

"Special refunds of employment taxes

"(e)(1) Section 6413(c)(1) of such Code is amended—

"(A) by inserting 'and prior to the calendar year 1963' after 'the calendar year 1958';

"(B) by inserting 'or (C) during any calendar year after the calendar year 1962, the wages received by him during such year exceed $5,200,' after 'exceed $4,800,'; and

"(C) by inserting before the period at the end thereof 'and before 1963, or which exceeds the tax with respect to the first $5,200 of such wages received in such calendar year after 1962'.

"(2) Section 6413(c)(2)(A) of such Code is amended by striking out 'or $4,800 for any calendar year after 1958' and inserting in lieu thereof '$4,800 for the calendar year 1959, 1960, 1961, or 1962, or $5,200 for any calendar year after 1962'.

"Effective date

"(f) The amendments made by subsections (b), (c), and (d) shall be applicable with respect to remuneration paid after 1962.

"Technical Amendment

"SEC. 213. Section 3121(l)(6) of the Internal Revenue Code of 1954 is amended by striking out 'and the Federal Disability Insurance Trust Fund,' and inserting in lieu thereof ', the Federal Disability Insurance Trust Fund, and the Federal Health Insurance Trust Fund,'. The amendment made by this section shall be effective January 1, 1963.

"Part C—Railroad Retirement Amendments

"Health Insurance Benefits for the Aged

"SEC. 221. (a) The Railroad Retirement Act of 1937 is amended by adding after section 20 of such Act the following new section:

" 'Health Insurance Benefits for the Aged

" 'SEC. 21. (a) For the purposes of this section, and subject to the conditions hereinafter provided, the Board shall have the same authority to determine the rights of individuals described in subsection (b) of this section to have payments made on their behalf for health insurance benefits consisting of inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services within the meaning of title XVII of the Social Security Act as the Secretary of Health, Education, and Welfare has under such title XVII with respect to individuals to whom such title applies. The rights of individuals described in subsection (b) of this section to have payment made on their behalf for the services referred to in the next preceding sentence shall be the same as those of individuals to whom title XVII of the Social Security Act applies and this section shall be administered by the Board as if the provisions of such title XVII were applicable, references to the Secretary of Health, Education, and Welfare were to the Board, references to the Federal Social Insurance Trust Fund were to the Railroad Retirement Account, references to the United States or a State included Canada or a subdivision thereof, and the provisions of sections 1707 and 1712 of such title XVII were not included in such title. For purposes of section 11, a determination with respect to the rights of an individual under this section shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

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

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

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

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

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

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

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

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

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

"(b) Section (1)(q) of such Act is amended by striking out '1961' and inserting in lieu thereof '1962'.

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

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

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

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

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

"'(iii) At the close of the fiscal year ending June 30, 1963, and each fiscal year thereafter, the Board and the Secretary of Health, Education, and Welfare shall determine the amount, if any, which, if added to or subtracted from the Federal Health Insurance Trust Fund would place such fund in the same position in which it would have been if service as an employee after December 31, 1936, had been included in the term "employment" as defined in the Social Security Act and in the Federal Employment Contributions Act. Such determination shall be made no later than June 15 following the close of the fiscal year. If such amount is to be added to the Federal Health Insurance Trust Fund the Board shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Retirement Account to the Federal Health Insurance Trust Fund; if such amount is to be subtracted from the Federal Health Insurance Trust Fund the Secretary of Health, Education, and Welfare shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Federal Health Insurance Trust Fund to the Retirement Account. The amount so certified shall further include interest (at the rate determined under subparagraph (B) for the fiscal year under consideration) payable from the close of such fiscal year until the date of certification.';

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

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

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

"(2) The amendments made by paragraph (1) of this subsection shall be effective January 1, 1963. Such amendments and the amendments made by section 202(a) shall not be construed to increase or diminish the sums to be transferred, under the provisions of section 5(k)(2) of the Railroad Retirement Act before their amendment by paragraph (1) of this subsection, between the Railroad Retirement Account and the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund.

"Tax on Employees

"SEC. 222. (a) Section 3201 of the Railroad Retirement Tax Act is amended by striking out ': *Provided*' and inserting in lieu thereof the following: '. With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3101 of the Federal Insurance Contributions Act are increased with respect to wages by section 220 (b) of the Act which amended the Social Security Act by adding title XVII the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3101 are so increased with respect to wages: *Provided*'.

"Tax on Employee Representatives

"(b) Section 3211 of the Railroad Retirement Tax Act is amended by striking ': *Provided*' and inserting in lieu thereof the following: '. With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3101 of the Federal Insurance Contributions Act are increased with respect to wages by section 220(b) of the Act which amended the Social Security Act by adding title XVII the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by twice the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3101 are so increased with respect to wages: *Provided*'.

"Tax on Employers

"(c) Section 3221 of the Railroad Retirement Tax Act is amended by inserting after '$400' the first time it appears the following: '. With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3111 of the Federal Insurance Contributions Act are increased with respect to wages by section 220(c) of the Act which amended the Social Security Act by adding title XVII the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3111 are so increased with respect to wages'.

"Part D—Health insurance benefits for presently uninsured individuals

"Coverage Provisions

"SEC. 231. Anyone who—

"(1) has attained the age of 65.

"(2)(A) attained such age before 1967, or (B) has not less than 3 quarters of coverage (as defined in title II of the Social Security Act or section 5(i) of the Railroad Retirement Act of 1937), whenever acquired, for each calendar year elapsing after 1964 and before the year in which he attained such age,

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

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

shall (subject to the limitations in this part) be deemed, solely for purposes of section 1705 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month in which he dies or, if earlier, the month before the month in which he becomes entitled to monthly insurance benefits under such section 202 or meets the requirements set forth in sub-

paragraph (B) of section 21(b) of the Railroad Retirement Act of 1937.

"Limitations

"SEC. 232. (a) The provisions of section 231 shall apply only in the case of an individual who—

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

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

"(b) The provisions of section 231 shall not apply to any individual who—

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

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

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

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

"Payments to Trust Fund

"SEC. 233. There are hereby authorized to be appropriated to the Federal Health Insurance Trust Fund (established by section 201 of the Social Security Act) from time to time such sums as the Secretary deems necessary, on account of—

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

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

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

in order to place such Trust Fund in the same position in which it would have been if sections 231 and 232 of this Act had not been enacted.

"Part E—Miscellaneous provisions

"Studies and Recommendations

"SEC. 241. The Secretary of Health, Education, and Welfare shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to (1) the adequacy of existing facilities for health care for purposes of the program established by this Act; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; (3) the feasibility of providing additional types of health insurance benefits within the financial resources provided by this Act; and (4) the effects of the deductibles upon beneficiaries, hospitals, and the financing of the program."

Make appropriate changes in the table of contents.

Mr. MANSFIELD. Mr. President, will the Senator yield with the understanding that he will not lose his right to the floor?

Mr. ANDERSON. I yield with that understanding.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MANSFIELD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk called the roll and the following Senators answered to their names:

[No. 112 Leg.]

Aiken	Fulbright	Miller
Allott	Goldwater	Monroney
Anderson	Hart	Morse
Beall	Hayden	Morton
Bennett	Hickenlooper	Moss
Boggs	Hickey	Mundt
Byrd, W. Va.	Hill	Murphy
Cannon	Holland	Muskie
Carlson	Hruska	Neuberger
Case	Jackson	Pastore
Chavez	Javits	Pell
Clark	Johnston	Proxmire
Cotton	Keating	Randolph
Curtis	Kefauver	Smith, Maine
Dirksen	Kerr	Sparkman
Dodd	Kuchel	Symington
Douglas	Long, Mo.	Thurmond
Dworshak	Long, Hawaii	Wiley
Eastland	Mansfield	Williams, N.J.
Ellender	McClellan	Williams, Del.
Engle	McGee	Young, N. Dak.
Ervin	McNamara	Young, Ohio
Fong	Metcalf	

The PRESIDING OFFICER (Mrs. NEUBERGER in the chair). A quorum is present.

Mr. ANDERSON. Madam President, I ask unanimous consent that without losing my right to the floor, I may yield now to the Senator from Missouri [Mr. SYMINGTON] in order that he may present a matter.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. SYMINGTON. I thank the Senator from New Mexico for his courtesy in yielding to me.

Madam President, as we stated on the floor of the Senate on July 3, and as reported in the CONGRESSIONAL RECORD for that date on page 11782, Missouri and a number of other States are deeply concerned about one of the provisions in the Public Welfare Amendments Act of 1962, H.R. 10606.

As passed by the House and as reported by the Senate Finance Committee, the long established dollar-for-dollar matching formula on the welfare programs under social security would be subject to change if the States did not meet minimum standards on certain additional administrative services not yet spelled out by the Secretary of Health, Education, and Welfare.

This problem would be corrected by a series of five amendments, intended to be proposed by the senior Senator from Massachusetts [Mr. SALTONSTALL], numbered "6-23-62—A." The Senator from Massachusetts is unable to be in the Senate today, but I have been assured of his continued support for these amendments. My colleague [Mr. LONG] joins in offering them.

Madam President, I ask unanimous consent that these amendments be considered at this time.

Actually, Madam President, there are five amendments, in order to take care of this single item; they appear on five different pages. In each case, the word "one-fourth" is stricken out, and the word "one-half" is substituted for it.

I have previously explained these amendments. I understand there is no objection to them; therefore, I ask unanimous consent that they be considered at this time.

Mr. YOUNG of North Dakota. Madam President, will the Senator from Missouri yield?

Mr. SYMINGTON. I yield.

Mr. YOUNG of North Dakota. I wish to join in supporting the amendments. The executive secretary of the public welfare board in my State, Mr. Carlyle D. Onsrud, says they are necessary in our State. He advises me the welfare program would be badly crippled without these amendments which would permit continued administrative matching funds at 50 percent regardless of whether or not the State failed to comply with minimum services to be prescribed by the Secretary of Health, Education, and Welfare.

The PRESIDING OFFICER. Is there objection to temporarily laying aside the pending amendment of the Senator from New Mexico, in order to consider the amendment offered by the Senator from Missouri? The Chair hears none; and the amendments offered by the Senator from Missouri, for himself, the Senator from Massachusetts [Mr. SALTONSTALL], and the junior Senator from Missouri [Mr. LONG], will be stated.

The LEGISLATIVE CLERK. On page 25, in line 5, it is proposed to strike out "one-fourth" and insert in lieu thereof "one-half".

On page 27, lines 5 and 6, strike out "one-fourth" and insert in lieu thereof "one-half".

On page 29, lines 12 and 13, strike out "one-fourth" and insert in lieu thereof "one-half".

On page 31, lines 10 and 11, strike out "one-fourth" and insert in lieu thereof "one-half".

On page 90, lines 1 and 2, strike out "one-fourth" and insert in lieu thereof "one-half".

Mr. CURTIS. Madam President——

Mr. SYMINGTON. I yield to the Senator from Nebraska.

Mr. CURTIS. I wish to thank the distinguished Senator from Missouri for calling up these amendments on behalf of himself and the Senator from Massachusetts [Mr. SALTONSTALL].

I have received a telegram from Gov. Frank B. Morrison, of Nebraska, urging that this action be taken; and I have before me a letter from Mr. F. M. Woods, director of the State of Nebraska Department of Public Welfare, in which he states:

> These are matters which can and should be resolved by the States themselves. Federal regulations in the field will be of very little direct benefit to recipients of public assistance. Rather, such interference will result in chapters of written regulations, mountains of useless reports, and unnecessary expenditure of administrative funds.

The action the Senate has taken has prevented the long arm of Federal bureaucracy from reaching farther down into matters which can be handled by the various States, through their departments of public welfare. I thank the Senator for the service he has rendered in this connection.

Mr. SYMINGTON. I thank the Senator from Nebraska.

Mr. LONG of Missouri. Madam President, will my colleague yield to me?

Mr. SYMINGTON. I am glad to yield to my colleague.

Mr. LONG of Missouri. I wish to compliment my distinguished colleague for calling up these amendments at this time. As he knows, the absence of these amendments could have meant a $2 million loss to our State, and possibly would have meant curtailment of old-age assistance and other necessary welfare programs in Missouri.

Mr. SYMINGTON. Yes. My colleague and I have carefully studied this matter together, and we know that would have been the result in our State.

Mr. LONG of Missouri. I feel that certainly this is the better way to handle the matter, rather than to maintain the penalty in connection with the 50-50 matching program.

Mr. SYMINGTON. It is; and I thank my colleague for his contribution.

The PRESIDING OFFICER. Without objection, the amendments will be considered en bloc.

The question is on agreeing to the amendments of the Senator from Missouri.

The amendments were agreed to.

Mr. SYMINGTON. Madam President, I thank the Senator from New Mexico for his courtesy in allowing these amendments to be considered and adopted at this time.

Mr. COTTON. Madam President, will the Senator from New Mexico yield to me?

Mr. ANDERSON. Madam President, I ask unanimous consent that at this time I may yield to the Senator from New Hampshire, without losing my right to the floor.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. COTTON. I thank the Senator from New Mexico.

Madam President, I send to the desk an amendment intended to be proposed by me to the so-called Anderson amendment; and I ask that this amendment be printed and lie on the table.

The PRESIDING OFFICER. Without objection, the amendment will be received and printed, and will lie on the table.

Mr. MORTON. Madam President, Will the Senator from New Mexico yield to me?

Mr. ANDERSON. Madam President, I ask unanimous consent that I may yield now to the Senator from Kentucky, without losing my right to the floor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MORTON. Madam President, I ask that a bill I have introduced, Senate bill 3386, be considered as an amendment in the nature of a substitute for the Anderson amendment; and I wish to have my amendment considered and wish to bring it up on the floor of the Senate tomorrow, and have it disposed of. It is not my intention to press for a yea-and-nay vote on my amendment; but I think tomorrow this amendment in the nature of a substitute can be disposed of.

I call attention to the fact that my amendment is the text of Senate bill 3386, and is being offered as an amendment in the nature of a substitute for the Anderson amendment.

Mr. JAVITS. Madam President, will the Senator from Kentucky yield in connection with his amendment in the nature of a substitute?

Mr. MORTON. I yield.

Mr. JAVITS. This looks very much like the so-called Bow plan. Can the Senator from Kentucky in any way identify the amendment for purposes of our study and consideration—in short, to indicate what differences or what similarities there are?

Mr. MORTON. My amendment differs from the Bow plan, in that my amendment provides for a needs test. In other words, one who pays no income tax would not pay for his insurance policy; the Government would pay for it. One who pays an income tax of $100 would make a certain payment—and so forth. So my amendment provides for a needs test, and in that way is different from the Bow plan.

Mr. JAVITS. I thank the Senator from Kentucky.

Mr. MORTON. Madam President, I offer my amendment.

The PRESIDING OFFICER. The amendment of the Senator from Kentucky, offered as a substitute for the Anderson amendment, will be stated.

The Chief Clerk proceeded to read the amendment.

Mr. MORTON. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment offered by Mr. MORTON as a substitute for the Anderson amendment is as follows:

That this Act may be cited as the "Health Care Benefits for the Aged Act".

DEFINITIONS

SEC. 2. For the purposes of this Act—

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

(b) The term "State" includes the District of Columbia.

(c) The term "State plan" means a State plan for health benefits for the aged.

(d) The term "State agency" means the agency established or designated in accordance with section 4(a)(11).

(e) The term "contract" means the policy, contract, agreement, or other arrangement entered into between a carrier and a State agency for the purpose of providing for the participation by individuals in a health benefits program under a State plan.

(f) The term "health benefits program" means a group insurance contract provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services.

(g) The term "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the costs of, health services under group insurance contracts in consideration of premiums payable to the carrier.

(h) The term "premium" means the amount of the consideration charged by a carrier for participation by an individual in a health benefits program provided by the carrier.

(i) The term "State share" means the portion of the premium to be paid by the State with respect to the participation of an individual in a health benefits program.

(j) The term "individual share" means the portion of the premium to be paid by an individual for his participation in a health benefits program.

(k) The term "taxable year" means a taxable year as defined in section 441(b) of the Internal Revenue Code of 1954.

(l) The term "Federal income tax liability" means, in the case of any individual, the amount of the income tax imposed for the taxable year on such individual under part I of subchapter A of chapter 1 of the Internal Revenue Code of 1954, determined without regard to the provisions of part IV of subchapter A of chapter 1 of such Code (other than section 37 of such part IV). The amount of the Federal income tax liability under a joint return shall, for purposes of the preceding sentence, be deemed to be the amount of the Federal income tax liability of each of the parties to such return.

APPROPRIATION

SEC. 3. For the purpose of enabling each State to assist individuals residing therein who are age sixty-five or over to obtain, through prepaid health benefits plans, provisions of, payment for, or reimbursement for the expenses of, health care services at subscription rates which such individuals can afford to pay (determined on the basis of the amount of their Federal income tax liability for the taxable year), there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this Act. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for health benefits for the aged.

STATE PLANS

SEC. 4. (a) A State plan for health benefits for the aged must—

(1) provide for the participation, on a voluntary basis, by all residents of the State who are age sixty-five or over in a health benefits program which complies with the provisions of section 7;

(2) provide for adequate dissemination to such residents of full and complete information concerning the benefits provided under such program, the terms and conditions thereof, and the amount of the premium therefor;

(3) provide for such review by the Secretary and such other safeguards as the Secretary may determine to be necessary or desirable to assure that the premiums for participation in any such health benefits program reasonably and equitably reflect the cost of the benefits to be provided thereunder, and that participants therein shall receive the benefits to which they are entitled thereunder without undue delay;

(4) make suitable provision for the receipt, under such program, of benefits by participants residing in the State but who are temporarily absent therefrom;

(5) provide that any individual, who is enrolled under such a program for any taxable year, and who, during such year, changes his residence to another State, shall not be precluded from continuing to participate in such program for the remainder of such year by reason of his change of residence;

(6) provide that the full amount of the premium for such program with respect to each individual participating in such program shall be paid by the State;

(7)(A) provide that the individual share of any such premium shall be fixed in accordance with regulations issued by the Secretary under section 8, and that such share shall be collected by, or under the supervision of, the State agency; and

(B) provide that the tentative amount of such share, in the case of any individual, shall be determined on the basis of the amount of the anticipated Federal income tax liability of such individual as contained in his most recent declaration of anticipated Federal income tax liability (filed in accordance with section 9), and that, in the event of any discrepancy between the amount contained in such declaration and such individual's actual Federal income tax liability as reported to the State agency pursuant to section 11, a proper adjustment in the amount of such share will be made;

(8) provide that the State plan shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(9) provide that the cost of administration of the State plan will be paid by the State;

(10) provide such methods of administering (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(11) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(12) make provision, in accordance with regulations promulgated under section 10, for verification of representations made by individuals incident to the determination of their share of the premium for participation in such a health benefits program; and

(13) provide for prompt notice to appropriate law-enforcement officials of any facts or circumstances suggesting that any fraud or misrepresentation has been committed by any individual in connection with his participation, or application for participation, in a health benefits program under the State plan.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility to participate in a health benefits program provided under such plan—

(1) any residence requirement which excludes any resident of the State; or

(2) any citizenship requirement which excludes any citizen of the United States.

PAYMENT TO STATES

SEC. 5. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has a plan approved under this Act, for each quarter, beginning with the quarter commencing October 1, 1962, an amount equal to the sum of the amounts expended, during such quarter, under the State plan as the State share of the premium for a health benefits program under such plan with respect to each individual participating in such program, not counting so much of any expenditure with respect to any individual which is attributable to payment of such a premium in excess of $125 per annum.

(b) The method of computing and paying the amount referred to in subsection (a) shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a). Such estimate shall be based on (A) a report filed by the State containing its estimate (determined in accordance with regulations issued by the Secretary) of the amount payable to it under subsection (a), (B) records showing the number of individuals in the State who are sixty-five or over, and (C) such other data as the Secretary shall find useful. In making any such estimate with respect to an individual who, prior to the date such estimate is made, has (incident to his participation during such quarter in a health benefits program under the State plan) filed in accordance with section 9 a declaration of anticipated Federal income tax liability, the estimated amount payable to the State under subsection (a) with respect to such individual shall be based on the State share of the premium for such individual's participation in such program, determined on the basis of data contained in such declaration.

(2) The Secretary shall then certify to the Secretary of the Treasury, the amount so estimated by the Secretary, reduced or increased, as the case may be, by any sum by which the Secretary finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter.

(3) The Secretary of the Treasury shall thereupon, prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary, the amount so certified.

OPERATION OF STATE PLANS

SEC. 6. In the case of any State plan which has been approved under this Act by the Secretary, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration plan finds—

(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 4(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 4(a) to be included in the plan, or any other provision of this Act (or regulation issued thereunder by the Secretary) relating to the administration of the plan;

the Secretary shall notify such State agency that further payments will not be made to the State until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

HEALTH BENEFITS PROGRAMS

SEC. 7. (a) In order to qualify under the State plan, a health benefits program must—

(1) be offered by a carrier which is licensed to issue group health insurance in the State;

(2) be offered under a contract which contains a detailed statement of benefits offered, including such maximums, limitations, exclusions, and other definitions of benefits as the Secretary shall by regulations prescribe;

(3) offer participation of a noncancellable or guaranteed renewable basis; and

(4) offer each participant in the program a choice of either (A) ordinary or short-term illness coverage, or (B) long-term or catastrophic illness coverage.

(b) Subject to the requirements contained in subsection (a), a health benefits program may be of the following types:

(1) SERVICE BENEFIT PLAN.—
(A) Hospital benefits.
(B) Surgical benefits.
(C) In-hospital medical benefits.
(D) Ambulatory patient benefits.
(E) Supplemental benefits.

(2) INDEMNITY BENEFIT PLAN.—
(A) Hospital care.
(B) Surgical care and treatment.
(C) Medical care and treatment.
(D) Prescribed drugs, medicines, and prosthetic devices.

(3) COMPREHENSIVE MEDICAL PLANS.—Benefits of the types specified in this subsection under paragraph (1) or (2) or both.

(c) For purposes of this section the term—

(1) "service benefit plan" means a statewide plan under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described in subsection (b)(1) rendered to participants in such plan, or, under certain conditions, payment is made by a carrier to the participant;

(2) "indemnity benefit plan" means a statewide plan under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described in subsection (b)(2); and

(3) "comprehensive medical plan" means—

(A) a group-practice prepayment plan which offers health benefits of the types referred to in subsection (b)(3), in whole or in a substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. Such group shall include physicians who represent at least three major medical specialties which are applicable to aged persons, and who receive all or a substantial part of their professional income from prepaid funds; or

(B) individual-practice prepayment plans which offer health services in whole or substantial part on a prepaid basis, with professional services thereunder provided by individual physicians who agree, under certain conditions specified under regulations issued by the Secretary, to accept the payments provided by the State plan as full payment for covered services rendered by them including, in addition to in-hospital services, general care rendered in their offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which are offered by organizations which have successfully operated for a period of not less than six months prior to entering into a contract with a State agency.

AMOUNT OF STATE SHARE AND INDIVIDUAL SHARE

SEC. 8. (a) The amount of the State share with respect to any individual for any period within a taxable year of such individual shall be based on the Federal income tax liability of such individual for such year and shall be determined in accordance with a schedule issued by the Secretary.

(b) Such schedule shall provide that the State share shall be—

(1) in case such period is a period of twelve months and the amount of the annual premium is $125 or less—

(A) an amount equal to 100 per centum of the premium, if the individual has no such tax liability for such year, (B) an amount equal to 20 per centum of the premium, if the individual has such a tax liability of $400 or more for such year, and (C) an amount (equal to not less than 20 per centum nor more than 100 per centum of the premium) established by the Secretary in regular inverse proportion to the amount of such individual's tax liability as aforesaid, if the individual has such a tax liability for such year but the amount thereof is less than $400;

(2) in case the amount of the annual premium is more than $125, the amount provided by paragraph (1) with respect to the first $125 of such premium plus 100 per centum of the excess of such premium over $125; and

(3) in case such period is less than twelve months, an amount which bears the same ratio to the amount of the State share (as determined under paragraph (1) or paragraph (2), as the case may be) as the num-

ber of months in the period bears to the number twelve.

(c) The amount of the individual share of any individual for any period shall be equal to the amount, if any, by which the amount of the premium with respect to such individual for such period exceeds the amount of the State share with respect to such individual for such period.

DECLARATION OF ANTICIPATED FEDERAL INCOME TAX LIABILITY

SEC. 9. (a) As a requisite to participation in a health benefits program under a State plan by any individual for any period within any taxable year of such individual, such individual shall file in duplicate, prior to the beginning of such period, with the State agency (or the local agency administering the State plan) a declaration (in such form and manner as hereinafter prescribed) of his anticipated Federal income tax liability for such year.

(b) Any such declaration shall be filed under oath or affirmation and shall be filed on forms supplied to the State agency by the Secretary. Such forms shall be prepared by the Secretary with the advice and assistance of the Secretary of the Treasury and shall require the submission of such data as may be necessary to provide, insofar as possible, an accurate estimate of the Federal income tax liability of the individuals filing such forms.

REPORT OF AMOUNT OF FEDERAL INCOME TAX LIABILITY TO STATE AGENCY

SEC. 10. Each individual who, during any taxable year, has participated in a health benefits program under a State plan approved under section 4(b), shall, at the time he files his Federal income tax return for such year, report to the State agency (on such forms and in such manner as the Secretary shall by regulations provide) the amount of his Federal income tax liability as determined by appropriate data contained in such return.

VERIFICATION OF ACCURACY OF DECLARATIONS OF ACTUAL FEDERAL INCOME TAX LIABILITY

SEC. 11. The Secretary and the Secretary of the Treasury shall cooperate in promulgating rules, regulations, and procedures for the purpose of—

(a) comparing amounts of actual Federal income tax liability reported by individuals to State agencies pursuant to Sec. 10 of this Act and the amounts of the actual Federal income tax liability of such individuals, as disclosed by Federal income tax returns submitted by such individuals or as determined by the Internal Revenue Service subsequent to the submission of such returns;

(b) assuring that, in the case of any such discrepancy, appropriate action will be taken to adjust the amounts of the State share and the individual share of the premium with respect to the individual to whom such discrepancy relates.

AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1954

SEC. 12. Section 213(e) of the Internal Revenue Code of 1954 (relating to definition of medical care for purposes of deduction of medical expenses) is amended by adding after paragraph (2) thereof the following new paragraph:

"(3) Notwithstanding the provisions of paragraph (1)(A), no amount paid with respect to an individual toward any premium for participating in a health benefits program under a State plan approved under section 4(b) of the Health Care Benefits for the Aged Act shall be considered as an amount paid for medical care."

Mr. ANDERSON. Madam President, this afternoon amendments to my amendment have been offered. I am happy that that is taking place, because it is an extremely important measure.

One of the things that is regarded as most significant is that hearings have not been held in a regular committee session to consider this proposal.

In 1960 there was a vote without 1 hour's consideration of the measure by the committee. At the same time we took a whole series of amendments, on which there had been no public consideration. I regret that there has been none on this amendment. Nevertheless, I proposed a motion inside the Finance Committee months ago to afford that opportunity. It was refused. I do not question the judgment of Senators who voted that way. All I say is that, because of that fact, it is necessary to present this measure without adequate committee hearings.

One of the questions raised frequently is the question of financing. Certain persons say there are different kinds of answers to financing. One person said, "I thought it was going to cost me $13. Now they say it is going to cost $27.50."

The proposals in the bill deal with more than health insurance. Therefore, I shall place in the RECORD a brief statement, with tables that will be helpful, in order that it may be possible to understand what we have in mind.

Our proposal provides for financing the health benefits which it would add to the OASDI system through an increase in the payroll tax of one-fourth percent each for employers and employees, and of three-eighths percent on earnings from self-employment, and an increase from $4,800 to $5,200 in the tax base—the maximum annual earnings subject to tax.

Most of the revenues thus raised would be used for the financing of health insurance benefits. A smaller part would go to pay for increased cash benefits for persons whose earnings are greater than $4,800. Persons earning $4,800 or less would not, of course, be affected by any raising of the tax base. Under the existing social security system, benefits are weighted, that is, they are a greater proportion of lower average monthly earnings under the system than of higher monthly earnings. Therefore, the income received from the combined employer-employee tax through an increase in the tax base to $5,200 is greater than the cost of paying the increased benefits which accompany such an increase. Under the proposal, the additional revenue—above that required to finance increased cash monthly benefits—would go toward the payment of the cost of the health insurance.

In terms of dollars, the person who earns $4,800 a year would pay $12 more than under present law. The person earning $5,200 or more would pay $27.50 additional under my proposal. Of this $27.50 only $17.68 would go toward health insurance costs, however. The remainder would go toward the payment of the old-age, survivors, and disability insurance benefits which would be increased for this group.

Madam President, I ask unanimous consent that a table showing the tax rates for employees in 1964 and later years under the system with health insurance benefits added, compared with those under present law, be printed at this point in my remarks.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

Contribution rate and amount of contributions for an employee under present law and under the proposal

	Contribution rate (percent)	Yearly earnings				
		$2,400	$4,800	$5,200		
				Total	OASDI	Health insurance
1964–65:						
Under the proposal	3⅞	$93	$186	$201.50	$183.82	$17.68
Under present law	3⅝	87	174	174.00	174.00	
Increase	¼	6	12	27.50	9.82	17.68
1966–67:						
Under the proposal	4⅜	105	210	227.50	209.82	17.68
Under present law	4⅛	99	198	198.00	198.00	
Increase	¼	6	12	29.50	11.82	17.68
1968 and thereafter:						
Under the proposal	4⅞	117	234	253.50	235.82	17.68
Under present law	4⅝	111	222	222.00	222.00	
Increase	¼	6	12	31.50	13.82	17.68

Mr. ANDERSON. Madam President, there have been a great many questions as to what changes will be made in the bill. I tried to review these at some length on Tuesday afternoon. Let me review what some of them may be.

There is a change in the establishment of a separate health insurance trust fund. In the original bill there would have been a separate account. I have never regarded as a separate account payments into a fund, as is done in a bank by different persons. If I have an account in a bank and someone else has an account in the bank, those accounts are not marked as separate accounts or separate deposits for purposes of insurance. What we want to be sure of is that the checks I write are not charged to his account and that the checks he writes are not charged to my account. We want to make sure that the accounts

are kept separately. I thought the problem in the original bill which involved the separate account was reasonably easy of solution. Others thought a trust fund would be better. Since we were both trying to reach the same base, I saw no objection to the establishment of a health insurance trust fund.

Second, in respect to a great deal of proposed legislation, we have had the proposal for blanketing in, for health insurance benefits, of two and a half million uninsured aged. We did not feel, at the beginning of this discussion, that this group of people should be covered under the health insurance fund through social security, because obviously they could not be paid from the social security fund. Therefore, in the earlier editions of the so-called King-Anderson bill there was no separate provision for the blanketing in of those two and a half million people.

Many people were seriously concerned about this problem and thought it should be attacked at the same time. I subscribe to that point of view. The senior Senator from New York [Mr. JAVITS] was one of those who recognized the problem. He recommended that in any final draft of the amendment we should take that problem into consideration. Others did the same. Therefore, we have incorporated in the amendments a proposal for blanketing in these two and a half million people.

Many have asked, "What would this do in my State? Who would be involved in my State?" Therefore, I ask unanimous consent to have printed at this point in the RECORD a table showing "Estimated Population and Persons Eligible for Health Benefits," under the amendments now before the Senate for its consideration.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

Estimated population and persons eligible for health benefits under the Anderson amendment, Jan. 1, 1964

[In thousands]

State	Total population 65 and over	Number eligible under OASI	Number eligible under RRA	Total eligible under RRA and OASI	Number blanketed in
Total	17,877	14,448	794	[1] 15,009	2,500
Alabama	276	195	12	203	68
Alaska	7	4	----------	4	3
Arizona	109	83	6	87	19
Arkansas	201	148	9	155	42
California	1,514	1,191	52	1,227	249
Colorado	169	122	10	129	36
Connecticut	262	233	5	237	22
Delaware	38	33	3	35	2
District of Columbia	72	47	2	49	----------
Florida	686	535	27	554	111
Georgia	308	208	14	218	83
Hawaii	31	27	----------	27	2
Idaho	62	53	3	55	6
Illinois	1,038	856	60	898	125
Indiana	464	410	27	429	28
Iowa	338	276	17	288	45
Kansas	250	198	17	210	36
Kentucky	303	239	19	252	46
Louisiana	260	156	10	163	93
Maine	108	96	5	99	6
Maryland	245	189	13	198	33
Massachusetts	594	505	13	514	68
Michigan	695	624	20	638	50
Minnesota	379	304	23	320	54
Mississippi	196	137	7	142	51
Missouri	26	404	28	424	90
Montana	69	57	6	61	6
Nebraska	171	137	10	144	24
Nevada	20	15	2	16	3
New Hampshire	69	63	2	65	2
New Jersey	613	541	22	557	46
New Mexico	57	39	4	42	13
New York	1,811	1,555	56	1,595	186
North Carolina	334	271	10	278	51
North Dakota	60	50	3	52	7
Ohio	943	788	49	823	67
Oklahoma	260	176	7	181	74
Oregon	197	175	10	182	11
Pennsylvania	1,190	1,024	78	1,079	90
Rhode Island	93	86	1	87	4
South Carolina	158	117	5	121	34
South Dakota	75	61	2	63	11
Tennessee	326	243	18	256	75
Texas	819	565	33	588	217
Utah	66	53	5	57	6
Vermont	44	38	2	39	4
Virginia	306	239	21	254	35
Washington	296	250	13	259	26
West Virginia	174	149	14	159	13
Wisconsin	429	377	16	388	36
Wyoming	29	22	3	24	4
Puerto Rico	135	83	----------	83	51
Virgin Islands	2	1	----------	1	1

[1] Corrected for duplication.

Mr. ANDERSON. Madam President, we made a third change. We tried to provide that private organizations, such as the Blue Cross plans, might be used for administration of the programs in making payments to hospitals.

Mr. KERR. Madam President, will the Senator yield?

Mr. ANDERSON. I yield.

Mr. KERR. To what extent?

Mr. ANDERSON. That would depend upon the extent to which the local agency desired to make use of them.

Mr. KERR. Do the amendments provide that any beneficiary or prospective beneficiary under the proposal would obtain money from the fund with which to pay for Blue Cross protection?

Mr. ANDERSON. They do not.

Mr. KERR. Is it not a fact that the only reference to Blue Cross in the amendments is one which would authorize the administration to channel the money through the Blue Cross to pay the hospital for the benefits to be provided?

Mr. ANDERSON. That is correct.

Mr. KERR. And the benefits would not be thereby increased or changed?

Mr. ANDERSON. That is correct. But there are a great many people who have gone up and down the country saying, "You are trying to break into this sacred relationship between the doctor and his patient." If people are worried about the sacred relationship, there should be no objection to the Blue Cross taking over the administrative phase and handling all the details, if it is their wish that Blue Cross do so.

Mr. KERR. If it is whose wish that it do so?

Mr. ANDERSON. The person involved.

Mr. KERR. The beneficiary?

Mr. ANDERSON. That is correct.

Mr. KERR. The beneficiary would get no more benefits.

Mr. ANDERSON. He might get benefits in this way: If he now has a Blue Cross policy, his policy may be very limited. He may have only a few days or a few weeks of benefits. If the amendments were agreed to and the bill was passed, it would be possible to extend the benefits a person would get from Blue Cross to a far greater field. It would not increase the benefits available because of the payment.

Mr. KERR. The beneficiary would get the same benefits, in addition to his own private coverage, whether the benefits provided for by the amendments were paid for through the Blue Cross or not, would he not?

Mr. ANDERSON. That is correct.

Mr. KERR. Is it not a fact that the only thing which the Senator's amendments would do with reference to Blue Cross would be to increase the administrative cost of the program without giving to the beneficiary a single dollar of added benefits?

Mr. ANDERSON. The point is that the administration can pay to Blue Cross the cost it would normally absorb itself in administration.

Mr. KERR. That is, the cost the Government would absorb?

Mr. ANDERSON. No; I did not say that.

Mr. KERR. The Senator said the Government could pay to Blue Cross what its own cost would be.

Mr. ANDERSON. What its own cost would be; that is correct.

Mr. KERR. The Government's cost.

Mr. ANDERSON. If the Government wished to do so, it could contact the Blue Cross to administer the program. The Blue Cross administration costs have been running about 3 percent. If they increased to 5 percent, that still

would not be an extravagant figure. It would cost the Social Security Administration something to administer the program. If it wished to allow the money for administration to be spent by Blue Cross, we would see no objection to that.

Mr. KERR. I see no objection to it. I merely wish to make the record clear that that provision in the amendments would not give an added dollar to the local beneficiary, but only would bring the Blue Cross in as an intermediary between the Government and the hospital. There would be an expense in connection with the Blue Cross handling that Government fund, which the Government would have to pay, but as a result of which the beneficiary would not get another dollar in benefits.

Mr. ANDERSON. I operated a little insurance company for quite a while. I had two options in that regard. I could use the claim adjusters of my own on every case, or I could hire an adjuster service. The costs were about the same.

That is what we are trying to provide. If someone wishes to use Blue Cross and to pay them a reasonable fee for adjustment, it would probably balance out to what it would cost if the Government had the Government employees do the work themselves.

This provision results from a great demand that we allow the Kaiser plan, for example, to continue operation for the people who are already under the plan. I think the Kaiser plan is a good plan. I should like to see an arrangement under which it might be utilized by all those who wish to utilize it.

I have no objection to the Blue Cross. The Blue Cross has done good work. Therefore, if any group, county or State wishes to make use of the Blue Cross, I do not object to their doing so.

I do not think agreeing to the provision would result in a double charge, because I do not think the Government could possibly administer the program without some cost.

Mr. CURTIS. Madam President, will the Senator yield to me?

Mr. KERR. If the Senator will permit, I should like to ask another question.

In connection with the insurance company which the Senator says he has operated, with reference to which claims arose, which claims had to be settled either by his own adjusters or by outside adjusters, the Senator refers to claims which were undetermined as to the exact amount; does he not?

Mr. ANDERSON. Yes.

Mr. KERR. Under this program the specific benefits would be spelled out in the legislation; would they not?

Mr. ANDERSON. Yes.

Mr. KERR. So there would not be a question of adjustment with regard to how much in benefits was to be provided. That would be in the law.

Mr. ANDERSON. There is a problem of adjustment in determining how many dollars are to be paid as between the Federal Government and the person who enters the hospital.

The person entering the hospital would have to pay a part of the cost. He might have to pay $10 a day for perhaps a maximum of 9 days.

There would be a question with regard to Blue Cross providing certain additional benefits over and above those provided for the basic law. I point out that if Blue Cross wished to say, "We will pay the basic benefits ourselves," the Government could well afford to give it money to do so.

Mr. KERR. To pay the basic Blue Cross benefits?

Mr. ANDERSON. No.

Mr. KERR. To pay only the Government benefits?

Mr. ANDERSON. That is correct. They could recover from the Government the amount paid out.

Mr. KERR. For the Government?

Mr. ANDERSON. For the Government.

Mr. KERR. Plus a fee?

Mr. ANDERSON. Only when there was a decision by the Government itself that this involved an arrangement needing adjustment. If arrangements could be made with Blue Cross, at a cost of from 3 to 5 percent, I personally think that would be a good range of cost for the Government.

Mr. KERR. Madam President, will the Senator yield further?

Mr. ANDERSON. I yield.

Mr. KERR. Has the Blue Cross indicated it would either desire or accept such an arrangement.

Mr. ANDERSON. The Blue Cross representatives have been in my office a few times suggesting that they would like to be included in some sort of an arrangement of this nature.

Mr. KERR. I asked the Senator if they had indicated a desire or willingness to participate in this program as provided by the Senator's amendments on the basis set forth in the amendments for them to participate?

Mr. ANDERSON. I answer by saying that they have no authority or power to commit their organization until something is presented to them. We have no way of saying today what the bill will look like when it emerges from this Chamber or from the Congress.

Mr. KERR. I am assuming that the bill will emerge as the Senator has suggested it emerge.

Mr. ANDERSON. If the bill should emerge as I have suggested, the Department of Health, Education, and Welfare should be well advised to immediately get in touch with the Blue Cross to see if the many representations they have made of a desire to participate in this program would actually result in any service to be given by them. If they then want no part of the program, that will be fine.

In the case of the Kaiser plan, representatives of the Kaiser plan have suggested language to put in the amendments to make it easier for the Kaiser plan to do what is necessary.

I do not know what form the final language will take. I can say only that the Senators from New York [Mr. JAVITS and Mr. KEATING], the able Senator from Kentucky [Mr. COOPER], the Senator from California [Mr. KUCHEL] and other Senators have suggested that certain plans be included.

The result was a rather limited option, I grant the Senator. Whether that option will have to be extended or expanded I do not know. I cannot tell what the Congress will wish to have done.

I know that the able Senators from New York [Mr. JAVITS and Mr. KEATING] and other Senators have worked steadily to find out if there is any basis on which the option itself might be altered in this proposal, to make it more workable. That is a hard problem to solve. It is very difficult to put in an option without changing the plan fundamentally. We have not yet been able to do so.

If we could devise such a provision, it would be proper, I think, to take it up with the Kaiser plan, the Blue Cross, or anyone else. Thus far we have not been able to accept the language submitted by the Kaiser plan. Whether we shall be able to deal with Blue Cross I do not know.

I can only say that many times Blue Cross has expressed the hope that we could keep this provision open so that they could give it consideration.

I believe that, as an organization, they would find it to their advantage, when they went to cover a case that is now under Blue Cross, to say, "If you are under the basic coverage of the social security approach which is carried in the bill, we will handle your adjustment. We will present a claim for the Government's portion. We will add 3 percent, or whatever it may be, for administration, and we will also take care of our own section of the claim, which the bill does not cover, because the provision is only basic. At a subsequent time we will ask for a payment from their own funds." I do not know what form it would finally take. We would try to keep it open so that the companies could make a presentation.

Mr. KERR. But no basis has yet been established as between the sponsors of the measure and the companies.

Mr. ANDERSON. The Senator is correct.

Mr. CURTIS. Madam President, will the distinguished Senator yield?

Mr. ANDERSON. I yield.

Mr. CURTIS. In the case stated, would the Blue Cross assume any of the risk?

Mr. ANDERSON. It depends on what the Senator means by "assuming any of the risk." If a person should go into a hospital, under the provisions of the bill he would have 90 days of protection. If the Blue Cross had issued a policy guaranteeing to pay that person from the first day onward, without any deductions, and for 100 days into the future, Blue Cross would assume a portion of the risk, because their policy overlaps the policy that would cover the basic considerations, but it would assume no part of the basic risk covered in the bill.

Mr. CURTIS. It would assume no part of the Government's risk?

Mr. ANDERSON. That is correct.

Mr. CURTIS. Is it anticipated that the Government would audit each indi-

vidual claim handled and paid by the Blue Cross?

Mr. ANDERSON. That question was asked of me two or three times in the preparation of the option amendment. My only answer was that I would hope not. At the present time a great many bills come to the Department of Health, Education, and Welfare for services supplied by the Blue Cross. The Department of Health, Education, and Welfare audited those bills for a while and found that the Blue Cross bills are—I was about to say always in line, but I had better not make that statement. Some may have been found out of line. But so far as I know, the Department has never found anything wrong with bills sent by Blue Cross.

I assume that if the Blue Cross took a section of the plan, or if the Kaiser Co. did, or if it were handled through Eastman Kodak Co.'s plan or handled through some other large organization's plan, the Government would audit a few of the claims. It might do as the Internal Revenue Department does with reference to the income tax returns. It might audit every 5th claim, every 10th claim, or every 20th claim until it had established for itself that since there was no financial advantage to Blue Cross to pad or reduce the claim, and since the conduct of the company had been exemplary all the way through in the handling of claims, they could be accepted with very little audit.

Mr. CURTIS. Is it not conceivable that a case might arise in which, if the Government's claim were paid in a larger amount, Blue Cross' supplementary requirement to pay a supplemental amount would be less?

Mr. ANDERSON. I cannot conceive of that. If the bill should become law, a man coming into a hospital would be eligible to receive 90 days of hospitalization, for which he would make a contribution for the first 9 days at $10 a day. How the Blue Cross would pad the hospital bills and make the hospital sign up for some service it did not render, is beyond my comprehension.

Most hospitals are operated by charities, not by grafters.

Mr. CURTIS. I understand. But suppose some medical attention were rendered in a hospital. Who would decide whether or not the service was incident to the hospitalization, and therefore should be carried under the Government's plan, and who would decide that another carrier—possibly the Blue Cross—should pay for the service?

Mr. ANDERSON. I assume that in the last analysis it would be the Government. Last August I went into a hospital and had my gall bladder removed. I could have submitted my claim to three different companies. I chose one. I presented the claim and notified the rest of whatever other insurance I had. Somehow the companies made the necessary adjustment. I assume that something like that would happen again.

Mr. CURTIS. What organizations or business institutions besides Blue Cross could take advantage of the option under the language in the amendment of the Senator from New Mexico?

Mr. ANDERSON. I mentioned the Kaiser plan. I mentioned the fact that many labor unions have a provision in their agreements that would allow their present benefits to be expanded in case a bill of the nature of the one before the Senate should pass, and therefore additional benefits would be made available to their workers.

I refer specifically to the General Motors contract, with which the Senator may be familiar. If the bill should pass, a basic coverage would be provided under the bill under which it is conceivable that General Motors could say, "in order to balance what we have been doing previously, we will not only give you the benefits which we agreed to extend at one time, but we will add other things, because of the assumption of basic risk under social security."

Mr. CURTIS. How about the case of a nonprofit fraternal insurance society?

Mr. ANDERSON. A "sick and bury" society?

Mr. CURTIS. Could a nonprofit, nontaxable fraternal insurance society that may be writing hospital insurance qualify under that section?

Mr. ANDERSON. I can say only that I believe it would be a question which would depend upon what sort of nonprofit organization it was, and would best be handled by the individuals who would pass on the question when the bill was passed and not by me. I would not want the measure to tie up the Secretary of Health, Education, and Welfare so that he could not operate.

Mr. JAVITS. Madam President, will the Senator yield?

Mr. ANDERSON. The Senator from New York has had more to do with the option provision than I have, and I recognize the fact freely. The two Senators from New York [Mr. JAVITS and Mr. KEATING], the Senator from Kentucky [Mr. COOPER] and others came forward with option provisions that seemed to me to be a step in the right direction. Because I regarded it as a step in the right direction, such a provision was inserted in the bill. The Senator from New York is more familiar with it than I because for many days and nights the two Senators from New York have tried to work to find language that would fit perfectly into the bill. I commend them for it.

Mr. CURTIS. Madam President, I ask unanimous consent that the present colloquy may take place without the distinguished Senator from New Mexico losing his right to the floor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JAVITS. Madam President, I should like to refer my colleague to the language on page 47, lines 8 to 12, of the amendments, which provides for a carrier which is exempt from income tax under the Internal Revenue Code, and thereby would open a door to nonprofit organizations of all characters, whether they are cooperative groups, unions, fraternal organizations, or otherwise.

I also call to the attention of my colleague the fact that the definitions which are contained in the bill also relate to private carriers, that is, profitmaking carriers, and would require them either to be national in scope, in terms very analogous to the kind of carriers that function under the Federal Government's employees insurance plan——

Mr. CURTIS. In other words, an insurance company operated for profit could qualify under the bill.

Mr. JAVITS. Provided it was either national in scope or represented an appreciable part of health coverage in a particular State. I think the Senator will find that the principles which are contained in the option in the bill will be finalized when the Senator from New Mexico [Mr. ANDERSON] and we agree upon the final character of the option. For example, we may make a change in the percentage of health insurance business which an insurance company must carry in a State in order to qualify. I think the 10-percent figure which is now contained in the amendment is too high, but the principle will be established that it can either be as it is now written, a nonprofit organization, fraternal, or otherwise, provided it is either a national company or a substantial company within a State. The 10 percent represents the experience of the Senator from New Mexico in his own company. That is the way in which the program would operate. As I say, there are three aspects: Nonprofit, a national company, or a company of appreciable consequence in the health and insurance field in a State will be able to qualify under the provision.

If the Senator from New Mexico will allow me to proceed, we are at the stage of elucidation, and I appreciate the way in which the Senator from Oklahoma [Mr. KERR] has opened the question. People are much more interested in what we are tyring to do rather than in the merits or demerits of the proposal, which we will have plenty of time to hammer out.

In terms of what we are trying to accomplish, I point out that, like the AMA, the insurance companies have been very much against the proposal—and I do not say this invidiously, because they are honest and sincere in their opposition. In connection with these options we worked in the field of two aspects. First, we have had to study the present practice in order to determine whether the option would lend itself to being adapted within the context of the present practice of Blue Cross and other organizations; second, we have had to do our utmost to look forward to a time when this provision could be law and when a company, in judging the provisions, would find a sufficient inducement in the option to get into this business, using Government benefits, as it were, as a business.

Mr. CURTIS. Madam President, how many insurance companies does the Senator anticipate would qualify as being national in scope?

Mr. JAVITS. I believe we can give those figures. We have found that there are about 750 insurance companies in the country which write health insurance. The best information we have been able to get from reliable sources is that under the definitions now contained

in the amendment, even before a change is made, about one-third of those companies would be eligible under this option. We are advised—and this is all I can tell the Senator—that this provision is an even more liberal provision than that contained in the statute for the insurance of Government employees for health, and that this provision allows even more companies to participate than does the regular Government employees' health plan.

Mr. CURTIS. Would the Secretary have authority arbitrarily to decide that 50 insurance companies, for example, could act as adjusting or servicing agencies, and would anyone who qualifies be entitled to such a contract?

Mr. JAVITS. The latter is the case. We have done our utmost to set out criteria which are self-operative. I remind the Senator from New Mexico that he said there was one situation in which Blue Cross could participate. I believe there are two under the terms of the bill, and therefore I think the record should be made clear on that point. I should like to have the record clearly show that one would be under the option provision which we are now discussing, which is by all odds the most pertinent. The other would be under the provision of the Anderson amendment, which I should like to read by number, so that we are clear about it. It is section 1715, at page 41, entitled "Use of Private Organizations to Facilitate Payment to Providers of Service."

There is introduced a nongovernmental entity servicing a group of hospitals, whether in a section, or area, or some other identity.

Mr. CURTIS. What kind of service?

Mr. JAVITS. As an intermediary between them and their accountings with the Federal Government. I am speaking now for the Senator from New Mexico, and I am sure he will correct me if I am in error. The Senator from New Mexico has ascertained that in many areas hospitals would prefer to continue their existing relationship with Blue Cross and let it have the relationship with the Government as being more convenient.

Mr. CURTIS. Who would make the selection of Blue Cross?

Mr. JAVITS. The hospital itself. We are talking about two different parts of the bill now.

Mr. CURTIS. I know.

Mr. JAVITS. We are talking about section 1715, which relates to the use of Blue Cross as an agent of the hospital, and we are also talking, quite separately and distinctly, about section 1716, which involves the use of Blue Cross or any other nonprofit or profit organization as carriers, using the option which is given to them.

Mr. CURTIS. The Senator means not taking the risk to pay the corpus of the benefits. Is that correct?

Mr. JAVITS. They would take some risk. They would take whatever part they contracted for, over and above the governmental part.

Mr. CURTIS. Not the Government's part.

Mr. JAVITS. No.

Mr. ANDERSON. Only the basic risks covered by the law.

Mr. CURTIS. Is it conceivable that a hospital would elect to have Blue Cross exercise the duties set forth in section 1715 as a go-between between the Government and the hospital, and that the patient in the hospital, being otherwise qualified, would elect a private insurance company to handle his claim?

Mr. KERR. Under section 1716.

Mr. CURTIS. Could that happen?

Mr. JAVITS. Yes. In that case the relationship between the insurance company would be with Blue Cross which represented the hospital, instead of with the Government. The problem could be handled very efficiently and conveniently in that manner.

Mr. CURTIS. Is it the Senator's proposal that there be a Government audit of all transactions between Blue Cross and the hospital pursuant to section 1715—an audit of the hospital claim and and audit of the insurance company?

Mr. JAVITS. On the question of audit, the answer would be "Yes." We would build up an audit situation with respect to individual claims. Let us remember that if we do not have the Blue Cross as an intermediary, there is involved either the individual hospital or the beneficiary himself. The question of audit exists in this situation, no matter how it is done.

Therefore, the answer to the Senator's inquiry about an audit would be "Yes." Of course, we must immediately say that that does not mean that every claim would be audited. There we get into the administration of claims audited by a Government department. No matter where we go, whether in the Department of the Interior or the Department of Agriculture, or any other branch of Government, although they have the right and power and authority to audit, they do not necessarily audit every claim.

Mr. CURTIS. We will leave the audit matter for the moment. Will every one of these claims be approved or disapproved by a representative of the U.S. Government?

Mr. JAVITS. The Senator from New Mexico will correct me if I am in error, but I would say that the Government will have full authority within the terms of the law. The answer to the question, "Can anyone qualify who can meet the terms of the law?" is "Yes." The Government would have complete authority as to the arrangement which is made, in toto; but that does not necessarily mean that the department will audit every claim. That would apply whether it involved Blue Cross, an insurance company, or a pension and welfare fund. Therefore, the arrangement would be entirely with the Government and entirely under the jurisdiction of the Secretary. That does not mean that he would audit every claim.

Mr. CURTIS. Suppose an individual otherwise qualified should spend only 1 day in the hospital. Would he be entitled to benefits?

Mr. JAVITS. As I understand the benefits laid out in the King-Anderson bill, he would not; he must himself pay for the first 9 days at $10 a day and at the very minimum, $20. If 1 day should cost more than $20, which is almost inconceivable, he would have a claim against the Government.

Mr. ANDERSON. If I may interrupt the colloquy at this point, Madam President, there are many technical questions being presented in the debate, and I therefore ask unanimous consent that representatives of the Department of Health, Education, and Welfare, particularly Mr. Robert Ball, Commissioner of Social Security, and Mr. Irwin Wolkstein, of that agency, may be privileged to sit in the Senate Chamber during the discussion.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JAVITS. I, too, hope the Senator from New Mexico will take counsel of his experts and interrupt those of us who he may feel have responded to a question in a way which he believes to be wrong.

Mr. ANDERSON. I did not make the request because I thought the answers the Senator from New York was making were incorrect. The subject is extremely complicated, and I thought we should make certain that the information we give is correct.

Mr. CURTIS. I appreciate the patience of both the distinguished Senators for their answers, because, after all, hearings have not been held on this proposal.

Mr. ANDERSON. How did the Senator from Nebraska vote on the question of holding hearings on the proposal?

Mr. CURTIS. I voted against holding hearings.

Mr. KERR. Did the Senator vote to hold hearings if and when a bill came from the House?

Mr. CURTIS. Yes.

Mr. ANDERSON. That is true. But the committee always holds hearings if a bill comes from the House. We tried to have hearings on this proposal.

Mr. KERR. Did the Senator try to have hearings on this provision?

Mr. ANDERSON. On what provision?

Mr. KERR. The provision in section 1716(a) was not in the bill on which the Senator asked for hearings.

Mr. ANDERSON. We made some changes in a good many provisions. Those are questions which normally would have arisen if hearings had been held. The Senator from New York would have come before the committee and made suggestions, and the committee would have accepted or refused to accept them.

But the Senator from Nebraska raised the point that the committee has not had hearings. I suggest that that is not the best thing to say, when it was the Senator from Nebraska who prevented the committee from having hearings.

Mr. CURTIS. I prefaced the statement without specifying who was to blame. I took the position that there could not be hearings until a bill had come from the House.

Mr. ANDERSON. Other Senators probably voted that way because they

thought it was the right way to proceed. I do not question that.

Mr. KERR. A request was never made to the Committee on Finance to have hearings on section 1716(a), which is one of the two items about which the Senator from Nebraska was asking.

If the Senator from New York is available, I should like to ask him a few questions, in view of the fact that the Senator from New Mexico has yielded to him.

Mr. ANDERSON. Certainly. Madam President, I ask unanimous consent that the Senator from Oklahoma may have the opportunity to discuss this subject with the Senator from New York, without my losing the floor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KERR. Do I correctly understand that section 1715 was in the Anderson amendment?

Mr. JAVITS. That is correct.

Mr. KERR. Section 1716(a) was not?

Mr. JAVITS. That is correct.

Mr. CURTIS. What about (b), (c), (d), (e), (f), and (g)?

Mr. KERR. All of them were in the two sections, sections 1715 and 1716.

Under section 1715, the provision with reference to the agreement between the Secretary and any organization or group of organizations is triggered by the providers of the services seeking an agreement.

Mr. JAVITS. That is correct.

Mr. KERR. But under section 1715(a) the organization with whom the contract is made, so far as this bill is concerned, does not add to or take from the benefits provided in the law.

Mr. JAVITS. If the Senator has not misspoken himself, my answer to his question is "Yes." Is he still talking about section 1715(a)?

Mr. KERR. I am.

Mr. JAVITS. That is correct.

Mr. KERR. The agreement, if made, would be made at the request of the provider; and if made, would be an agreement between the Secretary and the organization—it might be the Blue Cross or any other organization—whereby the designated organization would pay to the provider, so far as the agreement was concerned, the benefits provided in the bill, and them only.

Mr. JAVITS. That is correct.

Mr. KERR. Section 1716 would be triggered by a patient asking for the privilege of having the benefits to which he was entitled under the bill paid to the provider by Blue Cross or some other organization.

Mr. JAVITS. If the Senator will substitute for "patient" the word "beneficiary," I would say "Yes."

Mr. KERR. Yes. He could not be a beneficiary without being a patient.

Mr. JAVITS. There is a difference.

Mr. KERR. Suppose he were the beneficiary.

Mr. JAVITS. I am not being captious. The patient is a person already confined to a hospital; he is already collecting benefits; whereas a beneficiary is a person who may or may not ultimately collect the benefits. The option, therefore, is to be exercised by the person who is the beneficiary.

Mr. KERR. By the person who would get the benefit under section 1617(a)?

Mr. JAVITS. That is correct.

Mr. KERR. By his making that request and triggering a situation whereby Blue Cross or someone else became the payor of the amounts of which the beneficiary was the recipient, the benefits from the Federal Government under the bill would not be increased or decreased by his taking that action, would they?

Mr. JAVITS. That is correct.

Mr. KERR. But in each instance—that is, under the situation triggered under section 1715 or under section 1716—for the same identical benefits that would be payable without action being triggered under section 1715 or 1716, the Federal Government would pay the same benefits plus a fee for the disbursing of the amount by the intermediary.

Mr. JAVITS. I cannot agree with that statement for this reason: it would pay, plus a fee, and it would receive value.

Mr. KERR. I did not say it would not receive value; I said it would pay the expense plus the amount agreed to under the agreement between the intermediary and the Secretary.

Mr. JAVITS. That is correct.

Mr. KERR. The patient would get no more benefits.

Mr. JAVITS. I cannot agree that the patient would not get more benefits. In the first place, he would get more efficient administration, which helps in the sense that things run more smoothly between the hospital and the Government. That would be under section 1715.

Under section 1716, the beneficiary would get the advantage of being able to induce those who are able to offer broader benefits to engage in that line of business.

Mr. KERR. The Senator has said that the program would be administered better if there were a Blue Cross intermediary doing those things. Is he thereby saying that Blue Cross is able to administer more efficiently than the Department of Health, Education, and Welfare?

Mr. JAVITS. Not necessarily. I merely say that in those cases in which the hospitals would choose the intermediary, the beneficiary would be getting the benefit of the fact that the hospital would provide if there were a more efficient way to deal with the Federal Government.

Mr. KERR. But the beneficiary would not get any more benefits.

Mr. JAVITS. I think he would get more benefits when things were going smoothly between the hospital which was looking after him and the Federal Government.

Mr. KERR. But he would not trigger the procedure in that event.

Mr. JAVITS. It does not matter who triggered it. The question is, Would he get any advantage under the arrangement that I have referred to in the bill? I think he would.

Mr. KERR. He must indulge the assumption that the hospital would be more efficient in caring for the patient if it were getting its money indirectly from the Government than if it were getting its money directly from the Government.

Mr. JAVITS. I think what is implicit in the Senator's statement is that the administration as between the hospital and the Government is also a factor in the kind of operation the hospital can carry on, and therefore its service to the patient.

Mr. KERR. In other words, the Senator from New York takes the position that a hospital would give a patient better service if Blue Cross were paying the hospital for the service than it would give if the Government were paying it for its service, although the money in both instances would come from the Government—in the one instance through the Blue Cross, and in other instance direct.

Mr. JAVITS. The Senator from New York does not take any such position in terms of the personal bedside service that a patient might get. The Senator does take that position in terms of efficiency of operation between a group of hospitals and the Government, if it choose to operate through an intermediary. I thing we have a right to assume that the operation would be smoother for them and, therefore, in those very strange ways which contribute to the satisfaction of a patient, the smoothness of operation between the privider of the service and the Government would, in my view, also benefit the patient.

That does not mean that there would be an orderly around at all times with a bedpan; but in those interesting ways which, in a hospital organization, communicate themselves to patients when things are going smoothly and efficiently, as compared with when they are not, if the hospitals choose to have an intermediary between them and the Federal Government, the operation will go more smoothly, in my opinion, and will be of benefit to the patient.

Mr. KERR. In each analysis, the Federal Government will have to determine whether it will pay the claims or not.

Mr. JAVITS. Yes; it will.

Mr. KERR. In the event it pays the claim through an intermediary, the Government will pay the claim plus a fee. Is that correct?

Mr. JAVITS. That is correct. But I say that for that the Federal Government will get a benefit in the reduction of its own cost of administration and in the greater efficiency, in my opinion, with which, in that particular case—because that is the way the hospitals choose to conduct their business—it would operate with the hospital.

Mr. KERR. Has the Senator heard from Blue Cross as to whether they desire this arrangement?

Mr. JAVITS. I have not. In the first place, this is not my arrangement, so I would not have heard from Blue Cross as to section 1715. The Senator from New Mexico would have to answer as to that.

Mr. KERR. The Senator has sponsored it, has he not?

Mr. JAVITS. I will have to answer for that. It is easy to jump from one to another. We are talking about section 1715. In respect to section 1715,

I am a party to the bill. I believe in it as fully as does the Senator from New Mexico. But as to the direct evidence of communication with Blue Cross, I must leave that to the Senator from New Mexico to answer.

As to section 1716, I can speak, myself. I have done my utmost by consulting those in the field whom I consider to be of very great competence regarding the way in which the Blue Cross operates—and I shall be glad to give the Senator the name of my expert, so that when this option is finally turned out in its final form—for it is not yet in a form which is to my satisfaction——

Mr. KERR. Then the Senator from New York is not yet satisfied with section 1716?

Mr. JAVITS. I am satisfied with its basic principles. I stated the areas in which I am not yet satisfied with it; and we are now in what is, relatively speaking, an early stage of this debate. I have done my utmost to ascertain the principles now incorporated in this option, and the principles which will be incorporated in it when it is perfected. We may differ as to a percentage here or there, but this is now essentially as it will be, as regards the principles and the operating basis, which should interest Blue Cross and other cooperatives, and should also interest the insurance companies. I cannot get them to say now that they will use this. The opposition of all these entities is, as the Senator knows, very deep, but it is sincere. However, I am confident that if we set up a plan which, in the final analysis, will be such that they will be able to engage in it, there will be an excellent chance that they will engage in it.

But I think it is idle to suppose that we can now guarantee the extent to which the option will be exercised. However, the bill is not premised on that. The bill is premised on the opportunity; and we believe the opportunity will be presented in an effective way, so that it can be availed of by those within the complex of these private-enterprise entities.

Mr. KERR. But in order to do that, the Senator is assuming that the language of the bill will be changed, so that it will be acceptable to those who have not yet indicated to the Senator that it is acceptable to them; is that correct.

Mr. JAVITS. I think the changes of language will merely serve to improve a situation which, in my opinion, is already workable.

Mr. KERR. But the Senator has said, with reference to the language now in the bill, that he has not been able to get them to agree to operate under it.

Mr. JAVITS. That is correct; I have not yet been able to get anyone to agree to operate under it. And in my opinion that will be impossible until the bill becomes law, because the opposition of all these entities—their opposition to the bill and to the option and to everything else in that connection—is so deep that they will not agree that they can do anything with it, because they feel—and feel it quite sincerely, I believe—that such agreement by them now would compromise the depth and the intensity of their opposition. So if the standard of judgment is going to be that Blue Cross or the insurance companies will agree that they will use this, if I am going to accept that as the standard of judgment, then I guarantee the defeat of this whole proposition. So I will not do that, and I do not think it is necessary to have it before Senators decide whether they will vote yea or nay on this measure. I think other Senators will have to do what I have had to do, namely, determine on the basis of my experience and all the research I can make that this measure, as it will be passed by the Senate, will be susceptible of use; and thus there will be an option, and an opportunity—but not a guarantee in that connection—for the insurance companies and others actually to utilize the option.

Mr. KERR. Madam President, will the Senator from New York yield?

Mr. JAVITS. I yield.

Mr. KERR. Is the opposition to which the Senator refers—the opposition which he has said is so deep seated—any greater than the opposition the Senator from New York himself expressed in 1960, on the floor of the Senate, in connection with a plan proposed under a social security tax program?

Mr. JAVITS. Yes, I think it is much more deep seated and severe than the opposition I expressed to the social security method of financing, because they do not favor any kind of a medicare bill; and at that time, and to this very day, I am for a medicare bill; and my support of that position is superior to my opposition in the other case, so I have since changed my reason for being opposed to that method of social security financing.

Mr. KERR. But in 1960 the Senator from New York was deeply opposed to the Social Security financing plan, was he?

Mr. JAVITS. I was.

Mr. KERR. And the Senator from New York so expressed himself on the floor at that time, did he?

Mr. JAVITS. Yes.

Mr. CURTIS. Madam President, will the Senator from New York yield?

Mr. JAVITS. I yield.

Mr. CURTIS. Referring to section 1715, on page 41, what organizations or institutions or entities, other than the Blue Cross, can be utilized in connection with that section?

Mr. JAVITS. There are a wide range of organizations that can be. For instance, in New York we have two organizations: one is called Group Health Insurance—GHI; the other is the Health Insurance Plan. They are very large organizations; for example, one of them covers all employees of the city of New York. I believe that probably an organization of that type—and New York is not unique in that respect; there are others, in other parts of the country—could come under that plan. In addition, as the Senator from New Mexico [Mr. ANDERSON] has said, there are many other plans throughout the country—plans of industries and of trade unions—which have the necessary contractual flexibility to come within the purview of these provisions, once the provisions are available to us.

Mr. CURTIS. In reference to section 1716, beginning on page 45, could a newly formed, tax-exempt organization qualify for the purposes of that section?

Mr. JAVITS. If a newly formed organization is tax exempt and is licensed to do business in the State from which it requests approval to operate under that section, it may be qualified.

Mr. CURTIS. Could a newly formed insurance company, without qualifying nationally and without qualifying in whatever percentage is provided in lines 20 to 25, on page 47, qualify?

Mr. JAVITS. That would depend on the definition of "newly formed." A newly formed insurance company with even a modicum of experience—for example, experience of a year or two or three years, which is a rather small amount of experience for an insurance company—could qualify in a State under the percentage provision on page 47, in lines 20 to 25.

Mr. CURTIS. It would have to have at least 10 percent of such payments in that State, would it?

Mr. JAVITS. Yes. That calls for a certain amount of maturity, let us say, on the part of the company. In other words, it could not qualify the day it was organized, unless it could qualify under subsection (B) which requires a determination by the Secretary that the company is national in scope.

Mr. CURTIS. Does the Senator have any idea as to whether the words "10 percent of such payments in such State" refer to premiums or to other payments?

Mr. ANDERSON. I should like to say that a newly formed company which never has written any business obviously could not qualify. But the same thing could happen to such a company that is now happening to the Government Employees Health Plan—where the larger companies which have taken over these risks are allowed to farm out portions of the risks, and they are doing it now; they are doing that under all these policies that are being issued. They have a right to do it, and they do do it.

Mr. CURTIS. That was part of the basic legislation and the contract, was it not?

Mr. ANDERSON. It was required, but I do not think it is in the contract.

Mr. CURTIS. Is it required in this bill?

Mr. ANDERSON. No. We discussed including such a provision; but someone suggested that since they had done it under the other program without such a requirement, they probably could do this without such a requirement.

Mr. CURTIS. But I do not know what the 10 percent requirement on page 47 figures out to. It may be that some sound, established companies which are not now nationally known could not get 10 percent of that business.

Mr. ANDERSON. Let me explain how that version was included. Not every insurance company tries to write insurance in every State. So I tried to find a figure which would be a little more liberal than the one used originally in the Government Employees' Health Act, which provided that the company must be licensed in all 50 States. At one time, Texas passed the Ferguson Act, which

required life insurance companies to invest inside the State of Texas all their assets representing reserves for that particular State. So companies, such as New York Life and Prudential and Equitable, withdrew from Texas; and a whole flood of new companies were organized in Texas to handle that business. Most of the big companies have now gone back into Texas; but for a long time they were out of Texas.

So a requirement that such a company must operate in all 50 of the States would have meant that a big company would have been excluded if it had not been operating in Texas at that time. Then we included the provision about being national in scope; and the provision is that if the Secretary determines the company is national in scope, that will be satisfactory.

The provision in regard to 10 percent comes about in a different way. In many States there are companies which have a large amount of business in a particular State. I think the Lamar Co. is the largest writer in Mississippi—or, at least, it is one of the large writers there. Certainly it would write more than 10 percent of the business there; and, naturally, under those circumstances it would be able to qualify under this 10 percent requirement.

I say very frankly to the Senator from Nebraska that I do not guarantee that 10 percent is the proper figure. Five percent may be better. I do not know.

Mr. CURTIS. It is conceivable that there might be 40 or 50 well qualified, sound insurance companies writing hospital insurance in the State of Nebraska, and very few of them would have 10 percent of the business. Are they to be barred, and are only those which have 10 percent of the business to get in?

Mr. JAVITS. Madam President, will the Senator yield to me on this point?

Mr. ANDERSON. I yield.

Mr. JAVITS. This is one of the areas of the bill which I consider as unfinished. I am delighted to have heard the Senator. I think the figure will be fixed at 5 percent, and not 10 percent. I hope, too, that Senators as deeply interested in this subject as is the Senator from Nebraska will ascertain for us the appropriate information, because we are interested in factual information as to what would be a fair breaking point as between a company operating substantially in a State, and companies that have a very minor or small interest.

Mr. ANDERSON. I tried to bend over backward, as far as a human being could bend, to make sure that there were no exclusions of that nature in the amendment. Not only are the original provisions retained, but 10 percent is quite ample, because if there are 40 or 50 companies located in Nebraska writing insurance——

Mr. CURTIS. They do not have to be located in Nebraska. For example, New York Life, or Prudential, could be writing insurance in Nebraska; and we have a dozen of our own.

Mr. ANDERSON. If the Senator could imagine the Secretary of Health, Education, and Welfare saying that Prudential was not national in scope, he would be imagining the impossible.

Mr. CURTIS. I am talking about a business that asks for it but cannot get 10 percent of it.

Mr. ANDERSON. If the Senator will turn to the next page, it provides:

> In the case of a carrier which is not included in subparagraph (A), (B), or (C), is licensed to issue group health insurance in the State with respect to which it requests approval hereunder.

The situation can be taken care of. If the insurance commissioner says, "It is a small company, but it is being managed by good people, and is well known," it can qualify, and the Secretary of Health, Education, and Welfare can approve it; but it must write group insurance, and not merely individual policies.

Mr. CURTIS. But if the companies do write for groups, they qualify in toto?

Mr. ANDERSON. That is correct.

Mr. CURTIS. I thank the Senator, as well as the Senator from New York, for their great patience.

Mr. ANDERSON. I think the questions of the Senator from Nebraska are entirely proper. In the last few days we have asked hundreds of questions among ourselves.

The question as to which company should qualify was one in which I had a personal interest, because when I launched a company many years ago, I could not qualify under the law. I had to put up money I did not personally have. I had to borrow it and take out a policy on my life to insure repayment of the money.

Mr. AIKEN. Madam President, will the Senator yield for a question?

Mr. ANDERSON. I yield.

Mr. AIKEN. I am wondering if the insurance companies have indicated a desire or willingness to carry on the medicare program under the provisions of the Anderson amendment. Do they generally support the amendment of the Senator from New Mexico? What is their position? I have had communications from them asking my position, but, so far as I know, none of them has indicated to me what its position is, although I can infer, from reading between the lines, they are not happy with the amendment of the Senator from New Mexico.

Mr. ANDERSON. There is a mutual casualty group to which I have made contributions as president of a mutual insurance company, and a few days ago I received from them a vigorous letter telling me how awful this bill was. So I assume it is typical of the sort of comment we constantly receive from all sorts of insurance groups.

When the original Social Security Act was underway, there were those of us who were rash enough to predict it would be a fine thing for the insurance business. That view was not universally shared by those in the insurance business. The Senator from Vermont will recall that.

I pointed out, in that early day, if people were assured that their retirement needs were protected, they would have money to buy life insurance. Many insurance policies were annuity policies for protection of old-age requirements. They were wonderful if the people lived; but if they died there were not many benefits for their families. By establishing social security, the life insurance companies were permitted to show the value of having life insurance. There has been a great increase in pension plans and life insurance.

I predict to the Senator that if this measure is enacted into law, we shall see the greatest expansion of the health insurance business that this country can imagine.

Mr. AIKEN. I know how the Senator from New Mexico feels. He may recall that I worked for the St. Lawrence Seaway for 20 years, and when that law was finally enacted those who worked hardest against its establishment derived the greatest benefits from it. It seems to me the same thing may happen in the case of the medicare bill.

Mr. ANDERSON. My guess is that in the first few years after the bill becomes law we shall see a great expansion of insurance, because once the basic coverage is taken care of, people can always take care of themselves through the Blue Shield or similar plans. We shall see labor organizations getting contracts providing for the very basic needs, and there will be an expansion in the insurance field far beyond what is now in effect.

While the Senator from Michigan [Mr. McNAMARA] was absent from the Chamber, I referred to the insurance plan of the United Auto Workers in which there is specific provision to permit them to expand far beyond what is now in effect.

This will be one of the great blessings of the law. One of the reasons why I have said that, in the last analysis, this measure will be a boon to the medical profession is that there are many doctors who cannot get their bills paid, because when patients get through paying hospital bills nothing is left. Because of the expansion of service provided by this bill to take care of people, they will be able to pay their doctors, and that would be a fine thing.

Specifically, the answer to the question of the Senator from Vermont is that the insurance companies generally are not enthusiastic about this measure. They were not enthusiastic about the first provision. They were bitterly opposed to disability insurance in 1956. It was a horrible thing. It was going to destroy them. The bill passed, and we do not hear a word now against it from anybody. It is a fine proposal. Just as occurred in the case of the St. Lawrence Seaway, we shall find the same thing in this case. People who fought against it will say it is a good thing.

Mr. JAVITS. Madam President, will the Senator yield?

Mr. ANDERSON. I yield.

Mr. JAVITS. I would like the world to know that I will stand shoulder to shoulder with the Senator from New Mexico [Mr. ANDERSON] on this bill. Whatever our problems are with the option provision, we will solve them.

Second, I think we have not broken through the hard crust of opposition, which is merely opposition which comes to us from the insurance companies which do not want government in the insurance business. They have not gotten down to what the bill means, the opportunities under it, and so forth.

I would count it as fortunate—and I know the Senator will help us if he can—if we could get some of the insurance companies down to the specific cases of what they can do with particular provisions of the measure, or what they cannot do. That would be most helpful in respect to the drafting of the bill itself.

Mr. AIKEN. One thing which bothers me considerably about the proposal is that the financing involves a tax on people with low incomes, incomes of $5,200 a year or less, whereas there is to be no restriction on the benefits. It seems to me that most of the retired corporation officials of this country have reached the age of 65 and would get the full benefits of the program, without regard to cost. I do not like to see the burden of the cost placed on people with low incomes.

Mr. JAVITS. Madam President, if the Senator will yield to me further, no doubt the Senator from Vermont will remember that I was one of the most ardent opponents of the regressive aspect of financing the proposal through the social security system. I opposed the program at the time it was before the Senate, and some thought at great political risk. I voted against the bill in August of 1960. I am proud I did so.

Madam President, I am thoroughly persuaded that this is the way the people who are in that income bracket would like to have it. If they look at it in that way, from the point of view of a hardheaded, pay-as-you-go approach, it involves a vast source of money, and I do not see how we as Senators could in good conscience say, "We are not going to permit you to do so."

We have not had a plebiscite or a referendum upon the subject, but I say to my beloved colleague that I am convinced that the overwhelming majority of people who are under social security want to finance the program in this way. They take a certain pride in the fact that they would actually deposit the money themselves. I do not see why we should prevent them from doing so, because that is a very hardheaded way of paying for most of the cost of the program as we go along.

Mr. AIKEN. Both the proponents and the opponents of the Anderson amendment have behind them powerful national organizations which perhaps wield some influence on their members. I know a few people who belong to labor unions who perhaps do not agree with the top-level leadership of such unions. I know doctors who have not spoken in ultracomplimentary terms of the AMA, and with respect to whom one gets the feeling that they merely "go along."

I shall listen to the debate as attentively as possible, as it continues. When the time comes to vote, I shall weigh the advantages of the measure as it may then be worded against its disadvantages. I shall vote accordingly.

Mr. JAVITS. I thank my colleague.

Mr. PASTORE. Madam President, will the Senator yield to me at this point?

Mr. ANDERSON. If the Senator does not mind, first I should like to yield to the Senator from Ohio [Mr. YOUNG], who has been waiting.

Mr. YOUNG of Ohio. Madam President, I fully agree with the statement which has been made by the distinguished senior Senator from New York. In 1960 I voted for a medical-care-for-the-elderly program within our social security system. There has never been a doubt in my mind that this is what the vast majority of Americans desire and are entitled to.

The distinguished junior Senator from New Mexico is correct in the statements he has made concerning insurance company executives and the attitude they have taken in the past. In 1949 and 1950 I was a member of the Committee on Ways and Means of the other body. That committee then worked for some 6 months in respect to liberalizing and expanding the social security program. At that time, despite the fine experience which the American people had had from 1935 to 1949 with the social security program, executives of many of the insurance companies of the United States appeared before the Committee on Ways and Means and denounced the great work which was being done in that committee at that time in respect to expanding, liberalizing, and extending the social security system.

Despite their continuing opposition over the years from 1935 to this good hour, the private insurance companies of this Nation have increased their business by leaps and bounds. Years ago, people were not security minded. The social sceurity law has brought about a change in the feelings of the people of this country, and has caused them to become more security conscious in regard to their aging years. That has been a good thing for all, including private insurance companies.

Like the Senator from New Mexico and the Senator from New York, I am sure I am numbered with many people who look forward to the day when the social security law of this country will be universal in its application, when it will adequately cover all who are employed by others and all who are self-employed.

We are undertaking a great work in the Senate in connection with the amendments which have been offered by the distinguished Senator from New Mexico. We are going forward. Under the leadership of the junior Senator from New Mexico we shall provide a great service for the American people. Someday, the executives of the life insurance companies will realize this. More and more the physicians and surgeons of this country who are members of the American Medical Association are realizing the great service provided the American people by the social security laws. I think the rank and file of the American Medical Association are now beginning to realize that they have been on the wrong track in the past and that this legislation is in the best interests of all Americans, including those in the medical profession.

Mr. ANDERSON. Madam President, a great many people who are connected with insurance companies are most sympathetic to what has been suggested.

They recognized that it is probably not wise to advocate this sort of program. I agree with that, because it is a program which sometimes has caused some misunderstanding and at times had led to some abuse.

Many of those people, however, have been extremely helpful in regard to providing information. For example, I wrote to one of the large insurance companies and asked the question, "Has your business grown since the passage of the social security law because people have had money to put into life insurance, whereas they did not have it available before?" I have been provided with much valuable information, showing the tremendous growth of the insurance companies.

Madam President, I yield to the Senator from Rhode Island [Mr. PASTORE].

Mr. PASTORE. Madam President, I should like to add my voice in support of the proposed legislation. I have been in the Chamber only a short period of time, but I have heard most of the colloquy between the distinguished Senator from New Mexico and the Senator from New York. I quite agree that one of the phenomena in regard to the proposed legislation, as pointed out by the Senator from New York, is that the people who are under social security are really the ones who favor this approach to the problem. They want to build up the fund during their productive working years, to provide for themselves in the twilight of their lives, when, most likely, they will be subject to this kind of expense and will not have the available funds with which to pay for it.

There is another amazing thing which I have experienced. I do not know what has been the experience of others in this Chamber, but I have every regard for their sincerity, as I hope they have for mine. When one speaks to an individual doctor—and I have talked with many of them—one finds his position often quite different from the position taken by doctors as members of an organization.

Not long ago I was asked to address the wives of the staff members of a Rhode Island hospital. Our discussion drifted into the question of hospital care. I asked them if they knew what was contained in the pending proposal. Many of them did not know what was in it. When one talked to them about it lucidly and individually, they did not see any objection to the proposal. They did not see how it had anything to do with them. No choice of doctors is involved. There is no question of medical expense involved in the proposed legislation.

The proposal merely calls for hospitalization, and for that kind of hospitalization involved after a certain number of days, as I understand. The sickness

must be chronic in nature before any real benefits will be available to an individual under the proposed legislation; is that correct?

Mr. ANDERSON. I would not use the word "chronic," I would say the sickness would have to be severe.

Mr. PASTORE. How many days would a person have to be hospitalized before he could receive benefits?

Mr. ANDERSON. A person could start receiving benefits the first day, if his bill were large enough. This involves $10 a day as a deductible for the first 9 days. At the present rates of hospital care, that might be not nearly sufficient. The average cost to the hospital has gone from about $9.50 a day in 1946 up to about $35 a day at present.

Mr. PASTORE. In other words, for the first 9 days a person would have to pay $10 a day?

Mr. ANDERSON. The person would have to contribute $10 a day for the first 9 days. The balance of the bill would be paid by the fund. That would be, at the present time, about $20 or $25 a day.

Mr. PASTORE. In other words, an individual would be required to pay out of his own pocket $10 each day for the first 9 days.

Mr. ANDERSON. And the doctor must certify that he had to come to the hospital.

Mr. PASTORE. There would be no featherbedding under that provision.

Mr. ANDERSON. Certainly not.

Mr. PASTORE. Clearly the last place people wish to go is to a hospital. Most people do not want to go to a hospital unless they are really required to go. But for the life of me I do not know why anyone would resist proposed legislation that would assist individuals building up a fund during the time they are employed so they could take care of themselves on their own with dignity when they really need the hospital care after becoming 65 years of age.

The only people who talk about freedom of action and choice are—God bless them—those who do not need it to begin with.

I thank the able Senator.

Mr. KEATING. Madam President, will the Senator yield?

Mr. ANDERSON. I yield to the Senator from New York.

Mr. KEATING. Let me add a point to what the Senator from Rhode Island has just said. Last year, I conducted a poll on health care for the aged which was sent to about 1,050 doctors in New York State. The names were selected at random from the telephone book, 43 percent of them were selected from the city of New York and 57 percent from outside the city of New York. These percentages were selected because that is the voting ratio between New York City and the rest of New York State.

Rural doctors were not included, but 43 percent of the doctors from New York City and 57 percent from Buffalo, Rochester, Syracuse, Albany, and the other principal cities of New York State, were included.

The first question asked was approximately as follows:

Do you feel that the Federal Government has any responsibility in the field of medical care?

Approximately 80 percent answered "Yes," to that question.

The next question had to do with financing which, of course, includes the Kerr-Mills method, the voluntary approach, and financing under social security. I was very much surprised to find that one-third of those who favored a Federal role in this field supported financing under social security. Perhaps it is indicative of the high level of interest in this issue that over 50 percent answered the poll, which is considered a very high percentage.

Mr. ANDERSON. Very good.

Mr. KEATING. Approximately 500. Of those who felt that there was a responsibility on the part of the Federal Government, one-third said that they thought that it should be financed under social security. This is a little addition to what the Senator from Rhode Island has said.

I believe it would be fair to say that probably the large majority of doctors are opposed to this proposed legislation, even in its revised form. But I do not think their opposition is as intense as it was to the original bill. At least, I hope not.

As my survey and other similar polls have shown, there is a very substantial body of doctors who feel that the sound and proper method of financing medical care is under social security.

Mr. PASTORE. Mr. President, will the Senator yield?

Mr. ANDERSON. I yield.

Mr. PASTORE. We continue to refer to "medical care." That is farthest away from what the bill provides.

Mr. ANDERSON. The Senator is correct.

Mr. PASTORE. It is really a hospital care program. That is all it amounts to. It would not pay for doctors. It would not prohibit, restrain, or compel the choice of a doctor. The bill merely provides for hospital care, and for the first 9 days of hospitalization an individual would have to pay $10 a day out of his own pocket.

Mr. ANDERSON. The Senator is quite correct. We should get away from using the term "medical care."

Mr. PASTORE. It is not medical care.

Mr. ANDERSON. The hospital is the center of all medical care. For that reason it is important to get patients into a hospital early. They must realize that they should be in the hospital. We should make it possible for doctors to send patients to hospitals in time to do some good for the patients. I think it is a fine thing that doctors are coming to accept that idea.

I was surprised when the medical society in my hometown decided to conduct a poll on the question. Then the problem arose as to whether it should be a secret poll. The idea was opposed, but finally a secret poll was agreed upon. I was satisfied with the number who believe that the proposed program might be a successful approach.

I wish to return to one of the principal points I have made. People in the classes concerned would tax themselves for the benefits proposed. The social security benefits are what the worker really wants. He wants the help without a means test, and he knows that he can get the assistance he will need in later years.

A short time ago testimony was received that persons at lower earning levels would receive a greater return for their contribution than those at higher earning levels because the benefit formula is weighted in favor of those at the lower earning level. Under the health care proposal a worker earning $2,400 a year would pay $6 in increased taxes and a worker earning $4,800 a year would pay $12. Both would receive the same health insurance benefits. Thus the proposal would add an additional factor favoring the low-income worker.

We have had a great deal of discussion as to the plan. I was in a doctor's office talking to the doctor about my difficulties one day. On his desk lay a pamphlet entitled "Medical Aid for the Aged." Naturally I had more than passing interest in it. I picked it up, read it, and asked him if I could put it in my pocket. I did. I carried it with me. Those pamphlets are what the American Medical Association was putting out. These are further reasons why we believe socialized medicine for the aged should be rejected.

Those who have joined in trying to have a bipartisan approach to this question have tried to write into the bill a provision that would make sure that it would not be regarded as socialized medicine. There are provisions in the bill with respect to the selection and accreditation of hospitals. We put the provisions on the highest possible basis.

Accreditation by a committee would be required. Accreditation would include credentials from the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons. There is no way in the world that someone could call that an attempt to build up socialized medicine.

Mr. MILLER. Madam President, will the Senator yield?

Mr. ANDERSON. I yield.

Mr. MILLER. I should like to cite to my good friend the Senator from New Mexico an example and see how the bill would affect the example. Incidentally, it is an actual case. The case is that of a young man, age 25, married, with two children, working at a job, covered by social security. He came down with multiple sclerosis, which in that particular case went on for about 8 years before he passed away. During practically all of that time he was completely bedridden. What would be the coverage that he or his family would receive under the amendments of the Senator from New Mexico?

Mr. ANDERSON. I am sorry. It is a bill for aged. It is not a health care program.

Mr. MILLER. I was wondering if, because of the fact that the young man became eligible for disability benefits under the social security system, there would be any provision in the bill that would cover him?

Mr. ANDERSON. I say again to the able Senator from Iowa that the amendments do not set forth a general health protection program. A person 25 years old would not be covered by a bill that provides for health care at the age of 65.

Mr. MILLER. There is no provision in the bill for coverage of someone under the age of 65 who becomes eligible for social security benefits on account of disability, then?

Mr. ANDERSON. Only his widow when she is 65 years of age, under the bill.

Mr. MILLER. I wished to ask that question of the distinguished Senator from New Mexico because I wanted to be absolutely sure that my impression was correct. My impression was that the man assumed in my example would not be covered.

Mr. ANDERSON. If we were to attempt to write a complete program of universal medical coverage, we could not do so with an addition of one-quarter of 1 percent to the social security payments. That is why we must hold to those things that can be covered.

There are many instances of the nature described by the Senator from Iowa that are very difficult. I received an account of one today in my mail. We get them constantly. The case to which I refer is that of a woman 45 or 48 years of age. She had been saving to send her boy to college. She had enough money to start him into school and was well satisfied with the situation. She is a widow. A short time ago she discovered that she had cancer. All the funds that she had set aside for the son's schooling are now gone. She said, "What can I do for my boy?"

Those are tragic instances. No one can wipe them away or laugh them away. At the same time it is not the purpose of the bill to try to control all the things that happen in a society.

Mr. MILLER. The point I should like to make is that we should really try to base the benefits of the bill on a financial need basis instead of extending them to millionaires as well as to poor people, and that we might arrange to cover the catastrophic situations such as the one that I have given. Several other situations have been brought to my attention which I hope to bring before the Senate before the debate on the amendments is completed. My point is that we have these catastrophic situations confronting us which, I believe, every Member of the Senate would like to have covered and which, as the Senator from New Mexico has said, we cannot cover at one-eighth of 1 percent contribution, if we are to have complete and general coverage. I believe we could cover situations like that if we were to limit the benefits to those who actually need them, rather than to give them to everyone, rich and poor alike.

Mr. ANDERSON. A great deal has been said about the fact that the bill would cover millionaires. I say to the Senator from Iowa that men with very large incomes already have all the protection they need when they get past 65. Once a person become 65, his entire doctor bill is deductible, as I discovered when I celebrated my 65th birthday, and as I have enjoyed since. Shortly after I became 65 I went to a very good dentist who built a small model of the Taj Mahal in my mouth. I worried about it. I thought he was taking in more territory than he should. As a member of the Committee on Interior and Insular Affairs I wanted to confine him to a restricted area. However, he took in a very substantial area and fixed things up in a fine fashion. When I got the bill I was not very calm about it. I thought it was more than it should be. I pointed that out to my wife. She, having more sense than I have, said, "Have you stopped to consider that you are past 65 and that this bill is deductible?"

The reduction for what the Senator says is a millionaire past 65 can run to 91 percent of the bill. Many people in the lower income tax brackets would like that too. It is not much satisfaction to a man who is well supplied with money to have this new benefit come to him. One might make that same statement with reference to the whole social security system in general.

Mr. MILLER. If it is not much satisfaction, why do we enact legislation to give them that benefit?

Mr. ANDERSON. We do not legislate for the benefit of millionaires. We legislate for the benefit of all people who are past 65. In that way we deal with people who may have a $50,000 income, who constitute three-tenths of 1 percent of all of those who are eligible under OASI. For those who have incomes of over $10,000 or more, it is only 3 percent. The other 97 percent are the ones for whom we legislate. We cannot help it if three-tenths of 1 percent get under the tent and are eligible for the benefits. I do not expect them to ask for it. I am told that there is a man in the Senate who, if he wanted to, could go out to Walter Reed and have certain sections of his anatomy removed, and the Government would take care of the bill. I believe there is historic precedent for that, for men high in Government. Not so long ago I had my gall bladder taken out. I went home and had my own physician take it out in a church hospital. I felt I got value received for my money. I also concede that it was deductible. I am not too worried about this general situation. There are men in the Senate who are eligible to retire from the Senate with large retirement pay. I suggest that the Senator from Iowa go to them and say, "Why don't you retire? You can draw your money." Those men still stay here. They do not quit. I understand there is a Member of the Senate who is not only past 60, but is past 70, and he might even be past 80, and is, for all of that, a rather young man. I would not suggest that he retire and draw the maximum of his retirement pay. He seems to be vigorously pursuing a political career and I hope he will be reelected.

Mr. MILLER. I did not intend that our colloquy should enter the field of the retirement of our colleagues in the Senate. What I should like to bring out is that we have it within our power to draw the pending bill in such fashion as to keep these benefits from going to waste, from going to those who do not need them. We could with the same stroke of the pen, so to speak, provide for coverage for a catastrophic situation of the kind to which I have referred, but which the bill does not cover. In that way we would be doing much more equity than by providing general coverage. It is not enough to say that if inequities result, and some of this money goes to people who do not need it, that is the way it is. It does not have to be that way. We have the ability to do something about it.

Mr. ANDERSON. I do not know exactly how we could write a bill to provide that benefits should be available to all who earn them, but that anyone who does not need them or does not want them, does not have to take them.

Mr. MILLER. The Senator has said that workers do not want a means test. I attended a meeting in my hometown of Sioux City, which was attended largely by workers. At that meeting they sought my support of the King-Anderson bill. However, when I pointed out that the benefits would go to those who did not need them, as well as those who need them, and when I pointed out the case that I related here, the strong consensus of that meeting was that benefits ought to go to those who need them. It may be that some other groups do not believe there should be a means test. However, if by having a means test we could reduce the benefits that would go to those who do not need them and turn those benefits over to victims of catastrophic situations of the kind I have outlined, I believe we would be doing equity. I cannot see why people would object to a means test if that were the end result of having such a provision in the amendment.

Mr. ANDERSON. The Senator says, "If that were the result." If it were the result, that would be one thing. The amount of money that we would save by a means test for people who have large incomes is negligible. In the first place, they do not claim the benefits. That has been proved to be the case many times. There are Senators who probably are entitled to a great amount of retirement pay. They are not worried about it. Senators have left the Senate and have not drawn their retirement pay. Not all people draw these amounts.

Mr. MILLER. I am not advocating a means test for those who have a $50,000 taxable income. I would go much lower than that. In that way more benefits would be available for catastrophic cases.

Mr. ANDERSON. How low would the Senator go?

Mr. MILLER. I have not reached a determination on this point but I would say, for example, that we might relate this to the amount of income which re-

duces the social security benefits. The Senator knows that if a person is over 65 and has income of a certain amount, he does not get social security benefits. I believe we might interrelate this matter.

Mr. CURTIS. Madam President, will the Senator yield?

Mr. ANDERSON. I yield.

Mr. CURTIS. It is not an income test. It is a work test. An individual can have an unlimited income and still draw his social security. It is, by ruling, tax free. I have never heard of anyone declining it, contrary to statements that have been made.

Mr. MILLER. I appreciate the Senator's clarifying that point. I recognize the fact that it is a work test. My answer to the Senator from New Mexico would be to tie the amount of income under the work test into what we have been talking about.

Mr. CURTIS. Is it not true that an income test is applied to every veteran of the United States who has served in the military forces for his use of a veterans' hospital, unless his disability is service connected?

Mr. ANDERSON. I think that is correct.

Mr. CURTIS. Does that test also apply if the disability is service connected?

Mr. ANDERSON I do not know.

Mr. CURTIS. Does the Senator know what the income test is?

Mr. ANDERSON. It does not apply if the disability is service connected.

Mr. CURTIS. Does the Senator know what the income test amounts to?

Mr. ANDERSON. I do not.

Mr. CURTIS. Would the Senator agree that so far as all persons who are now retired are concerned, they will not have contributed anything to the hospital trust fund, assuming they continue to be retired?

Mr. ANDERSON. This situation has occurred over and over again. Congress passed a disability provision in 1956. The people who were able to take advantage of the provision had not contributed anything to the system.

Mr. CURTIS. But an individual who had been disabled all his life could not take advantage of it. He had to have a certain social security experience.

Mr. ANDERSON. Not on the social security level. We do not say this shall apply to future cases.

Mr. CURTIS. I do not take that point of view. I am referring to the present retired veterans of the country. Under this provision, if it passes as written, the present retired veterans would get hospital benefits far more liberal than the veterans of the country can avail themselves of under veterans' laws.

Mr. ANDERSON. Veterans can get hospitalization under veterans' laws.

Mr. CURTIS. Not without meeting an income test. The burden is on the veteran to trace his disability all the way back to his military service; and if he cannot meet that test, he must meet an income test before he can receive hospitalization in a veterans' hospital. While that is our historic policy with the veterans, the proposal of the distinguished Senator from New Mexico would take all of the present retired aged and make hospitalization available to them.

Mr. ANDERSON. The question of veterans' benefits is a complicated one. I believe the provision is that if a veteran applies for hispitalization and says, "I cannot pay," even though he may have other income, he is admitted to a veterans' hospital on his mere statement that he cannot pay.

Mr. CURTIS. It is true that no rigid inspection audit is made. It is assumed that most applicants are conscientious persons. I am sure they are. But if they have income over a certain amount and reveal that fact, they cannot be taken care of in a veterans' hospital if the disability is nonservice connected.

Mr. PASTORE. But if a veteran is now over 65 years of age and is collecting social security for a non-service-connected disability, he can certainly come under this program.

Mr. ANDERSON. Surely.

Mr. CURTIS. If he has been disabled through the years and has never earned any social security credit, he cannot come under the program. But an individual who is already retired and who has not paid a dime into the hospital trust fund may come in.

Mr. PASTORE. That is correct; and the benefit cannot be cut off. How can it be measured? A person who is now 63 years old, or 60 years old, and is paying social security, will continue to pay for 2 or 5 years. Yet someone else, who is 21 years old, will be paying for many more years. If we started to scale the benefits down in that way, we would never reach a point of equity. It must be one way or the other.

It is true that under this amendment anyone who is now collecting social security—and this deals with whoever is entitled to this benefit after 65 would benefit.

It may be argued that they have not made a contribution.

Mr. ANDERSON. Virtually everybody over age 65, or who has attained age 65, would be taken care of.

If he were in a veterans' hospital, he would not be taken care of by social security. If he were not in a veterans' hospital, he would be eligible under social security.

Mr. CURTIS. If he does not have eligibility for social-security benefits, is not the hospitalization dependent upon appropriations?

Mr. ANDERSON. No; the person would be blanketed in under the bill.

Mr. CURTIS. He would be blanketed in under the bill; but where would the money come from?

Mr. ANDERSON. From the general fund of the Treasury.

Mr. CURTIS. Does the Senator anticipate annual appropriations?

Mr. ANDERSON. No.

Mr. CURTIS. How would the money be forthcoming?

Mr. ANDERSON. The Government would pay this bill in the same way it pays the Kerr-Mills bills. How are those paid?

Mr. CURTIS. I believe it is by annual appropriation.

Mr. ANDERSON. I am sure that if there is a provision which requires annual appropriation, it will come up; but the beneficiaries would be blanketed in under this program, the same as anyone else.

Mr. CURTIS. And the payments would be subject to annual appropriation. Their neighbors, who likewise do not pay anything into the hospital trust fund, could draw on the hospital insurance trust fund.

Mr. ANDERSON. I think this is exactly the same situation as that under the Kerr-Mills law. The States are allowed to advance money under Kerr-Mills. The Government promises to pay it back, and it does. No money is provided in the act, but Congress always provides the money, and it would do so for this proposal.

Mr. CURTIS. The Senator from New Mexico has been very generous in yielding. I appreciate that, because I freely admit that I did not favor holding hearings on this proposal prior to passage by the House.

This is what I find hard to reconcile in the bill. It means that employees and employers and the self-employed, which includes the whole army of young people who are buying homes, sending their children to college, and paying their own medical bills, will be taxed to pay the hospital bill, or a portion thereof, under this measure, for everyone, just because he has passed an artificially fixed age. It is conceivable that many of the payers are far less able to pay that bill than the beneficiaries.

Mr. ANDERSON. The Senator from Nebraska voted for the Kerr-Mills law.

Mr. CURTIS. Yes.

Mr. ANDERSON. Under the Kerr-Mills Act, the same thing happens. Health care is paid for by the general taxation of the country. This bill merely provides for a start in the making of social-security contributions.

Mr. CURTIS. When people pay through general taxes, they pay according to their income. The recipients, while not complete paupers, are unable to bear the expense of costly illness, and I agree that that is the concern of government.

Under the Kerr-Mills Act, if a costly prescription needs to be filled, it can be filled. If hospitalization is needed, or if a nurse is needed to call at a home, that can be taken care of.

But under this proposal, the Government will embark upon a system in which the young and the middle aged, the producers, and the farmers, who cannot pass their social security tax on to anyone else, will have to pay the hospital expense, or a part of it—and I hope that question will be discussed at a later time, because I do not know how much good this bill will do unless it can be enlarged a good deal—of people who have reached a fixed age, many of whom are more able to pay that the payers.

Mr. PASTORE. The Senator from Nebraska has brought up a very important point. I do not know what the experience of the Senator from Nebraska

has been. It is true that a young man who is now 25 years old and will start to pay toward the benefits cannot hope to gain anything under the act until he is 65. That is also true of middle-aged people. But I have not received one letter from such an individual who has opposed the proposed legislation. I invite any Senator to produce such letters. The remarkable thing is that objection has not come from those people.

I have received letters from people who themselves have fathers and mothers who might become subject to this measure. But I have not received one letter from anyone who is below age 50 or 55 or 60 who is opposed to this type of legislation on the ground that he would be paying for benefits which someone else would receive.

Mr. CURTIS. I have received such letters; but regardless of that, is it not true, if we are to be realistic, that this will be the beginning of a system; that it will be expanded to include more hospital care; that it will be expanded to include medical care; and that the age limit will be lowered? With millions of people paying, the money will be going, perhaps, to three-tenths of 1 percent of the people who come within a very high income category. I do not know whether it is three-tenths of the aged, or what percentage it is.

Mr. ANDERSON. All those who are over age 65.

Mr. CURTIS. I daresay that the income position of many persons aged 65 and over is far better than the income, property, and debt positions of individuals who are educating their youngsters, buying their homes, and paying all of their own hospital and medical bills.

Unless this bill is to be enlarged sufficiently to take care of everyone and to take care of all their expenses, it will never satisfy the American people. After all, a hospital bill of not more than $10 for 9 days is nothing. The point is that the costly things—such as the miracle drugs, and I am for them—are not covered at all by this measure.

So this is only a beginning, similar to the beginning which was made in Britain and in various other European countries. It is the beginning of a government system of medical care—at this time, only hospital care; but it is the beginning.

When Britain began its system in 1947, they had 1 doctor for about every 800 people; but today in Britain 1 doctor has to serve twice that many people.

Mr. PASTORE. Such statements were also made at the time we passed the Social Security Act, and also at the time we passed the unemployment compensation law. But, fundamentally, if the people of the United States want this program expanded after this beginning, what is so wrong about that? If the people of the United States want to pay for their hospital care by means of such insurance, in this fashion; and if they want this program, after they embark on it, to pay for more than hospitalization, what is wrong with that, if they want to pay for it?

Mr. CURTIS. Because it will ruin the free practice of medicine in this country.

Mr. PASTORE. I do not believe that for 1 minute. Certainly, among all the segments of our population, the doctors are well off, and make good incomes. In many instances they receive their education at public expense; the taxpayers pay for it. And I am happy that medical students are helped. I do not expect the doctors to go bankrupt 10 or 15 years from now, merely because we pass this law.

Mr. CURTIS. No; but I am talking about the patients. Why is it that all the countries of Europe that have government medicine no longer attract young doctors to go there to study and to practice. Instead, they come to the United States.

Mr. PASTORE. I would not say that is true.

Mr. CURTIS. I think it is.

Mr. PASTORE. There are many doctors in other countries. We do not have enough doctors here. Does the Sentor from Nebraska know why?

Mr. CURTIS. We have 1 doctor for every 750 of our people.

Mr. PASTORE. Does the Senator from Nebraska know why we do not have enough doctors in our country now? It is because over the past 25 years our medical institutions have not kept pace with the explosion of our population. Today we are graduating only as many doctors as we graduated 25 years ago.

Mr. CURTIS. We have as many doctors now as we had a few years ago; we have 1 doctor for every 750 patients. But the curve has gone in the opposite direction in any country that has a government system.

Mr. PASTORE. But I cannot contemplate that the doctors of this country will become paupers or bankrupt or discouraged merely because we are providing hospital care for sick people.

Mr. CURTIS. Neither do I; but I see poor service for the patients developing.

Mr. PASTORE. I do not see that at all.

Mr. ANDERSON. Madam President, as regards the doctors in Britain, I wish to say a few words. Let me refer to an article in which it was stated that doctors were leaving Britain in great numbers, and so forth. Dr. Robert Platt, president of the Royal Academy of Physicians, carefully investigated that allegation. In an article published April 1962, in the London Times, he pointed out that the figures developed in connection with that study were somewhere between 400 percent and 800 percent in error, and that among the reasons why the figures were in error was that doctors from the Irish Republic had been included, although of course the Irish Republic is not part of Great Britain. Those doctors study in Britain, and then return to Ireland. In addition, a great many medical students come to Britain from parts of what used to be the British Empire—for example, from areas such as Iran, Iraq, and other areas which always have been close to the British Empire. They come to Britain and study medicine, and then return home; but when they return home, they are included among the doctors alleged to have migrated from Britain.

I think one of the best articles I have seen in connection with this field was written by Robert H. Eastabrook, whom I admire and like very much. The article was published in the Washington Post on June 14. He wrote the article from London, where he has been observing for some time. The article is entitled "Britain Likes Its Medical Program." I ask unanimous consent that the article be printed at this point in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Washington Post, June 14, 1962]

BRITAIN LIKES ITS MEDICAL PROGRAM

(By Robert H. Estabrook)

LONDON.—How good is Britain's National Health Service? The question is pertinent in connection with President Kennedy's far less sweeping medical care plan for the elderly, and particularly with the many references to social medicine. Perhaps the fairest answer is: better than what the great majority of people had experienced beforehand.

Even today the National Health Act of 1946 is cited as the crowning achievement of the postwar Labor government. Under it all residents became entitled to "free" medical and dental care, medicines and hospitalization. Doctors, dentists and druggists were enrolled. Virtually all dentists and all but about 600 general medical practitioners participate, although some also retain private practices.

Patients are encouraged to select "family doctors." They are thereupon entitled to medical and dental consultation, surgery by specialists when necessary, ambulance service, blood transfusions, and rehabilitation. Hospitalization ordinarily is in general wards but private rooms may be rented when available for $3.45 a day.

Certain modifications in free services have become necessary. There are now minimal fees for prescriptions, glasses, dentures and appliances as well as for house calls, partly to discourage abuse. Employed persons also pay a special weekly insurance fee.

The system is financed 69 percent by national government appropriation, 12½ percent by insurance fees, and 8½ percent by local taxation. Direct charges to patients account for only about 4½ percent. Total expenditures of some $2.6 billion amount to about $50 per person per year. Doctors and local committees have a say in management of the program and in community health services.

Professional men are paid by the government on the basis of the numbers of patients on their lists. Payment to doctors and dentists are set to yield average yearly incomes of around $6,800 and $7,000, respectively. The typical doctor in National Health Service has a patient list of 2,300 persons. Additional payments are made to doctors with smaller lists and to those getting started.

In practice there are, of course, some shortcomings. Hospital facilities are still inadequate for the demand, and staffs are underpaid. Patients complain of delays for selective surgery, though not for emergency care. Perhaps in part because of too low a fee schedule there is a shortage of new doctors; there are charges, vigorously refuted by Minister of Health Enoch Powell, that dissatisfaction has caused substantial emigration. Despite the introduction of fees, costs of the program have continued to rise and are now double those of a decade ago.

Among the most comprehensive critiques is a study by Dr. D. S. Lees published by the Institute of Economic Affairs. Dr. Lees cites the inadequacy of medical and dental training and hospital building programs as evidence of the drawback of centralized control and reduced freedom to innovate. There is no proof, he says, that the general health improvement is attributable to National Health Service.

Dr. Lees also contends that the market is superior to the ballot box as a means of demonstrating consumer preference; he protests that the National Health Service eliminates individual decisions on how much to spend for medical care. He suggests that the program move away from free services to an insurance system that would reimburse doctors in private practice, as in some Scandinavian countries.

Lack of public awareness of costs is probably the most serious criticism. Doctors and dentists also could object that National Health Service makes them, in effect, public employees with their remuneration dependent upon Government fiat. Bureaucracy can be infuriating, and one hears occasional grumbling by doctors and patients alike. Some persons elect to go outside National Health Service when speed or delicate care is essential. At the same time, eligible foreigners who use National Health Service often are pleased by the service.

One point stands out, apart from arguments over principle and quality: There is remarkably little complaint that National Health Service has destroyed the doctor-patient relationship which the American Medical Association holds so sacred. Indeed, some authorities contend that this relationship has been improved by removal of the financial barrier. Criticisms must be weighed against relief from personal money worries.

In short, even with its faults most Britons seem proud of their National Health Service. Almost never is anyone encountered who wants to repeal it and return to the old system.

Mr. ANDERSON. The Senator has stated that the age would be lowered. But I do not think so, because those who still are at work want to keep the age level where it is. Voluntary insurance is doing a good job for these people.

As regards establishing an income test, that would tend to undermine the present cooperative relationships we have with the private plans, and there are more than 30,000 of them. The qualification provisions in connection with them are very liberal—just as those for many other private plans are. For example, the automobile industry has a liberal retirement program; and those who receive pensions would, under this means test, be eligible to receive medical care. I can see nothing wrong with using these plans, which apply during their working years, so that after the workers are 65 years of age, they can receive this care.

Mr. MILLER. Mr. President, will the Senator from New Mexico yield?

The PRESIDING OFFICER (Mr. METCALF in the chair). Does the Senator from New Mexico yield to the Senator from Iowa?

Mr. ANDERSON. I yield.

Mr. MILLER. The point was made that if the American people want this, we should give it to them. But my mail is running about 10 to 1 against the King-Anderson bill. I do my utmost to try to ascertain whether the letetrs are the result of spontaneous desires to write to me, or whether they are the result of requests by organizations that such letters be sent to me. I must say that my best evaluation of my mail on this subject indicates to me that although there is concern about meeting the hospital costs and nursing-home costs of our elderly people who cannot afford to do so—and there is no question about that, the great preponderance of those who are writing to me and those with whom I have visited in my State—which, as the Senator knows, has a very high ratio of its population in the older age brackets.

Mr. ANDERSON. But most of those are living in California.

Mr. MILLER. No, I must advise the Senator that although a great many of them have moved to California, and also to his great and beautiful State, there are still enough of them left in Iowa so that the ratio in Iowa of these senior citizens is much higher than the national average—in fact, very near the top. And the majority of those whom I have contacted have indicated to me that they do not want the King-Anderson bill—principally, I would say—although not necessarily only—because of the fact that it would extend these benfits to those who do not need them, those who can afford to handle them, at the cost of diluting the benefits which would go to those who do need them, and also at the cost of not covering some of the catastrophic situations to which I have referred.

I am sure that if there were a test vote, among the people of my State, as to whether they want to have cases, such as the catastrophic multiple-sclerosis case to which I have already referred, go by the board and not receive any coverage, or whether they wish to have benefits provided to a great many persons who have sufficient income to meet the costs of hospital and nursing-home care, their votes would be against the latter and in favor of the former.

That is why I point out to the Senator that I wish something would be done perhaps to tie in or interrelate the receipt of these benefits with the working-test rule of social security, so there would be sufficient funds to take care of the catastrophic cases, regardless of the age. When catastrophe strikes, it knows no age; and it seems to me there is a duty on the part of the Government to take care of catastrophic cases, when the persons involved do not have the wherewithal to meet the costs.

I thank the Senator from New Mexico for yielding to me.

Mr. ANDERSON. Mr. President, I yield the floor.

PUBLIC WELFARE AMENDMENTS OF 1962

Mr. MANSFIELD. Mr. President, is there further morning business?

The ACTING PRESIDENT pro tempore. Is there any further morning business? If not, morning business is closed.

Mr. MANSFIELD. I ask unanimous consent that the unfinished business be laid before the Senate and made the pending business.

The ACTING PRESIDENT pro tempore. Is there objection?

There being no objection, the Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

The ACTING PRESIDENT pro tempore. The question is on agreeing to the Morton amendment in the nature of a substitute for the Anderson amendment.

Mr. ROBERTSON. Mr. President, good health is vital to our economic as well as our physical strength. That is true not only for the elderly but also for the middleaged and the young. There is much wisdom in the saying that "the health of nations is more important than the wealth of nations."

In this country, inflation has hindered our ability to attain and preserve good health. Although personal incomes have increased, medical costs have risen even faster. Other living costs have gone up, too. These developments have made it harder for people with limited savings and income—including the elderly—to meet their medical expenses.

To benefit persons aged 65 years and over, the proposal now before the Senate would inaugurate another Federal health insurance program, even though a Medical Assistance for the Aged Act was passed as recently as 1960. This proposed program—to be financed largely by increasing taxes and coverage under the social security and railroad retirement systems—would do nothing to retard or reverse the rapid rise in the cost of medical care. On the contrary, it would tend to underwrite whatever the prevailing level of medical expenses might be. Rather than help to reduce medical costs, the proposal would shift the prevailing cost burden to favor one segment of the population selected solely on the basis of age rather than of need.

For these and other reasons that I shall mention later, I oppose this proposal. I urge my colleagues to do likewise.

We do not suffer today from any shortage of health insurance protection plans. Numerous plans and programs are now in operation. More and more persons, including the elderly, have been coming under private health insurance plans offered by many types of insurers. These programs may take the form of Blue Cross or Blue Shield plans, guaranteed renewable-for-life policies, prepaid group practice programs, pension plans, veterans benefit programs, old-age assistance plans, and many others.

Two years ago, the Medical Assistance for the Aged Act, Public Law 86–778, was approved. This Kerr-Mills law authorizes 50- to 80-percent Federal grants to States to help "furnish medical assistance on behalf of aged individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the cost of necessary medical services." I supported that legislation. I believe that it is entitled to a fair trial in the field before any new scheme may be considered seriously.

The Kerr-Mills law was signed on September 13, 1960. It has been in effect only a short time. Yet the Senate is now asked to pass upon an additional plan that would go far beyond this existing legislation.

The features of the proposal differ drastically from the Kerr-Mills law provisions that were approved by the Congress and the President. The proposal would be financed largely through the social security and railroad retirement systems; the Kerr-Mills law is financed solely through appropriations. The proposal would cover nearly all persons aged 65 years and over, regardless of need; the Kerr-Mills law limits aid to elderly persons, not receiving old-age assistance, who are needy. The proposal would cover only a portion of the average medical costs that elderly persons are likely to incur even during a limited period of time; the Kerr-Mills law is designed to be more inclusive. The proposal would require little administrative participation, and no financial participation, by the States; the Kerr-Mills law works solely through the States which must contribute from 20 to 50 percent of the total assistance. The proposal would involve expenditures estimated to exceed more than $1 billion in the first year, and billions more later—far in excess of outlays under the Kerr-Mills law.

Despite its novel features, this proposal has been brought up without any formal prior consideration by the Senate. The health insurance proposal was first introduced early last year (S. 909), but no hearings on it have ever been held in the Senate. Several new amendments to this proposal were first set forth in the CONGRESSIONAL RECORD only a few days ago. No hearings have been held, either, on these amendments.

We have had no chance to examine publicly through hearings how far the proposal might go in extending Federal control as well as Federal aid over the entire field of medicine. We have not been able to find out how the proposal might affect the operation of our medical institutions, the quality and type of medical services, the charging of medi-

cal fees, or the degree of free choice that beneficiaries would be permitted, by regulation, to exercise. We have no public record in the form of Senate hearings to guide us.

Even without the benefit of Senate hearings on the proposed program, I have serious reservations about the use of compulsory payments under the social security and railroad retirement systems to underwrite a health insurance scheme based on age rather than need. The billions of dollars in expenditures that would be made under this program would have to be offset by billions of dollars of additional taxes raised largely from social security and railroad retirement contributions. Yet even if this proposal is not adopted, a substantial increase in such taxes is already scheduled.

At present, the social security contribution rate payable by employers and employees is 3⅛ percent each upon the first $4,800 of wages and earnings, or a combined total of 6¼ percent. The rate payable by the self-employed is now 4.7 percent. Beginning next year, existing law requires these rates to be increased from time to time until the year 1968. By then, both employers and employees will be taxed at a rate of 4⅝ percent, or a combined total of 9¼ percent. The self-employed will be paying 6.9 percent.

High as these tax rates are, the proposed health insurance program would levy an additional combined tax of one-half of 1 percent, to be shared equally by employers and employees, and an additional tax of three-eighths of 1 percent upon the self-employed. The maximum amount of annual wages and earnings subject to the social security tax would be raised to $5,200 from the present level of $4,800.

Under the railroad retirement system, the current tax schedule calls for a combined rate of 14½ percent upon the first $400 of monthly earnings, to be shared equally by contributions from employers and employees. Starting in 1965, these rates will be raised at intervals until the year 1969. By that time, both employers and employees will be paying 9⅛ percent, or a combined total of 18¼ percent. An additional combined increase of one-half of 1 percent would, of course, be required under this proposed health insurance program, plus an increase in the wage base to cover beneficial benefits.

Despite the high contribution rate under the railroad retirement system, a substantial actuarial deficiency now exists in the railroad retirement account. At pages 8 and 9 of the Railroad Retirement Board's 1962 Annual Report, it is stated:

> Actually, as indicated by the recently completed triennial valuation of the system, there was an actuarial deficiency on December 31, 1959, amounting to 1.69 percent of the level taxable payroll, equivalent to $73 million annually. Adjustments for the 1961 Amendments to the Railroad Retirement and Social Security Acts and for the actuarially insufficient tax rates during 1960 and the first half of 1961 have increased the deficiency to 1.79 percent of taxable payroll, or $77 million a year, as of June 30, 1961.

The proposed health insurance plan would do nothing to improve the situation.

In summary, the health insurance proposal would be financed through the social security and railroad retirement systems by levying heavier taxes and by broadening the tax base. These additional taxes would be imposed even though social security taxes of as much as 9¼ percent for employers and employees combined, and 6.9 percent for the self-employed, are scheduled under existing law to take effect only 6 years from now. Part of this scheduled increase in social security taxes will come into operation next year, at the very time the administration has indicated that general income taxes should be reduced.

Additional taxes would also be levied under the railroad retirement system, even though contribution rates of as much as 9⅛ percent each for employers and employees, or a total of 18¼ percent combined, are slated under the existing law to be imposed only 7 years hence. The additional health insurance taxes would not ameliorate the existing actuarial deficiency in the railroad retirement account—a deficiency which might well be offset only by raising contribution rates still more. All these taxes, of course, would be payable along with regular corporation and individual income taxes.

Heavier taxes toward financing the proposed health insurance plan would be imposed only upon contributors to the social security and railroad retirement systems. Persons not covered by either system would pay no direct contribution, although nearly all of them would be eligible for a full range of medical insurance benefits. For these persons, the cost of the health insurance program would be financed through appropriations from the general fund of the Treasury. In the first year alone, the estimated gross cost to be met from appropriations would come to about $250 million. It is said that part of this cost would help to offset Federal medical care outlays that otherwise would be made under existing public assistance and veterans' programs.

As a result, persons contributing toward social security or railroad retirement would pay more than their fair share for the health insurance plan. They would pay once through increased taxes under social security or railroad retirement. They would pay again through general income taxes.

All these taxes would go toward supporting a massive compulsory insurance program, whether or not contributors needed coverage. Rich and poor alike would receive equal consideration, regardless of their ability to meet their own medical needs. Benefits would be available to all 14.5 million persons aged 65 years and over now under the social security system and all 500,000 or so persons aged 65 years and over now under the Railroad Retirement Act. Benefits would also be available to about 2½ million aged individuals not now a part of those systems. That would be the case even though both the retired and the uninsured would have made no contribution whatsoever toward the health insurance plan.

What would these benefits cover? Too little discussion, in my opinion, has been given to the matter of coverage. In many cases, a substantial portion of medical expenses would apparently be ineligible for insurance benefits.

To cite only a few items, physicians' fees for surgery, home, office, or hospital visits would be excluded, and so would drugs and medicines not supplied in a hospital. Inpatient service of general hospitals for stays in excess of 90 days would be excluded; so would skilled nursing home services after 180 days. Any services provided by mental or tuberculosis hospitals would be excluded completely.

For each of the first 9 days in a general hospital, an insured patient would have to pay a deductible amount of $10 a day, with a minimum deductible amount of $20 and a maximum of $90. An outpatient would have to pay $20 for each hospital outpatient diagnostic study.

The range and cost of services not covered by the proposed plan argue further, I believe, for public hearings that would put these facts on the record for all to study.

No matter what costs may be covered under the program, there appears to be a lack of agreement between Government and private actuaries whether the costs could be met satisfactorily by the proposed increases in social security and railroad retirement taxes and coverage, and additional appropriations. Here again, we need the benefit of Senate hearings to throw light upon some of the problems involved in determining how adequate the financing provisions may be.

Mr. President, for all these reasons I believe that it is premature to act without an extended consideration of this proposal in the form of hearings, committee action, and floor debate. It is premature to act before we have had a chance to observe the operations of the Kerr-Mills law, approved less than 22 months ago. It is too early to observe how effectively this program will work in many States. In my own State of Virginia, legislation authorizing participation in the Kerr-Mills program was enacted this year, and funds appropriated for this purpose will become available in 1964.

In other words, Mr. President, this is no time to rush into a vast new program of health insurance involving billions of dollars of expenditures even in the first few years. We already have a program, endorsed by the Congress, the President, and the States, that is just getting underway.

Consequently, I oppose the proposed plan, and shall vote against it.

Mr. ROBERTSON. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. ROBERTSON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

elderly. I shall not enumerate these five specific changes; however, I would like to take a few minutes today to show that these changes to a large degree remove the threat of Federal control over physicians and hospitals which has been advanced as a major argument in opposition to the administration's original King-Anderson bill.

The most important thing about any legislation in this field is how it helps and protects the elderly—but there are other considerations, and one of these is the impact which it will have upon the people who provide these health services. Will the doctors and hospitals involved come under the thumb of a huge Federal bureaucracy, or can means be found to accomplish our aims without subjecting these vital men and institutions to undue or excessive regulations from Washington? This is one of the major goals which we sought to achieve in working out the amendment now before us.

As far as hospitals are concerned, it provides that they shall be accredited for participation under the standards jointly established by the American Medical Association and the American Hospital Association—which together have for many years been in the business of accrediting hospitals. Only hospitals which meet these standards would be eligible under our amendment. The standards of the AMA and AHA are specific and measurable. The adoption of these standards enables us to rely on the expertise and good judgment of private citizens—rather than turn the responsibility over to a grand tzar of hospitals in some agency here in Washington.

Those few small hospitals in isolated communities which do not presently meet AHA–AMA standards will be certified—where suitable—by the Secretary of HEW who will administer a code of requirements based on the AHA–AMA standards but geared especially for exceptional cases, particularly small hospitals in out-of-the-way areas.

Madam President, as far as physicians are concerned, I remind the Senate that no doctors' services are provided under this measure. Furthermore, the option for private policies is developed so that private insurance companies will be strongly encouraged to write special policies which would take care of doctors' fees through private plans or various group health plans.

The option is designed to encourage people to obtain supplemental health benefits through private carriers at a relatively low cost. I envision that for somewhere around $3 to $6 a month in additional premiums, a person under this plan would be able to purchase a comprehensive health insurance package—including the basic benefits here provided, plus physicians' services, plus perhaps first dollar costs and some long-range protection for periods beyond the 90 hospital days which our amendment covers. Because this option is extremely easy to administer, I believe many people will take advantage of it. I hope private companies will eventually be eager to compete for this new business—which, in fact, will be made available as a direct result of this program.

Madam President, to reiterate, physicians are outside of this program altogether, hospitals are to be accredited by private experts, and insurance companies will be given an incentive to write supplemental health care policies including physicians' services, which entitles them to combine all of an individual's health insurance protection in one comprehensive policy.

While I still believe this option feature can and should be expanded, I am of the opinion that the bill before us today to a large part meets the major objections of those who are justly concerned that any new program in this field must not entail punitive or overwhelming Federal controls.

Madam President, these are not the only features of this new program which tend to avoid burdensome Federal controls. The plan we have devised explicitly permits State administration, where people would prefer it to Federal administration. It also allows private administration by groups like Blue Cross-Blue Shield or the Kaiser plan or private firms, where the providers of services and the Government can work out an arrangement to have this program privately administered.

Madam President, the social security program has been well accepted on both sides of the aisle. It sets a reasonable floor on want for retirement years. It says, in effect, that a person should have a minimal amount of food, clothing and shelter to meet his basic needs when he retires. Who would deny that the cost and advancements of health care in modern society make it necessary that this additional protection be provided?

I think this substitute is an excellent demonstration of our ability to work together to reach a common solution to a common problem. I very much hope that this debate will yield light—and not heat and partisan inflammation. I hope too that those of my colleagues on this side of the aisle who recognize the need for health care for the aged will find it possible in the final analysis to accept this sensible and carefully framed approach to one of our greatest legislative challenges, and I urge them to give support to this revised bill.

Mr. JAVITS. Madam President, will the Senator yield?

Mr. KEATING. I yield.

Mr. JAVITS. I compliment the Senator on his objective and excellent analysis of the measure which is now before the Senate and thank him for his outstanding cooperation in this field. I believe it is just such cooperation that has produced the results which have been achieved so far and which lead to some hope of realizing the long held objective of medical care for our older citizens.

I join with the Senator from New York in a plea to Senators to give their most careful and considered judgment to the proposal which is before the Senate. I share with him the feeling that it satisfies essentially and basically the objections which have stood in the way of a broader acceptance of the health care plan, which has been considered ever since August 1960, and brings it to a stage where it is worthy of acceptance

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. KEATING. Madam President, I understand that the pending business has been laid before the Senate. Is the Morton amendment to the Anderson amendment the pending question?

The PRESIDING OFFICER (Mrs. NEUBERGER in the chair). Yes.

Mr. KEATING. Madam President, I desire to speak concerning the Anderson amendment. In my judgment, it is a vast improvement over the old King-Anderson bill, which it replaces. It is a far superior and more responsible approach to the health needs of the aged.

The amendment contains five new features which were not in the King-Anderson bill and which a number of my colleagues on this side of the aisle and myself felt were essential in any legislation to meet the health needs of our

by all who have entertained a concern for private enterprise, private participation, freedom of choice, and State participation, so that the adjustment of benefits may become a reality, and not subject to abuse. These are the objectives which have characterized our attitude.

Mr. KEATING. Madam President, I thank my colleague for his remarks. All of us know that he has spent long hours, day and night, working to frame the terms of this revised measure. He has been a pioneer in the work in the field of health care, hospital care, and medical care; and he is undoubtedly as well informed on this subject as is any other Member of this body.

Madam President, I ask unanimous consent to have printed in the RECORD at the conclusion of my remarks an editorial from the Rochester Democrat-Chronicle, a very fine newspaper of my home city, which I feel sure would never and could never have endorsed the terms of the original King-Anderson bill, but which a few days ago published an excellent editorial in which it endorsed the provisions of this revised bill, and urged that it be enacted into law.

The PRESIDING OFFICER. Is there objection?

There being no objection, the editorial was ordered to be printed in the RECORD, as follows:

MEDICARE CALLS FOR COMPROMISE

As the issue of health care for the aged neared the discussion stage on the floor of the Senate yesterday, there appeared signs of a spirit of compromise in its best sense.

The emotionally and politically charged question has taken the form of a bipartisan measure that includes some of the stronger features of and adds some provisions woefully lacking in the administration-supported King-Anderson bill. It is the product of statesmanlike negotiations between Senator JACOB JAVITS, Republican, and Senator CLINTON P. ANDERSON, Democrat, and has picked up initial support from, among others, Senator KENNETH KEATING and the AFL-CIO.

Since this is a congressional election year, the chances are good that some kind of a health care bill will be enacted this year. As we have repeatedly emphasized, the medical care of 17 million older Americans is a responsibility that cannot much longer be postponed. The real question is how best to meet their needs.

Of all the plans with some chance of passage, the compromise proposal is the soundest and most comprehensive. Yet it provides the flexibility which both the Federal and State levels of Government require to deal with this awesome and complex problem.

It would do what the King-Anderson bill would not do—provide benefits for 2,500,000 Americans not covered by social security. It would let States set up their own health care plans, sending participating States lump sums to provide basic health care for their aged. States could contract with private insurance firms for group policies and, if they wished, add State funds to extend benefits. It would stipulate that medical care money be kept in a trust fund separate from other social security funds. Another obvious advantage—since 75 percent of all Americans are already covered by some form of health insurance—is that the measure permits participants to continue their private insurance plans, with the Government paying part of the premiums.

Unlike the King-Anderson bill, it provides reassurance for those who fear the program might undermine the independence of the medical profession, and it preserves the freedom of choice for those preferring private health insurance. Financing would be accommodated by the vast social security machinery already in operation.

As long as most Americans believe the Government must take the initiative in the field of health care for the aged—and apparently that is true—legislation to that end should in its earliest stage be as inclusive of human need as practicable. This bill fills the glaring pockets of omission in the King-Anderson bill while lessening the risk of regimentation and socialism inherent in the administration bill. It is a measure that can be supported in good conscience.

Mr. ELLENDER. Madam President, the State of Louisiana has a long and laudable history of providing health care for the needy; and when I say needy, I mean all the needy, not just those 65 and older.

Our system was begun in the 1930's, and has grown until today we have a total of seven State-owned and operated hospitals located throughout the State. These are administered, and for the most part are paid for entirely by the State. In addition to large, well-staffed, and well-equipped hospitals, in each of our 64 parishes, or counties, we have a parish health center whose services are available to all, regardless of whether payment can be made. These health centers, I may add, are administered entirely by local personnel. Their services are financed through State and local taxes, with some assistance from the Federal Government.

In short, Louisiana has been guided by this philosophy, and I suspect that this will be true throughout the Nation: To the extent that citizens, not only senior citizens, cannot provide for their own needs, these needs become the concern of the community.

Let me emphasize the words "local community," "town," "city," and "parish." Where greater expenditures are called for, the State acts to provide such necessary facilities as hospitals.

Our general hospitals, assistance programs, and community, civic, social, and charitable groups have been the historical method of handling the medical needs of the poor. To this was added the financial assistance of the Kerr-Mills Act, passed in 1960. I feel that my State has done a good job of answering the needs of her people, regardless of whether they are covered by social security or whether they are over 65 years of age. This has been done with some Federal assistance in later years, it is true; but it has been done without Federal controls, and it has been done well.

Years ago, before introducing and enacting legislation to allow the State to participate fully in any Federal-State matching medical-care programs, Louisiana systematically and thoroughly conducted laboratories in one-third of its parishes, to learn at the community level how it could best administer for its people, and without permitting the system to be abused.

Hospitals, nursing homes, and the medical profession cooperated fully with the State in drafting procedures for financing medical assistance wherever necessary. This careful examination paid off; and I speak with assurance when I say that no one in Louisiana, of whatever age or station in life, can fail to get the needed medical attention. He or she can get it without paying a cent, if necessary, and can obtain it for as long as is required.

This has always been true in our State-owned and operated hospitals; but due to the enactment of the Kerr-Mills plan, direct payments to other hospitals are being made at a maximum of $35 a day for each patient, for a period of 10 days. If the individual's private doctor feels it is necessary, this period can be extended to 30 days. This 30-day limit can also be extended in special cases.

Direct payments to the patient's own doctor and the nursing homes have also begun. Hospitals, nursing homes, doctors, and patients have found the Louisiana system, coupled with the Kerr-Mills Act, to be adequate.

If we wish to consider only those over 65 years of age, and forget all others, it can be shown that 51 percent of the old people who are currently hospitalized in Louisiana are cared for by State aid alone, or by a combination of State and Federal aid. This is counting in the seven State owned and operated hospitals, and also the others participating under the Kerr-Mills Act.

It is true that our State hospitals are crowded. Wherever free services are to be found, there will also be found crowds. One of the most important features of the Kerr-Mills Act, though not much publicized, is to channel some of the needy from the State hospitals and nursing homes into more or less private facilities. This is a feature not to be overlooked. At present, the number of citizens who require hospitalization, and whose hospitalization is based on need, can easily be cared for by the State hospitals, with some help from those not operated by the State.

But I fear that if some version of the King-Anderson bill becomes law, not only will the State hospitals be overcrowded, but the other institutions will become overcrowded, as well. We all know that this is one of the main problems of socialized medicine, toward which this bill would lead the country. This overcrowding has troubled England's National Health Service since its beginning in 1948. Today, patients in England must wait weeks, except in extreme emergencies, before being allowed to enter the crowded hospitals. According to U.S. News & World Report, the file of applications for admission to one large London hospital shows many names that have been on the waiting list as long as 3 years. I would not want to see this situation come to prevail some day at almost every hospital in the United States.

Furthermore, Madam President, the original King-Anderson bill provides that the first $90 in expenses must be paid by the patient, as well as the normal fees for drugs and many of the extra services performed by hospitals.

All fees by doctors must also be paid by those over 65 years old.

Madam President, under the rules and regulations in Louisiana, a single person can have as much as $250 monthly income—$3,000 per year—and still can qualify for assistance under the Kerr-Mills program. If he is the head of a family, he may earn as much as $325 per month—$3,900 per year—and any member of his family may qualify.

In addition, the recipient of Kerr-Mills aid may own his own home, and own property worth as much as $5,000, as long as that property can be classified as "income producing." He is allowed $1,000 worth of property that is not income producing if he is single, and $1,500 worth, if married. Also, if single, he may have $1,500 worth of life insurance, cash value, and, if married, the figure is $2,000.

In addition to these exemptions, he is allowed to own his own car, farm equipment, and any property necessary to earn his living.

These facts do a good job of fighting the argument that a person must be a pauper, or put his house up for sale, before he can qualify for assistance under Kerr-Mills. However, it should be noted that these figures do not apply in all the States. The Kerr-Mills Act says that to qualify, a person may not earn more than $1,800 per year, and allows the State to liberalize this amount if the State agrees to bear a larger share of the cost.

I am proud to say that Louisiana has done just that.

The most important differences between the original King-Anderson bill and the amendment now proposed are:

First. The amendment provides for covering everyone over 65, whether the person is covered by social security or the Railroad Retirement Act, or not. It is interesting to note that this additional coverage will be paid for out of the general revnues. This would open the door of the Treasury for later raids when the program proved to be more expensive than estimated.

Second. The amendment would set up a separate and brandnew trust fund to administer the moneys.

Third. The amendment makes provision for allowing private insurance companies, such as the Blue Cross, to participate.

Fourth. The amendment purports to make certain that the Government would in no way control the standards of doctors and/or hospitals by putting a portion of the controls into the hands of the American Medical Association and the American Hospital Association.

But the amendment still does not provide the benefits available under the Kerr-Mills Act. A patient's doctor bills would not be paid, nor would his first $90 worth of hospital treatment. In other words, $90 is deductible, and must be paid by the patient. The coverage would no doubt be expanded in later years to assist persons under the 65 age limit, and to provide fuller coverage.

At present, in Louisiana, Kerr-Mills provides for total coverage to give the needy complete medical coverage, doctor fees, drugs, hospital and nursing home care, and so forth. Kerr-Mills is, of course, financed through the general revenues paid by all the people.

I submit that the patients in the State hospitals would be unable to meet these requirements. Certainly the Kerr-Mills Act is more far reaching in this respect, for not only are the normal hospital and nursing home expenses paid, but also doctor bills, extra fees, and, in short, everything necessary to insure adequate medical care.

In my opinion, this proposed amendment is both more and less than it is cracked up to be. On the one hand it would not supply the coverage to be had under existing legislation, at least not among those groups where State services and facilities are needed so desperately. On the other hand, and no matter what its supporters say, it opens the door of this Nation's storeroom of medical knowledge and skill to the evils of socialized medicine.

It would also open the door of the Nation's Treasury to provide this service, which, in my view, is neither desired nor necessary. The supporters of this plan estimate its cost will be approximately $1.2 billion for the first year. I feel that this figure would prove to be totally unrealistic.

For an example, I again turn to the National Health Service of Britain. By coincidence, the first full year of that operation cost approximately $1.2 billion, almost exactly the estimated cost of the King-Anderson bill. But the supporters of the British plan had estimated that its cost would amount to something like $400 million. The total cost was over three times the esimate, and I predict that we would see the same thing happen here.

Today Britain's so-called free health service costs each British family, regardless of age or need, $140 a year. In 1961, socialized medicine cost the British Government $2.2 billion, up 13 percent from the previous year. This was about half what England spent for defense. This year we have pased a bill calling for the expenditure of almost $50 billion on defense. It is not inconceivable that the King-Anderson bill, or some measure like it, would soon be costing us about $8 to $12 billion, or one-fourth what we spend on defense.

To the Senator from Louisiana, this is unthinkable. I cannot see the need for this legislation, and it has no appeal to the country as a whole. Certainly it is not appealing in my State, for I have received only about eight letters in its favor, and literally thousands of letters against.

In this instance, I think the thousands are right. This is a bad piece of legislation, and I hope it will be defeated.

The PRESIDING OFFICER. What is the will of the Senate?

Mr. ELLENDER. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The Chief Clerk proceeded to call the roll.

Mr. MORTON. Madam President, I ask unanimous consent that further proceedings under the quorum call may be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MORTON. Madam President, I have been impressed with certain changes which have been made in the proposal of the distinguished Senator from New Mexico [Mr. ANDERSON], who has offered a modification of the original King-Anderson bill. This proposal has been supported and cosponsored by many of our colleagues on both sides of the aisle.

One of my principal objections to the King-Anderson bill still remains in the revised amendments; that is, the financing of the program through taxes levied on our social security system, through an increase in the taxes on the payrolls of America, an increase in the tax on the employer and an increase in the tax on the employee.

The social security tax in any business operation is a direct cost of manufacture or of processing, as the case may be. The total cost of manufacture is ground directly into the cost card of any company doing business. This is not so with regard to general taxes, and not so with regard to the corporate income tax.

I well remember that when first I had the responsibility for the management of a business the Federal corporate income tax was 13 percent. I had some part in the business, but was not active in management; when we disposed of the company in 1951, the Federal corporate income tax at that time was 52 percent. So, in the years in which I had some association with the business I saw the Federal income tax quadruple, from 13 percent to 52 percent.

Never once, Madam President, when the Federal income tax was increased, did we change the price of the consumer product which we manufactured. However, if our cost of raw materials went up one iota, or if our manufacturing or processing expense went up one iota, we found it necessary to change our prices in order to stay in business. We were in the grain processing business, which is much like the meatpacking business, in which one operates on a very close margin.

During the years of my association with the company our average net profit was far less than 1 percent of sales. When one is in a business operating on such a thin margin, one must immediately reflect in his prices the total cost of manufacture, and that of course includes the cost of wages.

I admit that what we are now talking about is a quarter of 1 percent tax on the manufacturer and a quarter of 1 percent tax on the employee, which sounds like minutiae, but this will be only the beginning of what might happen. Those of us who have taken the trouble to read the debates which occurred on this floor many years ago, when a proposed constitutional amendment was passed to permit the graduated income tax, know that once the program is started no one in this body today can foresee what ultimately will happen.

In one colloquy it was suggested that the tax might rise to 15 percent. The

speaker was then talking about the personal income tax. He felt that it would become a confiscatory tax.

The rejoinder from one who was sponsoring the amendment was, "Oh, no. It is inconceivable that the Federal income tax of the United States would ever reach 10 percent."

As we all know, today the income tax starts at 20 percent and goes up to 91 percent.

I believe the same thing would happen under the proposed legislation. As more and more programs are loaded onto social security, we shall be bound to raise the cost to American industry, and consequently raise the price of American goods.

Why am I concerned about that? I am concerned because today we find ourselves unable to compete in many of the markets of the world that traditionally have been ours. Those markets concern basic steel and include automobiles and all sorts of other manufactured items. U.S. companies have been forced to establish subsidiaries abroad in order to hold their markets.

As I pointed out yesterday on the floor of the Senate, the Japanese are thinking of trying to invest in plants in our country, because the Japanese have found that in spite of their low wages, in order to hold their business abroad they must build plants abroad. They have plants in Latin America, in Europe, and elsewhere. We have similar plants. Why are we building such plants? We are doing so in order to hold our market. The plants abroad are providing job opportunities to American workers in this country, because component parts are made here.

Our system is also helpful to our balance of payments, because profits from abroad are returned to our country. But it is a fact, known to all, that today American industry is in the fight of its life to hold its position in world markets. That point is easily understood when we compare the wage rates in our country with wage rates in foreign countries. No one wishes to see wage rates in our country reduced. But it is now proposed that we should add to the wage cost the direct cost of such programs as medical care for the aged. Almost all Senators are for a program of medical care for the needy aged. In an affluent society such as ours we must face our responsibility in that field. I for one am prepared to do so.

The proposal which I have submitted to the Senate in the nature of a substitute for the amendment offered by my good friend the distinguished Senator from New Mexico [Mr. ANDERSON] would provide benefits for the needy aged. I believe it would more adequately take care of their total medical and hospital needs than any other program before the Senate. But it would not finance the program through a payroll tax.

Much is being said about how small the increase in the social security tax would be under the Anderson measure. However, such proposals start in a small way.

For example, in Germany a pension plan was started in 1883.

Health insurance came into the picture in a small way in the 1890's. Originally in Germany a payroll tax was levied to provide a small amount of sick pay to low income workers. Since the last World War the program has had a terrific growth. In Germany now the tax for the social security benefit package for pension and health is almost one-quarter of the payroll. The worker puts up 7 percent toward health insurance and 4½ percent toward his pension. The employer puts up an equal amount. Those percentages total 23 percent.

In every country in which health insurance is tied to a payroll tax the cost has risen to four or five times the original estimates. People feel that it is an investment, and therefore they want a greater return for their money than they put into it. Benefits rise and the costs are pushed further and further into the future.

I will demonstrate what has happened in some of the countries. Between 1949 and 1962 the percentage of payroll tax to cover pension plans and health insurance paid by the employee and the employer—and these figures do not necessarily follow the German pattern of a 50–50 division—is as follows:

In France the tax has risen from 16 percent up to 19½ percent.

In West Germany, as I have indicated, the tax has risen from 11 percent to 23.6 percent.

In Italy the tax has risen from 13 percent to 23.6 percent.

In Belgium the tax has risen from 14 percent to 16 percent.

Let us examine the situation in France in a little more detail. In France, the employer now must pay social security taxes for the national pension system, for the supervisor pension plan, for employees' income tax relief, for work accidents, and for apprentice education, plus an allowance for the employees' houses or apartments and for the employees' families. Think of it. There is a provision in France requiring a payroll tax for employee income tax relief, which makes it a direct cost.

Those countries are able to compete effectively with us and undersell us in spite of the high taxes because their wage base in relation to ours is extremely low. I am sorry that I do not have the latest figures with me, but I have the figures as of April 1959:

In Italy the hourly wages were 35 cents; in the Netherlands, 44 cents; in France, 47 cents; in West Germany, 54 cents; in Belgium, 56 cents; Switzerland, 67 cents; the United Kingdom, 68 cents; Sweden, 94 cents; the United States, $2.22.

If we total the fringe benefits, which include the social security taxes—and we can call them by whatever name we wish in the foreign countries—we find that in Italy the costs have risen to a staggering 74 percent of the hourly wage, and since Italy started in 1959 with a basic wage of 35 cents, Italian industrialists are still able to undersell us in many areas.

In our own case all fringe benefits, including social security taxes, and those negotiated through union contracts, amount to about 20 percent of the hourly wage. So one can see what might happen if we should continue to dump program after program onto the Social Security System, making it not an indirect cost, but a direct cost, as reflected in the cost card in the price of the article. If, however, we should finance the program or similar programs through the general fund, we would distribute the tax burden in our traditional manner. A heavier burden would be placed on those most able to pay. Under the social security method of financing medical care, the president of General Motors, who is under social security, would pay exactly the same amount in total dollars as the man on the assembly line. That to me is not in keeping with the traditional tax pattern of our country.

Social security is a good program. I do not suppose there is anyone in Congress who would vote to repeal it.

However, certain misconceptions have been developed about it, and I believe that these very misconceptions have led the public to jump for and clutch for the King-Anderson proposal which finances medical care through social security. These misconceptions are:

First. That the tax is a premium and, therefore, workers are prepaying their own benefits.

Second. That social security is an enforced or compulsory savings program.

Third. That the life income of those on the benefit rolls is supported—and therefore guaranteed—by the assets in the trust fund.

Fourth. That compared to traditional insurance, social security is a bargain.

Fifth. That people now on the benefit rolls and their employers have bought and paid for their benefits.

To correct these misconceptions I would like to quote from a statement by Mr. Robert J. Myers, Chief Actuary of the Social Security Administration. He said:

> Still another argument claims that the beneficiary has "bought and paid for his benefits" because he may have been contributing as much as 24 years. In actuality, however, a person who has had the maximum covered earnings for the period 1937–60 has contributed only $1,290 (and his employer a like amount). This represents, at most, only about 1 year's benefits payments for a retired worker without dependents so it is quite obvious that no person has anywhere nearly "bought and paid for his benefits." In fact, actuarial calculations indicate that, at most, the maximum proportion of benefits that have been paid for by an individual's contributions is now about 10 percent, and in many cases of beneficiaries now on the roll, this proportion is less than 1 percent.

Madam President, this indicates clearly that those who are today paying social security taxes are paying only, at most, about 15 percent or 20 percent into a reserve for their own retirement, and the rest is going to take care of those now on the rolls. Here we have a proposal that we know will not be held at

one-half of 1 percent. We know from past experience that it is bound to go up and up. What this is doing is transferring to the workers today and, through increased manufacturing and industrial costs, the obligation for the care of those who are over 65 years of age.

Mr. CARLSON. Madam President, will the Senator yield?

Mr. MORTON. I am happy to yield.

Mr. CARLSON. The Senator from Kentucky is making a very interesting statement about the ever-increasing cost of programs once they have been included in the social security field. I am sure it was true also in the medical field. If the Senator has not already mentioned it, when social security legislation was first passed, the base pay on which the taxes were collected was $3,000, and the rate was 2 percent, which amounted to $60 a year. Yesterday the distinguished Senator from New Mexico placed in the RECORD the payments that are being made at the present time on $4,800. Under the new proposal the base pay will be $5,200, on which, in 1968 and thereafter, the rate will be 4⅞ percent. Under the present law it is 4⅝ percent on the employee and the employer, amounting to more than 9½ percent.

This is a program which those of us who have been in Washington for many years have watched grow in costs. First we increased the base on which the taxes were based and then we increase the taxes themselves. I fully agree with the distinguished Senator from Kentucky that this one-quarter percent on the employer and the one-quarter percent on the employee will be the beginning of a great program that some day will mean the collection of taxes from individuals who enter the program in an amount equal to or in excess of some of the amounts the distinguished Senator has mentioned as being collected in other nations who have had this type of program for years. The Senator is rendering a real service.

Mr. MORTON. I thank the Senator.

Mr. ANDERSON. Madam President, will the Senator yield?

Mr. MORTON. I am glad to yield.

Mr. ANDERSON. I do not wish to get into a discussion with the Senator on this question, because, as he knows, I admire the care with which he has prepared and presented his amendment. I should like to point out, with respect to what the Senator from Kansas has said, that it might be useful to compare what a dollar in 1937 bought with what a dollar in 1960 would buy. Food costs have gone up. Hospital costs have gone up from $9.25, in 1946, to $35. Naturally payments had to go up, too. They had to go up in order to keep the fund solvent.

I am not trying to be critical of the Senator from Kansas. He is a very faithful and conscientious member of the Committee on Finance, and we are longtime personal friends. I only say that we must compare costs as between one period and another, and take into consideration the erosion of the dollar, which all of us regret.

Mr. MORTON. I thank the Senator. I agree fully that the costs have gone up. None of us likes to see it happen, but it has happened. We have had a degree of deflation or depression or debasement of the dollar—whatever one wishes to call it. I hope it is over. It may not be, but may continue.

I believe that to be an added reason for not setting up a program, the costs of which we cannot measure 10 years hence, placed squarely onto a payroll tax. It is an added argument for financing it and funding it from the general fund, where it does not work toward denying Americans jobs and further forcing American industry out of the markets of the world.

Mr. CURTIS. Madam President, will the Senator yield?

Mr. MORTON. I yield.

Mr. CURTIS. The Senator is pursuing a line of thought which has much merit. The costs of the social security, even if the proposal before the Senate is not adopted, will increase a great deal. The program started out as a retirement program for the covered worker. I believe it was the late President Roosevelt who warned against expanding it too far. He said it was a floor of protection for the individual who could not, by reason of age, earn wages. Since that time the program has been extended to include a survivor benefit, not only for the surviving spouse in case of the death of the aged person, but also for the widow if the individual dies before he reaches the required age. If he leaves minor children it has a life insurance feature. It has been extended to include disability, first for those over 50 years of age, and later that was taken out. It has been projected for a period of 10 years in the future by the gentleman in the Department of Health, Education, and Welfare who is in charge of the legislation. I refer to Mr. Cohen. He is very learned in the field of social security. He has been one of the architects of the system. During the time that he was in private life, prior to the present administration, he was a professor who made many speeches and statements on the subject of social security. According to his pronouncements, he favors, at the end of a 10-year period, fixing the base for applying the payroll tax, not at the present $4,800 figure, but raising it to $9,000.

He has declared himself publicly, and has reaffirmed his views in official documents, in favor of the base's expansion, extension, and liberalization. The sum total of all of this would be a very high social security tax.

Actually, Mr. Cohen favors the proposed legislation which is before the Senate today. A few years ago he championed the Murray-Wagner-Dingell bill, which would have provided medical care not merely for the aged, but for all people. We who are realistic have good reason to believe that if the bill before the Senate shall be passed, its benefits will be extended so as to cover the purposes of that bill. That is logical.

If out of tax funds hospital bills are paid from the social security fund for individuals who are over age 65, regardless of their income, Congress will gradually move in the direction of taking care of bills essential for the individua who has had a long illness and has no earnings.

Mr. Cohen, on the basis of what he now advocates and has advocated in the past, has envisioned a program under which, when it is completed in 10 years, the self-employed individual making $9,000, and having a wife and two children, will be paying more in social security taxes than he will be paying in income taxes. From the income tax and other Federal taxes, all the expenses of the Nation are paid, including veterans' benefits and the retirement of the national debt. Yet it is proposed to move in a direction in which, under social security legislation, the $9,000 a year person, if he is self-employed, will be paying more for social security than he pays for all the other costs of government.

I commend the distinguished Senator from Kentucky for his study and his observations and for pointing up the fact that we are not proposing to give people something. We are proposing to add to a social program which will be endangered by its own weight. The reason why there is no widespread recognition of that fact at present is, as the distinguished Senator has pointed out, that the full impact of the program which is now in force has not been realized. The individuals now on the roll have made only a token payment for the benefits which they and their families will receive. A time will come when the burden under social security, which must be assumed by a young man just out of college and carried for 40 years or more—all through the years when he is buying a home, educating his children, and paying his own bills—will be very great.

This is not a proposal to give the people something. It is a proposal to pay some hospital bills now and add to the future burden of the individuals who will do the work of the country in the years which lie ahead. It will be an onerous burden.

I thank the Senator from Kentucky for yielding.

Mr. MORTON. I thank the Senator from Nebraska, who serves on the Committee on Finance, and who served in the other body for many years on the Committee on Ways and Means. He is one of the leading authorities in Congress on the subject of social security.

I wish to reemphasize some of the points which the Senator from Nebraska made. When the social security program was first enacted, it was assumed that the tax on the individual and the tax on the employer would never go beyond $90 a year per person. We have already seen that amount almost doubled. Without adding anything more to social security, without adding any new programs under the present law, there will be a 54 percent tax increase between 1961 and 1968. I recognize, as the Senator from New Mexico [Mr. ANDERSON] has stated, that costs have risen substantially since the social security program was inaugurated. As a Member of both the House and the Senate, I have voted for increasing the payments, and therefore increasing the

number of benefits subject to taxation. Other provisions have been placed in the program. I voted for them; I did not quarrel about them.

First, in 1939—which was before I became a Member of Congress, but I approved of the action—Congress provided for a surviving child under age 18, a dependent child under age 18, a dependent wife age 65 or over; a widow age 65 or over, a widow under age 65 and having a child under 18; and a surviving dependent parent age 65 or over. They were included as beneficiaries.

In 1950—and I voted for this program also—Congress provided for a dependent wife under age 65 having a child under age 18; a dependent husband age 65 or over; a dependent widower age 65 or over; a surviving dependent; a former wife having an eligible child under age 18.

In 1956, Congress provided additional benefits. There were included disabled workers between ages 50 and 64; a dependent, disabled child 18 or over—if still disabled at age 18—a surviving disabled child 18 or over—if still disabled at age 18. Congress was pretty much in agreement on that amendment.

In 1958, 2 years later, Congress included the dependent wife of a disabled worker age 50 to 64. Also, a dependent child of a disabled worker, aged 50–64, was included.

Two years later, in 1960, benefits were provided for a disabled worker under age 50.

All this is good. It was done knowing that the cost would be increased. But now it is proposed to enter an entirely new field. The housing program for the aged might just as well be placed under social security. I read a list of benefits which are provided in France, all of which apply to social security. Many social welfare programs in this country might be transferred to the social security tax.

The question of health care is only one program; but when we start, we do not know where we will stop. I dislike to see a start made in burdening the payroll of America with these programs, worthy as they are, because any increase in the cost of administering them immediately affects the price of American goods; and the price of American goods affects the employment opportunities for American workers.

Madam President, on June 7, in the Senate, I stated my approach to this problem. I started along four basic lines: First, that any medical assistance program for the aged, sponsored by the Federal Government, should not be compulsory.

Second, the program should be administered by the States.

Third, governmental assistance should he be given to all persons over age 65 who need it, but no monetary assistance should he be given to those who are able to finance their own medical needs.

Fourth, the burden of the program cost should not fall most heavily on the lower income wage earner, as would be the case with an increase in the social security tax.

I have dealt at length with point 4. For a few minutes I shall discuss point 3, namely, that governmental assistance be given to all persons over 65 who need it, but that no monetary assistance be given to those who are able to finance their own medical needs.

I was impressed with the argument to the effect that one has to take a pauper's oath or has to disclose his assets or has to go through all the embarrassment, if you will, of making a full disclosure of his assets, in order to be a full beneficiary of certain medical care programs or proposals. But I point out that for many of the veterans' programs that system prevails.

However, in providing for the establishment of eligibility for this program, I suggest that we use one simple criterion, namely, the filing of an income-tax return. If one paid no income tax, the Federal Government would pay up to $125 for participation in this program, which would be administered by the States. If one paid a moderate income tax—the individual and the Government would share in the cost on a graduated basis. The higher the individual's income tax, the greater would be his share of his medical insurance cost. So the program would not involve a pauper's oath, but merely would involve disclosure of whether the individual concerned had paid an income tax.

When a needy person whose medical insurance payment had been made entirely by the Federal Government went to a hospital or to a doctor for care, neither the hospital nor the doctor would know whether the person had paid for the costs or whether the entire payment had been made by the Federal Government.

The position of the State in this connection would be that of carrying out the administration. The Federal Government would pay the full amount of the premium of a needy person who was unable to pay, or would pay whatever part of the premium the needy person did not pay. However, the States already have welfare organizations established, and could easily administer this program, and they should administer it. A State would approve two, three, four, five, six, or whatever other number of optional policies such a person could get.

A person who was completely indigent would perhaps want a policy which would particularly emphasize taking care of his day-to-day needs for drugs and medicines and doctor and dental services, and would not be so much concerned about catastrophic illnesses, because today a person who is a complete indigent is taken care of, one way or another, when he has catastrophic illnesses.

A person who had some means and could take care of his day-to-day drug and medical expenses and his doctors' and physicians' and dentists' bills might be disturbed about the possibility of a catastrophic illness which might wipe out whatever savings he and his family had. So that person would be more interested in purchasing a policy which would give consideration to, and would make provision for, the expenses in connection with a catastrophic illness.

We have already faced this problem, in connection with a bill passed under the leadership of the late great humanitarian, Senator Dick Neuberger, of Oregon; and we, ourselves, and all Federal employees have an option as to what type of insurance will best meet our needs. I believe that with the counsel and guidance of the welfare workers in the several States, the people would buy the policies which best fitted their particular needs or requirements. The policies would vary from State to State, of course. A person in Alaska might want to be covered against frostbite; but a person in Florida certainly would not be interested in such coverage. Of course, the policies would have to meet the broad guide lines established by the Secretary of Health, Education, and Welfare. In short, I think the people would get their money's worth.

Under my proposal, up to $125 would be paid for such an insurance program. Perhaps someone will say, "I am already sick, and no company will insure me." But the point is that the policies will be group policies, and no medical examination will be required. For example, a person over 65 years of age who today is in a hospital could get such insurance. But only in connection with a group policy could such a situation prevail. So I think that argument is of little weight or value.

What will be the benefits? What could be provided for $125? I think the benefits would be rather substantial. In my bill, I have deliberately left a degree of latitude, so that we would not require one particular type of policy, but would provide for a broad freedom of choice. So an elderly person could obtain a policy in accordance with what he or she thought the need would be.

Some definite benefits are spelled out in the so-called Bow bill, which has been introduced in the other body. I have made a sufficient investigation to know that those benefits could easily be covered under the $125 payment which I suggest in my bill. Senators who are interested in this matter can find these items beginning on page 3, line 18, of the so-called Bow bill, H.R. 10981.

In the bill we passed for Federal employees, we authorized a program under which insurance companies submitted bids, and then they were passed upon by the appropriate Government agency. A typical example is as follows—and I am sure that my proposal would cover this:

Subject to an overall $50 deductible, $12 for hospital room and board charges per day of confinement, for 90 days, plus $180 miscellaneous expenses and a $300 surgical schedule; or by increasing the deductible amount to $100, hospital visits and nursing home benefits of $5 in hospital doctor calls for 50 days and $6 nursing home for 31 days could be added.

Another would be $15 for room and board for 31 days, plus 75 percent of the first $750 of miscellaneous expenses, and a surgical schedule of $250, and $3 for doctors' calls for 31 days. Those are examples of benefits which I am sure could be covered by a policy costing $125 a year.

I shall not burden the RECORD or my colleagues by stating here the details set forth on these pages, but they give the details for the policies in connection with bids received from reliable insurance companies, for various types of outlined care which could be given under the retired Federal employees' health insurance program; and I feel sure that the $125 would give far greater end benefits to those in need of doctors' care, hospital care, medical care, surgical care, or dental care than is practicable under the approach outlined, certainly, in the original King-Anderson bill, and even in the Anderson amendment.

Madam President, I know that if we adopt the Anderson amendment and if it becomes law, there will be demands on us, as Members of Congress, beginning almost immediately—beginning next year—to add benefits. That would require us to add taxes on the payrolls and to add to the social security burden and to further impede our ability to maintain our markets and to withstand foreign competition and to provide job opportunities to the American people.

The history in other countries has been that the cost has immediately gone up four or five times the originally contemplated cost. And once we further opened up the social security tax as a device for financing worthy programs, we would have many other programs which would be clamoring to get in under the same tent, financed by social security.

A moment ago I mentioned housing for the aged. I think it is a typical example. There is no more reason for keeping housing for the aged out of this program than there is for putting medical care under it. After all, it does little good to keep a person healthy if he does not have a place in which to live; and I think it would follow, just as night follows day, that if we started this, we would be called upon to provide a much more pretentious housing for the aged program, to be handled through social security.

So, for all these reasons, I hope my substitute will be seriously considered by my colleagues.

First, I think it more effectively deals with the basic problem.

Second, it is more in keeping with the American tradition of taxing those who have the ability to pay.

Finally, I think it is certainly in keeping with many programs. This administration is interested in increasing our business abroad, in keeping America competitive, in increasing job opportunities here at home. It seems to me we get into constant contradictions. We get a program brought up to do one thing, and then we come up with another program that vitiates the purpose of the first one. A tax program is proposed that will hurt American business abroad and will restrict job opportunities at home through inability to export.

Now we have this medicare program before us which will add directly to the costs of American business, and therefore further impede job opportunities at home.

So for all those reasons—social, economic, and in the name of the spirit of American tradition—I think my substitute deserves attention, and I hope it will prevail.

Mr. JAVITS. Madam President, will the Senator yield for a question or two?

Mr. MORTON. I yield.

Mr. JAVITS. First let me state, with the Senator's permission, that the Senator from Kentucky is one of the most distinguished public servants in this body, not only in domestic but in foreign affairs. I think it is quite a tribute to him, in what we are trying to do, no matter how we are trying to approach the problem, that the Senator from Kentucky felt impelled to offer a constructive alternative, for which I have great respect, rather than rest on the proposition, which I think some persons do—and I hope very few—"Well, let us just leave it as it is and not get into this at all."

First of all, I feel that I am on the Senator's side because, whatever may be my position on the inadequacies of the Senator's proposal, the Senator is offering a constructive alternative.

Mr. MORTON. If I may interrupt at that point, the Senator from New York has given as much study to this matter as has any Member of this body. I remember that he gave us a positive approach to the problem in 1960. He offered a sound approach, which I was happy to support. My efforts here have been, in large measure, inspired by the great work he did in 1960.

Mr. JAVITS. The Senator is very kind.

The other day the Senator defined for me the differences between his bill and the Bow bill. I wonder if he would state them again, because I think it would be a good idea to have that statement in one place.

Mr. MORTON. First, under the Bow bill, the full insurance would be paid for all citizens over 65, regardless of need. Either the Government would pay for it or the full amount would be taken in a direct deduction when a person filed his income tax.

In my proposal, I have, to a degree at least, maintained the philosophy of need by putting it on a sliding scale: If the person pays no income tax, the Government pays the entire insurance premium cost; and then it graduates up to the point where the individual pays $400 in Federal income tax. At this point practically the full medical insurance premium would be paid by the individual.

Mr. JAVITS. The Senator mentioned another distinction.

Mr. MORTON. Another distinction is that the Bow bill spells out the benefits. My proposal leaves it in more general terms, merely requiring the States to certify a choice of plans, and those plans must be within the broad guidelines set by the Secretary of Health, Education, and Welfare.

Under the Bow bill, the persons would get their own insurance. My measure is on the group theory, so that anyone in a hospital today, for example, who might be 75 years old, would come under the provisions of the law.

Mr. JAVITS. Of course, in the measure of the Senator from Kentucky, the insurance contract is made by the State.

Mr. MORTON. Yes.

Mr. JAVITS. That is, the State contracts with as many carriers as it chooses?

Mr. MORTON. Yes.

Mr. JAVITS. Would the Senator contemplate that a State could contract with contractors and persons could have insurance with carrier A, B, or C, or does the Senator believe that, under his bill, the State would contract with a carrier to the exclusion of others, and therefore the people in that State would have to sign up for a policy with that particular carrier? What does the Senator have in mind in that respect?

Mr. MORTON. I would hope there would be several carriers, A, B, and C—not too big a number, but at least a reasonable choice, say, five, six, or seven. Although I do not specify it particularly, I think it is implied in my proposal that the Secretary of Health, Education, and Welfare, in his broad guidelines, would made it a requirement that a State would not favor one particular carrier.

Mr. JAVITS. If that is the case, does the Senator feel that the advantage is an actuarial advantage, in that a State would have a big bloc of subscribers to have insured? Also, would it not be a disadvantage that, unlike the option provision which is contained in the amendment of the Senator from New Mexico [Mr. ANDERSON] and our colleagues in its present state—and I hope we will improve it materially—it gives a wide range, through co-op plans, insurance companies, et cetera? Does the Senator feel that would be a fair point to make as between his substitute and the Anderson amendment?

Mr. MORTON. Yes. I would be perfectly willing to provide the same option under my plan. As I said at the outset, I think the bill the Senator from New York has had a chance to work on with the Senator from New Mexico is a tremendous improvement over the administration proposal or the King-Anderson proposal. I think it is a magnificent job. But my particular worry is the social security financing. However, that is not the point we are discussing now. I think the Senators have done a splendid job in developing an arrangement under which groups, cooperatives, and so forth, can be brought in. I do not think they would be precluded under my measure.

Mr. JAVITS. The Senator will note that under the Bow plan, which is in this respect not analogous, but which gives us a word of warning, it carries within it a lifetime limitation, so that under the plan of Representative Bow, if a person had a $100 deductible amount, his lifetime limitation which could be incurred under the plan would be $5,000 in cost. If it was a $200 deductible item, it would give that person a lifetime maximum of $10,000.

I ask the Senator whether it is not very likely that if we left the field strictly to the insurance people, they would write these provisions into other policies and therefore the policies would fall short of one of the very big problems which is involved in this area, which is giving people a sense of mental insurance

against catastrophe in all kinds of health problems.

Mr. MORTON. I do not contemplate writing any lifetime restrictions in the policies under my measure. I think experience and the competitive records of experience and the competition that is developing among groups which are seeking to sell health insurance today would work toward the highest possible liberalization of the policies.

Mr. JAVITS. Finally, I should like to ask the Senator this question. I was having a sandwich in the cloakroom, and the Senator may have already covered this point. Has the Senator from Kentucky made any estimate of cost under his measure?

Mr. MORTON. We have made an estimate, and as nearly as we can tell, it is somewhere in the neighborhood of $1.2 billion to $1.4 billion.

Mr. JAVITS. How many people does the Senator estimate that amount would cover?

Mr. MORTON. Of course, there are 17 million persons today who are over 65. Our difficulty in estimating cost came from trying to ascertain from the Internal Revenue Service how many of these persons paid taxes; and, if so, how much they paid in taxes. So our figures are somewhat of a guess. But we are pretty sure about the limit of between about $1.2 billion and $1.4 billion.

Mr. JAVITS. Certainly, the Senator's amendment would cover those who paid no tax at all?

Mr. MORTON. Yes.

Mr. JAVITS. And then those who paid less than $400? And it gives even a little to some who pay over $400 a year.

Mr. MORTON. Yes. Those over 65 years of age can deduct certain expenses now. They would get that benefit anyway.

Mr. JAVITS. I thank the Senator for his explanation. The Senator's plan would be premised upon appropriations to be made annually, in the amount somewhere between $1.2 billion and $1.4 billion.

Mr. MORTON. That is correct. That is a staggering amount of money, but there has been a great deal of talk about tax cuts. Some of our friends have been talking about a tax cut of as much as $10 billion. Perhaps we could ease up on the tax cut by 10 percent and have money available to provide for the health care of the needy aged.

Mr. JAVITS. I thank my colleague. Before I sit down I should like to express my appreciation for the constructive thoughtfulness which obviously has gone into the Senator's effort to meet this kind of problem. We often hear many words used in the endeavor to describe the ideology of Republican Senators—"liberal," "progressive," "conservative," and "ultraconservative." I prefer the word "thoughtful" for the Senator. I am very pleased that he has given his mind to this effort. I can only say that it will be helpful, whatever may be the fate of his particular proposal.

Mr. MORTON. I thank the Senator from New York.

Mr. MILLER. Mr. President, will the Senator yield to me?

The PRESIDING OFFICER (Mr. HICKEY in the chair). Does the Senator from Kentucky yield to the Senator from Iowa?

Mr. MORTON. I yield to the Senator from Iowa.

Mr. MILLER. Mr. President, I wish to join in the commendation of the distinguished Senator from Kentucky by my colleague from New York, for the excellent work he has done in endeavoring to come up with a reasonable, workable solution to the problem which confronts us.

I should like to ask my colleague from Kentucky a question about a subject which has troubled me considerably.

Although I like the approach used in the Senator's plan, I note that the means test, if we might call it that, seems to revolve around the concept of Federal income tax liability. I am sure that the Senator recognizes, as I do, that if we are to consider the economic means of people, the income tax liability does not necessarily reflect economic income. What the Senator from Iowa would like to have is a means test, based upon economic income.

On page 13 of the Senator's amendment, section 208, it is provided:

> The amount of the State share with respect to any individual for any period within a taxable year of such individual shall be based on the Federal income tax liability of such individual.

I should like to see that modified to reflect the economic income of the individual. The economic income could be defined to include the Federal net taxable income, which would be the adjusted gross income, minus the page 2 deductions, if there were any, or the optional standard deduction; and to that could be added the income not recognized for Federal tax purposes; such as, for example, tax-exempt bond interest or the unrecognized 50 percent of long-term capital gains.

I am sure we can visualize a situation in which many taxpayers might have no income tax liability whatsoever, but, as a result of having tax-exempt bond interest or long-term capital gains, might have a substantial economic income, which would put them in a preferred position as compared to those not having that income, if we should follow the approach used in the Senator's amendment.

My question to my colleague from Kentucky is whether it would be feasible to modify his amendment to include this type of approach.

Mr. MORTON. First, I recognize that the question posed by my colleague from Iowa is a valid question. I know the Senator is a distinguished tax lawyer and an expert in this field.

I thought of the point he has made. I think perhaps if we could provide for the economic income in a manner concise and easy, that approach would be better than my approach. However, there has been a great deal of talk about the "pauper's oath" and this, that and the other. I took what seemed to me to be the simplest device, even though I recognize there would be certain beneficiaries under the program who would be people of substantial means, who would pay either no Federal income tax or very little Federal income tax.

I am sympathetic toward the approach outlined by the Senator from Iowa, but I could not figure out a way to do it, I will say frankly, without getting the proposal so complicated that we would leave the basic objective.

Frankly, in total numbers I do not think we would find very many citizens who have substantial income from tax-free sources who do not also have large income from taxable sources. Therefore, they would pay income taxes.

Mr. MILLER. I agree with my colleague that the number probably would not be great. In my own State, and no doubt it is true in other States, I am sure it is true that there is a feeling that the economic status of an individual should be the critical test.

I recognize the practical problems of enforcement, when there is a departure from a simple test of income tax liability, adding in other factors.

Speaking from my own experience in my own State, I would suggest that this proposal should not be difficult to work out. As the Senator knows, on the Federal income tax return the full amount of long term capital gain is shown. It would not be difficult to obtain that information from the Federal income tax return. On the State income tax returns the tax exempt bond interest or other items exempt from taxation for Federal purposes are readily set forth. I do not believe we would encounter much difficulty in the administration of it, if we tied down the definition of economic income to the factors I have mentioned.

If the Senator thinks this suggestion has merit, the Senator from Iowa would be happy to sit down with him and try to devise an amendment to his amendment which would spell out a definition of economic income which would be practically enforcible. I do not think we need to get into too many refinements. The items I have mentioned are the two big items. I believe the two main items with respect to which we should take action are the unrecognized 50 percent of long term capital gains and the tax exempt bond interest. Both of those represent millions of dollars of income during any year. If we could get those out of the way, I think we would have a much more equitable approach, a much more palatable approach so far as the administrators in my State are concerned. I am quite sure the people in the social welfare administration in the State of Iowa would feel more comfortable about the program if an economic test tying in these other factors were used, rather than the straight income tax liability.

Mr. MORTON. Again I must say I have no way of knowing how many people are in that category. I think there are indeed very few people who have substantial income from tax-free sources, or who have long-term capital gains of any consequence, who do not at the same time have taxable income which would take them outside of the framework of the formula I have developed in my pro-

posal. I think we are talking about so few people that I would hate to see us get bogged down in the argument, when I am trying to establish a more basic, fundamental concept of how to pay for medical care for the needy aged in an affluent society.

Mr. MILLER. But the Senator's proposal would tie the hands of a State. For example, my own State of Iowa could not take into account these other factors I have mentioned. I believe when a proposal would tie the hands of a State we should be reluctant to override long-standing policies of a State, and I think those policies would be overridden if we relied strictly on the income tax liability.

Mr. MORTON. If the Senator will permit me to interrupt, I shall be glad to endeavor to work with the Senator to develop language which would permit the States to consider the problem on the basis of actual economic income instead of on the basis of income taxes paid.

Mr. MILLER. Then I say to my colleague that I think we might be able to work something out to make it a better amendment. I know the Senator has spent far more time going into this subject than has the Senator from Iowa. All I am trying to do is to be helpful in perfecting a reasonably good amendment, which I think will be much more supportable than the amendment now pending.

Mr. MORTON. I thank the Senator. I shall be glad to work with him on the problem.

I yield the floor.

Mr. ANDERSON. Mr. President, first I wish to say to the able Senator from Kentucky [Mr. MORTON] that while we may not agree with his amendment, and some of us may have some argument about it, I desire to commend him publicly for the fact that when the suggestion was made in the Senate Committee on Finance that a hearing be held on the bill, the Senator from Kentucky voted to have a hearing, because the bill is an important one and would involve a great deal of money.

I appreciate the fact that the Senator from Kentucky took the position he did in the committee. I am glad to see that he recognizes that at this time there is very little disposition on the part of people to repeal the basic social security legislation. I was appreciative of the recital which he gave of the changes which have been made in social security legislation through all the years to date.

It is important, however, to realize that we have made the system grow as people wanted it to grow. When features are added to the bill, naturally the cost of the program is increased. I am glad to say that the Senator from Kentucky is one of those who has been helpful in the passage of good legislation along that line. I was pleased to hear his recital today.

However, we have seen what happens when we come to the question of proposing an income tax method of handling the program. People will say that it is not a good means test. Their statement is correct. It is not a good means test. If we were to apply a good means test, the experience of MAA, the medical assistance for the aged program, would show an average cost of about $42 per case in order to put it on the books. Therefore I think the Senator from Kentucky has a good point in saying that if we should try to improve on the income tax approach by a means test, we would have a rather costly venture that might or might not be the correct approach to it.

The Federal payments toward premiums would vary in accordance with the Federal tax liability of the insured aged individual. One intent of the provision is, of course, to conserve Government funds by relating payments to individual need. There is some question, however, as to whether that provision would actually save the program a significant amount of money.

The Government would pay a $125 premium with respect to a person who has no Federal tax liability. About 80 percent of the aged have no tax liability, so the Federal Government would be involved in paying all the cost of 80 percent of the people. At the present time, with the number of people we now have, it would mean a cost of about $1,750 million, to which we would add certain other costs, which would probably bring the total closer to $2 billion. But if we take only the rough figure of $1,750 million, the amendment would be an expensive one which would certainly continue to throw our budget further out of balance.

An income test based on Federal income tax liability has some deficiencies. For example, such a test would exclude various forms of income from nontaxable securities, certain dividends, social security and railroad retirement benefits, and a part of certain long-term capital gains. A retirement income credit is also allowed. Income from State and local bonds and securities is not counted. The option to file joint or individual returns also raises an issue as to treatment of individual members of a couple. It is unclear how such cases are intended to be treated under the bill.

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

In any case, the test is not an effective means for preventing high-income people from receiving benefits exceeding $25 per year.

The administrative costs under the proposal of the Senator from Kentucky [Mr. MORTON] would be generally higher than that under my amendment. One of the basic reasons for this difference in cost is that Senator MORTON would require specific proofs in determining how much aid would be given to any aged person. The applicant would have to prove his age and each year a determination of his income would be involved. Considering that the average benefit to an individual per year would be in the vicinity of $100 if the cost of the determination were as low as $10, this determination alone would result in 10 percent costs for administration. While I have assumed $10 for this purpose, it should be recalled that in the MAA program administering the means tests costs $42 per case on the average.

So I hope the amendment will be rejected. I believe that it is an interesting proposal. I say again that the proposal of the Senator from Kentucky has been carefully drawn. I realize that it represents a good deal of thought, care and attention. But I think the amendment should be rejected.

Mr. JAVITS. Mr. President, I shall not detain the Senate very long. I did wish to make a few observations.

Mr. KERR. Mr. President, will the Senator speak a little louder?

Mr. JAVITS. I might suggest that if perhaps the Senator from Oklahoma would come a little closer, he could hear better.

Mr. KERR. If the mountain will not come to Mahomet, Mahomet will go to the mountain.

Mr. JAVITS. And the mountain will be very honored.

Mr. President, I wish to make a few observations on the very interesting substitute suggested by the distinguished Senator from Kentucky.

I preface my observations by pointing out that the amendment represents a very thoughtful effort to meet the problem. And admittedly it is a problem.

I make my observations only because there will be other amendments. The Senator from Connecticut [Mr. BUSH] has an amendment.

The amendment of the Senator from Kentucky may find favor with the Senate, although I hope it does not. There may be other suggestions which raise the same points. Perhaps it is just as well that at an early stage of the proceedings the Senate should consider those points.

First, there is the question of cost, which I believe is very important. My distinguished and beloved friend, the Senator from Oklahoma [Mr. KERR], in his usual trenchant way, made me face the fact yesterday that there was a time when I was very much opposed to social security financing. I should like to face that fact again today. The amendment of the Senator from Kentucky [Mr. MORTON] raises the point very properly. There is no question about the fact that the program would result in less cost, in terms of the Federal budgetary establishment, if the social security financing prevails.

The reason I was opposed was that I felt it would be a tax upon those elements of the population at the lower income levels. Therefore I criticized the tax as regressive. It took about 2 years

for me to come to the realization, which I repeat was my decision as a person in public life with an extrasensory perception which we all acquire after while, that those who would pay what I called and still call a regressive tax are not only willing but eager to pay it.

There is inherent in the concept dignity, strength, self-sufficiency, and self-help. The concept that people would be putting up some extra money to provide health protection for them when they grow older is an attractive concept to the working people of the United States. That strange alchemy occurs in a free society.

It is my observation—and I am acting upon it because I thoroughly believe it—that the great majority of the American people who would pay the extra percentage called for by the amendments of the Senator from New Mexico are willing and glad to pay the required amount for the protection which they consider they would be getting under a suitable bill. That is a classic case, so far as I am concerned, on the question of financing.

When I was working on my bill in August 1960, I had to admit that it would cost $1 billion to $1¼ billion. The Senator from Kentucky [Mr. MORTON] must admit that his bill would cost $1,200 million to $1,400 million. Therefore, we must compare that cost with the fact that under the substitute of the Senator from New Mexico [Mr. ANDERSON] which we have joined in, the cost out of the general Federal Treasury would be something in the area of $250 million. The rest of the cost, roughly $1 billion more or less, but on the whole just about that figure, would be produced out of social security taxes. Since I am intellectually convinced that people are willing and ready to pay that tax for the purpose stated, why should we stop them? It certainly would reduce the drain upon the regular Federal budget, the regular Federal expenditures, and what we consider to be the cost of running the Federal Government, especially in respect of a program of the character we are considering.

The second thing is the question of benefits, which I think is raised very admirably by the proposal of the Senator from Kentucky. There are two ways to approach the benefit question. One way is as he has approached it, by allowing the competitive forces in the insurance field to establish benefits competitive within approved limits. He names a category; he does not specify benefits.

The other way is to set a standard to which private enterprise is invited to repair—better, if it can, but a standard nonetheless. I rather think for myself—and again I speak solely as an advocate and as one who has worked in this field—I prefer the setting of a standard. I believe that the standard that will be set will be a notch above what the private enterprise system is likely to go to now. Nonetheless and notwithstanding the fact that it is a notch above what it will go to now, I think the way we have it, with the option added to it, it will result in giving the private enterprise system a new base upon which to stand.

May I repeat that, Mr. President? We are having a conversation not only with each other, but with the country on this subject. I believe it should be very clear to everyone what we are trying to attain and what people like myself, who have come over to a point of view, believe. I believe that we are setting a standard which will be a base for the private enterprise system at a level higher than what in my view it would attain for some time.

Therefore, the standard we would be setting in the bill, according to the Anderson substitute, is desirable. It is a standard which I believe represents a reasonable contribution to the adequate medical care of the individual over 65. We all know that it does not represent all of his medical care. We know, for example, the great power and effectiveness of preventive care in respect to our older people. We know, for example—and geriatricians tell us—that it is important to keep older people ambulatory. We know that not less than 50 percent or probably nearer 60 percent of their medical expenses will not be met by the pending bill even if it is passed in its present form. Nonetheless, it is a big contribution to medical security. That is what it is. It is a platform on which private enterprise can build higher. It can build even higher on the concrete base that the bill will provide, and bring about adequate medical care for people over 65 in terms of money and in economy.

Mr. CURTIS. Mr. President, will the Senator yield?

Mr. JAVITS. I yield.

Mr. CURTIS. The cost of the program under the Anderson proposal would be borne through taxation, would it not?

Mr. JAVITS. It would be borne through the social security tax.

Mr. CURTIS. That is a compulsory tax.

Mr. JAVITS. Yes.

Mr. CURTIS. What remedies can be resorted to if it is not paid voluntarily?

Mr. JAVITS. Well, the same penalties that would apply to any other mandatory tax imposed by the Federal Government.

Mr. ANDERSON. Mr. President, will the Senator yield?

Mr. JAVITS. I yield.

Mr. ANDERSON. When the Senator from Nebraska says "if it is not paid voluntarily," I only wanted to say that I have always thought that most social security taxes were collected at the source by the Government. I did not know that the Government went around to the individual to collect its dollar.

Mr. CURTIS. The self-employed pay it directly.

Mr. JAVITS. The employer pays both for the employee and for himself.

Mr. CURTIS. Severe penalties are imposed if they do not collect it and pay it. Where does the money go after it is paid in taxes?

Mr. JAVITS. Under our bill it will go into a separate trust fund, a medical trust fund set up solely for this purpose.

Mr. CURTIS. In the U.S. Treasury?

Mr. JAVITS. Well, it will go into a separate trust fund which is under the jurisdiction and control of the Treasury; yes.

Mr. CURTIS. Who will pay out the benefits?

Mr. JAVITS. The benefits will be paid out in the first instance from the trust fund by the Treasury.

Mr. CURTIS. The Government will make arrangements with the provider of the service, whether it be a hospital or nursing home?

Mr. JAVITS. Or with an agent or with a supplier of the service to the beneficiary, where the beneficiary has availed himself of it—a private enterprise operation.

Mr. CURTIS. The Government must furnish it one way or another?

Mr. JAVITS. The Government must pay one way or another.

Mr. CURTIS. What makes it a private enterprise system when the Government collects the money with all the force of law of collecting any tax and where the Government administers the program even though there is an option that permits them to have an agent assist with the administration?

Mr. JAVITS. I would say that it is a partially private enterprise system and a partially Government system. I would say it is a mixed system.

Mr. CURTIS. If an individual lives in an area where Blue Cross is not going to act as the agent for the hospital or for the beneficiary, what part of it would be private enterprise?

Mr. JAVITS. That part which actually supplies the service to the individual. It will be supplied in many cases by hospitals or nursing homes or some health service agencies, which are private enterprise.

Mr. CURTIS. The hospitals are not Government-owned.

Mr. JAVITS. In the main, that is true.

Mr. CURTIS. But the operation of the plan otherwise is a Government system of paid medicine.

Mr. JAVITS. Well, I cannot agree with the Senator that this is a Government system of medicine. I think a fair description of it is that it is a system of private enterprise and Government. It is a mixed system of giving medical care—it is not really medical care—giving health care to those over 65. I cannot agree with the Senator. I know he is an able questioner, and I would like to go along with him, but I am intellectually convinced that this is not strictly a Government plan.

Mr. CURTIS. Turning to another subject, does the Senator know what the cost of a hospital bed runs to? Let us say a hospital bed in a semiprivate accommodation or in a ward.

Mr. JAVITS. There is great variance. I would fix the cost at somewhere in the $10 mark and as high as $35. It depends on the place.

Mr. KERR. That is per day.

Mr. JAVITS. Yes. It depends on the type of accommodation that is furnished.

Mr. CURTIS. If the beneficiary finds it necessary to go to a hospital and his illness is such and the facilities are such that he is placed in a bed which costs not to exceed $10 a day and he stays 8 days in the hospital. How much of the hospital bill will be paid by the plan?

Mr. JAVITS. Nothing.

Mr. CURTIS. Very well. My next question is, What is the average length of stay in the hospital for an aged person?

Mr. JAVITS. Our researches, when we looked into the matter, showed that last year in round figures it was 15 days. I do not believe the figures are any different today. The Senator will not hold me to a slight percentage, I am sure.

Mr. CURTIS. I cannot even hold the Senator to that figure, because it is too round. I believe it is much lower.

Mr. JAVITS. It is actually 14.7 days average stay. I said 15.

Mr. CURTIS. For what class of people?

Mr. JAVITS. Over 65.

Mr. CURTIS. Those figures vary from the ones I have. I would be interested in the source of the Senator's figures, because I believe we are all in danger of having figures from my point of view and from the Senator's point of view which will not be complete.

Mr. JAVITS. I could not agree more with the Senator from Nebraska. When one draws upon one's recollection, it is always dangerous. So I ask the Senator's leave to submit to the Senator, and for the record, the precise figure and the precise source. This is not the end of the matter, so we can go into it again at another time.

Mr. CURTIS. Does the Senator from New York know what percentage of the aged of the country now have some sort of private health insurance or hospital insurance?

Mr. JAVITS. I would not wish to say about health.

Mr. CURTIS. I will confine it to hospital insurance.

Mr. JAVITS. My understanding is that some kind of health coverage extends to something like 7 million-plus of persons over age 65. Again, the Senator is entitled to my source and to every detail; but, again, I am giving the Senator my best recollection.

Mr. CURTIS. Seven million out of how many million?

Mr. JAVITS. About 7 million out of about 17,500,000.

Mr. CURTIS. Has that number increased materially in the last 10 years?

Mr. JAVITS. I am sure it has increased materially, because the whole rate of increase in health coverage, through various types of health plans, is very great.

Mr. CURTIS. Does the Senator from New York have any facts to indicate that that increase will not be greater in the next few years than it has been in the past?

Mr. JAVITS. The Senator from New York cannot give the Senator from Nebraska those facts, except to point out that the rate of increase is slowed as a certain rate of participation is reached. But one of the main factors, which also affects the 7 million, is the extent of the coverage, which is one of the important points which have been made in these debates, which explains, in many cases, perhaps even the majority of the cases, the very limited nature of the coverage. There is health coverage, but it is quite limited in nature.

Mr. CURTIS. To what is it limited?

Mr. JAVITS. It varies with different plans and different types of participation.

Mr. CURTIS. Does it include prescriptions?

Mr. JAVITS. I could not say that to the Senator generically. Could the Senator tell me to what plan he refers?

Mr. CURTIS. I am talking about the new plan.

Mr. JAVITS. I beg the Senator's pardon. I understood the Senator to be talking about the so-called voluntary plan.

The plan of the bill does not include prescriptions. It includes such medicines as are provided in connection with hospitalization, and there is a fair degree of procedural formulas.

Mr. CURTIS. In other words, if there is an aged individual who, in order to sustain life, must have a prescription filled once or twice a week, this program would not provide for that?

Mr. JAVITS. I would not say that.

Mr. CURTIS. If he is not in a hospital?

Mr. JAVITS. If he is not in a hospital, that is a fact, except for one minor difference. There is a certain amount of outpatient diagnostic service provided in the bill, with a deductible amount of $20.

Mr. CURTIS. That is a cheap way of keeping the person out of the hospital.

Mr. JAVITS. Well, let us say that.

Mr. CURTIS. Suppose an aged person had to report to his doctor's office once a week. What would the Anderson proposal do for him?

Mr. JAVITS. Aside from the outpatient service, to which I referred, the Anderson proposal would not cover the doctor's service.

Mr. CURTIS. Suppose such a person called the family doctor, and the doctor went to the home. Would such service be covered under the Anderson proposal?

Mr. JAVITS. No, it would not.

Mr. CURTIS. We are asked to inject the Federal Government into a plan under a universal tax which will provide some benefits, and the proponents admit that the benefits are rather small. What is the Senator's estimate, or what is the best figure the Senator can obtain, concerning what a private carrier would charge for all the protection which is provided in the Anderson bill as now written?

Mr. JAVITS. We have tried to get various estimates on that subject for the 90 days of hospitalization with the $90 deductible. The best figure I can give the Senator is this. Our research has indicated wide diversities. Many companies have much lower ratios of operatings to premiums than do others.

We are told that the optimum ratio was somewhere in the 80- to 85-percent bracket. That is not even attained. The best figure I can give the Senator is that I calculate the cost to the Federal Government of this type of coverage, on a premium basis, as in the order of magnitude of $100 a year. What a private company would charge for that service remains a question, because the private companies have not been faced with this issue. However, I think it is fair to assume that Representative Bow rather carefully did his utmost to ascertain what insurance coverage would cost in connection with the proposed Bow plan.

It is rather significant to me that even with a lifetime limitation of $5,000, on the basis of $100 deductible, and $10,000 on the basis of $200 deductible, on the whole his figures for a $125 premium give, if anything, fewer benefits than the benefits provided by the Anderson plan. For example, because, again, we want to have our figures correct, his plan A—he has two alternatives in his proposal—provides 90 days' hospitalization, assuming a cost of $12 a day, which I think is a pretty low cost assumption, because apparently insurance companies, generally speaking, prefer an overall figure of $1,080 for all days of confinement in a calendar year. They give $120 for hospital ancillary charges, including surgery and emergency treatment; $6 a day for convalescent hospital room and board charges; and $186 for all such days of confinement in a year. So they are talking about 31 days, and they pay surgical charges—which the Anderson plan does not—according to a fee schedule with a $300 maximum for any single operation.

I submit that those benefits are rather materially lower than the Anderson benefits. The insurance companies are protected by a lifetime limitation, which I have described. Nonetheless, apparently the optimum figure which Representative Bow was able to get is $125 a year.

Mr. CURTIS. That includes surgery.

Mr. JAVITS. I know; I equated that fact with the nursing home service and the health service provided in the Anderson bill. Therefore, what will be provided by the Federal Government, even on this actuarial cost basis, is very much more for the money than what is provided today. I am hoping for much better things.

Mr. CURTIS. For whose money?

Mr. JAVITS. For the individual payer's money. The individual payer of the social security tax will get more for his money today than he would, generally speaking, in the insurance field.

Mr. CURTIS. When the Senator speaks of "today," is he referring to the young man of 25 years of age who begins to pay the bill?

Mr. JAVITS. No; I am talking about the man who needs coverage at age 65.

Mr. CURTIS. He will get his service free if he is already retired. That is pretty cheap.

Mr. JAVITS. That is correct; it is very cheap. But we are now talking

about the impact on a man of average age when he becomes 65 years of age.

Mr. ANDERSON. Mr. President, will the Senator from New York yield at that point?

Mr. JAVITS. I yield.

Mr. ANDERSON. In connection with the discussion about the length of stay in a hospital, I ask unanimous consent to have printed at this point in the RECORD a table from the "Health Statistics of the National Health Survey of the United States, 1958–60." Table 12 shows the average length of stay in days for both sexes in different age groups. In the age group 25 to 34, the average length of stay is 6 days. In the age group above 65, the average length of stay is 14.9 days.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

TABLE 12.—*Average annual number of hospital days and average length of stay by sex, family income, and age: days for discharges from short-stay hospitals, United States, 1958–60*

[Data are based on household interviews and refer to the living, civilian, noninstitutional population. The survey design and information on the reliability of the estimates are given in appendix I. Definitions of terms are given in appendix II]

Family income and age	Average annual number of hospital days in thousands			Average length of stay in days		
	Both sexes	Male	Female	Both sexes	Male	Female
All incomes						
All ages	166,935	77,018	89,916	8.4	10.5	7.2
Under 15	20,560	11,353	9,207	6.0	6.1	5.8
15 to 24	18,322	5,881	12,441	5.3	8.2	4.5
25 to 34	22,954	7,252	15,703	6.0	9.3	5.2
35 to 44	24,074	11,091	12,984	8.4	11.8	6.7
45 to 64	48,401	23,680	24,721	11.8	12.2	11.5
65 plus	32,623	17,762	14,861	14.9	15.9	14.0
Under $2,000						
All ages	32,125	16,345	15,780	11.4	15.0	9.1
Under 15	2,477	1,328	1,149	9.3	8.7	10.3
15 to 24	2,950	1,085	1,865	5.5	10.0	4.4
25 to 34	2,630	986	1,644	8.0	14.5	6.3
35 to 44	3,345	1,944	1,401	13.6	23.4	8.6
45 to 64	7,635	3,948	3,687	12.5	15.0	10.6
65 plus	13,087	7,053	6,034	15.7	17.0	14.5
$2,000 to $3,999						
All ages	35,947	18,179	17,768	8.3	11.1	6.6
Under 15	4,430	2,567	1,863	6.2	6.4	5.9
15 to 24	4,814	1,268	3,546	4.8	6.9	4.3
25 to 34	5,241	2,425	2,817	6.9	12.9	5.0
35 to 44	4,839	2,323	2,515	9.4	12.9	7.5
45 to 64	8,741	4,817	3,923	10.9	12.3	9.6
65 plus	7,883	4,779	3,104	15.0	16.4	13.2
$4,000 to $6,999						
All ages	51,389	20,378	31,010	7.4	8.3	6.9
Under 15	8,245	4,847	3,398	5.7	6.1	5.2
15 to 24	5,990	1,386	4,604	5.1	6.5	4.7
25 to 34	9,003	2,220	6,783	5.4	6.9	5.1
35 to 44	7,759	3,175	4,584	6.9	8.4	6.2
45 to 64	16,039	6,531	9,508	13.4	11.5	15.2
65 plus	4,353	2,220	2,133	13.6	13.1	14.0
$7,000 plus						
All ages	31,486	14,921	16,565	7.4	8.9	6.4
Under 15	3,912	1,869	2,043	4.8	4.6	5.1
15 to 24	3,273	1,599	1,674	6.6	10.9	4.8
25 to 34	4,607	1,331	3,276	5.5	8.4	4.8
35 to 44	5,420	1,865	3,555	6.5	7.2	6.2
45 to 64	10,125	5,704	4,421	10.1	10.6	9.5
65 plus	4,149	2,553	1,597	14.6	16.2	12.7
Unknown						
All ages	15,989	7,194	8,794	10.3	13.8	8.6
Under 15	1,496	742	754	7.4	7.1	7.8
15 to 24	1,295	543	752	5.3	7.6	4.4
25 to 34	1,473	290	1,183	5.9	7.1	5.7
35 to 44	2,712	1,783	928	18.0	44.6	8.4
45 to 64	5,862	2,680	3,183	12.1	14.9	10.4
65 plus	3,150	1,156	1,993	14.3	13.4	15.0

NOTE.—Estimates of discharges are based on the experience of members of the sampled households who were alive at the time of the family interview.

Mr. CURTIS. Mr. President, may I inquire if that is the average length of stay of everyone who went to the hospital, or is it the average based upon all persons over age 65?

Mr. ANDERSON. It is the average length of stay, in days, of persons who went into the hospital.

Mr. CURTIS. Who went into a hospital?

Mr. JAVITS. It is based on discharges per 100 persons.

Mr. CURTIS. But the average person did not spend that many days in the hospital.

Mr. JAVITS. That is correct.

Mr. CURTIS. My last question is: Can the Senator enumerate for me the list of businesses in which the U.S. Government has engaged, in which the Federal Government operates more efficiently and economically than does private enterprise?

Mr. JAVITS. Of course——

Mr. CURTIS. I would not suggest that the Senator start with the Senate restaurant or the Post Office Department.

Mr. JAVITS. The Senator could start with the protective services of the FBI; I think that would be a fairly good example.

Mr. CURTIS. But that is not a business.

Mr. JAVITS. I think there are in the country a number of persons in that business—Dougherty, the Burns organization, and a number of others.

Mr. CURTIS. The first inherent power of the government is the police power, to maintain order; and that is a government power. It is not a private business. But I mean the running of a restaurant or construction or work on force account or similar activities. I should like to have a list of examples in which the Government has excelled private enterprise in terms of progress and low cost.

Mr. JAVITS. Mr. President, I do not believe that a debater should ever be drawn into arguing for a point which he does not maintain.

Mr. CURTIS. I thank the Senator for his concession.

Mr. JAVITS. I would point out to the Senator from Nebraska that in 2 years I have rather worn myself thin in bringing into this plan the private enterprise element, because I think in this respect that mix might give us the most economical and just plan we could possibly get.

Mr. CURTIS. But when has a mixture of private enterprise and socialism ever worked?

Mr. JAVITS. Again the Senator from Nebraska bases his question on a postulate which does not arise here. None of us is talking about socialism. We are talking about Government and private enterprise, and that mix is working very well, in the main—for example, in the production of weapons systems; and, somehow or other, we have been able to work it effectively in war; and the other day we passed, with practically no opposition, a renegotiation statute which provides for a mix of Government and private enterprise. If we are to make progress in the directions in which this world must make progress and if we are to carry on enormous works, of a size today undreamed of, our business community will have to become more accustomed, rather than less accustomed, to this idea, because the alternative is all government; and that I, myself, reject with all the strength and force of my being.

Mr. CURTIS. Does the Senator from New York mean that a little bit of it is good?

Mr. JAVITS. No, I do not say that. I say that in order to make progress and in order to do the work which must be

done, our private enterprise is learning; and I think one of the things it is learning in connection with this field and in connection with other fields is the ability to work with Government.

Mr. CURTIS. I thank the Senator from New York.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Kentucky [Mr. MORTON].

Mr. KERR. Mr. President, will the Senator from New York yield?

Mr. JAVITS. I yield.

Mr. KERR. I have been intrigued by what the Senator has said about this being a mixture of private enterprise and Government. Yesterday, in response to questions by me, the Senator from New York admitted that under both sections of the Anderson-Javits amendment which have to do with disbursing money in paying for the benefits to be provided, the Government would pay all the money, and beneficiaries would not get any more benefits under the program, whether the Government paid for it directly or whether it was paid for by the Government through intermediary, a private enterprise; and the Senator from New York admitted that if the payment was made through a private enterprise, through an intermediary, in addition to paying for the benefits, the Government would pay a fee to the intermediary, but it would not be a program in which the intermediary would be operating at a profit insofar as the health or hospital program itself was concerned. I believe that is a fair statement of what the debate yesterday disclosed.

Mr. JAVITS. Well, with all love and affection, although it is alleged that I said that, I do not believe that is a fair statement of what I said. But I shall wait for the Senator's question.

Mr. KERR. My question is this: To what extent is private enterprise involved, other than the extent I have just now described?

Mr. JAVITS. I have pointed out that the benefits which will accrue to the individual will include an opportunity for him to purchase on a better basis than he otherwise could, the additional coverage he needs, if he wishes to have more complete coverage than the Anderson plan would give him.

Mr. KERR. Then the Senator from New York would have to say that through this program the intermediary will get more money for the services provided by this bill than the cost of the services or than the amount the intermediary will pay to the hospital or to the nursing home or to the health service.

Mr. JAVITS. I would not have to say that at all, because under the option provision, which I gather is the one the Senator from Oklahoma is talking about——

Mr. KERR. There are two options; the Senator from New York said, yesterday, that there are two options.

Mr. JAVITS. I am talking about the option provided in section 1716.

Mr. KERR. Very well.

Mr. JAVITS. Under that, there will be no private enterprise operation except in addition to the basic guarantees of the plan—for the reason that the one giving the service cannot charge a premium for what is contained in the plan. So unless a person furnished service greater than that provided by the plan in the Anderson bill, he would not qualify as a person with whom such an option could be exercised.

Mr. KERR. But the beneficiary would not get any more from the Government, by reason of having exercised the option, than he would if he did not exercise it.

Mr. JAVITS. That is correct; he will not get any more from the Government; but he will get something from the company or the entity with which he exercises the option, as payment for it.

Mr. KERR. If he pays for it?

Mr. JAVITS. Yes. And if he does not, he will not.

Mr. KERR. Does any provision here require that the beneficiary shall receive more than what the intermediary is paid for—more than he would get if the Government did not make the payment to the intermediary?

Mr. JAVITS. The answer is "Yes."

Mr. KERR. I ask the Senator from New York to show it to me.

Mr. JAVITS. Because no payment may be charged by an intermediary for the services the Government provides.

Mr. KERR. But that was not my question. I asked whether any provision here states that the beneficiary will get more for the money he pays to the intermediary than the services provided and paid for by the Government.

Mr. JAVITS. But the Senator is not stating what the beneficiary is paying.

Mr. KERR. Does the Senator from New York assume that any payment by the beneficiary under this bill would require the intermediary to give that beneficiary more, if the payment were made under the provisions of this bill, than if the payment were made directly?

Mr. JAVITS. Of course. Suppose he paid a premium of $250 a year. He would get the services the Government would provide; and, in addition, he would get much more.

Mr. KERR. He would get $250 worth.

Mr. JAVITS. And much more, in addition, including probably surgical services, medical services, and all kinds of things.

Mr. KERR. But he would get only what he paid the intermediary for, would he not?

Mr. JAVITS. Certainly. Under any insurance policy, one gets only what he pays for.

Mr. KERR. Certainly, and that is the position I am taking.

I ask the Senator from New York what the beneficiary would get for his payment to the intermediary, under the provisions of this bill, that he would not get in the absence of this bill?

Mr. JAVITS. He would get the basic service the bill provides, plus many other things that he would not get if he bought a straight policy under a $250 premium. He would get more than he otherwise would get today for a $250 premium, because the carrier could give him the service the Government gives, plus many other things, in addition. Therefore, he would get a very much better deal.

Mr. KERR. But he would get only as much of a better deal as he paid for out of his own pocket, would he not?

Mr. JAVITS. But he would pay for the actuarial risk; and that risk is very much reduced when there is a provision that the Government will make reimbursement for the cost.

Mr. KERR. Will the Senator read the provision in the bill which requires the intermediary to give the beneficiary more for what the beneficiary pays than the intermediary would give the beneficiary if the deal were directly between the two and were limited to the deal? Does the Senator mean he would get the same service twice if he paid for it and the Government paid for it?

Mr. JAVITS. No; I do not mean that at all.

Mr. KERR. He would get two bottles of aspirin instead of one?

Mr. JAVITS. No. I mean when the insurance carrier can charge the premium for giving the service——

Mr. KERR. Where is that provided for?

Mr. JAVITS. I will get that language. The Senator has broached this question rather suddenly, he will admit.

Mr. KERR. I do not believe any Senator knows what is in section 1716 if the Senator from New York does not know, because he knows as much about the language as any Senator does whose name is on the bill.

Mr. MANSFIELD. Mr. President, will the Senator yield?

Mr. JAVITS. I yield.

Mr. MANSFIELD. Are we discussing the substitute offered by the Senator from Kentucky, or the amendment offered by the Senator from New Mexico?

Mr. KERR. I will answer the question of the Senator from Montana, and say the Senator from New York has been discussing neither.

Mr. ANDERSON. Mr. President, if the Senator will yield, may I ask the Senator from New York if we may vote on the pending amendment first, before discussing the other amendment?

Mr. JAVITS. I shall be glad to withhold any further statement and take up the matter again after the vote on the pending amendment.

Mr. KERR. I have asked the Senator from New York a question. I hope I succeed in getting a more direct answer than what I have received.

The Senator from New York said a while ago that he was limiting his remarks to what the beneficiaries would get under the bill today. Then the Senator made a statement, which I think I understood, and if I did not, I hope the Senator will correct me, "I am hoping much better things for them in the future."

Mr. JAVITS. No; I do not think that is a fair characterization of what I said.

Mr. KERR. If the reporter who took down the Senator's remarks is here, perhaps he can read what the Senator said.

The reason why I asked the question is that in 1960 the Senator from New York made a statement, which appears on page 15716 of the RECORD, as follows:

Mr. President, I think the hard nut of the issue is, Do we wish to inaugurate in the social security system what is, for all

practical purposes, a health care scheme? I would not say it is exactly what the British do, but it is very much like it. * * *

We are now starting with the aged over 68, but once we have imbedded it so fundamentally into the responsibility of the Government in terms, at the very best, of a Government insurance program, of course it will develop, without any question.

That is what the Senator said in 1960.

What he said a while ago today is that once we get written into the law what he has offered in this bill in the way of benefits for the beneficiaries, he hoped very much better things for them in the future.

In other words, as I understand the Senator from New York, today he hopes for things under this system in the future which in 1960 he feared would be the result.

Mr. JAVITS. No; I said no such thing. I said no such thing in 1960, and I have said no such thing now.

Mr. KERR. The Senator from Oklahoma read what the Senator from New York said in 1960.

Mr. JAVITS. I agree, as interpreted by the Senator. If the Senator will allow me to interpret what I said——

Mr. KERR. The Senator said that in 1960.

Mr. JAVITS. The Senator from New York reserves the right to explain what he said in 1960, if the Senator from Oklahoma will allow it.

Mr. KERR. I could not stop the Senator, and would not if I could, because the more the Senator speaks, the deeper he sinks into the mire of his own contradictions.

Mr. JAVITS. If the Senator will allow for the contradictions of Senators, which are famous——

Mr. KERR. I hope the Senator will speak for himself only in that regard.

Mr. JAVITS. The Senator from New York will.

In 1960 I was against the social security method of financing, and I used every argument at my command against it.

If the Senator from Oklahoma will let me have his attention, I would appreciate it. Having made his point, I think I would like to make mine.

In 1962, coupled with what I consider to be an option method, a radical difference in the whole approach and thrust of this bill, opening it to the cool, clean air of the private enterprise system, I have accepted the social security method of financing for the reasons which I have stated.

Among those reasons are that the people want to pay for such medical insurance; that there is no other way of getting a bill passed; that a medical care bill is desirable; and that there are precautions, which we have gone over time and again, which have overcome a good many of the objections I had to the bill originally.

I would be less than honest with myself, and less than honest with the people whom I represent in the State of New York, if, having come to that conclusion, I did not act on it, which I have done. I am not dismayed by remarks which I made in 1960, of which the Senator may find more, which indicated the basis of my conviction upon the previous occasion in reference to the bill which I then sponsored.

I would like to point out to the Senator that that bill provided for a system of broad medical care for our older citizens substantially as now exists in the pending proposal. The only difference between that bill and the Anderson bill was in the method of financing.

Whether the Senator from Oklahoma thinks so or not, the present Anderson bill has been widely hailed as being a real departture, in substantial terms, from the previous King-Anderson bill, on which we voted in 1960.

In answer to the substantive question which the Senator asked me before, I invite his attention to the provision of section 1716, subsection (b), which reads——

Mr. KERR. From what page is the Senator reading?

Mr. JAVITS. Page 45, lines 14 through 23:

An individual may make an election under subsection (a) with respect to the plan of an eligible carrier only if he was covered by a plan of such carrier (or an affiliate thereof), providing or paying for the costs of inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services which are subject to no greater limitations and deductibles than are provided in section 1704, and providing or paying for the costs of some additional health services, continuously—

And so on. I point out particularly the words "some additional health services."

In short, whether we have expressed it artistically or to the satisfaction of the Senator from Oklahoma—and if we have not expressed it artistically, the Senator from Oklahoma is perfectly free to correct it—it is our desire and intention to make only those private plans available which have an additional quotient over and above the services provided by the Anderson bill.

Mr. KERR. But for which the patient himself pays.

Mr. JAVITS. He will pay a premium.

Mr. KERR. And having paid it, there is nothing in the provision which provides that he will get more benefits than if he had not paid for it.

Mr. JAVITS. That is correct.

Mr. CURTIS. Mr. President, will the Senator yield?

Mr. JAVITS. I yield.

Mr. CURTIS. With reference to the cost of the two plans, is it not a fact that the social security tax paid by an individual is not an allowable deduction from the income tax, but that a payment for a private hospital and medical insurance premium for a person over 65 is a deductible item?

Mr. JAVITS. That is correct.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Kentucky [Mr. MORTON] in the nature of a substitute for the amendment of the Senator from New Mexico [Mr. ANDERSON].

The Morton amendment in the nature of a substitute for the Anderson amendment was rejected.

POSITION OF AMERICAN MEDICAL ASSOCIATION

Mr. ANDERSON. Mr. President, in course of the past several months an increasing number of doctors have voiced support of proposals to provide health care for the aged through social security. They have taken a stand in direct opposition to the spokesman of the American Medical Association. I ask unanimous consent that the following letter to the editor from the El Paso Times of June 20, 1962, be printed in the RECORD. It is a fine statement by four physicians who support the social security approach.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

[From the El Paso Times, June 20, 1962]

SPEAKING THE PUBLIC MIND

EDITOR, EL PASO TIMES:

At a time when careful and intelligent thought is needed on the very real problem of providing good medical care for our growing elderly population, it is most regrettable that there is at present a paucity of such thought by most segments of our population. Pressure groups have loudly presented their propaganda in an effort to achieve their objectives.

One such pressure group is the American Medical Association, a group which wrongly represents itself as the spokesman for all American physicians. By no means is this the case. Many thoughtful physicians, while endorsing wholeheartedly the AMA's programs of fighting health quackery and of aiding in the maintenance of high standards of medical education in this country, emphatically oppose the organization's ultraconservative political statements.

The AMA has recently, it seems to us, been guilty of perpetrating in numerous periodicals and in pamphlets placed in physicians' offices many half-truths and outright falsehoods concerning the King-Anderson bill and its supporters. We are ashamed and deeply disappointed that a group of men who like to consider themselves scientifically oriented are capable of reasoning of a caliber which would lead to failure of any freshman philosophy examination and of sordid emotionalism. Their publications accuse supporters of the King-Anderson bill of desiring to establish a National Health Service similar to that of Great Britain and insinuate in at least one publication which we have seen that perhaps there is a definite interest of Moscow in the passage of this bill. They have absurdly asserted that "the average income of those over 65 is greater than for those under 65." According to the New York Times, a usually reliable source, "the median annual income of families headed by persons over 65 is $2,897, as compared with $5,905 for other families" (May 27, 1962, p. 2E). They assert that living costs for the aged are lower, when we all know that grocery stores, utility companies, clothing stores, and landlords do not have special prices for the aged, nor should they. They pretend that medical expenses are no greater a threat to an individual over 65 than for a younger individual, ignoring common knowledge and life insurance statistics and the fact that a minority of these persons is gainfully employed. They speak of the King-Anderson bill's "interference with the doctor-patient relationship," when it pertains only to payment of hospital and nursing-home bills and has no clause which interferes with the patient's right to choose his own physician or the physician's right to diagnose and treat.

The Kerr-Mills bill covers those who qualify for and are willing to accept welfare aid. It does not adequately cover millions of aged

citizens who are unable to afford prolonged and expensive medical care. Nor is it true that all physicians will see welfare patients. We have known of some who will not. We do not believe that the plan to add medical care to the social security system is unreasonable. The argument that this is a forerunner of frank socialism is not valid. The same argument has been given against every important piece of social welfare legislation from social security to slum clearance and is advanced by those who oppose any change in the good old status quo.

We hope that physicians, social scientists, and those entrusted with making the laws of this land will join to work for better medical care for all citizens, applying rational and informed minds to this very complex problem.

MAX M. KINKEL, M.D.
LEONARD M. LIPMAN, M.D.
JOHN A. PAAR, M.D.
MARK J. YANOVER, M.D.
812th Medical Group, Walker Air Force Base, N. Mex.

(NOTE.—The above are physicians currently stationed at Walker Air Force Base. This letter is to be understood as expressing solely the private opinion of its writers, and in no way expresses the policy of the 812th Medical Group or of the Medical Corps of the U.S. Air Force.)

Mr. MANSFIELD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The Chief Clerk proceeded to call the roll.

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the order for the quorum call may be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. ANDERSON. Mr. President, I ask unanimous consent that the pending amendment be set aside in order that the Senator from Illinois [Mr. DOUGLAS] may offer an amendment to the bill.

The PRESIDING OFFICER. Is there objection? The Chair hears none, and it is so ordered.

Mr. DOUGLAS. Mr. President, on behalf of myself and other Senators, I send to the desk an amendment which I ask to have stated.

The PRESIDING OFFICER. The amendment of the Senator from Illinois will be stated.

The CHIEF CLERK. The Senator from Illinois [Mr. DOUGLAS] (for himself, Mr. HUMPHREY, Mr. YARBOROUGH, Mr. BURDICK, Mr. DODD, Mr. FULBRIGHT, Mr. GRUENING, Mr. HOLLAND, Mr. JACKSON, Mr. LONG of Missouri, Mr. MCCARTHY, Mr. METCALF, Mr. MOSS, Mr. PELL, and Mr. RANDOLPH) proposes an amendment to the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes, viz:

On page 78, line 13, strike out "and" and insert in lieu thereof the following: "except that, in making such determination with respect to any individual claiming old-age assistance, the State agency may disregard not more than $25 per month of earned income; and".

On page 100, between lines 15 and 16, insert the following:

CERTAIN EARNED INCOME MAY BE DISREGARDED IN DETERMINING NEED FOR OLD-AGE ASSISTANCE

SEC. 156. Section 2(a)(10)(A) of the Social Security Act (as amended by section 106(a)(1) of this Act) is further amended by striking out the word 'and' at the end thereof and adding in lieu of such word the following: "except that, in making such determination, the State agency may disregard not more than $25 per month of earned income; and".

On page 100, line 24, strike out "and 134" and insert in lieu thereof "134, and 156".

Amend the table of contents of the bill so as to add, after the description of the contents of section 155 of the bill, the following:

SEC. 156. Certain earned income may be disregarded in determining need for old-age assistance.

The PRESIDING OFFICER (Mr. HART in the chair). The question is on agreeing to the amendment offered by the Senator from Illinois for himself and other Senators.

Mr. DOUGLAS. Mr. President, I ask unanimous consent that the name of the junior Senator from Wisconsin [Mr. PROXMIRE] may be added to the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DOUGLAS. Mr. President, the purpose of the amendment is to allow those on old-age assistance to earn small amounts of pin money by babysitting, gardening, and other casual work without being penalized. The amendment would accomplish that objective by permitting States to exempt from the determination of an aged individual's need for old-age assistance an amount of earned income up to $25 a month. If enacted, the amendment would take effect beginning on July 1, 1963, which is at the beginning of the next fiscal year, and not during the current fiscal year.

The present law provides that in determining need under old-age assistance, the entire income and resources of an individual are to be taken into account.

What that means in practice is that any amount an aged person earns is deducted from the grant which has been determined to represent his need.

For example, suppose an aged individual is receiving a grant of $58 a month, which is the nationwide average excluding vendor medical payments. The average cash grant is approximately $58, and the medical assistance given is the equivalent of approximately $14 a month. In April 1962, the average money payment was $57.91 and the average medical payment was $14.33.

Mr. AIKEN. Mr. President, will the Senator yield for a question?

Mr. DOUGLAS. I yield.

Mr. AIKEN. Can the Senator inform the Senate as to the maximum grant in any State?

Mr. DOUGLAS. We have the figures. For April, California had the highest average money payment of $89.31. Including vendor medical payments, the California average was $101.60. In Connecticut, including medical payments, the average was over $111. Of course, in exceptional cases an individual monthly payment can run over $500 including medical payments.

Mr. AIKEN. I was wondering why the Senator arrived at $25 as the amount which could be earned over and above the grant? Why not $35 or $40?

Mr. DOUGLAS. I tried to be very conservative.

Mr. AIKEN. Possibly the Senator thought that he was dealing with conservative people in offering his amendment.

Mr. DOUGLAS. Yes; extremely so.

Mr. AIKEN. Nevertheless, it seems to me that $25 is little enough.

Mr. DOUGLAS. Mr. President, that statement is very interesting. When I submitted an amendment in 1956, I included in it the amount of $50 a month. On a yea-and-nay vote in the Senate the amendment was agreed to, but it was lost in conference. This time I thought I would be more modest.

Mr. AIKEN. The conservative individuals to whom I referred would not have been the Senate anyway.

Mr. CURTIS. Mr. President, will the distinguished Senator yield?

Mr. DOUGLAS. I am happy to yield.

Mr. CURTIS. Does the amendment of the Senator from Illinois have the support of the Department of Health, Education, and Welfare?

Mr. DOUGLAS. I am not certain.

Mr. CURTIS. I should like to ask one further question. At the present time additional earnings on the part of a recipient of old-age assistance are in the same category as a gift or some assistance from a relative. Is it not true that if a recipient of old-age assistance were drawing the average which was mentioned—$72—and it was learned that a son, daughter, or some other relative by some sacrifice was giving the recipient an additional amount of $25, if that fact were disclosed, the old-age assistance would be reduced from $72?

Mr. DOUGLAS. The Senator is correct.

Mr. CURTIS. But the amendment of the Senator from Illinois would not take care of that situation?

Mr. DOUGLAS. No. The amendment merely provides for an amount up to $25 of earned income. It would not apply to gifts, but to earned income.

Mr. CURTIS. I thank the Senator.

Mr. AIKEN. Mr. President, will the Senator yield for a further inquiry?

Mr. DOUGLAS. I yield.

Mr. AIKEN. How much unearned income would a recipient be entitled to retain with, we will say, an average old-age assistance payment of $72 a month?

Mr. DOUGLAS. Unearned income would be treated in the same way that earned income would be treated, and would automatically be deducted from the cash allowance which otherwise would be paid.

Mr. AIKEN. Can the Senator enlighten me as to how a person living on old-age assistance can live on $72 a month or even $97 a month?

Mr. DOUGLAS. The $72 is not necessarily the total income of the individual.

Mr. AIKEN. That is what I thought.

Mr. DOUGLAS. The amount of old-age assistance is the difference between the needs of the aged man or woman as determined generally by social workers, on the one hand, minus the resources of the aged man or woman.

Mr. AIKEN. I see.

Mr. DOUGLAS. The difference is the amount of old-age assistance. On the average $58 is approximately the cash payment and $14 is the average medical assistance.

Mr. AIKEN. I thank the Senator for the explanation.

Mr. DOUGLAS. The difference between the needs of the aged man or woman as determined by a social worker and the resources found by such a social worker represents the amount of the individual's old-age assistance grant. Suppose the aged person found that he could obtain a small amount of healthful and personally satisfying employment doing gardening work during summer months. If he earned $10 in 1 month, the full amount of his earnings would have to be reported and it would be subtracted from the cash grant $58.

He would get $48 in old-age cash assistance for that month. If he could arrange for similar employment for consecutive months, this amount of regular small earnings, though very small, would be subtracted from his grant, so that his determined regular payment would be only $48 in cash.

Now, the disadvantages of such a provision are obvious. First, the old-age assistance recipient is discouraged from any useful paying work because, if he follows the law and reports his income, he will lose every dollar of it. And second, if he does accept some regular income for a few months and then loses it or gives it up, he will experience, in many cases, frustrating delays and difficulties in getting a return of his full entitlement under old-age assistance.

Thus, the old-age assistance recipient is not only discouraged from seeking casual and part-time employment but he is actually penalized for doing so.

What could be further from the purpose of our welfare programs than to enforce idleness and total dependency on the part of our older citizens by penalizing those who have insufficient resources when they attempt to work to meet some of their needs?

Moreover, I think we should take into consideration the unfortunate effect that this provision of the law has on the self-respect and psychological well-being of the individual. The opoprtunity to perform useful work for pay is important both to the "inner man" and to the individual in relation to his family life. For the aged person living with members of his family, and perhaps relying on them in some degree, it is certainly helpful to family harmony if the person able to do so is permitted to do rewarding work.

This provision of the law is antiquated. It stems from the depression days when the community wanted to discourage as many old people from working as possible in order to open up jobs for younger people.

But our employment problems are not basically of this kind today. The median age of the old-age assistance recipients is 76.4 years. Of the 2¼ million old-age assistance recipients very few will prevent younger persons from working by seeking casual employment yielding $25 or less a month.

Except for the amount of the exemption—this amendment is identical with the amendment which I offered in 1956 and which the Senate adopted by a roll-call vote of 56 yeas to 34 nays. Primarily because of the opposition of the Eisenhower administration, the amendment was lost in conference.

In 1958, I again offered a similar amendment to the social security amendments bill of that year, but including the exemption of an amount of earned income for ADC parents as well. This amendment was strongly opposed by the administration, and it failed to pass on a division.

In the 1956 amendment passed by the Senate, the exemption provided was $50. At that time, the average total old-age assistance payment was about $56. In April of this year, the average total payment had gone up to $72.24, including $14.33 of vendor medical payments. Thus, there has been some increase and under H.R. 10606 an additional small increase would be permitted. Because of this, but particularly because I would like very much to have this principle embodied in my amendment become law, I have submitted the amendment calling for only a maximum exemption of $25.

Of course this increase from $56 to $72 in the average payment is stated in current dollars. In 1957–59 dollars, the increase is only from about $60 to $68.65. So this amendment calls for a very small exemption.

The total cost of all this is somewhat clouded because it is not certain how many States will accept the provision. It is not mandatory upon the States to do so. It is only permissive. If they do so the Federal Government is ready to meet its share of the cost. There will be something of a windfall to the States because it will make more aged persons eligible for old-age assistance and Federal aid exceeds 50 percent of the cost on the initial amounts paid. In some cases a State may receive as the Federal Government's "matching" share as much as 5 or 10 times the amount actually paid to the new old-age assistance recipient.

Mr. President, I ask that the Senate adopt the amendment and thereby take this very gentle and moderate step, to show the 2¼ million recipients of old-age assistance that we have not written them off as having nothing to contribute to our economy in a modest way or as undeserving of a little earned pin money.

Mr. MONRONEY. Mr. President, will the Senator yield?

Mr. DOUGLAS. I yield.

Mr. MONRONEY. I compliment the distinguished Senator for bringing the amendment to the Senate, and following up the fight he has made for many years for an adequate opportunity for people to earn a very limited amount in their old age to supplement their old-age assistance by meager earnings in doing odd jobs, thus obtaining some income that is necessary to provide a bare subsistence standard of living.

I, too, have been working on this idea. I have come into complete agreement with the Senator as to the need and as to the logic of offering these people—who never would be able to qualify for social security, and whose problems were inherited from the days when it was no concern of the Federal Government or of the States whether they were able to exist or not—with an opportunity to provide themselves with this little income.

If my memory serves me correctly, we are talking about a declining number of people, as the Senator has said, who are around 76 years of age. I am told that today approximately two-thirds of the aged population have social security benefits for which they have paid and to which they are entitled. They may earn up to $1,200—I believe the figure is—a year, or perhaps more under social security.

Mr. DOUGLAS. One thousand three hundred and fifty dollars.

Mr. MONRONEY. The correct figure is $1,350. These people in most States are denied even income from selling chickens and eggs and the very meager change that they might earn in supplementary work.

I know that all the sociologists believe that one of the best means of helping to maintain respectability and the feeling of being wanted in old age is an opportunity to earn a few dollars.

I agree with the Senator that the earnings limitation is obsolete, because today the problem in small towns, as in large towns, is the problem of finding people who will do part-time work, who will babysit for parents who go out, as well as finding people who will take care of children of working mothers, and widows who have only a pittance on which to rely.

Mr. DOUGLAS. And people who will cut the lawns and do a little gardening.

Mr. MONRONEY. And those who will cut lawns. Consequently there is this void in the labor supply. Young men today want full-time jobs and salaries of about $200, for a high school graduate. Yet the aged citizens are denied this opportunity to work even though the need for work is there, such as taking care of cars, parking cars, pumping gasoline, working in a supermarket, and doing many other things that can give a feeling of being needed, and at the same time supplement income.

The national average monthly cash benefit of old-age assistance people runs to about $57 a month. Added to this is about $14 in vendor payments for medical care. Therefore, if the national average monthly cash benefit is in the neighborhood of $57, a greater earning allowance could logically be made.

Several of my colleagues in the Senate, among them the distinguished Senator from West Virginia [Mr. RANDOLPH], who is here, and the distinguished Senator from Vermont [Mr. AIKEN], who is here, feel that since this does not add to the money the Government pays out this should be more liberal than the $25 figure. I know the Senator wishes it to be more liberal. I believe that earnings of $50 a month would be possible without any serious impact upon the cost of the program. By that I mean that most of the people who retire today receive social security. Persons who have been on the rolls, subject to the means test, have been on social security for years, because Congress has expanded social security so much.

The idea that a new class would be opened by allowing persons to earn $50 a month or $25 a month is simply not factual in the light of the situation that exists today. Since this money comes from earnings, it will not come out of any money which will be appropriated.

I wish the Senator would go along with the amendment I should like to propose and to raise the amount to $50 a month. Five or six dollars a week will not encourage these people to run the risk of being cut off of the retirement rolls in the States.

Mr. DOUGLAS. May I reply to the Senator?

Mr. MONRONEY. Yes.

Mr. DOUGLAS. I am somewhat astonished at my own moderation. I came to the Chamber expecting to be torn limb from limb for proposing $25. Now I find the Senator from Oklahoma and the Senator from Vermont, who are very thrifty men, not upbraiding me, but suggesting that I should double the figure. I am afraid the cost would be high. Much as my heart beats with them, let us be moderate about this proposal; let us not go overboard. We should remember that this will make more persons eligible and that the States will get a windfall from the Federal payments. The greater the exemption, the greater the windfall. I am trying to combine prudent thrift with humane generosity.

Mr. MONRONEY. I believe we are being more than moderate when we limit earnings to about $6 a week. In other words, if a man has to take 2 days to mow his lawn, and he might get $7.50, and he might have a regular customer for whom he would tend a lawn at $7.50, then 1 week he will have to skip the job.

Mr. DOUGLAS. Why not have us start at $25; and if that is not enough, the amount can be increased later. Let us not swamp the system to begin with.

Mr. MONRONEY. The Senator from Illinois has been a pioneer in this field. It was his leadership that helped to establish this program twice in the Senate. As he mentioned, today's dollar is not the dollar of the days when he first presented the $25 amendment.

Mr. DOUGLAS. There has been an increase of 15 percent since 1957–59.

Mr. MONRONEY. Let us be reasonable and start it where it will be worth while for persons to have an earning capacity and go out and try to help themselves. I think it would be real frugality to help those who help themselves.

Mr. AIKEN. Mr. President, will the Senator from Illinois yield?

Mr. DOUGLAS. I yield to the Senator from Vermont.

Mr. AIKEN. I should like to add my voice to what has been said by the junior Senator from Oklahoma.

I would not consider that permitting an old-age recipient to earn up to $50 a month as being the acme of radicalism, exactly, because I would not say that $105 a month on which to live would permit any of them to become spendthrift.

Mr. DOUGLAS. Could they not live very handsomely on that in the little villages in the State from which the Senator from Vermont comes. Could they not live handsomely in the Connecticut River Valley at Thetford or Putney?

Mr. AIKEN. They could have at the time I was born, but they could not today. I have heard about going back to the pre-McKinley days; but actually the cost of living has been increasing in Putney, Vt., Thetford, Vt., and other places in Vermont.

I know the Senator from Illinois spent much of his early life—shall we call them formative years or informative years?—in the State of Maine. I never knew of anyone who came from the State of Maine or the State of Vermont to resist the opportunity to bargain.

While I would favor permitting an old-age recipient to earn up to $50 a month, that would not be taking it out of anyone else, because he would, for the most part, be doing much of the work he would be doing anyway. It would be just that much more money to be spent in the community, and it would increase business generally.

Mr. DOUGLAS. I believe thoroughly in the principle, but I never thought I would be reproached for not giving enough.

Mr. AIKEN. Everyone has his conservative moments. I suppose the Senator from Illinois is entitled to his. But if the Senator from Illinois, who was raised in the habits of New England, is unwilling to accept $50, what would he accept?

Mr. DOUGLAS. Now we have reached the point of bargaining on the Senate floor.

Mr. KERR. Mr. President, will the Senator from Illinois yield?

Mr. DOUGLAS. I yield to the senior Senator from Oklahoma.

Mr. KERR. Has not the Senator amended his amendment to the point where it is permissive instead of mandatory?

Mr. DOUGLAS. That is correct; that is a still further concession.

Mr. KERR. If the $50, suggested by the junior Senator from Oklahoma [Mr. MONRONEY], the Senator from Vermont [Mr. AIKEN], and the Senator from West Virginia [Mr. RANDOLPH] were accepted, it would not be mandatory upon the States.

Mr. DOUGLAS. That is correct.

Mr. KERR. It would only provide the authority to do that if they had the money to carry their program with the additional provision.

Mr. DOUGLAS. That is correct. But the Federal payments would increase by a greater ratio.

Mr. KERR. If a State could not go above $25, it would not be compelled to do so; but if it had the money which would enable it to do so, it could pay as much as $50 under the permissive provision.

Mr. DOUGLAS. Is the Senator from Oklahoma arguing in favor of raising the amount from $25 to $50?

Mr. KERR. I am.

Mr. DOUGLAS. My heart, is deeply pleased; but my judgment is dubious.

Mr. RANDOLPH. Mr. President, will the Senator from Illinois yield?

Mr. DOUGLAS. I yield to the Senator from West Virginia.

Mr. RANDOLPH. Hot or cool, we all seem to be warming to the subject. As a cosponsor of the amendment which has been offered by the astute Senator from Illinois, whom we admire——

Mr. DOUGLAS. I have never been charged with being astute.

Mr. RANDOLPH. I did not charge the Senator with being astute; I commend him for it.

Mr. DOUGLAS. I have never been so labeled.

Mr. RANDOLPH. It is my feeling, in view of the lucid arguments presented by both the junior Senator from Oklahoma [Mr. MONRONEY] and the senior Senator from Vermont [Mr. AIKEN], that I not attempt to present further reasons or seek to reinforce points well made, but rather that I should appeal to the Senator from Illinois to raise our figure. I trust he will do so. I am in full agreement with the desirability of having the amendment provide for $50 rather than $25. Of course, I would not oppose the amendment for $25. I favor the principle of this proposal, but I believe the amount is too conservative as provided in the amendment which I have cosponsored with other Senators, under the leadership of the senior Senator from Illinois. I sense there is a meeting of minds and a harmony of heart on this matter of equity to older persons who do part-time work, and should be rewarded rather than penalized for their initiative and industry.

Mr. DOUGLAS. At times we can pass measures by a bare majority. At other times, I yearn for a consensus. Since the proposal of $50 was opposed by the Eisenhower administration both in 1956 and 1958, I was afraid I would run into trouble from our friends on the other side of the aisle, if I proposed that sum again. Therefore, I thought I should be more moderate and, therefore, could then have the amendment adopted by a stronger vote.

But now, when the revered and respected Senator from Vermont [Mr. AIKEN], who is one of the spiritual leaders of the Republican Party, says he would like to have the amendment provide for $50, it makes me feel that possibly we might have success. But I wish more of our Republican friends would express themselves, so that I will not be led down the primrose path to the ultimate destruction of a good principle.

Mr. KERR. Mr. President, will the Senator from Illinois yield?

Mr. DOUGLAS. I yield.

Mr. KERR. The Senator is aware of the fact, is he not, that if this amount is increased, it will still be necessary to go to conference?

Mr. DOUGLAS. Yes.

Mr. KERR. If he makes the $50 maximum permissive, is he not in a better position than he would be otherwise?

Mr. DOUGLAS. That all depends on who would be the conferees. I have had a bitter experience with the statement, "We will take it to conference." Again and again I have said that that is the parliamentary equivalent of taking a proposal into a secret chamber and cutting its throat.

Mr. KERR. Is it not true that the position of the Eisenhower administration was expressed to a mandatory provision, not to a permissive one?

Mr. DOUGLAS. No; I think it was permissive.

Mr. KERR. The Senator from Oklahoma remembers it the other way.

Mr. MANSFIELD. Mr. President, will the Senator from Illinois yield?

Mr. DOUGLAS. I yield to the Senator from Montana.

Mr. MANSFIELD. It is my understanding, so long as the question has been raised, that the Department of Health, Education, and Welfare is not opposed to the amendment as offered by the Senator from Illinois and a number of other Senators. I feel fairly certain that if a reasonable figure should be reached, the Department would still not be opposed to the amendment, which is not mandatory, but leaves the payment to the discretion of the States.

Mr. DOUGLAS. Even of a larger figure than this?

Mr. MANSFIELD. Even of a larger figure.

Even for a larger figure.

Mr. DOUGLAS. Well, that is very reassuring. I may say to the senior Senator from Oklahoma that I hold in my hand a press release which I issued in 1956, and it stated that my amendment of 1956 was permissive, not mandatory.

Mr. KERR. And in what amount?

Mr. DOUGLAS. Fifty dollars a month.

Mr. KERR. Has the Senator from Illinois grown that much more conservative over these years?

Mr. DOUGLAS. O, I get more conservative every year. [Laughter.]

Mr. KERR. Then roll back the hand of time, and lift the banner you held aloft in your youth, that it may prevail. [Laughter.]

Mr. DOUGLAS. Well, the Senator from Oklahoma is a man mighty in valor and in strength.

Mr. MONRONEY. Will the Senator from Illinois accept the $50 amendment?

Mr. MANSFIELD. Mr. President, if the Senator will yield, let me say, in response to the question raised before by the Senator from Oklahoma [Mr. MONRONEY], that the Department of Health, Education, and Welfare does not oppose the amendment if it is optional.

Mr. MONRONEY. This is not only optional; when we talk about $50 in any 1 month, this will not automatically guarantee that any of the thousands of people on old age assistance will ever reach $600 a year.

Mr. DOUGLAS. That is correct.

Mr. MONRONEY. But if one on Social Security is allowed to have $1,350 of earnings, I do not think we are doing a grave injustice if we provide here for one-half of that amount of earned income. It will not be a balanced level; perhaps in the summertime it will be more. Also I venture to say that the total of earned income of the 25 or 33⅓ perecnt of those who may find employment will come closer to being $25, on the average, for the 12-month period than to being $50 a month.

This is optional for the States; but it is also problematical as to who can work, and, second, who can find the kind of job that will fit.

Mr. DOUGLAS. If the Senator from Oklahoma is prepared to offer an amendment to strike out the $25 and substitute $50, I will not object. In fact, secretly, I will exult. But if this should defeat the bill—if our friends on the other side of the aisle and their allies on this side of the aisle combined to defeat the bill—I would be unhappy.

Mr. MONRONEY. I would be very unhappy, too; and if I felt that the amendment would have that effect, I would be the last on this floor, or the next to the last, to offer this amendment.

Would the Senator from Illinois care to join in sponsoring the $50 amendment?

Mr. DOUGLAS. No. I think the Senator from Vermont [Mr. AIKEN], and the senior Senator from Oklahoma [Mr. KERR], and the Senator from West Virginia [Mr. RANDOLPH] should join in sponsoring the amendment; and I will accept it.

Mr. MONRONEY. But the amendment of the Senator from Illinois is the genesis of this amendment. I simply proposed the amendment in order to arrive at a better earning rate.

Let me say this applies to earned income; it has nothing to do with a person who obtains his income from investments or rent, and so forth.

Mr. DOUGLAS. That is correct.

Mr. MONRONEY. So it means he will have to find this much additional work.

Mr. DOUGLAS. Does the Senator from Oklahoma wish to offer the amendment formally?

Mr. MONRONEY. I shall send the amendment to the desk. It is the same as the Senator's amendment, except that——

Mr. DOUGLAS. But I do not want the amendment to be offered as a substitute for mine. It would be better merely to strike out the $25 and substitute therefor $50, would it not?

Mr. MONRONEY. Yes; that will be the amendment.

Mr. AIKEN. Mr. President, will the Senator from Illinois yield?

Mr. DOUGLAS. I yield.

Mr. AIKEN. I should like to add that I will do the best I possibly can to keep the 35 Members on this side of the aisle from defeating the 64 Members on the other side of the aisle. [Laughter.]

Mr. DOUGLAS. I thank the Senator from Vermont. We frequently have to deal not merely with the 35 over there but also with their numerous and powerful allies on this side.

Mr. MONRONEY. Mr. President, I ask to have the names of my colleague [Mr. KERR], the Senator from West Virginia [Mr. RANDOLPH], and the Senator from Vermont [Mr. AIKEN] added as sponsors of the amendment.

Mr. DOUGLAS. And if other Senators wish to "hit the sawdust trail," they will be welcome. [Laughter.]

Mr. KERR. Mr. President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator from Oklahoma will state it.

Mr. KERR. Has the amendment offered by the Senator from Oklahoma [Mr. MONRONEY], on behalf of himself, myself, the Senator from Vermont [Mr. AIKEN], and the Senator from West Virginia [Mr. RANDOLPH], been accepted?

Mr. DOUGLAS. Yes; I accept it.

Mr. KERR. Then the question is on agreeing to the amendment offered by the Senator from Illinois on behalf of himself and other Senators, as amended by the amendment submitted by the Senator from Oklahoma [Mr. MONRONEY], on behalf of himself, the Senator from Vermon [Mr. AIKEN], the Senator from West Virginia [Mr. RANDOLPH], and the senior Senator from Oklahoma [Mr. KERR].

The PRESIDING OFFICER. Does the Senator from Illinois so modify his amendment?

Mr. DOUGLAS. Yes; I do.

Mr. KERR. Then, Mr. President, I ask that the amendment, as modified, be accepted.

The PRESIDING OFFICER. The amendment of the Senator from Illinois has been modified accordingly.

The question now is on agreeing to the modified amendment of the Senator from Illinois. [Putting the question.]

The amendment, as modified, was agreed to.

Mr. DOUGLAS. Mr. President, never in my wildest dreams did I think that such an amendment as this would be accepted unanimously by the Senate. [Laughter.]

Mr. KERR. Mr. President, if the Senator from Illinois is able to withstand a further shock, I should like to have his attention.

Mr. DOUGLAS. Yes.

Mr. KERR. Mr. President, I move that the vote by which the amendment, as modified, was agreed to be reconsidered.

Mr. McNAMARA. Mr. President, I move to lay on the table the motion to reconsider.

The motion to lay on the table was agreed to.

PUBLIC WELFARE AMENDMENTS OF 1962—AMENDMENTS

Mr. SALTONSTALL. Mr. President, on behalf of Senator AIKEN, Senator SCOTT, Senator FONG, Senator BOGGS, Senator PROUTY, and myself, I submit amendments to House bill 10606, to extend and improve public assistance and child welfare services programs of the Social Security Act, and for other purposes, and ask that the amendments be printed and lie on the table.

The PRESIDENT pro tempore. The amendments will be received, printed, and will lie on the table.

Mr. BUSH submitted amendments, in the nature of a substitute, intended to be proposed by him to the amendments designated 6–29–62—A, proposed by Mr. ANDERSON (for himself and other Senators) to House bill 10606, supra, which were ordered to lie on the table and to be printed.

result would be quite similar to the unsatisfactory experience of England and Canada. It would be certain to result in much abused and costly programs. It would be the beginning of the deterioration of our fine medical practice. No country in the world can equal the high standard of medicine practiced in the United States under our present system.

The modified King-Anderson proposal, which would place a heavy tax on every person covered by social security to pay hospital bills for millions of Americans who are financially able and willing to pay their own, is only one of its great weaknesses. The modified King-Anderson proposal still would only take care of a small part of the medical problems of people 65 years of age or over. It would only pay for a part of the hospitalization costs. Any elderly person in need of doctor's care, surgery, dental work, drugs, eyeglasses, and many other needs would still have to depend on their present State programs of which the Kerr-Mills Act is a part.

Mr. President, these are only a few of the reasons why I shall vote against the King-Anderson proposal. All during my 30 years in the State legislature and in the Congress of the United States, I have tried to help the elderly and voted for many programs to give them much needed and well-deserved assistance.

I have consistently voted for huge increases in funds for cancer, heart, and other forms of health research. This is the type of program in which the Government can rightfully play a major role. It can do a great amount of good without being directly involved in the private practice of medicine.

I recognize that there is great need for more assistance to elderly people. I believe this can be met within the framework of our present programs which do not and will not overturn our great present system of medical practice.

PUBLIC WELFARE AMENDMENTS OF 1962

Mr. YOUNG of North Dakota. Mr. President, the pending modified King-Anderson medical care proposal in the form of an amendment to the public welfare bill is a considerable improvement over the first draft of this proposal. It is still far from acceptable, however. Putting the Federal Government into the business of hospitalization and other health insurance would be taking the first step toward socialized medicine. Inevitably, there would be future steps to put the Government all the way into the medical field. The end

PUBLIC WELFARE AMENDMENTS OF 1962

Mr. HUMPHREY. Mr. President, I ask the Chair to lay before the Senate the unfinished business.

The PRESIDING OFFICER. Without objection, the Chair lays before the Senate the unfinished business.

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

The PRESIDING OFFICER. The amendment offered by the Senator from New Mexico [Mr. ANDERSON] for himself and other Senators is the question now pending.

AN OUNCE OF PREVENTION: HEALTH BENEFITS THROUGH SOCIAL SECURITY

Mr. LONG of Missouri subsequently said:

Mr. President, as one of the spokesmen for the State with the second highest proportion of older people in the Nation, I am particularly concerned that we move ahead without further delay to provide health benefits through social security. I believe that this is the only constructive method of dealing with the problem—the only way of applying the principles of prevention to the financing of health costs—the only way of being sure that we will not have to face today's problems all over again tomorrow.

In Missouri, 11.7 percent of our people are aged 65 or older. This is a significantly higher proportion than in the Nation as a whole—9.2 per cent. Only one State—Iowa—exceeds our percentage.

Proportionately, more of our older people live in rural areas—38 percent as compared to a national average of 30 percent.

The average income in our State is slightly below the national average.

During the course of the six hearings I held in Missouri last year for the Senate Special Committee on Aging, I had an opportunity to delve behind these State averages. My committee found that in some of our Missouri communities, as many as one in every four or five people have passed their 65th birthday—a proportion that cannot help but have

a significant impact on the economy of the community. We learned that in the 10 rural counties in the eastern Ozarks section, nearly half of the farm households where the principal breadwinner was 65 or older had family incomes of less than $1,000 for the year; 82 percent had incomes of less than $2,000. In some of our counties, 7 out of every 10 aged people are still on old-age assistance.

Missouri cannot adequately meet the needs of its older population through the public assistance approach. Because of our more agricultural economy, our working people were not covered by the original Social Security Act to the same extent as in the more industrialized States. Much of this lag has been made up through subsequent extensions of coverage; more than three-fifths of our people over 65 were receiving social security benefits in mid-1961. But we still have a relatively high proportion—22 percent—who are dependent on old-age assistance for their basic maintenance needs.

In Missouri, we are not now meeting the standards we have set for basic requirements for people on old-age assistance—with "basic" defined to exclude special needs such as medical care. According to a special study in the autumn of 1960, we were falling short of meeting these basic needs by $1.3 million monthly, or nearly $16 million a year.

If we cannot meet even basic everyday needs for persons already on old-age assistance, how can we adequately finance the medical care they need? Currently, payments for medical care made on behalf of old-age assistance recipients average under $6 a month. Obviously, this is a completely inadequate amount for a group of people of very advanced age with heavy needs for medical care.

And if we cannot fulfill our obligation for people already on relief rolls, how can my State move beyond this group to finance medical care for other aged persons?

This is the problem with which we are now struggling in Missouri. Currently, an interim committee on medical problems of the aged is exploring these questions with specific reference to implementation of the Kerr-Mills Act.

We have been unsuccessful thus far in arriving at a solution "primarily because of the substantial cost involved and not because of indifference or lack of interest on the part of the members of the general assembly." I quote from the statement of our director of the division of welfare at our Kansas City hearing.

I contend that we will not be able to work out a sound program of financing public assistance medical care—even with the very substantial help offered by the Federal Government in the form of grants—unless and until we have a basic program for financing health costs through social insurance.

We need to emphasize the preventive approach in the financing of health costs just as we have emphasized the prevention of dependency in our present social security program.

In 1935, when this Nation established a social security program, it chose as its first line of defense against economic dependency a social insurance program. Through a system of compulsory old-age insurance, workers began contributing to a fund out of which payments would be made when they were no longer working—thus assuring that most of them would never reach a state of destitution. This is the preventive approach, the approach that seeks to prevent poverty from arising instead of waiting to deal with it after it has become a fact.

Wisely, the Nation also established a second line of defense—a public assistance program for those whose needs were not met by the insurance program. The numbers primarily dependent on old-age assistance have decreased over the years—but the numbers who need assistance to supplement social security benefits have increased. Of persons now being added to the old-age assistance rolls, about every other one is a social security beneficiary, many of whom have had to turn to public assistance because of medical expenses.

Our experience over the years has proved that the dual approach to economic security in old age is sound. Why can we not apply the same approach—the approach that has earned the wide support of all our people—to the financing of medical costs?

To the extent possible, should we not prevent the poverty which health costs create among the aged rather than wait for the poverty to occur and then provide help only to those who have already exhausted their own resources? If we withhold health benefits until people have exhausted their resources, do we not create further poverty and greater need for basic assistance?

Our medical profession has long been aware of the importance of prevention in health care. Doctors have properly emphasized the preventive aspects—the necessity to innoculate against disease instead of waiting to treat it—the foresight and timely care that eliminates or greatly reduces the acute emergency.

Why then do they resist the principle of prevention when applied to the financing of health costs? Why is the old adage: "An ounce of prevention is worth a pound of cure," not equally applicable to the economics of medical care?

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. ANDERSON. Mr. President, I wish to place in the RECORD, without taking any time to discuss them, some editorial comments and articles dealing with the subject now pending before the Senate. I understand the Senator from Florida is ready to address the Senate.

First I wish to have printed in the RECORD an article entitled "Medical Aid in Britain," written by Seth S. King and published in the New York Times of yesterday, Sunday, July 8.

I believe that this article, detailing how the national health service plans has worked out in Great Britain, would be of some interest to Senators.

The author of the article points out that 14 years after the birth of the medical plan in Great Britain, two unchallengeable conclusions can be drawn. He says:

> The British people want it and would not hear of any radical changes in what they have. British doctors are still skeptical of some of its methods, but 98 percent of them participate voluntarily in some phase of the national health service.

Mr. President, we are not trying to advocate and we do not advocate the British medical system in the United States. I believe we are all opposed to it. However, many things have been said about our program, among them that it will eventually lead to the system now in effect in Great Britain, which is always portrayed in the most gloomy terms possible.

I ask unanimous consent that the article by Mr. King be printed in the RECORD at this point.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

MEDICAL AID IN BRITAIN—DESPITE SOME CRITICISM FROM MEDICAL PROFESSION THE NATIONAL HEALTH SERVICE HAS BECOME ENTRENCHED

(By Seth S. King)

LONDON, July 7—Fourteen years ago this week Britain's National Health Service came into being, bringing with it womb-to-tomb medical and dental care for everyone.

In the days since its inception it has had its confusions and difficulties. It has been praised and damned, with equal fervor, by both doctor and patient.

But 14 years after its birth, two unchallengeable conclusions can be drawn: The British people want it and would not hear of any radical changes in what they have; British doctors are still skeptical of some of its methods, but 98 percent of them participate voluntarily in some phase of the National Health Service.

From the system's beginning in Britain there have been no rebellions by doctors such as Saskatchewan is now experiencing.

Today, out of the 42,000 qualifying physicians practicing or administering hospitals, the British Medical Association estimates that barely 500 are engaged exclusively in private practice.

CHANGES TRIED

This virtually universal acceptance does not mean that the British medical profession has made no attempts to amend the system the Labor government imposed on them in 1948.

There have been constant efforts by the medical societies to improve the lot of the doctor, and, in their opinion, to make the service more attractive to the patient.

Some of these efforts have succeeded. Others are still being pursued.

The National Health Service functions with relative simplicity. A new patient begins by getting from local authorities a list of doctors practicing in his neighborhood. He chooses one and presents himself at this doctor's surgery (as his office is called). He is given a small card to fill out and on it he writes his name and address, his age, and his national insurance number. If he is a nonresident foreigner, he does not need to have a number.

He takes his turn in the usually crowded waiting room. The doctor examines him and prescribes a remedy. If he needs additional treatment, such as surgery, physiotherapy, special appliances, or whatever, he is referred to one of the hospitals in the neighborhood. There he is treated, or makes application to be treated when his turn comes, by a resident specialist.

HOUSE CALLS

A National Health patient may ask his doctor to make a house call on him. The response to this is considered no more reluctant than for most general practitioners in the United States.

For virtually all the medicine the patient requires he pays a fee of 2 shillings (28 cents) for each prescription. If he needs special appliances, he may be asked to pay part of the cost of these.

For all this the head of each family pays 10 shillings 7 pence ($1.48) a week. Three-quarters of this goes to unemployment and other relief and only one-quarter for the National Health Service.

If he is not satisfied with his doctor, he may change to another in his neighborhood.

The general practitioner in the National Health Service is paid on the basis of a capitation fee. He receives a set amount annually for each patient who registers with him, regardless of whether he treats that patient once or daily. There are other added fees paid to him for certain services. Rural doctors get special allowances as compensation for the generally fewer patients they treat.

An individual doctor may handle a maximum of 3,500 patients. The average city general practitioner has about 2,000 patients on his list. For this, plus his extras, he earns about £2,425 ($6,790).

A specialist, beginning at the age of 34, gets a base annual salary of £2,550 ($7,100). As he grows older and becomes more skillful, this may rise to £3,900 ($10,920). In addition, if he becomes an outstanding man in his specialty, he will be given merit awards, decided by the local medical board where he practices. These may run as high as £4,000 ($11,200) a year. So the handful of top specialists may earn as much as £7,900 ($22,120).

In addition, both specialist and general practitioner may legally have as many private patients as he chooses to handle. In the case of the specialist, private patients are referred to him by other doctors when these

patients choose to get their treatment in the specialist's private clinic or nursing home. Private patients come to general practitioners during the hours when the surgery is not maintained for National Health patients.

Under these conditions, it is obvious that the specialist has the best of both worlds, with his fees for public patients guaranteed through a government salary while he may also be paid by as many private patients as he attracts.

The general practitioner has less to cheer about and it is here that the greatest discontent with the system is voiced.

GLORIFIED ATTENDANTS

With the rise of personal incomes in Britain, more people are indulging in the extra attention they get as private patients, and the incomes of many general practitioners are rising.

For the patients themselves, there are certainly annoyances in the system. Britain is shockingly short of hospital bed space. A child who needs a tonsillectomy may wait under National Health, as long as 9 months before his turn comes.

It is generally conceded that a general practitioner often cannot give enough time to routine examinations that might catch some diseases earlier.

But the British public has embraced the security that National Health gives them, and they would not be without it. The poorest dust-bin man has access to Britain's greatest surgeons and her best hospital care and he has no worry of how to pay for it.

"It's true that we may not get as much personal attention and sympathy from a doctor under the National Health as we might in private systems," a British businessman explained not long ago. "But we know we are going to get treatment when we need it, and no matter how much we need, we aren't going to mortgage our future to pay for it."

The discontent of some British doctors over the system is getting more attention of late in the British press. A spirited debate is going on over how many British doctors are migrating and whether Britain is training enough medical students.

DOCTORS LEAVING

Some private studies have produced claims that as many as 600 doctors are leaving Britain each year to work elsewhere. The Government has challenged these assertions. It argues that the National Health System is actually increasing by 500 doctors a year after retirements and deaths have been replaced.

It has been estimated in the last week that about one-third of the doctors who are now protesting so bitterly in Sasketachewan are British doctors who migrated there because they refused to practice under the National Health Service.

But however an individual doctor or patient may feel about the National Health scheme, there is no British politician bold enough to attack it outright.

Even Enoch Powell, the current Minister of Health, who is a paragon of modern Toryism, took the trouble recently to point out that the National Health Service has carried the support of all major political parties in Parliament and that therefore it could not properly be called "socialized medicine."

Mr. ANDERSON. Mr. President, a great deal of trouble is connected with the Canadian situation, about which all of us have read in the newspapers recently. Many people are wondering whether that kind of trouble will not also arise here at home. It is a problem which has arisen recently, but which was never anticipated during the early discussion of the subject. It shows what can take place when there is a struggle on the part of doctors against the establishment of practices to take care of the aged. I call attention, in this connection, to an editorial entitled "Doctors Outside the Law," published in the Globe and Mail of Toronto of July 4, 1962. The first paragraph reads:

The doctors of Saskatchewan have taken action which is not open to any individual or any group within a democracy. They have deliberately decided to disobey a law of that province, a law duly enacted by a duly elected government of the people.

Further along in the editorial it states:

The doctors have not indulged in acts of violence in Saskatchewan, but the passive resistance they have instituted is the worst form of violence that could be perpetrated against the people of Saskatchewan.

I ask unanimous consent that this editorial be printed in the RECORD at this point.

There being no objection, the editorial was ordered to be printed in the RECORD, as follows:

DOCTORS OUTSIDE THE LAW

The doctors of Saskatchewan have taken an action which is not open to any individual or any group within a democracy. They have deliberately decided to disobey a law of that Province, a law duly enacted by a duly elected Government of the people. They have withdrawn their services from the people of the Province, refusing to practice medicine under the Government's Medical Care Insurance Act.

Earlier in the week this newspaper condemned the International Brotherhood of Teamsters and the Seafarers' International Union of Canada for acts of violence and intimidation outside the law. What applies to truckers and to seamen applies equally to doctors. None has the right to set himself above the law. That way can only lie anarchy, and the destruction of our democratic way of life.

The doctors have not indulged in acts of violence in Saskatchewan; but the passive resistance they have instituted is the worst form of violence that could be perpetrated against the people of Saskatchewan. Except for emergency staffs in 34 of the Province's hospitals, they have left the sick and the injured without medical care, they have exposed those people to permanent disability and death; and they admit that they have done so in order to force the Government to repeal the Medical Insurance Act.

Such action cannot be condoned in a law-abiding community. The doctors disapproved of the act, and that was their privilege; but there are proper methods of registering disapproval of and seeking to change the laws of a democracy, and these the doctors have not employed.

The doctors of Saskatchewan could have worked within the framework of our system and sought to persuade the electorate to throw the Government out at the next election and replace it with one that would repeal the act. Results of the recent Federal election would indicate that in such a move they might well have been successful. They could have decided to remove themselves from Saskatchewan and practice medicine where such a law does not apply; in that case there would have been a moral obligation upon them to give their patients sufficient notice of such termination of service to enable them to provide for alternative medical care.

They did neither. They announced that they would not practice medicine under the law as it applied in Saskatchewan, and they went on strike. Even legal strikes in services essential to the welfare of the community are today condemned; and earlier this year the Ontario Legislature took legislative action to prevent such a strike among employees of Ontario Hydro. How much more to be condemned, therefore, is this illegal strike.

Premier Woodrow Lloyd might have been well advised to call the legislature into session to deal with the situation. But the doctors have already rejected a number of Government compromises which removed their chief expressed objections to the plan; and it is apparent that their leaders, at least, demand nothing less than total surrender by the Government. Those leaders, supported, it must be suspected, by the Canadian and American Medical Associations, are fighting, not this particular medical insurance plan, but any form of government health insurance anywhere on this continent. It is unlikely that the legislature, any more than the Government, would have found them prepared for compromise.

In the ugly and dangerous situation which has developed, Dr. Allan Bailey, professor of medicine at the University of Saskatchewan, had words of reason on Monday for his fellow physicians. He told them: "Strike action, or its equivalent—withdrawal of services—is in my opinion unethical and illegal for a doctor." He said that, while he disagreed with several features of the Medical Insurance Act, he believed the impasse between the doctors and the Government could be settled by reasonable men, and he proposed that new negotiations and a mediation board be sought. In the meantime, he urged that doctors continue to treat their patients:

"Surely if doctors are willing and courageous enough to refuse services to their patients, then they have the courage to refuse to fill out a specific form (required by the insurance commission). I cannot desert my patients who are referred to me and I urge doctors to work, and if they so desire, work outside the act as I will do. * * * Doctors, it is time for us to return to our work as free persons bound neither by the Government nor the Saskatchewan division of the Canadian Medical Association."

What Dr. Bailey proposes is still technically without the law; but it is a proposal for temporary action by a reasonable man who believes that agreement is possible and is prepared to work toward it. It is to be hoped that the rank and file of Saskatchewan doctors will heed his advice, and end this massive and horrifying breach of the law by which an honored profession strikes at the democratic foundation of its country.

Mr. ANDERSON. Mr. President, I also ask unanimous consent to have printed in the RECORD at this point an article entitled "Doom of Private Medicine Seen in Doctor's' Strike," written by Harry Nelson, medical editor of the Los Angeles Times, and republished by the Washington Post. It also deals with the Saskatchewan situation.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

NO TURNING BACK NOW—DOOM OF PRIVATE MEDICINE SEEN IN DOCTORS' STRIKE

(By Harry Nelson)

One week ago today in Saskatchewan, Canada, the private practice of medicine as we have known it for hundreds of years on this continent was dealt a blow from which it will never recover.

For better or for worse, medical economics will never again be the same.

The precedent has been set in Saskatchewan. And in spite of the opposition of organ-

ized medicine, there will be no turning back.

On July 1 the government of that prairie Province became willing to assume the medical burdens of all its 900,000 residents. The government is having considerable difficulty getting the program started, but it is bound to win—if not this time, then soon.

BASIC ISSUE ECONOMIC

It will win because the basic issue is an economic one. People, even people with money, don't like the high cost of medicine. It's cheaper, or perhaps just easier, to use taxes as a pay-as-you-go medium.

The doctors opposing the scheme, both in Canada and in this country, say it will deteriorate the quality of medicine.

Doctors opposing the scheme sincerely believe what they say. They are not saying these things to frighten the public in demanding a repeal of the act.

Saskatchewan doctors, like most doctors in the United States, are true individualists. The imperfect state of the art of medicine has taught them to hold strong convictions about medicine which carry over into economic and political philosophies.

In the beginning there will be a period of transition during which the quality of medicine probably will suffer. It will suffer because the doctors who are economic individualists will either cease practicing or pull up stakes and head for greener pastures—freedom, they call it.

In Saskatchewan, for example, because many of these individualists are the topflight specialists, there will be a temporary deterioration of the kind of medicine practiced.

FAILURE HELD SURE

But the doctors' strike is doomed to failure. The government, foreseeing the exodus, long ago began a recruitment drive in Great Britain. Already the replacements are arriving in Regina and Saskatoon at the rate of four a day. Others come from other Provinces in Canada and even from the United States.

But all of Saskatchewan's doctors will not leave, even when the truth that their fight is fruitless finally sinks in. In fact, some have already accepted the inevitable. There are two good reasons why this is so.

First, the conviction that there is something wrong in receiving fees from a government source is not uniformly strong among all doctors. This lack of conviction, if it can be called that, is especially strong among the country doctors of the predominantly rural Province.

For most people, including doctors, the prospect of having to sell office and house, say goodbye to friends and patients and head for the unknown is not pleasant. It is especially unpleasant if the doctor realizes he will soon face the same threat elsewhere.

It is far easier to stay and to hope that the restrictions which inevitably will come from the government will be bearable. And a doctor's sincere concern for patients whom he has known and cared for for years—and this is especially true in rural areas where ties are closer—makes the decision to stay easier.

But there is another reason and it is strictly economic. As with doctors everywhere, much of the country practitioner's service is done gratis. In Saskatchewan, however, a doctor who cooperates with the government plan will never again go unpaid. He will, in fact, never again have to send a bill. He will receive payment for every service he performs. True, he may occasionally see the medical necessity for a service not currently covered. But all in all, he will make more money than he has in the past.

It is this attraction, considering Canada's higher economic standards, which is attracting the doctors from Great Britain. The average income of a Saskatchewan doctor in 1959 was slightly over $18,000 a year. The Saskatchewan government is promising immigrating physicians an income of $10,000. Even this is more than the average doctor makes in England.

There is a less than even chance that the Saaskatchewan doctors may temporarily win their strike. This could happen if a spontaneous public uprising, triggered by a death or some kind of medically related tragedy, were directed against the government instead of the doctors. Then the party in power, the New Democratic Party (also called the Cooperative Commonwealth Federation or CCF), which is already in a precarious political position, may be forced to back down.

This party, an ultraliberal coalition of farmers and labor unions, is gambling its future on the success of socialized medicine in Saskatchewan.

THE PARTY LEADS

It can be said that the party actually is leading the people into socialism rather than merely following the dictate of the people. Most of the people of the Province want socialized medicine, but their thinking is not yet as far advanced as that of the NDP social planners who are giving it to them.

It is possible that the public, incensed by some medical calamity, may decide the government has gone too far too quickly and demand an alteration.

But if this does happen, the effect will be merely to delay socialized medicine. In the Canadian political campaigns a few months ago, every major party had a platform offering some type of socialized medicine.

Before leaving Regina 3 days ago, I had dinner with three top Government officials.

"How long will it be before your medical care insurance act is picked up by every Province in Canada?" I asked.

"Five years," they said.

"How long before it seeps down into the United States?"

"Ten years," they said, "and it will make its first appearance in California."

Mr. ANDERSON. Mr. President, finally, I ask unanimous consent to have printed in the RECORD at this point an article entitled "Embattled Canadians View U.S. Medicare Plan as Modest," written by Allan Blanchard, a contributing writer, which appeared in the Sunday newspapers. In the article the writer points out how very simple and rather modest the program proposed by the Anderson amendment could be.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

EMBATTLED CANADIANS VIEW U.S. MEDICARE PLAN AS MODEST

(By Allan Blanchard)

REGINA, SASKATCHEWAN, July 7.—Medicare in the United States, as it is proposed under the pending Kennedy administration bill, would hardly cause a ripple if suggested in Saskatchewan, where doctors are engaged in a pitched battle with the Provincial government over compulsory government health insurance.

When the question is brought up here in Regina, capital of the first Socialist Province, or State, in North America, there is a quiet chuckle, and a remark similar to this one from a young government officer in the newly constituted Saskatchewan medicare office:

"What's being proposed in the United States is really a misuse of the word medicare as it applies here," he said. "Actually the United States is far behind us in the matter of government health insurance—or maybe far ahead of us, depending on one's political viewpoint."

The provisions contained in the King-Anderson medicare bill now before the United Senate have long been in effect here in one form or another. And there has been no great stir about them within the medical profession here.

DIFFERENCE STRESSED

Basically, the U.S. medicare plan is an old-age hospitalization program paid for partially by the patients themselves through increases in the social security tax on wages. It provides limited hospital service (up to 90 days in the hospital for each illness) and does not include doctors' bills.

More than this was provided to all Saskatchewans as far back as 1947 when the Provincial hospitalization plan was put into effect. In fact, since 1957 almost all Canadians are under Provincial hospitalization plans much more far-reaching in benefits than the Kennedy-sponsored bill would provide.

Under the Provincial hospitalization insurance here, individuals pay a premium of $24 a year, with a maximum of $48 set for families. For this the patient, regardless of age, receives unlimited hospital care, including all drugs and services needed during his stay.

How long the patient is able to stay in the hospital is left solely to the judgment of his doctor, with the government footing the bill.

Last week as the medical care act which is causing the present doctors' strike was put into effect, the government also extended its old hospitalization program to include all diagnostic services (X-rays, laboratory work, etc.) provided on an outpatient basis.

WIDE SERVICES

For persons incapable of paying the minimum hospitalization premiums required by the government, public welfare pays the hospital bills.

Moreover, for persons 70 years of age who receive old-age assistance the government has another plan in effect for several years, under which the Saskatchewan Department of Public Health Medical Division provides 50 percent of the cost of drugs, all basic medical and surgical treatment, dentures, hearing aids, eye glasses, wheel chairs and prosthetics appliances.

Saskatchewan also has two major cancer clinics, one here in Regina, the other in Saskatoon which are operated by the government and which offer complete diagnostic treatment service to cancer victims free of charge. A doctor who suspects his patient has cancer sends him to the clinic where a staff of government physicians is supplemented by top specialists who work on a per diem basis.

If the diagnosis happily proves to be incorrect the patient is charged a fee of $10 for the examination. If it turns out he has cancer, all of his expenses for treatment of the disease are picked up by the government.

All of these programs have been instituted by the Provincial government without a doctor's strike such as the one afflicting Saskatchewan now.

ABOUT 930,000 INVOLVED

The controversial Saskatchewan Medical Care Act passed last November is an attempt by the Government to provide complete medical insurance for all of the province's 930,000 citizens.

The Medicare Act, simply defined, will pay the doctor bill. It has been drawn up in such a way to dovetail into the other Government health programs in the province so that there will be no overlapping of services. The only things exempted by the act are the cost of drugs, eye glasses and dental work, except as it is needed in oral and facial surgery.

The act is expected to put the two private health insurance programs, Medical Services, Inc., and Group Medical Services, out of business. Already large withdrawals from the two plans which are operated by doctors

have been noted, especially as companies began switching their group plans to the Government medicare program as prescribed by the new law.

Only two-thirds of Saskatchewan's citizens were covered by medical insurance before the Medicare Act became effective. Now health insurance is compulsory—everyone must enroll in the plan under penalty of fine for failure to do so.

The medical care insurance fund is collected from the following sources:

Twenty-eight percent from personal premiums ranging from $12 annually from each adult and not more than $24 a year from each family.

Fifty percent from 1½ percent sales tax increase which brings the provincial sales tax to 5 percent.

Twenty-two percent from corporation and income tax increases.

The taxes went into effect the first of the year, while the collection of premiums will not begin until January 1963. Total needs of the fund and its administration are expected to run about $22 million annually in the beginning years. The Government expects the cost will rise gradually in subsequent years.

The Government insurance will reimburse the doctor at the same rate set up by the two private plans—85 percent of the fee.

The schedule of fees, drawn up by the Sakatchewan College of Physicians and Surgeons for use by the private plans remains in effect..

BILLS TO GOVERNMENT

The plan as put into law initially made it compulsory for doctors to practice under the medicare program. The doctor was to send his bills to the Government and in turn he would be reimbursed once a month by Government check. This has been one of the key points in the doctor's protest against the act. Before the strike began, Premier Woodrow Lloyd's government gave an order in council (an administrative order) allowing the doctors to practice outside the act.

This meant that the doctor would bill the patient. The patient would then bill the Government which in turn would send the patient a check for 85 percent of the fee allowed in the schedule of fees.

The doctors turned this down on the basis that the Medicare Act is a written statute and that the order-in-council edict would not be valid without an amendment of the act by the legislature. The legislature does not meet until next February.

Besides, the doctors said the modification amounted to looking at the same horse from a different end.

The main argument used by the doctors against the act is a paragraph that gives the eight-man Medical Care Commission the right to make regulations "prescribing the terms and conditions on which physicians and other persons may provide insured services to beneficiaries."

The doctors argue vehemently that this provision gives the council dictatorial rights over the practice of medicine in Saskatchewan.

GOVERNMENT ADAMENT

The Government has not offered to amend this provision, and it is doubtful that it would solve anything if it did. The physicians go through paragraph after paragraph of the 30-page act and point to things they feel infringe upon the right of a professional man to mind his own business.

Unfortunately, the situation even before the strike began had degenerated into a matter of "principles" on both sides with communication between opponents virtually shut down and with neither giving the other an indication of the terms that would be acceptable for settlement.

The feeling in Canada is that the minute points of argument over the Medicare Act are not the meat of this strike, but instead that this has become the battleground against "socialized" medicine in North America.

Deputy Premier J. H. Brockelbank has intimated that the Government believes the American Medical Association is hand in hand with the Canadian Medical Association in outlining strategy and providing support for the striking doctors of Saskatchewan. He admits, however, that he has no evidence of this.

In the meantime, the strike continues without much change. No mediation is yet planned although the Government and the doctors represented by the College of Physicians and Surgeons and the CMA each have taken one step forward.

Today their positions amount to something like this: "We will call a special session of the legislature," says the Government, "if you will call off the strike."

"And we will go back to work," reply the doctors, "if you will suspend the Medicare Act."

Mr. MANSFIELD. Mr. President, what is the pending business?

The PRESIDING OFFICER. The pending question is on agreeing to the amendment of the Senator from New Mexico [Mr. ANDERSON].

Mr. MANSFIELD. I should like to ask the distinguished minority leader if he is prepared to vote on the Anderson substitute at this moment.

Mr. DIRKSEN. I am afraid not.

Mr. KERR. Mr. President, will the Senator yield?

Mr. MANSFIELD. I yield.

Mr. KERR. Does the Senator mean to vote without a quorum call?

Mr. MANSFIELD. We will have a quorum call and then vote.

Mr. KERR. I thought the Senator said he wanted to vote now.

Mr. MANSFIELD. Yes.

Mr. KERR. Without a quorum call first?

Mr. MANSFIELD. If the Senator will agree, we will have a quorum call and vote immediately thereafter.

Mr. KERR. We could not agree to that proposal.

Mr. MANSFIELD. Mr. President, I propose that we vote on the Anderson substitute at this time.

Mr. DIRKSEN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The Chief Clerk proceeded to call the roll.

Mr. DIRKSEN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. McGEE. Mr. President, I wish to address myself for a few moments to the Anderson amendments, which seek to provide funds for medical care for senior citizens through social security.

This proposal has generated across the Nation one of the most active and acrimonious debates that has occurred in many years. Unfortunately, the debate has generated considerably more heat than light. Too often those entering the debate have obtained their mental exercises by jumping to conclusions.

Therefore I should like to discuss a few of the more obvious misconceptions which it seems to me have obscured the real issue. Io do so in the hope that we may then reach the real issue, which is whether we can devise an adequate plan to help our elder citizens obtain necessary medical care.

The first misconception is that most of America's 17 million citizens in this age group do not need help in financing their medical bills. But obviously a majority of those in that group do need such help. Although it is true that much health care is provided free of charge to those who need care for which they cannot pay, public assistance agencies, private charitable organizations, and many physicians provide free services only to the extent that they can with the limited funds available. The sad fact is that many elder citizens who are sorely in need of medical care do not obtain it, because they are too proud to request charity.

Mr. CURTIS. Mr. President, will the Senator from Wyoming yield for a question?

Mr. McGEE. I am glad to yield for a question.

Mr. CURTIS. What portion of the almost 17 million persons over 65 years of age are able to pay their own hospital bills or purchase insurance for that purpose?

Mr. McGEE. I should say that a very small fraction of the total can bear the entire burden without making considerable sacrifices in their standard of living which were not expected.

Mr. CURTIS. How many of the 17 million are able to buy hospital insurance which would provide benefits equal to those provided by the Anderson amendment?

Mr. McGEE. I am advised by members of the staff who are closer than I to the statistics involved that the percentage is very small.

Mr. CURTIS. I am concerned about the statistics, but I am also concerned about the Senator's view. At what income could a person 65 years of age afford to buy his own hospital insurance?

Mr. McGEE. I think that question calls for a generalization and a calculation which it would be difficult for an elderly person to make, for the reason that in connection with a long serious ill-

ness such a person could easily spend $100,000. Thus, it would be unjust to set a hard-and-fast figure as the minimum income necessary to enable an elderly person to pay all his medical expenses, and, in that connection, to avoid any uncertainty as to those who would stand the chance of having their funds wiped out under such circumstances.

Mr. CURTIS. But the pending bill gives no assurance against being wiped out. The pending bill would not pay for any drugs or medicines, or any surgical treatment. My question is, at what income can such a person well afford to buy the hospitalization which would provide benefits equal to those called for by the Anderson amendment?

Mr. McGEE. I think the question should be reversed, for it is obvious that any person over 65 years of age, who does not now have the income he had during his younger years, would lack the funds necessary in order to meet his medical expenses.

Mr. CURTIS. But suppose he then has the highest income of his entire life.

Mr. McGEE. But that would be to suppose the improbable.

Mr. CURTIS. Oh no; many people make more money after age 65, for a few years, than they do before that age; and under this proposal it is not necessary that one retire.

Mr. McGEE. I dare say the Senator from Nebraska would agree with me that most persons over 65 years of age do not make more money than they did in their younger years. Some do, but most do not; and that is the point which is made in connection with the proposed legislation.

Mr. CURTIS. But the Senator from Wyoming overlooks the fact that more people under 65 years of age are paying for their homes and are sending their children to college and are paying the medical bills and the hospital bills for a family of four, rather than a family of two; and the Senator from Wyoming cannot escape the fact that many persons at age 65 have income and savings far beyond what would be required in order to pay for all the benefits which would be provided by the bill.

So I should like to ask the distinguished Senator from Wyoming at what level of income he believes such an elder person could provide his own hospital insurance sufficient to give him as many benefits as those proposed to be provided under this measure?

Mr. McGEE. Let me say that as a U.S. Senator my salary is $22,500; and I manage to keep even with my medical bills, with a family of four children. But if I were receiving less income, even with fewer dependents, I would probably find it a severe financial drain to pay my medical bills.

I remind the Senator from Nebraska that the retired income of most persons who have been employed is but a pittance in comparison with their earnings while they were at the peak of their earning capacity. The average is somewhere between $2,500 and $3,000 a year; and certainly that would not go very far if there were large medical or hospital bills, even when there are no college bills to be paid or no payments to be made on homes, but when such persons are merely trying to keep body and soul together. I think that is the real basis of the proposed legislation.

Mr. CURTIS. My question is quite simple; namely, At what income level does the Senator from Wyoming think a person 65 years of age should be able to purchase his own hospital insurance?

Mr. McGEE. I should say that when a person retires and is on the downgrade from the peak of his earning capacity, the pinch is on as regards his ability to meet his hospitalization requirements.

Mr. CURTIS. Is not the Senator from Wyoming aware that these hospital benefits are not available to the retired, as a class? If someone should avail himself of the right to retire because of disability, the bill as it now stands would not provide for any hospital payments. If a woman should retire at age 62, she would not be covered by the Anderson amendment. If a man should elect to take reduced retirement payments and retire at age 62—and most of them do so because of health reasons—he would be retired under the social security law, and would not be covered by the Anderson amendment.

More than 1,200,000 are eligible to retire, but have not done so. So the failure to retire does not provide a uniform test in this case.

Mr. McGEE. Is the Senator from Nebraska suggesting that perhaps the bill does not go far enough, and that the need is more desperate?

Mr. CURTIS. No. I am trying to find out at what level of income the Senator from Wyoming thinks an individual who has reached age 65 should be able to pay for the cost of his own hospital insurance.

Mrs. NEUBERGER. Mr. President, will the Senator from Wyoming yield to me?

Mr. McGEE. I yield to the Senator from Oregon.

Mrs. NEUBERGER. I was especially interested to hear the Senator from Nebraska say that most women who retire at age 62 do so because of poor health.

Mr. CURTIS. Mr. President, if the Senator from Wyoming will yield again to me, let me state that I said that was the compelling reason for early retirement for many men. The argument advanced in the committee report in connection with the retirement of women at age 62 is that, as a general rule, they are a bit younger than their husbands; but it is pointed out that men who retire at age 62 do so, among other reasons, because of declining health, and that many do retire for that reason at that age, although they are unable to qualify for disability retirement benefits.

Mrs. NEUBERGER. I was questioning the statement that most women who retire at that age do so because of declining health. Such a statement does not seem to be in accord with the facts. I am a member of the President's Commission on the Status of Women; and in that connection we find that most women who retire do not do so because of declining health, but in order to be able to enjoy some of the waning years of life, at a time when they are in very good health. Of course, one of the reasons for that is that medical science has greatly increased the span of life. It is true that many persons in that age group are faced with catastrophic illness; but we cannot make the generalized statement that most women who retire at that age do so because of failing health or bad health.

Mr. CURTIS. Mr. President, will the Senator from Wyoming be so kind as to reply to my question?

Mr. McGEE. The Senator from Nebraska has asked what income is necessary to enable these people to meet their medical bills. I think one of the studies referred to in the course of the debates on this question showed that a couple with an income of from $2,300 to $3,100 could expect that all of their income would be used to pay rent and the other items in connection with the ordinary cost of living, and that there would be no excess to be applied to unexpected medical expenses.

It seems to me that, when we talk about costs of medical care, the Senator and I must think about the lower income groups, and not the upper income groups.

Mr. CURTIS. The Senator is correct.

Mr. McGEE. It is to such groups that this bill is directed. With an average income of from $2,500 to $3,000, there is not enough margin left for them to pay for their medical costs. The number under $2,000 with no medical insurance is about 33 percent of the total number of the elderly.

Mr. CURTIS. If the Senator will yield further, at what level of income does the Senator think an aged person is able to buy his own hospital insurance?

Mr. McGEE. The Senator persists in turning the questions around in inverse order.

Mr. CURTIS. No.

Mr. McGEE. The fact remains that a person is not able to buy it if he does not have it now. I have mentioned that a study of those over 67 shows that about 33 percent have no insurance at the present time.

Mr. CURTIS. That is not because it is not available; is it?

Mr. McGEE. It is because they cannot afford it.

Mr. CURTIS. Who cannot afford it?

Mr. McGEE. The 33 percent who make under $2,000, and I submit, also those who make under $3,000.

Mr. CURTIS. Then those who make over $3,000 can afford insurance?

Mr. McGEE. No; those are the figures which show——

Mr. CURTIS. At what point does the Senator believe they are able to pay for insurance?

Mr. McGEE. I think it is ridiculous to talk about a point at which they can afford the insurance, because it is more a question of whether they are eligible for insurance. Many of these people would not be eligible for any insurance at any price.

Mr. CURTIS. Why?

Mr. McGEE. Perhaps, because of phyical conditions of which they are not

aware, they could not have any insurance. There are 1 million diabetics walking the streets who do not know they have it; and if they should apply for insurance and the discovery were made, the insurance would not be available to them.

Mr. CURTIS. What would the Anderson amendment do for them?

Mr. McGEE. The incidence of diabetes is greater at a later age. Under the bill, they would be eligible for insurance regardless of their health condition.

Mr. GORE. Mr. President, will the Senator yield?

Mr. McGEE. I yield to the Senator from Tennessee.

Mr. GORE. Would not the questions as to ability to purchase or pay for insurance, those who could pay the premiums, and the point at which one could or could not pay, apply with equal force to the ability, or age, or other questions relating to the feasibility of individuals purchasing for themselves retirement insurance policies? In other words, would not all these questions apply to the social security program, in the same way they would apply to hospitalization and medical care in connection with the social security program?

Mr. McGEE. Indeed, they would. The Senator from Tennessee is correct.

Mr. GORE. One important point which seems to be overlooked by some persons is that a mass program, with a wide base and wide coverage, would not only spread the risk, but would also bring into the program the mass of the people a large portion of whom would not, through lack of initiative, decision, ability, or otherwise, have hospitalization and medical care insurance.

Mr. McGEE. The Senator is absolutely correct. We must bear in mind the element of financial insecurity. This was the element of fear that Franklin Roosevelt often talked about years ago—the great uncertainty about whether, in approaching old age, an individual would be able to take care of his health needs on his own responsibility.

It seems to me the key to this bill is that, through the social security system, an individual can, through his contributions, take care of his health needs in his declining years.

We must remember that the incidence of breaks in health and the need for hospitalization multiply several times over as one's years increase. We are trying to face up to the hard fact that at the very moment when people need health care—except for the few wealthy friends of the Senator from Nebraska—they have the least ability to pay their own medical costs, which become more intensive and out of proportion to their expected income.

For that reason, we must face this problem not as a new hospital plan, not as a new medical program for the American people, but as a way to permit an individual, honorably and honestly, in his own lifetime, to contribute to a fund to pay for medical costs in his aging years.

I suggest that the question of whether senior citizens need medicare or not was attested, sometimes in dramatic and heart-rending fashion, in a series of hearings held throughout the country by the distinguished Senator from Michigan. One has only to acquaint himself with stories of people whom we do not see here every day, people who are not lobbying for special interests, to realize the need for people to have a chance to pay for medicare. The bill would provide that opportunity.

Mr. GORE. Mr. President, will the Senator yield?

Mr. McGEE. I yield.

Mr. GORE. I wonder if the Senator has the statistics as to the number of our citizens who are now covered under the social security program with respect to unemployment compensation and old age and survivors' retirement.

Mr. McGEE. Let me check with the staff. That is one of those statistics that I do not carry in my head.

I am told by members of the staff that it is 70 percent now and that, under the pending legislation, the percentage would increase to about 85.

Mr. GORE. Is the Senator in a position to hazard a guess or estimate as to the proportion of this vast number of our citizens who, without the social security program, would now have in effect insurance policies for their retirement and for unemployment insurance which they would have purchased on their own initiative.

Mr. McGEE. I would have to hazard a guess. I hope it might be an educated guess. It would be influenced largely by the experience of the past 25 or 30 years. I think an educated guess would be that, without the social security system, a very small minority would have taken care of their possible medical costs in their later years in advance.

Mr. GORE. That brings up the question of whether it is advisable to have a "compulsory" system, under social security. I should like to inquire of the Senator whether the social security program is a compulsory program.

Mr. McGEE. The social security program indeed is a compulsory program. It was instituted, as Franklin Roosevelt said, to help overcome the aura of fear which seemed to be the central disease undermining our Nation in the 1930's. The social security program, when instituted, did more than any other single enactment to remove the great sense of uncertainty and fear which plagued the American people at that time. As President Roosevelt said—I am sure the Senator from Tennessee knows this better than I—"We have nothing to fear but fear itself." That fear was partly because of uncertainty as to what one could do in respect to retirement in the later years of life.

Mr. GORE. Is not the unemployment insurance program in effect in all 50 States a compulsory program?

Mr. McGEE. Indeed, the programs are compulsory, under the State enactments as well as under the Federal enactments.

Mr. GORE. Does the Senator know of any program of the Federal Government, or of a State government, which levies a tax for its support and operation, which is not compulsory?

Mr. McGEE. I know of no such example. A voluntary tax program, as the Senator knows, might leave something open with respect to desirable returns.

Mr. GORE. Then why do so many people wish to condemn the program of hospitalization and medical care through the social security program because it would compulsory?

Mr. McGEE. This I cannot understand, except that there are vested interest groups which always oppose this kind of approach.

I well remember, that in my earlier years, when some individuals were talking about private financing schemes for paying the costs of medical care—one of them was called White Cross, one of them was called Blue Cross, and one became Blue Shield—many people condemned them. Now some of the voices which are being raised against the social security approach for paying for the proposed program are those which condemned the Blue Cross, as being a device which would be used to destroy the initiative of private medicine, which would set up a dictatorial regime for regimentation of the medical fraternity. Those same voices are today defending Blue Cross as the greatest thing since Adam and Eve.

That does not suggest that those persons have demonstrated a great deal of foresight, a great deal of vision, or a great deal of straightforward recognition of the problem at hand. They have been only against, without attempting to address themselves to the problem.

If these same people think this problem will go away, if they think that somehow we can sweep it under the desks of Members of the Senate and dispose of it, I say to them that something much more extreme and all-inclusive will descend upon us in years to come, and before very long, because the situation is desperate enough and the problem is extensive enough so that the movement will go in that direction.

Therefore, it is imperative in the interests of private medicine, and imperative in the interests of those who cry "socialized medicine"—which is so much "bunk" with respect to this bill—that we take action now, to protect the dignity of the individual citizen in respect to financing his own medical costs, so that it will not be necessary to adopt some more extreme system in order to meet the needs.

Mr. GORE. Does the Senator know of any way by which the Government could have a self-supporting, pay-as-you-go, actuarily sound program of any sort—whether it be for health insurance, a retirement program, social security, unemployment compensation, highway construction, or anything else—except that it be based upon a requirement of a certain category of citizens who would participate and make regular contributions thereto?

Mr. McGEE. There is no actuarily sound alternative to this approach. The Senator is correct in the import of the question which he has asked. That is why I cannot understand the attitude of those who oppose the social security approach. Many of them are the same

people who say that we ought to be fiscally responsible, that we ought to pay for what must be done for us. They are the ones who would try to avoid doing the same thing they preach, at least on the floor of this body. They would not meet the problem in terms of the deed, which this would permit them to do, through the financing of the measure under social security.

Mrs. NEUBERGER. Mr. President, will the Senator yield?

Mr. McGEE. I am glad to yield to the distinguished junior Senator from Oregon.

Mrs. NEUBERGER. I have been interested in the colloquy between the Senator from Tennessee and the Senator from Wyoming.

I had some experience with a pension plan which was noncompulsory in its terms. In Portland, Oreg., when I was a schoolteacher, in the beginning of the depression days, a pension plan was inaugurated. At that time schoolteachers were being paid approximately $125 a month. A good many of the fine, retired teachers were suffering.

The school board decided that it did not wish to force anything on anybody, so the retirement program was not a compulsory one. Many teachers, especially those who were older, took the position, "I have always planned for my old age, and I have always been able to save my money." Therefore, a percentage of the teachers did not go into the Portland Teachers Retirement Association.

Little did I know, in those days when I joined the group, that I should be called upon as a member of the Legislature of the State of Oregon to help straighten out those poor benighted souls.

Naturally, in order to make the retirement fund work, it was necessary to have a larger percentage of teachers in the association. As time went on, we who invested our money—and I must admit we did not have much money to invest—assumed the risk involved in starting this program. It proved successful.

What happened? A group of somewhat fewer than 100, I think, petitioned the legislature for State help and city help to make up the back payments. A benevolent State, and all of us, forgave them for not having the foresight to join. We passed legislation to bring in the group.

They came to me at the legislature and said, "How foolish we were; but also how foolish the district was not to make this program compulsory, so that everybody would participate equally."

One would think that by now we should have enough experience and enough examples, as Senators have pointed out. We have observed the history of the Social Security Act. "Bugaboos" and scare words should not continue to confront us. What is the value of history, if it is not to teach us something? We have had a good base of experience in the history of the past, on which to build.

Mr. McGEE. To paraphrase a famous historian, history repeats itself when Senators fall for the same scare words over and over again.

Mr. GORE. Mr. President, will the Senator yield to me so that I may ask the distinguished Senator from Oregon a question?

Mr. McGEE. I am glad to yield.

Mr. GORE. As the distinguished Senator from Oregon knows, there is in effect a very fine wildlife program, which provides conservation, protection, care, and enforcement of the rules during hunting seasons. It is a self-supporting program.

Mrs. NEUBERGER. The Senator is correct.

Mr. GORE. Hunters buy duck stamps. Is the duck stamp a compulsory stamp, or is it not? Of course, the answer is that it is compulsory to the extent that if a person is caught duck hunting without a duck stamp he is subject to the penalty of law.

I should like to ask the distinguished junior Senator from Oregon what percentage of duck hunters she thinks would buy duck stamps for the privilege of hunting ducks if they were not required by law.

Mrs. NEUBERGER. Of course they would not buy any stamps, but the duck hunters have a choice as to hunting ducks. People who become sick have no real choice as to whether they will die or go to the hospital. They cannot control the problem.

Mr. GORE. I deduce from the Senator's statement that the Senator does not think it the height of wisdom to make duck stamps compulsory and payments into a health and medical care program voluntary.

Mrs. NEUBERGER. Those interested in the duck stamp program know that they will get protection, and that the swamp areas will be maintained so that they may hunt and pursue their interests. People who pay into a medical fund of the kind of which we speak know that they will get full value, just as the duck hunter does.

Mr. McGEE. I thank the Senator from Oregon for her comment. I thank the Senator from Tennessee for the additions he has made in our colloquy on the question.

The point was raised a moment ago as to the possibility that the elderly could be helped along the road with assistance from their families and their children. I think it is a really important point that we should bear in mind in our discussions on the bill. The suggestion has already been advanced on the floor of the Senate that young people who are raising their families are buying homes. They are preparing to send their children through college. That involves a considerable expense. It is a point that many Senators fully appreciate. The additional expense of having to care for elder members of their clan would likewise impinge upon a successful financing of family operations. Therefore, from the point of view of young people—and not alone from the point of view of the anxiety of the elderly themselves—from the point of view of the fiscal stability of young couples starting out, it is important that some kind of financing operation for medical costs for the elderly be instituted.

I should like to turn from the first suggestion I made; namely, that most of the 17 million seniors need some kind of assistance in their declining years in view of the uncertainties of medical costs, to a second suggestion that is often made; namely, that the existing Kerr-Mills bill offers adequate medical benefits.

It has been incredible to me to observe the number of members of the medical profession who have suggested that that bill would be sufficient to cover most cases. As we well know, so far as the Kerr-Mills bill is in operation now—and I believe it is in operation in less than half of the States—it limits medical assistance to extreme instances in which the individual can prove that he is incapable of financing his medical costs. Under the law now on the books medical services are available only to those who can prove that they have failed economically in the pursuit of the fruits of life. For example, as the present occupant of the chair, the distinguished junior Senator from North Dakota [Mr. BURDICK], has reminded me, in the State that he represents in part a mere handful of individuals are able to avail themselves of assistance under the Kerr-Mills bill. That situation does not address itself to the broad base of medical need in the age group with which we are concerned under the proposed legislation.

Mrs. NEUBERGER. Mr. President, will the Senator yield?

Mr. McGEE. I yield.

Mrs. NEUBERGER. Are not the provisions of the Kerr-Mills bill close to socialized medicine?

Mr. McGEE. Running the risk of using inflammatory terms, it seems to me that is very close to socialized medicine. It provides a handout to those who must have it if they can prove they are bankrupt or poverty stricken and cannot pay the necessary expense. It is desperately close to socialized medicine.

For that reason I cannot understand why the same individuals, almost in the same breath, will condemn a measure with a base of individual financing of his own medical costs and approve another method that is the opposite of what is good enough for them.

Most of those who are opposed are able to afford the kind of medical care they need, through any private agency they choose, but that is not so, as we know, of the great masses of our people.

I turn to the third misconception that is recklessly bandied about, which comes down to the issue of socialism. We are told that the social security approach to the financing of care for the ill and the aged under the King-Anderson bill would be a step toward socialism and Government control of medicine. That is perhaps the most ridiculous and the most obviously false argument that is being used against the measure. In the literature that comes to me, in the letters that have been organized and mailed to me, in the solicitations that have been made door to door in the communities in my State by the doctors themselves, the people have been advised, "Write your Senator and tell him you do not want socialized medicine."

I say that is a complete falsehood. It is the perpetuation of the evil of misrepresentation, and it has been coming from the mouths of some of the fine doctors in our land. We ought to deal with those questions as problems that face us rather than through name-calling stunts designed only to confuse and obfuscate the issue which we want to resolve, we hope, with wisdom.

It is difficult to think of any new step forward this country has taken in the past 60 years that has not been condemned first as socialistic. I say that in our system of democracy it is time that we face an idea as an idea, and address it to the problem at hand to see if we can conquer the problem that threatens to weaken the fiber of our society. If we can do so, we had better make that idea a part of our democratic theme. That is precisely what has been done.

For example, we recall the critical years in the 1890's and at the turn of the present century, when a program was advanced for modernizing democracy. The secret ballot was proposed. The direct election of Senators was proposed. Monopoly controls and the postal savings system of our country were proposed. This whole package of suggestions for improvements in our democratic system was condemned everywhere across the land as socialistic, as dangerously un-American, and as unconstitutional. Yet within 15 years the same people that condemned those proposals were writing them into the platforms of their political parties and proposing that on both sides of the political fence, they be made a part of the law of the land.

That again suggests the folly of trying to destroy an idea with a name or trying to destroy a proposal with a slogan. It is imperative that we consider the ideas advanced in terms of their substantive quality and in terms of how well they meet the problem at hand.

No one needs to remind Senators of the frequency with which we heard the cries of "socialism" in the 1930's. Socialism was the major indictment against the inception of the social security system. Yet it is difficult to find a voice ever raised on the floor of this body proposing to roll back social security or to repeal the social security law. If it is socialism, why do not those who oppose socialism get up their courage, stand before their constituents, and ask for the destruction of the social security approach to the financing of the problems of the people of our land?

One of the great steps forward that our country took in the 1930's was to disregard the scare word of "socialism" and attack the great problem of fear that people had about their own well-being and their elder years. That program—and it alone—preserved the deep and strong roots of American capital enterprise, or American free enterprise, as some call it.

We need not think back very far to recall that capital enterprise was "on the ropes" in 1929. The direction in which our country was to go was very much open to question. We did not know whether it would go to the Communist left or the Fascist right. We came closer to going in one of those two directions than some people in our country like to remember.

Students of our country's history should refresh their memories once again, because not long ago we were on the brink of abandoning the American capitalistic private enterprise system because of the desperateness of the hour in the years 1929–32. The New Deal, with its social security elements that were condemned with all kinds of words, provided the fiber of faith and confidence in the American people to put us back on the road once again in our capital enterprise system. We found the agreeable road. We found it without violence and without the extremes of one of the "isms" to the left or to the right. Therefore I say we had better face the question now or there will descend upon our heads, as the problem worsens, a solution much worse, much more extreme than even that dreamed of by the oral opponents to the social security approach to financing medical costs at the present time.

Mrs. NEUBERGER. Mr. President, will the Senator yield?

Mr. McGEE. I am glad to yield to the Senator from Oregon.

Mrs. NEUBERGER. I know that the Senator comes from a predominantly rural State, similar to Oregon, which has many small communities, and which at one time had a great shortage of hospitals. Does not the Senator believe that some of the doctors who worry about the pending bill bringing socialized medicine are doctors who practice in what might be called socialized hospitals? Where would we be in Oregon and Wyoming if we did not have Hill-Burton funds with which to construct hospitals?

Mr. McGEE. That is different. That is called incentive. That is incentive to a more vigorous private practice of medicine. We cannot call that socialism.

Mrs. NEUBERGER. The hospital, of course, furnishes accommodations for the doctors, but it does not interfere with the patient-doctor relationship in any way.

Mr. McGEE. It certainly does not. The doctors live with it, and they have found it successful. No one has ever proposed that we turn that back.

Mrs. NEUBERGER. The bill would help the patients pay hospital bills, nursing home charges, and bills for X-rays.

Mr. McGEE. I believe it would help a doctor to collect his bill. People would have help in paying their hospital bills, and would have money left with which to pay the doctor. We are reminded of what some of these people said 20 years ago about Blue Cross. That has been a great success. Certain people, having said what they did about Blue Cross, are not experts to whom to turn for insight and wisdom and farsightedness as to how to meet the present problem.

My father-in-law was a country doctor, a general practitioner. He knew what it meant not be be paid. He knew what it meant to get a couple of chickens in payment for a house call. He knew what it meant to get a shank of meat in payment for a simple operation.

Those days are gone. In America we have in effect moved to towns, to areas in which distances have been reduced. Our people are no longer in the position of bartering. It means paying or not getting a service. Of course, we are not now talking about paupers. We are talking about honorable Americans who would like honorably to meet their financial obligations in their retiring years.

For that reason it seems to me that we ought to stop talking in terms of hokum about socialized medicine, and about Government control and Government medicine. We are trying to make it possible for an individual American to hold up his head, knowing that he has a chance to enjoy retirement out of a retirement reserve, without that reserve being eroded by the severity of a lengthy stay in a hospital.

Mr. LONG of Louisiana. Mr. President, will the Senator yield?

Mr. McGEE. I yield to the distinguished Senator from Louisiana.

Mr. LONG of Louisiana. Does the Senator believe that if the program he is advocating is started, of using the social security system to provide for medical care for those who are well able to pay their own bill—I realize that at the moment it does not cover doctors' bills, but only hospital bills—it will be extended to other fields, and applied to the disabled, and various other individuals? Does he not believe that it will be extended to other people, and eventually will cover everyone's hospital and doctor bills?

Mr. McGEE. Various approaches would have to be evaluated in trying to cover medical costs. I speak of medical costs in the broad sense. At this stage, medical costs are extremely severe—both doctor and hospital costs—but I confine myself to meeting the cost factor, not how benefits are to be received or how the program is to be administered.

Mr. LONG of Louisiana. Has the Senator any idea that if we start this program it will not be extended to cover others, perhaps the disabled, and then the blind? Does not the Senator believe that the majority of those who support the present proposal will eventually seek to extend the plan to all hospital costs and all doctor costs? Has the Senator any doubt that that would probably be the end result?

Mr. McGEE. I hesitate to say that that would be the probable end result. Each of these steps ought to be considered as a social question which is a part of the economic scene. Some of the elderly groups are already assisted by various kinds of programs. Therefore, the question of extending this particular approach to the blind and various other groups of disabled would not be a very real one, because of the existing programs. What the Senator is getting at, apparently, is that trying to finance the medical costs of the elderly would be only the beginning of a much more extensive and more encompassing program. I believe we must address ourselves to the problem at hand, rather than to a problem that may exist 10 years from now.

Mr. LONG of Louisiana. I asked the Senator that question because I am one of those who made the fight at the time social security benefits were extended to those who were disabled, starting at age 50. There was no doubt in my mind that in the end, if we won that victory, to start the benefits at age 50, we would later seek to take care of disabled persons of any age. We are doing that now. The day we adopted the amendment referred to, I started planning another amendment, to be the first to start with such a proposal, to extend the social security benefits to those who are disabled below age 50. In fighting for it I felt I was fighting for the beginning of a program that would be extended. I am frank to say that if I were to support the Senator's position I would feel that in fighting for it I would be accepting the responsibility for feeling that I was fighting for the beginning of a principle that would be extended to all medical costs. I wonder whether the Senator would agree with that statement?

Mr. McGEE. What I am trying to suggest to the distinguished Senator is that I do not believe we ought to undertake to bring new issues into this question now. There has been enough of a tangent issue brought in to confuse a great many people back home. If we were to follow the Senator's course we would trigger different kinds of responses. I believe we must keep focused on the one idea of trying to bring about the financing of medical costs in this category with respect to elderly citizens, and do that successfully, in order to resolve the problem in the most expeditious manner possible.

Mr. LONG of Louisiana. Some of those who have supported this position came to me early in the history of the proposal and suggested that I should be the one to offer this proposal. This happened many years ago. I did not agree with them. I am frank to say that it was their view then that this would be the beginning of a program that would be extended to other areas. I believe the best argument for the program can be made by applying it to the aged, and that the argument becomes weaker as one tries to apply it to other groups. I am frankly content to debate it on the basis that it is not a good thing to do so far as the present issue is concerned. However, if we vote for it, we ought to recognize what we are in for eventually in other fields.

Mr. McGEE. Any other field would have to be another subject for legislation. It would have to be weighed on its merits, irrespective of what we do or do not do in this session of Congress on the pending question. Therefore I believe it would be an unrealistic approach to pose the hypothesis the Senator has put as to what the next step might be.

Mr. LONG of Louisiana. I believe that I have been as strong a welfare supporter as any other Senator. Many times I fought for increases in payments and additional benefits to persons who through no fault of their own were unable to provide such benefits and payments for themselves.

For the most part what the amendment does initially is to tax the young people to pay the costs of medical expenses for others, whether they be millionaires or people with substantial resources, or at some other level of economic life.

That is somewhat in conflict with my theory that people ought to be taxed to pay for the medical care of other people only if they are unable to pay for the care themselves. I am willing to support the principle of paying taxes to pay the medical bills of persons who cannot pay the bills themselves. I would include more than the medical cost. I would include the doctor's bill, the cost of outpatient care, and anything else which might be necessary. But when you propose to extend a tax bill to pay the medical costs of people who are well able to pay their own medical bills—some of them being millionaires—I find it difficult to support such a proposal.

Mr. McGEE. I am really more concerned about the tens of millions of people who are not in the millionaire class, whose earnings are not the earnings of millionaires, but who are already plagued with this problem. I would rather let the experience of the operation determine what should happen later, after we have started to cover these people. We can then determine whether there should be any modification, to make certain that we are not doubling back on the millionaires. Even so, millionaires will still pay for their costs, whether they can finance them themselves or not. Such a program would not cost the Government anything. The millionaires would be paying for their costs in their contributions.

Mr. LONG of Louisiana. They may have been retired and living on retirement income. They would not be taxed on social security in that event, but they would still be drawing social security benefits.

Mr. McGEE. The uncertainty at age 25 or 30, when a young couple are starting out in life, as to who is going to be a millionaire at age 65 is probably a reasonable question to put. We are trying to act at a time when the cost is low, so that we can build up the program to the point where it is actuarially sound, over a long period of years; and to finance the cost, considering the risk circumstances, in such a manner that it would be possible to pay the medical costs of some of those people 30 years later.

Mr. LONG of Louisiana. If this program becomes effective, the Government will be paying for a greater amount of medical treatment than the people would buy for themselves, even if they had all the money of Midas with which to pay for it. In Louisiana, the experience in State medicine has been that the average patient in a State hospital would stay 50 percent longer than he would stay in a private hospital. A problem in a State hospital is persuading a patient to leave the hospital as soon as he is sufficiently well enough to go home. For instance, maternity cases stay much longer in a State hospital than they would in a private hospital, where they would pay their own expenses. So, too, all other cases.

One of my own relatives, who required all the influence we could muster to put him into a veterans' hospital, felt like staying on indefinitely, because he enjoyed it so much. If he had been paying for his hospitalization himself, he would have been eager to get out at the earliest possible moment. But when he found it pleasant, with all sorts of facilities available, and good treatment, his desire was to remain in the hospital for a while longer.

That has been the history in Louisiana when the State pays for the hospitalization. My guess is that that would be the history under the proposed legislation. My guess is that the same is true of veterans' hospitals.

Mr. McGEE. I have been in hospitals a number of times. I do not enjoy it; my desire is always to be discharged as soon as possible. But the decision as to whether I should remain in the hospital was not mine; it was made by the doctor.

If we have a medical profession of integrity, such a decision is made by the medical profession, not by the whims of a family or by anybody else. It is a medical decision. I trust the Senator from Louisiana does not believe that this kind of decision ought to be injected into the program envisaged by the Anderson amendment.

Mr. LONG of Louisiana. In Louisiana, the average stay of a patient in a State hospital is 50 percent longer than it is in a private hospital. I shall be glad to marshal the evidence to prove that statement. It is a matter of cold, hard fact, which doctors recognize. A human factor is involved. When a person is paying his own expenses, he desires to get out of the hospital as soon as he can. But there is a certain reluctance to move soon when he is not paying his own expenses.

Mr. McGEE. Would that have any bearing on whether he ought to have remained in the hospital longer? Is there any evidence that the cost might crowd some people out? I hope the decision is one that can be left to the doctor to determine. That is where the decision is made in every instance I know of.

Mr. LONG of Louisiana. In Louisiana, it is the same doctor in either case. The doctors who treat the patients in a State hospital volunteer their services. They would be paid for their services in a private hospital; but they volunteer their services in a State hospital. Inasmuch as about 50 percent of the hospital days are spent in State hospitals, all the factors that this Senator has been able to imagine—and my impression from discussing them with doctors who are treating in both State and private hospitals are the very factors to which I have referred—if a person is paying his own medical bill is concerned about the cost, he wants to get out as soon as possible.

Mr. McGEE. Where does the Senator get the information that the patient himself determines when or when not to leave the hospital? This is a strange aspect of the question that he has introduced.

Mr. LONG of Louisiana. I am speaking from the factual side of the situation.

Our State experimented, as an economy measure, with discontinuing free ambulance service. Many doctors with whom I have spoken seemed to think that that was the most expensive economy that could be imagined. There are some persons whom it will not be possible to save. Some have cancer or other incurable diseases. They will linger for years before they pass away. If we are trying to do the best we can for the greatest number, after a doctor has done all he can for the person in a hospital he sends him home to the family. If that person is in a State hospital, the family would try to put pressure on the hospital to keep him there. About the only way to get such a patient home is to take him home in an ambulance, so as to make room in the hospital for other persons who require treatment, rather than to allow incurable cases to remain indefinitely. That is one more illustration of the problem to which I have referred.

Mr. McGEE. If that is the point of the Senator's suggestion, my guess is that persons whose illness is incurable ought not to become a burden in a private home, where they cannot receive the necessary care that modern medicine makes available.

Mr. LONG of Louisiana. The proposal for which the Senator is arguing would not keep people in those hospitals indefinitely. I assume that if this system ever went into effect, he would want to extend it to the people in question. But personally there is a question as to how far to go in providing at State expense that at which families ordinarily pay themselves. In the case of a person who is suffering in the last stages of cancer, the Senator's proposal would not undertake to keep the person in the hospital indefinitely. The person would go home and might linger there for a year; and the proposal now before us would terminate the hospital services after a certain period of time.

Mr. McGEE. I find it difficult to accept the Senator's suggestion. Consider the case of an incurable cancer in a person over 65, with all the haunting elements that are present. I have been familiar with two or three such cases. They did not involve members of my family, I am grateful to say. I would find it hard to accept the philosophy that such people ought to be returned to their homes, to die a slow death, with that kind of burden, and the absence of continual watching and medication which brings some relief under those circumstances.

I think the example cited would be a good case in point, as to what we ought to look forward to, to make sure it is covered. But I am only developing the initial point of the experiences in Louisiana. In cases where people like to go to the hospital and stay as long as possible, and it is difficult to get rid of them, I wonder whether there is a deductible provision or clause in the State regulations. Do the patients pay a certain part of the bill for a certain period of time?

Mr. LONG of Louisiana. No; I am talking about a case in which the State takes care of the entire expense. A person can go home and convalesce, and then go back to work; or a person may remain in the hospital and convalesce over the same period of time, after the doctor had done that which can be done in the hospital.

I believe the Senator knows that a great amount of healing and treatment must take place in the home, even if there is State medicine.

Mr. McGEE. But I would not be the one to make that judgment. My doctor alone would make it. I will not speak in defense of any State system which would take that decision away from the attending physician. In my opinion, that decision should be made by the doctor; and I think that references to such a situation injects into the debate on the proposed legislation an unrealistic element.

Mr. LONG of Louisiana. I believe the Senator would find that the doctor would send the patient home from the hospital as soon as possible, and thus the patient would not be worried about the cost of remaining in the hospital.

Mr. McGEE. I thank the Senator from Louisiana for his comments.

Mr. GORE. Mr. President——

The PRESIDING OFFICER (Mr. BURDICK in the chair). Does the Senator from Wyoming yield to the Senator from Tennessee?

Mr. McGEE. I yield.

Mr. GORE. If the Senator from Wyoming will permit me to do so, I wish to comment on the two points the able Senator from Louisiana raised. One was that if the program of insurance, hospitalization, and medical care were enacted, those of us who support it should take the responsibility of considering it as only a beginning. I am pleased to accept that responsibility; I think it would be the beginning of a sound program. If the program proves to be actuarially sound, and socially beneficial, on a pay-as-you-go basis, I think time will show that improvements will be needed.

The same argument was made at the time of the enactment of the social security program—as I am sure the able Senator from Wyoming will recall. Since then, as the junior Senator from Louisiana will recall, Congress has found it wise, in its judgment, to extend the benefits.

Congress has been a little tardy in a few instances in increasing the benefits in a manner commensurate with the increased need, both in connection with such costs and other factors.

A similar argument was made when compensation for the veterans of World War I was under consideration. Some said, "Once this is started, there will be no stopping." However, I point out that the Senator from Louisiana is the author of a bill, on which he conducted a hearing today, to permit veterans to continue their service life insurance. Some persons oppose this proposal; but today I was happy to find that the Veterans' Administration, after opposing the Senator's bill for several years, now endorses it, and informed the committee that it was actuarially sound, and that the program not only had proved to be sound, on a pay-as-you-go basis, but also had shown a surplus.

I shall not predict that a surplus will be accumulated in this case. I refer to that situation only as an example.

We have found that in the case of unemployment compensation it has been necessary in times of distress to extend the period of benefits; but no one has said that because we found that necessary and desirable, the program was unsound and should be scrapped or else it would wreck the country. If we are able to support, on a sound basis, a program that is beneficial to the people and that pays for itself as we go, then it may very well be—and I hope that would be our experience—that both the benefits and the coverage, and perhaps the degree of payroll taxes, would, by a future Congress, in its wisdom, judgment, and courage, be increased realistically. I do not question the capacity of the Congress of tomorrow to proceed in that way. I do not doubt the capacity of our people to sustain self-government. In looking to the future, I do not believe everything is going to be dark, and that if a program is begun, it will carry us over the cliff. That has not been the experience in this country in dealing with the social security field or the unemployment compensation field, or with veterans compensation, or with many other fields to which I could refer.

So I am prepared—as the Senator suggests those of us who support this program should be prepared—to assume the responsibility that this program may be a beginning. I believe it will be the beginning of a very good program which Members of Congress 10 years from now will never think of repealing. I point out that all such questions which have been raised in connection with this program apply equally to the social security program itself.

Let me ask whether the Senator from Wyoming minds if I refer to the second point which was made.

Mr. McGEE. Indeed not. I am pleased to have the Senator from Tennessee proceed.

Mr. GORE. The junior Senator from Louisiana [Mr. LONG] raised this point; and at this time I should like to reply to it, because it has been raised by a number of persons. It deals with an important point for our consideration—namely, the statement that this program would place a tax on the young people of today, in order to pay for the hospitalization charges of some persons who might be able to pay their own hospital bills. However, if we refuse to begin such a program on an actuarially sound basis and on a compensatory basis until that situation would not prevail, such a time would never come. Such an argument reminds us of the old question of whether the chicken or the egg came first.

If we had taken such a position, we would never have begun the social security program, because it came into effect as a result of the provision of benefits for those who retired at age 65 after they had paid into the social security fund a very small percentage of their paychecks during only a very few quarters. I have forgotten the exact number; as I now recall, it was over a period of 5 years.

Mr. CURTIS. Mr. President, will the distinguished Senator from Wyoming yield?

Mr. McGEE. I have yielded to the Senator from Tennessee.

Mr. GORE. I am advised by the staff that it was after a year and a half. But even if 10 percent of a person's salary were taken during a period of a year and a half, that would not be sufficient to entitle him, at age 65, to an annuity for the remainder of his life.

But we began the program; and it was based upon a mechanism through which we required almost everyone who was of working age to pay into the fund while he was working, in order that neither he nor his fellow workers, whatever might be their age, would become burdens on the taxpayers when they were old and no longer were able to work.

If we are to operate upon an insurance basis, upon a contributory, actuarial basis, we must go upon that course. I am sure the Senator from Louisiana would not suggest that a doctor who had a fire insurance policy on his home which was destroyed by fire should not be allowed to collect his insurance because he was a rich man. I am sure the Senator would not suggest that a man who had automobile collision insurance should be denied the right to collect upon his insurance policy when his Ford was destroyed because in his garage he had a Cadillac. That is not the basis upon which an actuarially sound compensatory program is based.

The Senator pays taxes into the retirement system. It may well be that he will not retire when he is 65. I hope to be either in the Chamber or in the galleries to hear his melodious voice long after he is 65. But in the event he retired, either voluntarily or involuntarily, the Senator would be entitled to share and participate in the fund into which he has been contributing, and into which he will continue to contribute. He would share and participate as a matter of right, not as a matter of charity.

If we are to criticize this program on that basis, we must accept the responsibility of criticizing the social security program, because it is on that basis.

Mr. LONG of Louisiana. Mr. President, will the Senator yield?

Mr. McGEE. I yield.

Mr. LONG of Louisiana. I should like to make a point. When the Senator talks about collecting on an insurance policy on which a person has paid, I hope the Senator is not trying to put that in the same category as a bill in which Congress proceeds to vote a tax on working people today to provide insurance for persons who have not paid 1 cent into that program so far as medical care is concerned, because at the time they took that insurance it was entirely a retirement program. They were not paying for medical care; they were paying for a retirement insurance program.

I hope the Senator does not propose that anyone should be entitled to collect on an insurance policy when he did not pay 5 cents for the insurance, did not want it, and did not have any interest in it. I hope the Senator is not putting his argument on that basis.

Mr. McGEE. If I may, Mr. President, I would like to put it on that basis, because, through the social security approach, which was a program to provide for some uncertainties, it could not be argued that after contributing to the fund for a year and a half, a person was eligible for benefits. It could not be argued that he had contributed enough money to make it possible to finance the cost of such a program when he drew upon the fund. It is not right to penalize a person who is 65 because of the failure on the part of the country to provide for him.

I think there may be ways to close the gap. The numbers outside the social security program are small. Some of them are being included under the amendments. So the bill penalizes certain members so far as actuarial soundness is concerned. But I do not think we have a right to penalize those who reached a certain age before we enacted the system.

Mr. LONG of Louisiana. If we are going to talk about someone getting something as a matter of right—and I question it—a person who cannot afford to pay because he is poor has more right to expect the Government to pay for his medical care than one who has not paid 1 cent for medical insurance has to expect to have his medical expenses paid for, even though he can well afford it.

Mr. McGEE. He has a right to expect that, because he did not know it was going to be the law of the land. I do not think we should penalize him because he reached the age of 65 before the program was enacted, and not let him share in a program that would tend to reduce his medical costs.

Mr. LONG of Louisiana. There is no criterion of need here. This program would be a medical care program at Government expense for a great number of people who have no need for such aid, because they are able to take care of themselves at their own expense. I concede that many people might need such help and could not pay for it, but the group the Senator's proposal would care for would include people who could take care of themselves, either by themselves or with the aid of relatives. I realize that the Senator knows that is implicit in what he is talking about here.

Mr. McGEE. I suggest again that the great bulk of this program—we are talking about numbers of people now—is addressed to people who do not have the means to meet the extra medical costs that may be imposed upon them. I suggest that out of this group of 17 million, those who have an annual income of as much as $10,000 to which they can turn for living costs would include only 3 percent. We are talking about the very large mass who have very low measurable income, the average of which is $2,500 to $3,000. In the urban communities, where most of them happen to live, the cost of living equals or exceeds that amount.

The Senator has raised some legitimate questions in terms of millionaires and those who are able to finance their own costs. However, that is not the group on which this question should be focused. The emphasis should be upon the group which is the greatest in numbers. Experience in this field will help us to work out the basis for a solution of the specific questions the Senator from Louisiana has raised about millionaires and those who are able to finance their own medical needs.

In connection with the earlier question, I suggest that the State hospitals in many of the States—and the Senator used that element as a part of his illustration—are required to take care of long-term chronic cases. This bill is not directed specifically toward that problem. Perhaps a bill should be, but this particular bill does not involve that ingredient. I think mental cases and TB cases fall in that category.

Likewise, the bill provides for a professional medical review board in each contracting hospital in order to effect standards of admission, discharge, and policies of the medical corps and medical doctors administering the cases in terms of occupancy of hospitals. The program has worked effectively in Colorado and Pennsylvania. I think there is enough of a record to suggest that there is a way to get at this problem without upsetting the purposeful impact or direction of financing this particular bill.

I yield now to the Senator from Nebraska [Mr. CURTIS], who has been very patiently waiting.

Mr. CURTIS. I commend the distinguished Senator from Wyoming for the statement he made when he started his speech, to the effect that what we needed on the subject was light.

What benefits will be available for the people who will come under the program, should the Anderson amendments be agreed to?

Mr. McGEE. In general, without spelling out the details of the proposal, for the first 9 days the individual would have to pay $10 a day. This provision is designed to eliminate the malingerers, the professional "go to the hospital" people, who like to lie in bed. It would minimize their number.

The difference between that $10 a day and the actual cost of the hospitalization would be picked up for that interval of 9 days. The hospital costs beyond that period, for the limited numbers of intervals spelled out in the proposal, would represent the benefits. A substantial economic burden would be borne by the program, if that burden should happen to descend upon an individual or his family.

Mr. CURTIS. For how long a time would the hospital bill be paid?

Mr. McGEE. It would be paid for 90 days.

Mr. CURTIS. With a $90 possible deductible?

Mr. KERR. Mr. President, will the Senator yield to me, to permit me to ask a question about his previous answer?

Mr. McGEE. I yield to the Senator from Oklahoma.

Mr. KERR. Did the Senator say there the hospital bill for the individual or his family would be paid?

Mr. McGEE. It would be for the individual patient.

Mr. KERR. I thought the Senator said for the individual or his family.

Mr. McGEE. I am sorry if that was what it appeared I said. I was trying to suggest that this program would reduce the burden the individual or the family otherwise might have to bear.

Mr. CURTIS. It is conceivable, then, that there would be many cases in which the first $90 for hospitalization would be paid by the beneficiary?

Mr. McGEE. That is not quite correct. I understand the cost would be $10 a day for 9 days.

Mr. CURTIS. It is conceivable, then, there would be many cases in which there would be a $90 deductible item which the beneficiary would bear?

Mr. McGEE. Yes.

Mr. CURTIS. What would be provided by way of medical prescriptions?

Mr. McGEE. Does the Senator refer to medicines the patient would get, in or out of the hospital?

Mr. CURTIS. Everywhere.

Mr. McGEE. The hospital drugs would be totally covered. The out-of-hospital drugs would not be covered.

Mr. CURTIS. So when we receive letters from our constituents stating they have costly medical burdens, expensive drugs they must buy once or twice a week, if they are not in a hospital this proposal would not relieve their burdens; is that correct?

Mr. McGEE. Yes. I understand from the hearings that the pharmacists did not wish to participate.

Mr. CURTIS. Is that provision out, because the pharmacists did not wish to come in?

Mr. McGEE. I remember that the pharmacists did not wish to come in.

Mr. CURTIS. Is that the reason the cost was not included in the proposal?

Mr. McGEE. That is not necessarily the whole reason. The point is that it it not in the proposal. The Senator's question was whether drugs were to be covered. I said that the hospital drugs were to be covered, and that drugs outside the hospital were not to be covered.

Mr. CURTIS. Would surgery be covered?

Mr. McGEE. No; surgery would not be covered. That is a doctor's charge.

Mr. CURTIS. Suppose an aged person had to call at his doctor's office for treatment or examination periodically?

Mr. McGEE. Doctor's bills are not to be covered.

Mr. CURTIS. Suppose a doctor had to call at a patient's home?

Mr. McGEE. That would not be covered.

Mr. CURTIS. In addition to the hospital cost coverage, there would be provided certain home nursing facilities, as a sort of substitute for hospitalization; is that correct?

Mr. McGEE. It would be supplemental, rather than a substitute.

Mr. CURTIS. If the amendments are agreed to, how many people will become eligible for benefits right away?

Mr. McGEE. About 17 million, I am informed.

Mr. CURTIS. How many of those 17 million have paid anything for the program?

Mr. McGEE. I would suppose that all but 2½ million have.

Mr. CURTIS. What have they paid?

Mr. McGEE. I wish to correct that statement. I was in error. I was thinking about the 2½ million people who were not under social security, to be brought in. The answer is that none have paid.

Mr. CURTIS. None have paid?

Mr. McGEE. That is correct, because it is to be a new program.

Mr. CURTIS. The Social Security Act was passed in 1936. It went into effect January 1, 1937. The first benefits were paid in 1940.

Someone who qualified under the act at the maximum rate, with the maximum covered wages at that time—and some of those people are still alive—may have paid $30 a year for 3 years, or a total of $90. That person, if still alive—and a number of such people still are—received a monthly check last month of $89. The benefit for 1 month was nearly equal to everything he paid. That person has been drawing benefits through the years.

That person has not paid anything into the hospital trust fund, has he?

Mr. McGEE. No; not at all.

Mr. CURTIS. Why has the age been fixed at 65 for the payment of the hospital benefits?

Mr. McGEE. I think it is to coincide with the social security system; that is, the preponderant portion of the social security system as it now operates.

Mr. CURTIS. Both men and women may retire now at age 62, and those who are disabled may elect to retire at any age.

Mr. McGEE. Yes. I think the age for retirement could be 62, 65, 67, or 60. That is not the issue in regard to this proposal.

Mr. CURTIS. Would a person have to retire to get the benefits?

Mr. McGEE. A person would not have to retire to get the benefits under this proposal.

Mr. CURTIS. So this would not be a retirement benefit.

Mr. McGEE. This is not to be a retirement benefit. This is to be a health benefit for persons who have reached the age of 65.

Mr. CURTIS. The cash benefits which are paid are intended to supplant wages, when someone can no longer perform work. Some people elect to retire at the age of 68 or 70, and they draw no benefits until that age. Some people elect to retire at age 62.

I wonder what is the magic about the age of 65.

Mr. McGEE. I do not think there is any magic.

Mr. CURTIS. Whether people are retired or not, regardless of job, regardless of capital, regardless of savings, regardless of income, if they are eligible for social security they are to be eligible?

Mr. McGEE. If the Senator will permit me to address myself to the question he asked, I think it is necessary to make an arbitrary selection of an age at some reasonable point. One could raise the same question about any particular line we might draw. The age of 65 has been a common retirement age, accepted in private industry, as well as in public fields.

The point which I think the Senator should bear in mind is that while some people may still be working at that age, the fact that they are still working will probably mean they will not draw upon the health insurance fund after the age of 65 quite as much as those who perhaps have had to slow down for health reasons, and have had to retire, as the alternative they have accepted.

In addition, those who are beyond the age of 65 who are still working likewise will be paying money in. That group will somewhat reduce the cost to which the Senator referred, for the 17 million people who will have paid in nothing. This program would work both ways. The kind of situation to which the Senator addressed himself a moment ago would be ameliorated.

Mr. CURTIS. The individual who cannot afford to retire will have to pay into the fund; is that correct?

Mr. McGEE. The individual who does not retire will pay into the fund.

Mr. CURTIS. Many older people continue to work from necessity; is that not correct?

Mr. McGEE. Some of them do. I am certain that is true. The desire is not to work in some cases, as soon as the budget can be balanced.

Mr. CURTIS. There is no arbitrary age for paying the cash benefits under social security. The test is, when did the person retire?

Mr. McGEE. The Senator is correct.

Mr. CURTIS. But in this instance an arbitrary age has been selected.

Mr. McGEE. The reason is that the age of 65, as medical records will reveal to the Senator—I am sure the Senator has studied them—is the age at which the incidence of health disaster mounts very sharply. It goes up after the age of 65, contrasted to the ages preceding 65. Therefore, it is as good a demarcation line as could be selected.

Mr. CURTIS. Has the Senator any idea what would be the cost of buying insurance to provide the benefits as set forth in the Anderson amendments?

Mr. McGEE. The cost of insurance to provide equivalent benefits?

Mr. CURTIS. Yes.

Mr. McGEE. I assume that the cost would be considerably more.

Mr. CURTIS. More than what?

Mr. McGEE. More than the cost under the social security approach.

Mr. CURTIS. What would it cost annually to buy that kind of protection?

Mr. McGEE. Under the social security approach the average would be somewhere in the neighborhood of $13 for a base of $4,800. As the amount increased, it would approximately double on an annual basis.

Mr. CURTIS. Of course, we would not know the answer to that question for many years.

Mr. McGEE. We have a reasonable way of making an educated guess, because we know the pattern of income in our country for the most part.

Mr. CURTIS. I am not so sure with reference to the present beneficiaries if we should start with the proposed program. What I am trying to determine is what it would cost to provide such protection if the individual went to a private insurance company in order to secure it.

Mr. McGEE. I am not sure I can answer the Senator's question. I do not have that information available.

Mr. CURTIS. What percentage of the people past 65 at the present time have some hospital insurance?

Mr. McGEE. About 50 percent.

Mr. CURTIS. Has that number increased in recent years?

Mr. McGEE. Yes.

Mr. CURTIS. Has the Department of Health, Education, and Welfare predicted that the percentage will continue to increase?

Mr. McGEE. I think the answer to that question is "Yes."

Mr. CURTIS. Do not many people—not all of them—have a coverage that would be equivalent, at least, and probably more than would be provided by the amendments of the Senator from Oklahoma?

Mr. McGEE. I think the element of difference is that the substance of the benefits under the Anderson proposal is the differential between the statistic that the Senator from Nebraska has asked for and the number who are over the age of 65 that have some kind of insurance. It is the amount of coverage that they have that, in relative terms, would establish the validity.

Mr. CURTIS. Is the Senator urging the adoption of the proposed system because it is needed or merely because in his opinion it would be a good system to follow?

Mr. McGEE. I think it is a very badly needed operation.

Mr. CURTIS. That point brings me back to my original question. Who needs it? At what point in income can a person over 65 be reasonably expected to provide his own hospital insurance?

Mr. McGEE. I am afraid the Senator must again face the fact that it is a question of income in relation to cost. We cannot select an arbitrary figure. All we know is that on the average there is a group over 65 who are receiving an average of $2,500 to $3,000 and we know they cannot pay the known and predictable medical expenses out of that income. Therefore, the success of their economic stability has been impinged upon.

Mr. CURTIS. Of course, under the bill they would not pay the known medical expenses.

Mr. McGEE. They would pay a substantial portion of them. If the Senator so proposes, we can make the bill provide a larger amount. The measure does not provide for the payment of all costs. All the Senator is doing is building a case for greater medical provision. I say that the proposal would be an important assault on the element of cost, even though it leaves out some of the big factors in cost.

Mr. CURTIS. The Senator from Nebraska believes that it is the concern of Government to provide not only hospitalization, but also surgery, medicine, office calls, and home calls for those who are unable to provide it for themselves. I think we should be generous in arriving at those benefits. The Senator from Nebraska does not believe that we should inaugurate a program that will not be paid for by the living workers, because the full impact of it will not have been reached in the lifetime of the present workers, but would be paid to a people who are well able to provide it themselves. That is why I have been trying all afternoon to find out at what point the distinguished Senator from Wyoming believes that a person of the age 65 should no longer be the concern of government? Would an income of $5,000, $6,000, $7,000, $8,000 or $9,000 indicate that point? After all, the costs would all be paid from taxes.

Mr. McGEE. I have tried to explain to the Senator from Nebraska again and again that it is an imponderable in terms of the relative impact of an unexpected, unplanned sickness cost on the income of a person over the age of 65. Studies that have been made suggest that the great majority of such persons have an income under $3,000 a year; $3,000 a year for a couple is not an adequate income to provide the kind of medical expenses that we are discussing. When the Senator refers to a couple over 65 whose income is $8,000, $9,000, or $10,000 a year, I remind him that that group is less than 3 percent of the age group we are talking about. We are addressing ourselves to the great majority of them. How many times must we go over and over the generalization about the capability of a person receiving an income under $3,000 a year to meet the known medical costs that are going to descend on his age group—if not on him personally, on his next door neighbor?

Mr. CURTIS. I fear the distinguished Senator did not understand my question. The question was not what percentage of the aged could pay for their own hospital insurance. My question was at what point of income the distinguished Senator from Wyoming thinks that they should be able to do so?

Mr. McGEE. I have suggested again and again to the Senator that it is a relative subject. We know that from the age of 65 on income drops very sharply. Most people in that age group are receiving less than $3,000; and, as I have said to the Senator previously, $3,000 is not enough.

Mr. CURTIS. Three thousand dollars is not enough?

Mr. McGEE. That is not an absolute figure. Again it is a relative cost; $10,000 would not be enough for some. It depends on the nature of the illness in relation to one's income.

Mr. CURTIS. The Senator recognizes social security taxes as taxes, does he not?

Mr. McGEE. I did not hear the Senator.

Mr. CURTIS. The social security payments that an employee, and employer, or a self-employed person makes are taxes, are they not?

Mr. McGEE. They are a form of taxes. But they are set aside in a fund.

Mr. CURTIS. An individual who works must pay those taxes from his first dollar of income. Is that not correct? There is no personal exemption.

Mr. McGEE. The Senator is correct.

Mr. CURTIS. So it is the most severe type of taxation there is. The Senator is advocating a system——

Mr. McGEE. Is the Senator now shifting the field of his questions from where we were a moment ago? Is the Senator now speaking about the form of taxation covered by the measure?

Mr. CURTIS. Yes.

Mr. McGEE. The Senator is opposing a social security type of taxation as the most vicious form of taxation there is?

Mr. CURTIS. A taxation that allows no personal exemption is about as tough as any I can think of.

Mr. McGEE. Is the Senator suggesting then, that we should modify the social security tax?

Mr. CURTIS. No. I am suggesting that we should not continue to add to it. We have a social security tax. No personal exemption is provided. At some future time I hope the personal exemption in the income tax law can be raised. The social security tax is one on which the worker pays from the very first dollar he earns. We would increase that tax to bring in a system to supply a need that is moving in the direction of being met. I think the distinguished Senator from Wyoming himself said a moment ago that half the people over 65 have some health insurance. That is a great deal more than the number who had it a few years ago. The prediction is that more people will have it.

I wonder what the Senator has to support the need for such a program at this time.

Mr. McGEE. The first thing that is compelling is that half of the people in most cases do not have sufficient coverage. The 50 percent is a very misleading statistic. The compelling reason is the element of need. I say to the Senator that this kind of investment is quite different from direct taxation, in that the contributor, the fellow with a job, who contributes one-quarter of 1 percent to the social security tax for health insurance in his later years is contributing to his own benefit in the predictable years ahead. It is different from some other forms or types of taxation. A sales tax is probably much more severe than a social security tax. This is, in effect, a forced saving for the individual

to cover the exigencies of his retiring years.

Mr. CURTIS. Are the beneficiaries at the present time getting back the forced savings that they have made?

Mr. McGEE. I am sorry I did not hear the full question of the Senator.

Mr. CURTIS. Are the present beneficiaries under social security merely getting a return of the forced savings that they have had to make?

Mr. McGEE. They are if they have retired and are getting $89 a month. This is a compulsory system.

Mr. CURTIS. Are benefits limited to that figure?

Mr. McGEE. There are many tangent programs, as the Senator knows, that try to approach particular extenuating situations.

Mr. CURTIS. I am talking about the social security benefits that people are now receiving. Are they getting a return on what they have been forced to save?

Mr. McGEE. It varies with the age of the individual, and how long he has been in the system.

Mr. CURTIS. Is it true for any beneficiary at this time?

Mr. McGEE. It would be theoretically true for one who had put in the equivalent amount if he were to draw it out by the time he died. It could be assumed that he had gotten, then, equivalent benefits.

Mr. CURTIS. I am speaking of someone 65 years of age who retires on July 1, 1962. He has been covered in the program for the maximum taxable and creditable earnings for every year since the program began, in 1937. Such a person would have a primary benefit of $123 a month. If he has a wife of exactly the same age, her benefit would be $61.50 as long as he was living, and $101.50 after his death. These figures assume that the individual had the maximum covered earnings of $4,800 in the first 6 months of 1962. On the basis of the U.S. White Life tables for 1949–51, which are the latest available official complete mortality tables, a man and his wife can expect to receive, on the average, about $32,600 in monthly benefits. The total amount of the employee taxes that this individual paid were $1,584. This is a part of a statement signed by Robert J. Myers, chief actuary of the social security system.

Consider the case of someone who has paid since 1937, to this date. He would have paid $5,184. He has benefits, on the average, of over $32,000.

The social security system is a system of social benefits which are paid not by the recipient, but by taxing the people who work, taxing the self-employed, and taxing employers. They will not catch up during the generation of the workers who are now over 21.

Therefore, we are discussing a program the full impact of which will not fall on the present workers, but on future workers.

I thank the Senator.

Mr. McGEE. I thank the Senator for his comments. I remind the Senator from Nebraska that the existing social security fund has been under repeated, continual reexamination, and that the fund continues to be actuarily sound. It is the strong feeling of economists that the proposed fund with respect to medical care will likewise be actuarily sound because of the interplay of a great many forces. Rather than take any more time—and I see the majority leader approaching apparently to ask me how soon we expect to conclude—I suggest that the remainder of my remarks be included in the RECORD. I had some extended statements prepared in addressing myself to the question of why private insurance cannot do the whole job.

I ask unanimous consent that these statements may be placed in the RECORD at this point.

There being no objection, the statements were ordered to be printed in the RECORD, as follows:

STATEMENT BY SENATOR MCGEE, OF WYOMING

The proposal now before this body, to provide funds for medical care for the aged through social security, has generated one of the most active and acrimonious debates across the Nation that has occurerd in many years. Unfortunateiy, these debates have generated considerably more heat than light. Too often we find that those entering the debate have obtained their mental exercise by jumping to conclusions. Therefore, I would like to discuss a few of the more obvious misconceptions which have obscured the real issues in the hope that we may then get to the real issue—whether or not we can devise an adequate plan to help our older citizens obtain adequate medical care.

Misconception No. 1: Most of America's 17 million seniors do not need help with their medical bills.

This is obviously a view alien to that of the majority. While it is true that much health care is provided free to those who need care for which they cannot pay, public assistance agencies, private charitable organizations, and many physicians provide free services only to the extent that they can with the limited funds available. The sad fact is that many older citizens who are sorely in need of medical care do not get it because they are too proud to ask for charity. Those who do receive paid care from public and private assistance agencies do so only after the humiliating experience of proving they are in want. And consider that people over 65 suffer twice as freqeuntly from chronic sickness as those under 65—even excluding those who are in institutions. They spend 2½ times as many days restricted to their beds—they are forced to limit their activities due to illness six times as often. Medical costs and health needs of the aged are greater today than those of other age groups in the population, their incomes often are too low for them to purchase private health insurance. The primary social security benefit (on which most retirees must rely exclusively) averages only $73 a month. The maximum benefit for a retired couple, which only a small proportion of beneficiaries receive, is but $180 a month. Out of these small sums must come rent, food, clothing, and other necessary expenses. There is no margin for huge medical expenses brought on by a stay in the hospital.

Opponents to this bill answer this with the suggestion that the aged should therefore look to their children or relatives for help. Families do, in fact, often provide such help. Too often, however, this burden is borne at the expense of the education and the well-being of the children and grandchildren of the elderly ill. This unfortunate fact brings a heavy cost in family harmony and in the future opportunities of the children involved; and, in many instances, the relatives themselves are totally unable to meet the heavy costs involved.

Misconception No. 2: That the Kerr-Mills bill offers adequate medical benefits.

But the Kerr-Mills law clearly spells out that each State "will furnish medical assistance to aged individuals as far as practicable under the conditions in such State." Under this law, the medical services available to eligible applicants are directly proportional to the ability of each State to purchase these services. Wealthier States like New York and Massachusetts offer more medical services than do poorer States. In no State are unlimited services available to the medically indigent aged. This bill, backed by most doctors, is proving a sad failure in most of the States that have adopted it, even in the richer and more progressive States. My home State of Wyoming, which will have an estimated aged population of 29,000 by January 1965, has not yet seen fit to adopt this law.

In short, Kerr-Mills requires a degrading poverty test; it covers only so-called charity cases; it guarantees no free choice of doctors or hospital; its program has not been adopted by most of the States; and—most important to those of us who are economically minded—it provides a drain on the Federal Treasury with no provision to balance that drain with new revenue.

Misconception No. 3: That the social security approach to financing care for the ill and aged under the King-Anderson bill would be a step toward socialism and government control of medicine.

This is, perhaps, the most ridiculous of the arguments against medicare. Nothing could be further from the truth. The improved King-Anderson bill clearly and forcefully spells out:

"There shall be no Federal controls over or intervention in the free practice of medicine."

Socialism exists when the doctors are salaried by the Government, when the hospitals are run by the Government, and when the Government controls the personnel and facilities. The proposed program would not provide a single medical service but would only help people finance the cost of their health care—and there are even alternatives to this in the compromise bill. It would in no way control, regulate, or interfere with the practice of medicine.

The patient also is free to choose his own doctor, who, in turn is free to work in the hospital of which he is a staff member. The bill further guarantees to hospitals the freedom of choice to participate in the President's proposed health care program or not.

If enacted into law, it will operate like Blue Cross with the doctors and hospitals free to disburse their services as they have done in the past. The only point of difference is the method of financing the costs of those services rendered. Instead of the individual or private insurance paying all, the social insurance trust fund will cover all or part of the allowable costs.

This health insurance is a reasonable and important part of income protection in retirement. Without such benefits the social security program cannot adequately provide basic security for the aged. This is the only way to remove the threat to the financial independence of older people posed by the high cost of illness.

Misconception No. 4: That this program would cost too much.

Under the social security insurance, under which the individual contributed during the working years when he can best afford the contributions, payments are spread out over a working lifetime and the cost to the individual is reduced to pennies a day. The program would be financed by contributions from both workers and their employers without imposing a burden on general revenues. In fact, reduction in expenditures which would otherwise be necessary by the

States and Federal Government under public assistance would partially offset the cost of the new program. The cost to the Federal budget would be nil whereas under the present law the cost was $280 million in fiscal year 1961. In fiscal year 1963 it will be an estimated $412 million.

Admittedly, the social security tax will be increased by one-fourth of 1 percent and the self-employed, covered by social security, will pay an additional three-eighths of 1 percent. In dollars and cents, this one-fourth of 1 percent amounts to about $12.50 per employee per year, or $1.04 a month, or 26 cents a week—less than the price of a pack of cigarettes—and undoubtedly healthier.

Misconception No. 5: That there would be an overutilization of services.

The plan provides at least three safeguards against overutilization. First, there are the attending physicians that must certify, and at certain times recertify, that services are required for medical treatment or diagnosis.

The second safeguard is provided by the institution itself, which would review admissions, duration of stay, and services furnished.

The third safety measure is built into the program in the types of services covered and in the requirements for deductibles. Since protection is provided against the costs of outpatient diagnostic, skilled nursing home, and home health services, there will be no financial incentive to unnecessarily use higher cost services when the lower cost services will suffice. The deductibles might also tend to reduce unnecessary utilization of hospital services.

Aging is a phenomenon both personal and public, both evident and elusive. Time passes: as an experience within, as a dimension without. New forces and new problems make disturbing patterns in the latter years. The stereotypes are only too familiar: the rocking chair, the empty hands, the illnesses of age, the unwanted look, the passive posture. Are these the only meaning of being old? Too long have these misconceptions persisted. These cobwebs have ensnared the struggling elderly, thus denying them their rightful place in the sun. Realities, if not ignored by those who do not want to admit hard truths, can bring security and peace of mind to those elderly who now face fear and deprivation as an unwelcome reward for their many years of toil.

Up to the present time, nearly all programs in behalf of the aging in the United States are the product of the welfare mood and of uncritical adoption of untested projects. The proposed administration bill for aid to the aged medically indigent is not only not welfare but has been tested through long and favorable experience. The time has come for Congress to provide the insight and the law to help both the younger and an older society to act with wisdom about age.

So far the debate on this proposal, now before us, has degenerated into a picayunish business which is smothering it under a landslide of verblage—and at a time when it desperately needs fresh air. At present there is the very real danger that this headless chase will end in a monster bill embodying just those aspects of the problem we wish to avoid.

We must not allow this comprehensive piece of legislation to be pecked to death. Rather, we must get off our petty and sometimes partisan political stumps, and provide for the urgent need of the elderly ill by passing this constructive and essential King-Anderson medical care bill, as improved, with all deliberate speed.

Private Insurance Cannot Do the Whole Job

(By Senator McGee, of Wyoming)

The proposals recommended by President Kennedy for health insurance benefits for the aged under social security have been opposed on the ground that private health insurance should and can do an adequate job in providing health insurance for older people. It is not surprising that people argue this way. In the postwar years, health insurance coverage figures have soared, both in terms of the number of people covered and in terms of the amount of benefits provided. Hospital insurance, which in 1945 covered only a quarter of the population, now covers about 70 percent. The proportion of people with some insurance against surgical costs has increased from 10 percent to nearly 70 percent. Over 45 percent of the population has insurance against the costs of other services by physicians in the hospital, as compared with only about 4 percent in 1945.

While commercial health insurance had its beginnings in the late 19th century, the commercials played a secondary role until the end of World War II. Since then the commercials have won a larger and larger share of the health insurance market, and in 1951 the commercials passed Blue Cross in enrollment. Today membership in commercial health insurance exceeds Blue Cross membership by more than 20 million.

But there is one major gap in this picture of increasing coverage. Health insurance for the retired aged is inadequate both in the number of people who are covered and in the amount of protection afforded those who are covered.

The national health survey, a comprehensive survey sponsored by the Public Health Service, found that in the first half of 1959, 46 percent of those 65 and over had some form of health insurance. As for the retired aged—those who did not usually work in the survey year—only 42 percent had any kind of health insurance.

In many instances, the protection aged persons have against hospital costs is inadequate. For example, the special guaranteed-renewable policies offered to senior citizens in normal health by a number of insurance companies typically provide room-and-board payments of $10 a day for 30 to 60 days, up to $50 or $100 for extra hospital expenses and surgical expenses up to $200 or $300. Such policies provide relatively little protection against the costs of hospital care, which may average $30 a day or more. Also, they often have lifetime limitations on total benefits. And these policies will become increasingly inadequate as hospital and medical costs continue to rise. In general, policies available to people in poor health have prohibitively high premiums or inadequate benefits, cancellable features, exclusions of preexisting conditions for the first 6 months or more (and sometimes forever, which may make the policy almost worthless to the insured), or a combination of such restrictions. And of course, very few older people have insurance against such health care costs as surgical and other physician's fees and the cost of drugs.

Why are the retired aged not able to protect themselves adequately through health insurance? It is a simple matter of economics. People over 65 have health costs that are twice as high as those of younger people, while their incomes are only half as high. The median annual income of an aged couple is only about $2,500, and the average aged person living alone has about $1,100. Furthermore, the retired aged are generally not in groups that can be insured, but instead must buy insurance on an individual basis, if at all. This form of coverage is, of course, quite expensive, sometimes costing twice as much as group coverage offering the same protection.

Not only is coverage now inadequate, but it tends to be concentrated in the higher-income group and among the better risks. The National Health Survey found that while more than half the population aged 65 or over had no health insurance, for older people in families with income of $2,000 or less (which include 40 percent of all older people) 67 percent had no health insurance. Among people aged 75 and over, 68 percent had no such insurance. Among the aged in poor health—people with chronic conditions who are unable to carry on their usual major activity—70 percent had no hospital insurance.

In considering the rate of future expansion in health insurance, the fact must be faced that any significant extension of adequate health insurance protection in the older age groups will necessarily involve people with lower incomes, those in the higher age brackets, those who are no longer working, those in ill health—in short, the very people who represent the poorest risk from a health insurance standpoint and who are least able to pay for protection.

Two special techniques have been developed to make it easier for high-risk, low-income groups to obtain adequate health insurance protection, but neither seems likely to succeed in this objective. The first technique is the so-called community-rating approach. This approach dates back to the beginning of the Blue Cross movement—to the early 1930's—and has been a basic tenet of the Blue Cross philosophy of public service to the community as a whole. Originally, the objective of Blue Cross was to offer one policy at one cost for all enrollees in the community. This community rating approach was intended to pass on part of the costs of insuring high-cost subscribers—including the aged—to the younger working group.

Since the entrance of the insurance companies into the health insurance field in the 1940's, the future of community rating has become clouded, and many observers believe that it is in a state of decline. The competitive nature of commercial insurance has inevitably led to following the opposite principle—that of experience rating, which results in a lower price for the good risks and a higher price for insurance for the aged.

In the competition between the Blues and the commercials, the commercial carriers have increasingly been able to attract the large low-cost groups. Conversely, the higher cost groups find the Blue Cross rates more attractive. Blue Cross premiums are thus driven higher; and as they are driven higher, good risks find the Blues less attractive. Under the circumstances, it is understandable that Blue Cross plans have found it increasingly necessary to compromise their community-rating principle.

Under the other technique for handling the problem of the high-risk, low-income group, the retired person's previous employer pays part or all of the health insurance premiums in retirement. Under this sort of arrangement, the retired employee ordinarily retains all or part of the group health insurance coverage he had while he was working. From the employee's standpoint, there are many advantages to this sort of an arrangement: In addition to having the advantage of the employer contribution, he benefits from the economics inherent in group coverage and from the fact that the level of benefit protection provided by group insurance is characteristically high.

Good as this approach is, it is clear that it can never reach the majority of workers. The worker's right to remain in his company's health insurance plan after retirement is usually tied to his eligibility for a pension. At present, less than 10 percent of the aged are drawing private company pensions, and only a small portion—about a quarter—of these are eligible for health insurance under the company plan. The number of pensioners will grow in the future—about 40 percent of the wage and salary workers are now covered—and thus undoubtedly more aged will have health insurance protection under group plans. However, it is necessary to consider that many workers covered by plans will never collect pensions; in many instances 20 or 30 years of work for one company, and even employment right up to the time of retirement, is required. Even allowing for an increase in pension plan coverage and health insurance protection under these plans, it is doubtful if, under the most optimistic assumptions, over 20 or 25 percent of the future retired aged will have health insurance protection under group plans. And those who will be protected under group insurance will be the very same sort of people who now have protection on their own.

A third method should perhaps be mentioned. There are for sale by a few companies individual policies providing paid-up protection at retirement. Such a policy guarantees that a specified set of health insurance benefits, payable, of course, in dollars rather than in services, will be available to the policyholder after he reaches a specified age. The great advantage of this sort of an arrangement is that the cost of post-retirement health insurance protection can be paid for while the individual is working and can better afford the premiums.

A paid-up indemnity plan, however, is of very uncertain value. After a lifetime of premium payments, the best indemnity plan for paid-up health insurance could become worthless if health care costs have increased substantially between the date of issue and age 65. For example, a policy written to meet 1940 health care costs would be almost worthless today. On the other hand, private insurance can hardly be expected to underwrite the cost of service benefits to be delivered 30 or 40 years in the future. Moreover, this type of policy has little promise as a timely solution to the problems of the aged, for the paid-up policies by definition cannot become effective for many years. Consumer interest and sales have not been impressive.

It is no wonder, then, that many students of the problem have come to the conclusion expressed by Dr. Basil C. MacLean, formerly president of the Blue Cross Association, in these words:

"A lifetime's experience has led me at last to conclude that the costs of care of the aged cannot be met, unaided, by the mechanisms of insurance or prepayment as they exist today. The aged simply cannot afford to buy from any of these the scope of care that is required, nor do the stern competitive realities permit any carrier, whether nonprofit or commercial, to provide benefits which are adequate at a price which is feasible for any but a small proportion of the aged."

If the problem cannot be solved by private insurance, why is it that the social insurance approach is effective? The social security program now provides protection for practically all working people and their families. More than 9 out of 10 people who work are covered under the program and already 85 percent of the people now becoming 65 are eligible for retirement benefits; this percentage will rise in the future to 95 percent or more. In the course of a year some 73 million earners contribute to the program; 86 million have contributed long enough to be fully insured. Coverage, then, is nearly universal.

People qualify for benefits under social security by working, and while they are working they pay toward the cost of those benefits. Thus the payments for health insurance protection under social security are made while the person can best afford it, rather than out of his reduced income in retirement.

Social security benefits are paid regardless of income from savings, pensions, investments, and the like, so that the worker is encouraged to supplement the basic protection afforded by his social insurance benefit with whatever additional protection he can afford to buy. The social insurance approach to meeting need is thus a major social invention, largely eliminating the old fear that meeting need will injure incentives to work and save.

The use of the payroll tax to finance the program has the effect of automatically increasing income to the program as earnings rise. The increase in income permits benefits to be adjusted somewhat in accordance with current levels of living and current prices. This is a particularly important point in providing a service benefit under conditions of rising costs.

It is these characteristics of social security that make it the most practical approach to making health insurance generally available to the aged.

Admittedly, the President's proposal is designed to meet only the most pressing health care needs of the aged. But as under the present program of old-age and survivors insurance benefits, people can be expected to build on the basic health insurance protection. At least some of the money the aged now spend to meet hospital costs, through insurance and otherwise, could be used to purchase insurance against the costs of the services of physicians and dentists, drugs, and the other health services and supplies not covered under the proposal. Also, many aged people who now go without any health insurance protection because they cannot afford to safeguard themselves against the financial catastrophe of a serious illness would also obtain supplemental coverage from private sources once real security becomes possible. Certainly, with basic protection furnished under the Government program a larger number of private companies will be encouraged to carry supplemental protection for their retired employees.

The President's proposal, then, is that Government and private insurance play complementary roles in meeting the need. The role of Government in the health insurance area, just as it is in the area of retirement income, would be to provide a guarantee of basic protection for the aged through the Nation's social insurance system. The role of private insurance would be to build supplementary protection on this base. Neither can do an adequate job alone, but in partnership the result can be a new level of security for our people in their retirement years.

Mr. McGEE. I close by again reminding Senators that no proponent of the pending measure is proposing socialized medicine or wants anything to do with socialized medicine. We want only to meet the financing of medical costs of our senior citizens, particularly of the great majority of them who find it impossible to meet such costs with their own resources. That is the nub of the proposal.

It is mistake, and it is a disservice to the country, to drag in the strawmen that have been set up and then try to knock them down, or to beat dead horses in this arena. Instead, we ought to address ourselves to the medical costs. In my judgment, the bill does exactly that. Therefore, I vigorously urge the adoption of the Anderson amendments by the Senate.

Mr. MANSFIELD. Mr. President, first I wish to say to the distinguished Senator from Wyoming that I was not approaching him to ask him to cease and desist. I was learning a great deal from what he was saying this afternoon. As a former professor of history at the University of Wyoming, he has much to offer the Senate. Personally I wish to express my thanks to him for the information which he has so generously given those of us who have been in attendance in the Senate this afternoon.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The Chief Clerk proceeded to call the roll.

Mr. DIRKSEN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MANSFIELD. Mr. President, on behalf of the distinguished minority leader and myself, I submit a unanimous-consent agreement and ask that it be read.

The PRESIDING OFFICER. The unanimous-consent agreement will be stated.

The Chief Clerk read as follows:

Ordered, That beginning Wednesday, July 11, 1962 after the morning hour during the further consideration on H.R. 10606, the public assistance and welfare bill, debate on any amendment, motion, or appeal, except a motion to lay on the table, shall be limited to 1 hour, to be equally divided and controlled by the mover of any such amendment and the majority leader: *Provided,* In the event the majority leader is in favor of such amendment the time in opposition thereto shall be controlled by the minority leader: *Provided further,* That there shall be 4 hours of debate to be equally divided on the substitute of the Senator from Massachusetts [Mr. SALTONSTALL], and there shall be 4 hours of debate to be equally divided on the substitute of the Senator from Connecticut [Mr. BUSH]: *Provided further,* the Senate shall proceed to vote on a motion to table the Anderson amendment at 3 p.m., Tuesday, July 17. If the motion to table the Anderson amendemnt should fail, there shall be a time limitation of 4 hours debate on the Anderson amendment. All time shall be equally divided as provided at the beginning of this agreement: *Provided further,* there shall be 6 hours of general debate on the bill to be equally divided as previously provided.

Mr. JAVITS. Mr. President, will the Senator from Montana yield for a clarifying question?

Mr. MANSFIELD. I yield.

Mr. JAVITS. It is understood that under the unanimous-consent agreement the 1-hour limitation on amendments may apply as well to amendments to the Anderson amendment, notwithstanding the fact that that is not expressly mentioned in the unanimous-consent agreement?

Mr. DIRKSEN. That is correct.

Mr. CURTIS. Would the 1-hour limitation on amendments apply to all amendments?

Mr. MANSFIELD. To all amendments.

Mr. CURTIS. Including amendments hereafter submitted?

Mr. MANSFIELD. Yes.

Mr. KEATING. Mr. President, will the Senator from Montana yield?

Mr. MANSFIELD. I yield.

Mr. KEATING. Has the junior Senator from Minnesota [Mr. McCARTHY] been consulted with regard to the amendment which he and other Senators may propose to the welfare bill, other than to the medical care portion?

Mr. MANSFIELD. Such amendments are in order; and the amendment or amendments of the Senator from Minnesota could be brought up. I feel certain that the proposed unanimous-consent agreement would be satisfactory to him, although I have not asked him.

Mr. KEATING. It might require some discussion.

Mr. MANSFIELD. The leadership was being as generous as possible, taking into consideration the needs of individual Senators.

Mr. KEATING. I do not make any point about it.

Mr. GOLDWATER. Mr. President, will the Senator from Montana yield?

Mr. MANSFIELD. I yield.

Mr. GOLDWATER. As I understand the unanimous-consent request, the Senate will vote at 3 p.m. on Tuesday, July 17, on the question of recommitting the Anderson amendment.

Mr. DIRKSEN. On the question of tabling the Anderson amendment.

Mr. MANSFIELD. That is correct.

Mr. GOLDWATER. Following that, there would be 4 hours of debate on the Anderson amendment. Would that preclude the submission of any other amendments prior to the 4 hours of debate on the Anderson amendment?

Mr. MANSFIELD. To the best of my knowledge, it would not.

Mr. GOLDWATER. Would the Senator definitely say "No"?

Mr. MANSFIELD. I would say definitely no.

Mr. HRUSKA. Mr. President, will the Senator from Montana yield?

Mr. MANSFIELD. I yield.

Mr. HRUSKA. The question was whether the submission of amendments could be made prior to that time. Could they be made after that time?

Mr. MANSFIELD. Yes.

Mr. HRUSKA. At any time?

Mr. MANSFIELD. At any time.

Mr. HRUSKA. Any amendments offered either before or after that time would be subject to 1 hour's debate?

Mr. MANSFIELD. That is correct.

Mr. DIRKSEN. Incidentally, the germaneness clause is not included in this request.

Mr. AIKEN. Mr. President, will the Senator from Montana yield?

Mr. MANSFIELD. I yield.

Mr. AIKEN. I listened to the question as to whether other amendments would be in order. If the Anderson amendment should be tabled, amendments would not be in order.

Mr. DIRKSEN. Not to the Anderson amendment.

The PRESIDING OFFICER. Is there objection to the unanimous-consent request?

Mr. KERR. Mr. President, as I understand under the proposed unanimous-consent agreement, although amendments to the Anderson amendment may be pending, at 3 p.m. on Tuesday, July 17, a vote will take place on a motion to table the Anderson amendment.

Mr. MANSFIELD. The Senator is correct.

Mr. HRUSKA. Would that vote be on a motion to table the Anderson amendment as amended at that time?

Mr. MANSFIELD. Yes; it would be on a motion to table the Anderson amendment as completed at that time.

Mr. HRUSKA. Namely, at 3 p.m. on Tuesday, July 17—a week from tomorrow?

Mr. MANSFIELD. A week from tomorrow.

The PRESIDING OFFICER. Is there objection to the unanimous-consent request? The Chair hears none, and the agreement is entered.

LEGISLATIVE PROGRAM

Mr. MANSFIELD. Mr. President, I thank the distinguished minority leader and his colleagues for their consideration. I thank the distinguished Senator from Oklahoma [Mr. KERR], the distinguished Senator from New Mexico [Mr. ANDERSON], and all other Senators for their cooperation in bringing about an agreement which is as near to a settlement as could be reached at this time.

The agreement does not mean that between now and Tuesday, July 17, the Senate will be considering only the welfare proposal, H.R. 10606. It is anticipated that at convenient times other measures on the calendar will be brought before the Senate for consideration.

For the information of the Senator from Oklahoma [Mr. KERR] and the Senator from Wisconsin [Mr. PROXMIRE], and with the concurrence of the distinguished minority leader, I announce that tomorrow, at an appropriate time, it is proposed to have the Senate consider Calendar No. 1593, H.R. 11737, to authorize appropriations to the National Aeronautics and Space Administration for research, development, and operation; construction of facilities, and for other purposes.

Mr. DIRKSEN. Mr. President, will the distinguished majority leader yield?

Mr. MANSFIELD. I yield.

Mr. DIRKSEN. Of course it is anticipated that if all the time is not utilized on amendments or substitutes, the majority leader should be in a position in which he can set aside the consideration of that measure and have the Senate resume the consideration of the satellite bill or proceed to the consideration of any other measure, so that the time will be used to advantage. I believe we have a thorough understanding in that connection.

Mr. MANSFIELD. I thank the distinguished Senator from Illinois.

In addition to the National Aeronautics and Space Administration bill, there is also on the Calendar No. 1631, Senate bill 3392, to authorize appropriations for the Atomic Energy Commission in accordance with section 261 of the Atomic Energy Act of 1954, as amended; and there is also on the Calendar the appropriation bill for the Department of Health, Education, and Welfare.

Mr. DIRKSEN. Mr. President, will the majority leader yield again to me?

Mr. MANSIFELD. I yield.

Mr. DIRKSEN. I presume there is some quandary regarding the possibility of the taking of votes during the session tomorrow, in view of a certain well-known athletic event which is to transpire in the Capital City. I assume that, other things being equal, there will be no record votes tomorrow to disturb the poise and enjoyment of those who may attend that event.

time he utilizes coming from the time on either side.

The VICE PRESIDENT. The Chair is informed that the unanimous-consent agreement does not go into effect until tomorrow.

Mr. SMATHERS. Very well.

PUBLIC WELFARE AMENDMENTS OF 1962

The VICE PRESIDENT. Is there further morning business? If not, morning business is closed, and the Chair lays before the Senate the unfinished business.

There being no objection, the Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. SMATHERS. Mr. President, in view of the fact that the Senate is now operating under controlled time, I ask unanimous consent that the Senator from Oregon may proceed without the

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

LET'S NOT BE STAMPEDED ON MEDICARE

Mr. BENNETT. Madam President, no bill which Congress will consider this year will have anywhere near the far-reaching effects of the proposal for medical care to the aged through social security. If we abandon the present system, the Kerr-Mills Act, and substitute the Anderson approach, we will be making a permanent and drastic change in the social security program which will affect Americans for generations to come.

I should like to discuss two things today. First is the overall effect of the social security approach. Second is the danger of enacting the Anderson amendment as a result of hasty floor consideration, without giving this highly complex and very controversial amendment the benefit of full committee hearings.

Recently, the Senator from New Mexico [Mr. ANDERSON] told the Senate—and I am quoting now from the CONGRESSIONAL RECORD—that "unless favorable action is taken now, health insurance could become a major issue in the fall elections."

I argue with his selection of the word "could." The fact is, social security financing of health care for the aged is a major issue as of this moment, and it will be an issue in the fall elections regardless of what happens to the distinguished Senator's amendment.

If this were not a major issue, it would not be for lack of trying. On no other subject has the administration demonstrated more forcibly its desire to drive—not lead—the Congress.

For months on end, administration officials have shuttled back and forth across the United States, lobbying social security medicine at the taxpayers' expense. Pamphlets have been published on the subject by the Department of Health, Education, and Welfare. Cabinet officials have journeyed throughout the Nation in order to speak at rallies organized to campaign for the King-Anderson bill.

Within the White House itself a special unit of government employees was set up to thump the tubs for the King-Anderson proposal—through television and radio scripts, the drafting of advertisements, and the production of press releases. President Kennedy himself addressed the Nation in support of this legislation from Madison Square Garden.

To this concerted effort must be added the relentless pressure of labor organized campaigns throughout the country, the steady pounding of the labor press and radio stations, the stimulation of letters to Congress, the employment of labor leaders as speakers before King-Anderson rallies, and so on.

PRESSURE ON CONGRESS

All of this campaigning had one purpose: to impress Congress with the political rewards or penalties involved in dealing with this legislation.

Yet, did a groundswell of national support for King-Anderson develop?

I am convinced that it did not, despite the calculated oversimplification, hard sell, distortion, and sometimes untruth developed in this massive, public relations campaign. What groundswell developed was, in my view, largely snythetic. I base that appraisal on the mail I have received from my constituents and from the reports I have had from other Senators.

Letters to Congress more often oppose the King-Anderson concept than they support it. Further, when Members of Congress have polled their districts on the subject of using the social security mechanism to provide health care for the aged, their findings have borne out my statement.

Some 52 polls had been reported in the CONGRESSIONAL RECORD up to and including June 23 of this year. Of these, which included more than 600,000 replies, 33 polls opposed the use of the social security mechanism and 19 favored it.

Breaking this down, 334,339 individuals opposed the use of the social security mechanism; 241,383 favored it; and the remaining 39,502 had no opinion. Stated in percentages, the tabulation shows 54.4 percent opposed: 39.2 percent in favor; and 6.4 percent with no opinion.

Excluding those with no opinion, the percentage in opposition to the use of the social security mechanism would be 58 percent, with those in favor 42 percent.

Madam President, I ask unanimous consent to insert the tabulation of these polls at this point in the RECORD.

There being no objection, the tabulation was ordered to be printed in the RECORD, as follows:

The following report of public opinion concerning the use of the social security mechanism to provide health care to the aged is based on polls conducted by Members of Congress in their districts and reported in the CONGRESSIONAL RECORD during the 87th Congress, up to and including June 23, 1962. Where the Congressman has reported 2 polls concerning this question, the latest poll has been used. Where the poll has not reported the number of responses received, the information was elicited from the Congressman's office.

Of the 52[1] polls, which included 615,284 responses, in this tabulation, 33 opposed the

[1] Two polls reported in the CONGRESSIONAL RECORD are not included in this tabulation.

The question posed by Mr. MCDONOUGH, Republican, of the 15th District of California, is such that the support or opposition to the use of the social security mechanism cannot be determined. However, Mr. MCDONOUGH interpreted the results as being in opposition.

The question posed by Mr. AVERY, Republican of the first District of Kansas, concerned the financing of medical care by 3 mutually exclusive mechanisms. The largest single vote (44 percent) opposed any Federal participation in health care for the aged.

use of the social security mechanism and 19 favored it—334,399 individuals opposed the use of the social security mechanism, 241,383 favored it, and the remaining 39,502 had no opinion. Stated in percentages, the tabulation showed 54.4 percent opposed the use of the social security mechanism, 39.2 percent favored it, and 6.4 percent had no opinion.

If those with no opinion are excluded, the percentage in opposition to the use of the social security mechanism would be 58 percent. The percentage of those favoring would be 42 percent.

While the results of these polls are in dispute with the recent Gallup poll, they tend to confirm that poll's finding of a reduction in the number of people supporting the President's plan. Of the 10 Congressmen reporting polls in 1961 and 1962, the 1962 poll shows an increase in opposition to the use of the social security mechanism in 8 districts.

Public opinion on the use of the social security mechanism to finance health care for the aged as tabulated from congressional polls during the 87th Cong.

	For	Against	No opinion
1. Alger (Republican), Texas—5th District, C.R. June 14, 1962, A4427	1,890	25,760	350
2. Ashbrook (Republican), Ohio—17th District, June 12, 1961, A4204	2,019	2,718	883
3. Baldwin (Republican), California—6th District, Mar. 26, 1962, A2281	15,609	6,638	1,752
4. Beall (Republican), Maryland—Senator, May 4, 1962, A3317	335	1,608	290
5. Berry (Republican), South Dakota—2d District, Mar. 15, 1962, A1985	1,024	5,376	----
6. Bolton (Republican), Ohio—22d District, Mar. 5, 1962, A1625	8,295	6,015	690
7. Brademas (Democrat), Indiana—3d District, June 21, 1962, A4707	10,811	7,429	760
8. Bray (Republican), Indiana—7th District, June 13, 1962, A4382	4,200	9,520	280
9. Broyhill (Republican), Virginia—10th District, Mar. 21, 1962, A2180	4,528	10,064	1,408
10. Chamberlain (Republican), Michigan—6th District, Apr. 11, 1962, p. 5916	7,800	12,200	----
11. Church (Republican), Illinois—13th District, May 22, 1962, A3773	2,541	7,505	3,260
12. Cohelan (Democrat), California—7th District, June 23, 1962, A4773	10,659	5,338	1,003
13. Collier (Republican), Illinois—10th District, Mar. 29, 1961, A3846	2,700	5,310	990
14. Conte (Republican), Massachusetts—1st District, June 12, 1962, A4299	817	1,233	500
15. Corbett (Republican), Pennsylvania—29th District, Mar. 15, 1962, A1998	9,856	7,744	----
16. Derwinski (Republican), Illinois—4th District, May 14, 1962, p. 7643	7,920	21,780	3,300
17. Devine (Republican), Ohio—12th District, Mar. 29, 1962, A2482	1,352	4,454	511
18. Findley (Republican), Illinois—20th District, Mar. 28, 1962, p. 4929	3,395	5,607	----
19. Fisher (Democrat), Texas—21st District, Apr. 17, 1962, A2951	2,799	11,317	882
20. Frelinghuysen (Republican), New Jersey—5th District, May 24, 1961, A3701	4,240	3,120	640
21. Gathings (Democrat), Arkansas—1st District, May 8, 1961, A3163	480	960	60
22. Hall (Republican), Missouri—7th District, Apr. 16, 1962, A2905	2,148	8,688	1,164
23. Harvey (Republican), Indiana—10th District, May 3, 1962, A3286	456	1,387	72
24. Harvey (Republican), Michigan—8th District, June 18, 1962, A4533	1,407	2,823	1,471
25. Hiestand (Republican), California—21st District, May 10, 1962, A3476	5,400	10,800	1,800
26. Hosmer (Republican), California—18th District, June 26, 1961, A4766	4,240	3,280	480
27. Kastenmeier (Democrat), Wisconsin—2d District, Apr. 19, 1962, A3083	1,777	1,412	----
28. Langen (Republican), Minnesota—9th District, May 2, 1962, p. 6957	2,178	6,435	1,287
29. Latta (Republican), Ohio—5th District, June 20, 1961, A4569	1,470	5,530	----
30. MacGregor (Republican), Minnesota—3d District, Jan 10, 1962, A4	4,044	6,072	1,884
31. Martin (Republican), Nebraska—4th District, July 5, 1961, A5014	2,240	16,200	1,400
32. Mathias (Republican), Maryland—6th District, June 13, 1962, A4381	1,400	2,440	160
33. May (Republican), Washington—4th District, Feb. 26, 1962, A1382	7,204	10,903	1,362
34. Miller, Clem (Democrat), California—1st District, Oct. 10, 1962, A8099	8,330	7,140	1,530
35. Minshall (Republican), Ohio—23d District, Apr. 18, 1962, A3035	9,960	8,900	1,120
36. Monagan (Democrat), Connecticut—5th District, Apr. 17, 1962, A2948	957	504	334
37. Moorehead (Republican), Ohio—15th District, June 4, 1962, A4033	1,221	3,828	451
38. Ostertag (Republican), New York—39th District, Apr. 19, 1962, A3067	2,673	3,510	515
39. Pelly (Republican), Washington—1st District, Apr. 11, 1962, A2785	4,042	4,423	531
40. Pillion (Republican), New York—42d District, Apr. 18, 1962, A3001	2,774	3,389	----
41. Pirnie (Republican), New York—34th District, May 15, 1962, A3597	4,623	5,363	1,048
42. Proxmire (Democrat), Wisconsin—Senator, Sept. 18, 1961, p. 18, 755	1,202	798	----
43. Rogers (Democrat), Florida—6th District, May 17, 1961, A3482	26,612	21,774	----
44. Santangelo (Democrat), New York—18th District, May 4, 1961, A3130	3,700	1,300	----
45. Schueebeli (Republican), Pennsylvania—17th District, May 1, 1962, A3162	2,200	4,300	3,500
46. Shriver (Republican), Kansas—4th District, Aug. 1, 1961, A5898	884	1,870	145
47. Stratton (Democrat), New York—32d District, July 20, 1961, A5539	7,070	2,270	660
48. Toll (Democrat), Pennsylvania—6th District, June 22, 1962, A4731	2,250	672	78
49. Tollefsou (Republican), Washingtou—6th District, Apr. 24, 1961, A2748	7,488	3,861	351
50. Van Zandt (Republican), Pennsylvania—20th District, Jan. 23, 1962, A412	863	1,731	----
51. Widnall (Republican), New Jersey—7th District, Aug. 23, 1961, A6630	7,500	4,500	----
52. Wilson (Republican), California—30th District, Sept. 14, 1961, A7252	9,800	9,600	600
Total	241,383	334,399	39,502

Mr. BENNETT. Also, Madam President, I ask unanimous consent to insert the latest Gallup poll entitled "Medicare Support Drops," taken from the Chicago Sun-Times, July 1, 1962.

There being no objection, the poll was ordered to be printed in the RECORD, as follows:

KENNEDY MEDICARE SUPPORT DROPS

(By George Gallup, director, American Institute of Public Opinion)

PRINCETON, N.J.—In the heated fight over medical care for the aged, the last few months have seen a dropoff in public support for the administration's proposed social security financing of such health benefits.

Since March, an increased number of voters have swung over to the belief that such aid for the Nation's older citizens could be better handled privately—through Blue Cross or other forms of voluntary health insurance.

The latest Gallup poll indicates that supporters of the public approach still outnumber those who prefer private financing. But the Nation is much more evenly divided on the issue than it was 3 months ago.

To measure the net impact of the rival efforts made recently by administration forces and by groups like the American Medical Association, Gallup poll reporters repeated a question first asked in March:

"Two different plans are being discussed in Washington for meeting hospital costs for older persons:

"One plan would let each individual decide whether to join Blue Cross or buy some form of voluntary health insurance.

"The other plan would cover persons on social security and would be paid by increasing the social security tax deducted from pay checks.

"Which of these two plans would you prefer?"

In March of this year, a majority backed the social security approach as follows:

	Percent
Social security	55
Private insurance	34
Undecided	11

Today the vote divides as follows:

Social security	48
Private insurance	41
Undecided	11

Further analysis reveals the administration's proposed public financing plan has lost support among both Republicans and Democrats, as well as among independent voters.

Mr. BENNETT. I am not suggesting, Madam President, that the Senate should allow polls to weigh very heavily in its deliberations on any legislative proposal. I am citing those polls taken by Members of Congress and printed in the CONGRESSIONAL RECORD only to show that the bandwagon psychology of the administration has not worked. And the longer this widespread public discussion lasts, the more the administration position loses adherents. The reason for this is simple: The facts of the matter are beginning to shine through the artificially created fog of emotion generated by the administration and its allies from the hierarchy of labor.

REASON FOR BYPASSING COMMITTEES

Why, then, are we urged to rush the Anderson amendment into law? Be-

cause this variety of social security legislation is rapidly losing public support and has never attracted congressional support from those who have studied it. And why has this effort been made to circumvent the Senate Finance Committee to prejudge the findings of the House Ways and Means Committee, to usurp the right of the House of Representatives to initiate all tax legislation? Because the supporters of the administration position know that reason, based on facts, would inevitably prevail if the proper procedures for legislating were followed.

Mr. Maurice H. Stans, former Director of the Budget and a highly respected public official, wrote a very pertinent column on the health care for the aged controversy. It is worth reading at this point.

MAURICE STANS ARTICLE

Under the headline "Our Changing Economy—Emotionalism Fogs Medical Care Issue," Mr. Stans wrote in a syndicated column appearing in the Times-Mirror of Los Angeles in late January 1962, and I ask unanimous consent that it may be inserted at this point in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

OUR CHANGING ECONOMY—EMOTIONALISM FOGS MEDICAL CARE ISSUE

(By Maurice H. Stans)

President Kennedy has repeated his request to the Congress to write a new law putting medical care for the aged under social security. It is likely to be one of the hottest and least understood issues in the current session.

Ever since medical care for the aged became a political issue early in 1960, it has generated an atomic lot of heat and a minimum of reality. Even today many people wrongly seem to believe the issue is medical care or no medical care. This is the result of another case of undue emotionalism in Washington—a surge of sympathy misdirected toward an excess of government.

There are no facts or figures, of course, a to how many people there are over 65 who need and want medical or hospital care and don't get it. Whatever their number, no one in this enlightened country wants anyone to suffer from that lack. The problem has been, and is, how to find the most sensible way to see that they don't.

We do know some facts. There are nearly 17 million people over 65. A large proportion of them are not medically indigent. Those over 65 account for 9 percent of our total population, and, despite the retirement majority, they still receive 8 percent of all personal incomes.

More than half of those over 65 have coverage under some form of health insurance, and the number is increasing rapidly. Millions more are safeguarded by their own wealth, the resources of their families, and services of local welfare and church agencies. Other millions are assured of present or future benefits by their rights and privileges under veterans' benefit programs. The number without adequate health protection is proportionately small. It will grow even smaller as those now under 65 and holding an even greater degree of coverage of their medical needs move into the over-65 bracket with retirement protection.

KERR-MILLS BILL

Under these conditions, the White House and Secretary Flemming in 1960 developed a plan that would fill the medical gap, whatever it might turn out to be. Under it, the provision of medical and hospital services to all those in need of assistance would be left to local communities. The State would advance the cost, and Washington would pick up 50 to 80 percent of the bill, variable according to the wealth of the States.

Depending on the scope of the benefits covered and the estimates of numbers of beneficiaries, the Federal Government's share would be something over $200 million in the first year of the program and about $400 to $500 million in later years. And it was accepted that under a widespread program like this, these costs would include a fairly substantial amount which would not represent new protection but merely a transfer of responsibility from existing sources to the State and Federal Governments.

With some changes, the Flemming plan was enacted as the Kerr-Mills bill in the 1960 session of the Congress. It is now in operation in 26 States and a dozen others are moving toward it. Unfortunately, the continued agitation for a more expansive plan under social security has slowed up action in some States. But there is no evidence that the present program is inadequate.

NO TEST OF NEED APPLIED

The social security proposal is entirely different in a fundamental way. It applies no test of need and gives everyone over 65, regardless of wealth, income, or other means, the vested right to submit medical and hospital bills to Washington to be paid. The cost would be paid by another increase in social security taxes, already scheduled to rise to 9¼ percent by 1968, to be shared equally by working people of all ages and their employees. The total annual cost of this plan has been estimated to be from $1.5 to $2.5 billion at the start and rising in later years to $5 billion or more.

I have never been able to understand why the social security way would make sense, or why any workingman would support it. It would multiply the tax collections and payments for medical care eightfold, tenfold, only to provide added funds to give to those who didn't need them.

It would, in other words, set up a program that benefited 8 or 10 people for every 1 that needed help. To cite an extreme, it would cover payments to the Fords, Rockefellers, Morgans, Harrimans, and other wealthy individuals over 65. It would mean that working men and women would dig up taxes to cover such expenses for Maurice Stans when he reaches 65 and for millions of others who ought to meet their own bills. It would double the social security bureaucracy, which now has 32,000 employees and a vast forest of electronic machines.

THREE MILLION UNPROTECTED

Despite this, it would fail to protect 3 or 4 million people over 65 who are not eligible for social security. And the program, I feel sure, would not stop at age 65. Let's not deceive ourselves. Within a year or so after it were operative, the drive would begin to lower the age qualification, especially since the taxes would be paid by younger employees, and the pressure could continue until everyone was covered. And certainly the administrators of the funds would have to fix limits and standards on the kind of medical care and hospital services that would qualify.

By degrees we would move into a socialization of medical and hospital practices. I can understand why the medical profession does not want this, and, with the ever-increasing cost experience of Britain and other countries as evidence, we should beware of it here.

Putting medical care for the aged under a mandatory social security program would be the beginning of the largest single step we could take toward government paternalism and the centralized state. If we want to preserve our personal pride, our sense of character and responsibility, our freedom of choice and decentralized government, we ought to oppose this to the fullest. And no one will suffer, because the machinery already in law will take care of everyone who needs help at a lot less cost to the taxpayer.

Mr. BENNETT. I concur with Mr. Stans—the machinery is already in law to take care of everyone who needs help at a lot less cost to the taxpayer. I was privileged to vote, with a majority of the Senate, in favor of the Kerr-Mills law; and it was similarly my privilege to work side by side with the distinguished senior Senator from Oklahoma within the Finance Committee where the Kerr amendment was shaped and written.

Why should not the Kerr-Mills law be given a chance to work?

Let us put aside controversy for the moment and identify one general area of agreement.

Both sides of the aisle have recognized the need to help our older people finance the costs of their health care, and have moved to meet that need.

We may be at odds on method. We are not at odds on the need to act effectively and wisely.

We are not here to create campaign issues but to discuss workable solutions to a human problem. It is my conviction that such workable solutions have already been found through voluntary health insurance, assistance programs, the contributions of individual citizens, and the Kerr-Mills law itself.

To cast these aside without fair trial is to act rashly.

SUMMARY OF KERR-MILLS LAW

Let me summarize the main provisions of the Kerr-Mills law. It made three basic changes in the existing old-age assistance program, which is covered by title I of the Social Security Act. These changes were made in order to encourage the individual States to improve and extend medical services for the aged.

The effect of the Kerr-Mills law was threefold:

First. It increased Federal funds to the States in order to provide medical services for the 2,400,000 older persons covered under the old-age assistance program.

Second. It provided Federal grants-in-aid to States for payment of part or all of the medical services required by aged persons with low income.

Third. It instructed the Secretary of Health, Education, and Welfare to develop guides, or recommend standards, for the use of States in evaluating and improving their programs of medical services for the aged.

In its previous form, title I of the Social Security Act provided Federal funds to the States for medical services to those of the aged determined to be in need by the individual States. In turn, the States gave those needy older people cash to pay for the medical services they required, or made payments to those who supplied the medical care—that is, the physicians, the hospitals, and the nurses.

Such programs varied widely, State by State, under the old law.

The Kerr-Mills law changed this by increasing the extent of Federal participation, thus giving strong encourage-

ment to the States to extend comprehensive medical services covered under the old-age assistance program.

The Kerr-Mills law further provided Federal grants to the States for payment of all or part of the cost of medical services required by those older persons with low incomes.

Participation in this Federal-State program is optional with the States, and each State may determine the extent and character of its own program, including standards of eligibility and range of benefits.

While the Federal Government made funds available to the States for the medical care of those on old-age assistance, prior to passage of the Kerr-Mills law, it limited Federal participation to a stated statutory proportion of average assistance expenditures. The maximum allowed under the old law was $65 per person per month.

The Kerr-Mills law as amended made additional Federal funds available to the States of up to $15 per month in addition to the existing $65 maximum.

The Federal share of the program ranges from 50 to 80 percent, depending on the per capita income of the State, when the State's monthly average payment is over $65. When the State's average monthly payment is under that figure, the Federal share is set at 65 to 80 percent.

The effect of amending title 1 was to make it clear that the States could extend their existing programs to cover the medically needy. The States were not only given the incentive to establish such programs where they did not then exist, but to extend programs inadequate in coverage and increase the scope of benefits they were then providing.

Finally, the Kerr-Mills law provided that the State standard for determining the need for medical assistance could be broadened substantially under the terms of the law and need not be the same standard as that for determining need for assistance payments.

Here, then, was the structure for helping every aged person in need of help, whether on old-age assistance, on social security, or on neither. So long as a need for medical care existed, the State could move to meet that need within a flexible, adaptable plan.

KERR-MILLS PROVIDED INCENTIVES TO STATES

It goes without saying that the Kerr-Mills law offered great incentive to a number of States with an acute problem of needed medical care for the aged. Prior to its passage, those States with less than the national per capita income had experienced great difficulty in getting such programs underway. But under the new law, it became possible for a low-income State to inaugurate a medical care program for its older people on the financing basis of $1 of State money to $4 of Federal money.

The question arises, How successful has the Kerr-Mills law been thus far?

In less than 2 years, the Kerr-Mills law has made astonishing strides. To the best of my knowledge, it is being implemented as fast as, if not faster than, any previous Federal-State matching program ever devised.

The following have initiated medical care under old-age assistance since Kerr-Mills became law:

Alabama, Alaska, Arizona, Georgia, Kentucky, Mississippi, South Dakota, Texas, Guam, and Puerto Rico. Delaware is also initiating such care, but has not yet set an effective date for the program to begin.

Medical care programs that were already in existence have been expanded in Arkansas, California, Connecticut, Florida, Hawaii, Idaho, Indiana, Iowa, Louisiana, Maine, Maryland, Michigan, Missouri, Nevada, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, my own State of Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, the District of Columbia, and the Virgin Islands.

Programs have been adopted for the medically indigent under the medical assistance to the aged facet of the program and are now operating in Alabama, Arkansas, California, Connecticut, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, my own State of Utah, Washington, West Virginia, Guam, Puerto Rico, and the Virgin Islands. Vermont's medical assistance to the aged program is expected to be in operation this month. Georgia and Iowa enacted programs in 1961 but have not yet acquired the funds to put those programs in operation.

FORTY-SIX STATES PARTICIPATE

Summing up, 46 States, territories, possessions, and the District of Columbia have now taken advantage of one or both facets of the Kerr-Mills law. Arizona and Delaware, which have now initiated old-age assistance medical care programs, already had excellent assistance programs at the local level which included medical care, so they will build upon a solid base.

I submit, Madam President, that this is not the record of failure. Indeed, it is a record of solid accomplishment.

Essentially, the medical assistance to the aged program is similar to other public assistance programs, but there are several important differences. All public assistance programs have, as their main purpose, the provision of help to a specific group to the degree that such a group needs help. Programs of this sort are administered by the individual States, with Federal financial participation being based on per capita income; and eligibility standards and the amount of help to be given are left to the States themselves.

The major difference between medical assistance to the aged and other public assistance programs is that medical assistance to the aged was set up to provide Federal funds only for medical and ancillary services. The other differences are minor, but worth noting: the provisions prohibiting a set length of residence in the State for eligibility; the provision that residents temporarily absent from the State be taken care of; the requirement that all counties within the State implement the program; and the requirement that both institutional and noninstitutional care be included in the State plan.

Yet potentially, depending upon the degree to which the States use it, the Kerr-Mills medical assistance to the aged program provides a mechanism for financing whatever health services are needed for any person over 65 years of age who cannot pay for them himself.

PLAN IS FLEXIBLE

Most important, the plan is flexible enough to strike a balance between the individual's medical needs and his ability to pay for care—and still not waste tax moneys on the one hand, or destroy the individual's ability to support himself after his treatment has been completed on the other.

As of the moment, some States have set up programs providing a comprehensive range of health services and elastic standards of eligibility under which the cost of services required is weighed against individual income. Other States have comprehensive services but more rigid eligibility requirements. Several States provide relatively few types of services but have set their eligibility regulations more broadly. And there are some States, admittedly, in which eligibility requirements are set stringently and services are likewise limited.

Thus, despite the record of success compiled by Kerr-Mills during its brief period of operation, the program has still not reached its potential. That does not mean, Madam President, that this potential cannot, or will not be achieved—given a little more time, and a little more encouragement.

The latter, let me point out, has been notably lacking.

Let me go further: Concerted efforts have been made to sabotage the program's success.

SABOTAGE OF KERR-MILLS

Ever since Congress passed the Kerr-Mills law, it has been disparaged by the very people who seek to force social security medicine down our throats. They have called medical assistance to the aged a program to pauperize the aged when its purpose and effect have been to prevent pauperization; they have said medical assistance to the aged was unwieldy administratively, while pointing with pride to the bureaucratic nightmare that social security medicine would become; and they have referred to medical assistance to the aged as a pork barrel while rolling out the succession of barrels that would accompany passage of King-Anderson type legislation.

I ask the Senators to consider the degree of success Kerr-Mills would now enjoy if the Department of Health, Education, and Welfare had devoted as much time and energy to its support as the Department has devoted to downgrading the program and hawking the administration-backed substitute?

If I have heard the statement once, I have heard it a hundred times: "The States don't have enough money to match the Federal funds granted under Kerr-Mills."

From this, it must logically follow—or so these people suggest—that the Federal Government can provide the only

solution through use of the social security mechanism.

I shall discuss the Anderson amendment in detail a little later, Madam President. For now I would simply like to point out that this amendment does not cover either mental hospitals or tuberculosis hospitals, which constitute the greater part of any State's hospital expenditures and which are supported by tax dollars raised within the State. So much for the plight of the States as the proponents of this legislation seek to alleviate it.

The question arises of why the administration has applied the brakes instead of the accelerator in getting Kerr-Mills into high gear? The answer is plain: The more successful the Kerr-Mills law, the more chances diminish of passing a King-Anderson bill in an atmosphere charged with ersatz panic and bogus emotionalism.

In addition to the campaign against Kerr-Mills, we have also been subjected to a barrage of propaganda to the effect that medical assistance for the aged would be outmoded by passage of some old age and survivors disability insurance oriented program like the Anderson amendment. And make no mistake about it, the propagandists warned, passage was inevitable—just a matter of time.

Is it any wonder that many States were reluctant to devote State funds to a program which seemed doomed to be superseded? Can the States be blamed for listening to Federal officials who presumably knew what they were talking about?

STATES PROCEED DELIBERATELY

Of course some of the States dragged their feet.

While I do not have the specific information, I understand that authorities in the State of Vermont adopted the Kerr-Mills program and turned the administration of the program over to a State official, saying to him, "From now until the time the legislature again meets, you are personally and solely responsible. You can decide what the benefits will be. You can decide what the qualifications can be. You are free to change your program from day to day or from week to week." That procedure was adopted on the theory that by so doing, when the legislature did meet again, they would have had sufficient experience to write a successful bill.

Other States moved cautiously out of laudable fiscal restraint. Still others regulated their pace to the speed with which information could be gathered on a number of unknown quantities. How many of the aged needed help? What sort of help did they need? It is no wonder that State legislatures, especially those inexperienced in the area of statewide vendor payment medical care programs, proceeded deliberately.

And yet, despite all of these factors, the Kerr-Mills law has moved ahead faster than did the medical vendor plan during a comparable period following its enactment in 1950.

I submit, Madam President, that in view of the pressures against the rapid implementation of the Kerr-Mills law, its success has not only been astonishing but demonstrative of the program's strength.

To those who attack the law because of its alleged administrative shortcomings, I would reply that it is impossible to attack the administrative mechanism at the Federal level without also damning all other Federal grant-in-aid programs. To attack the administrative mechanism at the State level—which was done, by the way, long before many of the States had even decided on what administrative plan they would adopt—is equally ridiculous. This program is no more difficult to administer than any other statewide aid program. I will go further: With all of the flexibility allowed the States under this law, administration should be simpler than that of other public assistance programs.

Can the States afford to implement Kerr-Mills? No, say the proponents of the Anderson amendment. But the States can afford social security medicine. To this spurious argument I can only reply with the old-fashioned observation that all the money spent by the Federal and State governments comes from the same place—the pocket of that harassed, put-upon, ofttimes forgotten man, the taxpayer.

PAUPER'S OATH ARGUMENT NOT VALID

I should like to comment on what may be the most nonsensical argument used against the Kerr-Mills law and in support of the social security approach. It is the argument against the means test—the "pauper's oath," as it is sometimes called. The "pauper's oath"—always surrounded by quotation marks, whether spoken or written—is "degrading" and carries a "stigma."

These are words of high semantic intensity, chosen carefully to obscure meaning and cause the adrenalin to flow. No one wants to be pauperized, degraded, or stigmatized, Madam President. Therefore, everyone should be in favor of using old-age and survivors disability insurance as a financial mechanism and consigning the Kerr-Mills law to the nethermost regions, along with child labor and the 60-hour week.

I should like to make it clear to the Senators that I am four-square against degradation, unalterably opposed to the pauper's oath, entirely against the imposition of stigma, and perfectly in favor of the means test.

I see no contradiction in that statement.

The means test came into being as a method whereby the people's taxes could be conserved for use where they were most needed. If, in the process of discharging this fiscal responsibility, some few of the States may have set up means tests which affront the individual's pride, there is nothing in the Kerr-Mills law to prevent those States from revising their procedures for determining eligibility for assistance.

It is not the means test itself which is degrading; it is the manner in which the means test is sometimes applied. We are, after all, dispensing tax-supported aid. We must do so based on a knowledge of the applicant's resources and need—or turn every assistance program into a bonfire fed by tax dollars.

Old-age assistance requires a means test for the needy aged who need money to buy food, clothing, and shelter, and who must have medical care provided for them.

Aid to dependent children, aid to the blind, aid to the permanently and totally disabled—all require means tests.

The Public Housing Administration provides low-rent housing for persons of low income, which involves a means test. Similarly, the Secretary of Agriculture must invoke a means test in determining what farmers can obtain financial assistance in building, improving or repairing their farm dwellings and outbuildings.

The school lunch program involves a means test. Veterans' pensions are based on the veteran's annual income—a means test again. Veterans' widows and children receive compensation on the basis of need—a means test.

There has been no outcry that I have ever heard about the means test required for non-service-connected care in Veterans' Administration hospitals.

And is not a means test involved in reducing or withholding payments under old-age and survivors disability insurance to beneficiaries who earn more than a specified amount each year.

For that matter, does not the King-Anderson bill provide a means test by automatically labeling every person over 65 as a medical indigent?

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

OTHER EXAMPLES AVAILABLE

Mr. BENNETT. Mr. President, I could go on indefinitely with other examples—like the programs to provide astance to old, disabled, or indigent Indians; like our surplus food programs; like our maternal and child health services; like our programs for crippled children; like our National Defense Education Act loan program, under which student loans are granted on the basis of need.

I believe, however, that I have made my point: in government or in private life, we help those who need our help—and neither give nor force our tax or philanthropic dollars on those who are not in need of them.

There is another reason why I favor the Kerr-Mills law and find it sound.

The funds for this program are derived from general revenue, to which the entire taxpaying population contrlbutes according to its ability to pay. Contrast this with the payroll tax called for under the Anderson amendment and similar proposals. Under such a social security taxing mechanism, according to the Department of Health, Education, and Welfare, some 40 percent of the national income would make no contribution to the fund.

In other words, the burden would fall heaviest upon those taxpayers earning $5,200 or less a year; and a man earning $5,200 a year would pay the same tax as a man earning $52,000 a year. To compound that inequity, the health services provided in the amendment would be furnished to the elderly with no consideration given to their ability to pay for them. Millions of older people can pay the costs of their health care and are doing so now in a wide variety of ways. Why, then, should younger workers assume this unneeded burden? Why should young families, during the period of maximum expense when there are mortgages to meet, children to clothe and feed, insurance to keep up, college educations to be financed, savings to be

accumulated, assume the expense of health care for millions of older people who do not want it and have not asked for it?

THE PRESENT SOCIAL SECURITY DILEMMA

Mr. President, the social security program already faces some very serious problems, resulting from the built-in imbalance in the system. U.S. News & World Report for July 2, 1962, had an excellent article pointing out some of the inequities of the present system and some of the fiscal problems facing the social security system.

As pointed out in this article, the social security commitment for today's workers is $624 billion. The fund now has only $22 billion. Taxes paid in by present workers and their employers will total an estimated $282 billion. This leaves a gap of $320 billion which must come from somewhere; and the only place it can come from is the social security taxes paid by the children and granchildren of present-day workers.

In other words, social security is a real bargain for those who are receiving benefits today; but in a few years every worker will be paying in much more than he can expect to get out, in order to pay for the benefits being paid out today.

If that is not the case, we will go on stretching the burden further and further into future generations. This situation is a result of the unwillingness of Congress to keep the social security program fiscally sound. Congress has been too willing to buy votes by making changes in social security benefits which just were not financially feasible.

We must not compound the mistakes of the past by making similar mistakes today. Those who say that participation in the social security medical care program will establish a right based upon the money the participant has paid in are misleading the public. The benefits will bear no more relationship to participation than is the case with the present system, and we will be saddling our future generations with a terrible burden, one which may threaten the destruction of the social security system itself.

It is unthinkable that Congress would approve so unsound a program when a far more equitable system—the Kerr-Mills law—already is in existence.

Mr. President, because the U.S. News & World Report article is so significant, I ask unanimous consent that it be printed at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. BENNETT. Mr. President, we in Utah have had MAA since our State legislature passed the public assistance act of 1961. Our State department of public welfare initiated the program nearly a year ago to the day—on July 1, 1961.

The legislation passed in Utah allowed the department of public welfare to exercise its discretion in establishing rules and regulations pertaining to eligibility and the expenditure of funds in accordance with the Federal program.

Rather than to leap blindly into a new plan with which we had no previous experience, we in Utah launched our MAA program on a relatively modest basis. Benefits were limited to physicians' and hospital services, and eligibility was restricted to State residents over 65 with limited resources.

How limited could those resources be?

We set the net value of liquid assets at $1,000 or less for a single applicant, or $2,000 for a couple or family. We set the net value of other personal or real property at $10,000 or less, not including a home owned and occupied, or a necessary automobile. We set the amount of net income at $110 a month for single applicants and $170 a month for married couples.

It was further provided that the recipient would have to pay the first $20 per quarter or 90-day benefit period for any physician's services, and the first $50 for inpatient hospital admission. The department then undertook to pay all amounts in excess of these deductible factors.

In other words, Utah designed its program to take care of major medical or catastrophic medical expenses.

Now all of this sounds like a very modest start. But as experience was developed with the program, we broadened our benefits.

By December 1, 1961, the public welfare commission had authorized the payment of nursing home care under MAA, and the payment of drug bills up to $15 a month for individuals in nursing homes.

By April 1, 1962, we had eliminated the $20 deductible for physicians' services.

And as time went on, we also discovered that our administrative costs were running far less than anticipated. MAA is now 1 year old in Utah.

Let me now read to the Senate, with considerable pride, this recent report of further progress. It appeared in the Deseret News of June 1.

STATE PLANS TO TRIPLE AID TO AGED—MEDICAL PROGRAM TO EASE ELIGIBILITY, BOOST OUTLAY

(By Clarence Barker)

The joint State-Federal program of providing medical assistance to the aged (MAA) in Utah will be accelerated by approximately three times its present cost, beginning July 1.

Ward C. Holbrook, State welfare commission chairman, announced Friday that the payments, after that date, will be liberalized and eligibility requirements will be lowered.

The MAA program is intended primarily to aid persons over 65 years of age who are unable to qualify for old-age assistance (OAA) because of their incomes, but who are still unable to pay for adequate medical service.

AMA ENDORSEMENT

The program is endorsed by the American Medical Association and other groups.

Utah is one of 27 States which enacted legislation to implement the Federal program.

"Although the Utah program has been in operation since last July, relatively few of our estimated 65,000 persons over 65 have taken advantage of it," Mr. Holbrook said.

During the 10 months, which ended April 30, only $400,000 in State and Federal funds had been spent on the program.

The liberalized program to begin July 1 will increase costs approximately three times.

TRANSFERRED TO MAA

In recent months, needy aged persons in nursing homes, which are qualified to give medical services, have been transferred from old-age assistance to MAA, thus relieving a stringency in OAA.

Changes in the program will be as follows:

Persons over 65 with monthly incomes of less than $125 per person or $200 per couple may qualify. The previous ceilings were $110 and $170 respectively.

Deductible factors requiring those receiving help to pay the first $20 of doctors' fees and the first $50 of hospital costs will be eliminated. This means that persons qualifying will not have to pay any portion of the costs of doctors' services or hospitalization.

OTHER FUNDS

The welfare department will pay for needed drugs up to a maximum of $15 a month and for dental care and eye care, including purchase of glasses and dentures.

Mr. Holbrook said the 1961 legislature appropriated $1.25 million for MAA which made available $2.3 million Federal matching money, for a total of $3.55 million State and Federal money.

The program as now planned will cost $2.4 million for the 2-year period, ending June 30, 1963.

In other words, Mr. President, there is still opportunity for further liberalization.

I have only one further comment to make on the Utah experience, Mr. President.

MANY STATES MAKE HASTE SLOWLY

It indicates to me that many States are, like Utah, making haste slowly. If our experience is significant, and I suspect it is, the financial need and ill health of the aged have been violently exaggerated. Of the estimated 65,000 persons eligible for help under Utah's MAA program, relatively few have taken advantage of that help. It is my conviction that there can be only one major reason for this: Most of those 65,000 people are self-sustaining until serious illness strikes. When that happens, Utah stands ready to help. But for the great majority of our older people, the need for help arises less often than the Nation has been led to believe by those who support social security health care.

One of the main reasons for this is the increasing ability of private health insurance to cushion the financial shock of illness.

It is a longstanding principle, Mr. President, that government should act only when private resources and initiative have failed to meet a public need. It is therefore germane, at this point, to inquire how well private resources are doing.

The answer is reassuring. As of the middle of last year, 53 percent of all persons 65 and over were protected by some form of voluntary health insurance. I realize that some will immediately respond to this figure by pointing out that 47 percent are therefore without insurance protection—for, while the optimist will say the bottle is half full, the pessimist will say the bottle is half empty.

But the fact that 53 percent of the aged have health insurance has more meaning than this figure alone would suggest. We must think of that figure

in terms of the growth it represents. The truth is that the amount of health insurance owned by the aged is growing at a faster rate than the rate at which the insurance owned by the population as a whole is growing. This can readily be appreciated when it is remembered that only 26 percent of persons 65 or over had health insurance of any kind in March of 1952. By contrast, 59 percent of persons of all ages were covered as of 1952, while 74 percent, or more than 135 million people, were covered as of the end of 1961.

This means, then, that while coverage for the number of persons of all ages rose 15 percent from 1952 to 1961, coverage for our aged citizens showed an amazing jump of more than 50 percent. And while the percentage figure has doubled, the number of persons covered has tripled—from 3 to 9 millions.

Furthermore, some 25 to 30 percent of the aged are not in the market for health insurance because their health care is provided through old-age assistance programs that predate the Kerr-Mills bill. We can therefore conclude—with considerable safety—that 70 percent of the aged who want voluntary and Government health insurance now have it.

PERCENTAGE WITH INSURANCE INCREASING

We can also conclude that this percentage will increase in the years ahead. The Health Insurance Institute of America estimates that by the end of 1965, 80 percent of the aged needing and wanting protection will be insured. The figure is expected to climb up to 90 percent by 1970.

Why, then, is it sensible to adopt such permanent methods as the Anderson amendment to a problem which is temporary in nature? Again, I must reply that the unseemly haste with which we are urged to pass such legislation—lest it become an issue in the fall election, to quote the distinguished junior Senator from New Mexico—is because if this measure is not passed soon, any justification for its consideration will evaporate before its proponents' eyes.

The extent of the growth of voluntary insurance and its availability to the aged at a reasonable cost are borne out by a recent publication of the Health Insurance Institute, entitled "Guaranteed Lifetime Health Insurance: For Persons Over 65; For Persons Under 65."

This report shows that more than 80 insurance companies are now providing a total of 157 health insurance plans and policies for persons in or near retirement.

RECENT DEVELOPMENTS

Furthermore, Mr. President, some of the recent developments in the health insurance field are well worth noting:

First. There are now mass enrollment programs under which guaranteed renewable coverage is offered to anyone 65 or over, regardless of his present or past condition of health. Almost a million aged persons have enrolled in these programs within the past 3 years.

Second. Many companies are now offering guaranteed renewable policies to those over age 65, with benefits as high as $10,000 and coverage for in and out of hospital expenses—including the costs of physicians, drugs, and private-duty nurses.

Third. Those now retired are eligible to enroll in group plans. An example of this is the group plan issued to the American Association of Retired Persons.

Fourth. The Connecticut age 65 plan breaks new ground. It is issued by a group of insurance companies under special State legislation actively supported by the companies involved. Two coverages are available, the higher providing $10,000 maximum major medical benefits. Enrollment is open to all, regardless of past or present health status. It is significant that other States have passed, or are now considering, bills of a similar nature.

Fifth. Increasingly, group health insurance plans are being written or broadened to continue coverage after retirement. Often the employer pays part or all of the cost of the retiree's benefits under these group programs.

Sixth. A nationwide Blue Shield program of surgical and medical care benefits has been developed for all persons over age 65, at an estimated cost of about $3 a month a person.

The important thing is that voluntary health insurance is contributing solutions to the problem of cushioning our aged population against the financial shocks of health care. The health insurance industry is a dynamic, creative partner of the Federal and State Governments; and it is developing the answers within the free-enterprise system.

A byproduct of the great strides being made by the insurance industry is, perhaps, even more important in terms of the future. I am speaking, Mr. President, of the ever-increasing number of Ameircans who will own adequate health policies when they move into the retirement years.

HEALTH INSURANCE PROGRESS

To give the Senate an idea of how vast the Nation's progress in the health insurance field is, I ask unanimous consent to have printed in the RECORD at this point an article from the Health Insurance News of June 1962.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

MORE THAN 135 MILLION PERSONS HAVE HEALTH INSURANCE; BENEFIT PAYMENTS TOPPED $6.3 BILLION IN 1961

More than 135 million Americans—74 percent of the civilian population—had some form of health insurance at the end of 1961, the Health Insurance Council said today in reporting on its 16th annual survey of the extent of voluntary health insurance coverage in the United States. The survey is based on reports from insurance companies, Blue Cross-Blue Shield, and other health care plans.

The council said both the number of persons covered, and the amount of benefits paid by health insurance reached new highs last year. Coverage increased 3.1 million during 1961 to reach a total of 135,042,000.

Benefit payments by all health insuring organizations to help cover the cost of hospital, surgical and medical care amounted in 1961 to more than $5.4 billion, up $600 million over 1960, said the council. In addition, persons with loss-of-income policies received $855 million in benefits from insurance companies to replace income lost through disability.

Thus, a grand total of $6,329 million in health insurance benefits were distributed during 1961, up 11.3 percent over 1960, said the council.

The HIC, a federation of eight insurance associations, said that based on early trends for 1962 it estimated that as of June 1, 1962, some 136 million persons had hospital expense insurance, 126 million had surgical expense insurance, 94 million had regular medical expense insurance, 36 million had major medical expense insurance, and 43.5 million were insured against loss of income, or had some other formal sick leave pay arrangement.

The council said these figures also revealed the breadth of health insurance protection which Americans have. The organization said that as of June 1, 93 percent of persons with health insurance had both hospital and surgical expense insurance, and 69 percent had hospital, surgical and regular medical expense insurance, the last of which helps pay for doctor visits for nonsurgical care. Five years ago, the figures were, respectively, 88 and 58 percent, said the council.

COVERAGE DETAILS

A breakdown of the number of persons with health insurance at the end of 1961, by type of coverage and type of insuring organization, is as follows:

Hospital expense insurance was provided by insurance companies to 81,369,000 persons; by Blue Cross-Blue Shield and similar groups to 58,797,000, and by other health care plans to 5,675,000. After deducting persons protected by more than one type of insuring organization, the council reported that 135,042,000 persons had hospital insurance, a 2.3 percent increase over the 131,962,000 persons so covered at the end of 1960.

Surgical expense insurance by insurance companies covered 78,861,000 persons; by Blue Cross-Blue Shield and similar groups 50,120,000, and by others 6,803,000. Allowing for duplication, 125,297,000 persons had surgical insurance, a 3.5 percent boost over the 121,045,000 persons of 1960.

Regular medical expense insurance accounted for 46,190,000 persons through Blue Cross-Blue Shield and similar groups; 44,399,000 through insurance company programs, and 7,007,000 through other plans for a total, eliminating duplications, of 92,633,000 persons, a 5.8-percent climb over the 87,541,000 persons in 1960.

Major medical expense insurance coverage through insurance company programs increased 24.4 percent, from 27,448,000 to 34,138,000 persons. Major medical insurance is designed to help absorb the cost of serious illnesses, and pays benefits up to $10,000, $15,000, or more for all areas of care prescribed by a physician.

Loss of income found 32,055,000 persons covered by insurance company policies. The number of persons who work where there are formal sick leave arrangements brought the total figure to 43,055,000 persons, said the council.

Mr. BENNETT. So much for health insurance, a vital part of the answer to the problem of how our aged population can, does, and will meet its health care costs.

Let us not forget, in our feverish haste to pass radical, enduring, expansive legislation before the fall elections, that a number of well-established welfare programs, both public and private, exist throughout the United States. It would be totally unrealistic to ignore these programs designed to help the aged, and others in need, to obtain health and medical care.

I shall not go into detail on these programs, with which most Senators are no doubt familiar. Perhaps it is enough to say that they constitute a basic resource for the needy aged, and that the individual taxpayer is already contributing to them at the community and State level.

At this point I should like to interpolate that we must remember there are innumerable local institutional programs operated by churches, fraternal organizations, and others, that make their contribution to the solution of this problem.

I ask Senators to consider, however, whether a Federal medical care program of the sort we must now consider would not cut across and conflict with these existing programs, leading to waste, inefficiency, and confusion, and perhaps the abandonment of many programs which are now working satisfactorily and successfully.

Communities have always been responsible for their members. These local and State programs are the natural outcome of that assumption of responsibility, and recognize an individual's right to call upon his neighbors in time of need for the help he requires.

What will happen to these locally administered, flexible plans under a Federal program of the sort proposed by this administration? Can they be replaced by a master blueprint of health services, drafted in Washington and run from Washington, for the aged throughout the entire Nation?

Here again is a virtue of our present law. Under Kerr-Mills, Federal assistance to the States in meeting the problem is a valuable supplement to existing aid programs—not a means of short-circuiting them and blowing out the fuses.

OUR PRESENT MEDICAL CARE SYSTEM

At this stage, Mr. President, let us pause for a moment to consider the Nation's present system of health and medical care, for it is surely the world's most unique.

It is unique because it operates in almost total freedom of Government controls.

This is not to say that government at all levels, from the local to the Federal, does not perform many essential functions. Government does, and has, for many years. But the Nation's complex of governmental medical programs reinforces rather than replaces our free system. It has been so designed. Not yet have we produced governmental straitjackets to constrain the practice of medicine. By way of contrast, government exercises varying degrees of stringent control over the provision and financing of health care in most every other nation of the world. Further, these controls are not restricted to programs which care for the indigent, but cover entire populations regardless of their need.

Yet, we in the United States remain an exception.

There are two schools of thought about this phenomenon.

One concludes that the absence of governmental controls in medical care is proof in itself that our Nation lags behind the others.

A second school of thought argues that we in the United States are wise to stay away from any sort of governmental programs developed abroad.

I am a stanch believer in this second school of thought. I feel that the tangible results of our unique free system speak for themselves.

In the United States, our health professions never cease their constant search for better methods of treatment, for more effective and powerful drugs, for more efficient techniques to use in the treatment of illness.

WORLD'S BEST MEDICAL SCHOOLS

I point, Mr. President, to our medical schools, which are recognized the world over as the best in existence. No longer do we send our young men and women abroad to study medicine. We teach them here, in what are recognized by authorities as the greatest medical schools extant. This is borne out by the increasing number of medical students from abroad who journey thousands of miles to study in the United States.

Who matches us in research? Who matches us in the development of new operating techniques? Who matches our health plants?

Clearly, we stand alone and unrivaled in the field of medical care.

Yet this is not good enough for some Americans. At the very moment when American medicine is acknowledged to be the world's best, these myopic people suggest that we try out the very systems under which one foreign nation after another slipped from a position of medical leadership.

THE BRITISH EXPERIENCE

It seems very much to the point, Mr. President, that we observe the lessons learned abroad and apply them to our lawmaking at home. Forget the relative merits or demerits of socialism for the moment, and let us view the British experience pragmatically; for it is recent, and, it seems to me, pertinent.

The British Labour Party has published a booklet entitled, "Members One of Another," which is subtitled "Labour's Policy for Health." On page 2 of that booklet, the following words appear:

> But in 8 years of Conservative rule, performance has not matched early promise.
>
> Nearly half a million people are waiting for hospital beds.
>
> Too many doctors' surgeries are still grim and gloomy.
>
> Too many hospitals are still out-of-date and make-shift.
>
> The mental hospitals are overcrowded and dilapidated, and, despite gallant efforts of those in charge, are quite unsuitable for modern psychiatric care.
>
> The committees and staff of the service have been frustrated by endless administrative delays, and inevitably enthusiasm has been dimmed.

I ask my colleagues to look around in their own communities and in the Nation's Capital to see if this description of hospital and medical services applies in the United States as it does in Great Britain. At this point I cannot resist the temptation to refer to a family experience. About 7 years ago my son was in Scotland and discovered that it was necessary to have an abdominal operation. He went to the British Medical Service, as he was required to do, and was told that, since he was not about to die, they could not get him into the hospital for that operation for at least 6 months. By that time no one knows what would have happened. I am afraid his American father telephoned him and said, "Find a doctor in a private practice who will operate on you as soon as possible, because obviously that is what you need."

I do not know how many people are in the same situation now that he was in at that time—forced to wait 6 months for an operation which in this country would be considered serious enough for immediate action.

I ask Senators to remember that this is the Labour Party itself speaking about its own, dearly beloved creation, the National Health Service.

It seems that all is not well with socialized medicine if this dreary little vignette is accurate—and who would know better than the British Labour Party?

Let me refer the Senate now to another British spokesman, D. S. Lees, Ph. D., senior lecturer in economics at the University College of North Staffordshire, and an expert on the British social services. Speaking before the Institute of Economic Affairs in London last October, Professor Lees had a number of pertinent observations to make on the British National Health Service.

The good doctor's comments are too long for me to read at this point, and I ask unanimous consent that they may be inserted in the RECORD.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

HEALTH THROUGH CHOICE

In Britain, as in other Western societies, individual freedom of choice is a prime social value. High priority is given to the right of individuals to spend (and save) their own incomes in their own way. This philosophy of freedom requires that governments should provide, through the compulsory payment of taxes, only those goods and services that cannot be provided through voluntary exchange in the market. The classic examples are defense and justice. Further, it is generally accepted that competitive markets result in a more efficient solution than collective provision by government: consumer preferences are more closely satisfied and the cost is lower. Governments have a continuing role to play in keeping markets free from restriction. If they do this, freedom and efficiency can go hand in hand.

The British National Health Service is in conflict with both principles. Under it, medical care is provided by the Government, virtually free of direct charge, with taxes meeting over 90 percent of the cost. The private medical sector is too small to generate effective competition nor, as for most other commodities, is there competition from substitutes or from international trade. The NHS is thus a monopoly of a unique kind, operating without a market and without competition. This is a measure of the revolutionary change that took place in 1948. The sensitive link between consumer demand and the supply of medical care was broken. Competition was eliminated. Dispersion of power was transformed into extreme cen-

tralization. The self-adjusting forces of the market were replaced by the single, overriding decision of the Minister of Health.

The NHS is also a monopoly buyer of the services of doctors and dentists, few of whom can earn adequate incomes in private practice. Before 1948, the bulk of medical incomes were determined by supply and demand in the market; since 1948, they have been determined by Ministerial decree. Incomes are settled by periodic bargaining between the Minister and the professional associations and here the Minister has an enormous advantage because the vast majority of doctors and dentists must sell their services to the NHS, or not at all, and this, coupled with the refusal of the medical professions to use strike action, gives the Minister dictatorial power.

The same kind of power extends to the manufacturers of prescription drugs, all of whose domestic sales go to the NHS. Here again, the Minister holds most of the cards.

This circle of governmental control is closed by the medical schools. These are attached to universities and are outside the NHS but the fact that universities rely for three-quarters of their income on public funds gives the Government close control over the intake of medical students and thus over the future supply of doctors and dentists.

Thus under the National Health Service, it is the Government and the Government alone which decides how much medical care there shall be; which fixes the incomes of the medical profession; which sets the prices and profits of drug firms, and which determines the future supply of medical skills.

We are surely right on general grounds to suspect this extraordinary concentration of power. All would be well if governments always made the right decisions. If that were so, the collectivist viewpoint would be irresistible. But there is no such assurance and the mistakes of government are larger and more important in their consequences than those of private groups. In the British medical system, there is no dispersion of decisionmaking power to prevent small mistakes becoming large catastrophies. The equilibrating forces of the market are missing. Nor is there competition to provide built-in guarantees against inefficiency or to stimulate sources of innovation and/or improvement. And while the consumer of medical care has a wide freedom of choice among the supplies allowed by the Government, consumers as a whole are not free to choose to have a larger total supply in the future, should they so desire.

It is a remarkable fact that the National Health Service had entered its second decade before it was subjected to an analysis in the light of these basic principles. Until then, it was assumed and frequently asserted, that the British system was the finest in the world and thought uncritically that the National Health Service was the only sensible way to arrange health affairs. One reason for this was a misconception of the state of British medical services in 1939—a misconception which the study by Profession and Mrs. Jewkes, "The Genesis of the British National Health Service," has gone far to redress.

Another reason was the paternalistic assertion that, if people were left to their own devices, they would not purchase as much medical care as they ought to do, i.e.; more medical care would be provided by the State than through the free market. The facts have turned out differently. In the United States and Switzerland, where people have free choice, a larger proportion of income is spent on medical care than in Britain and, further, expenditure has increased more rapidly in those countries over the past 10 years. So, far from the NHS pushing health expenditure up, it has held it down.

Thirdly, there was the notion that, if medical care was bought like other commodities, "the rich" would have an unfair advantage. Here again the evidence (supplied this time by Socialist writers) does not bear this out; it has been found that the middle-classes and not "the poor" gained most from the introduction of the NHS. But even if the notion were correct, it does not justify nationalizing health services and supplying them free. The problem is one of the distribution of income and this can be dealt with by means of taxes and subsidies without any governmental intervention in the medical market. This is by far the most effective line of policy: there would be general agreement that nationalization was irrelevant to the problem.

Allied to this was the demand for the abolition of the "financial barrier" between the patient and medical services so that every individual could have ready access to care irrespective of means. The most seductive appeal of the NHS is that its services are free. In a fundamental sense, they are not free; they are paid for by the alternative use of resources foregone: doctors rather than teachers, hospitals rather than schools, medical equipment rather than motor cars. It is another of the dangers of the NHS that it creates the illusion of getting something for nothing. But, that notwithstanding, the NHS does remove the financial anxiety from the users of medical services.

However, to argue for the collective provision of medical care of these grounds is to commit two elementary errors. In the first place, most financial anxiety could be removed in a free medical market by a combination of private insurance and public grants for those in need.

Secondly, the NHS achieves free health services only at the cost of abolishing the market in medical care and substituting centralized control for it. It is easy enough to eliminate prices; it is far more difficult to ensure an increasing supply of improving medical services, and these are more likely to be achieved by discriminating consumers in a free market than by harassed politicians in Government.

The anxiety in Britain today is not financial—it is about the availability and quality of care. Despite the claim in 1948 that only the vast resources of the State could put the war-scarred hospital system on its feet, only one new hospital has been built and stringent restrictions on capital resources have left the British hospital system the most dilapidated in the Western world. Doctors are now no better off (and some are worse off) than in 1939 and this depression of medical incomes in the context of growing prosperity is causing an increasing number of doctors to emigrate, mainly to the United States and Canada. Governmental refusal to expand the medical schools means that the output of doctors is now little higher than prewar, despite increased population and rising demand for service. An acute shortage of doctors is emerging and this will be intensified by early retirements in the next few years. Over half the junior posts in hospitals are now filled by doctors from Commonwealth countries (mainly India and Pakistan) finishing their training: without them, the hospital system would break down. There is a growing shortage of nurses and midwives. Beds are unused through lack of staff and hospital waiting lists are lengthening rapidly. Casualty departments are in a parlous state.

All this is clear from official reports and statistics. No one is in any doubt that the NHS is in a state of gathering crisis. The disagreement arises over the diagnosis. Many still hold that the NHS is "the finest in the world" and that the troubles now besetting it are incidental and can be corrected by enough will and resource on the part of government. I disagree profoundly with this view. My verdict would be that the crisis stems from the fundamental structure of the NHS itself and that wise policy would dismantle that structure and rebuild a free medical market in its place.

Mr. BENNETT. Mr. President, the closing words of Dr. Lees' statement are particularly sad. Wise policy, he says, would dismantle the present structure and rebuild a free medical market in Great Britain in its place. I fear it is too late, however, and that the damage has been done.

The furry young tiger cub brought home as a household pet has grown into a hungry, 600-pound, full-grown tiger; and he is no longer easy to deal with.

MIGRATION OF BRITISH DOCTORS

Meanwhile, British physicians are leaving by the hundreds to practice abroad—anywhere abroad where the heavy, deadening hand of government weighs less heavily on their shoulders.

With characteristic British understatement, Dr. John Seale, a consultant in medical economics and health services, writes in the British Medical Journal:

The data indicate a mass migration of young British doctors in the last 15 years away from their native land on a scale hitherto unknown. A possible explanation of the phenomenon is that practice in the National Health Service is relatively unattractive to young doctors economically, professionally, and idealistically. The great influx of doctors from India, Pakistan, and other countries to take junior hospital appointments in the National Health Service does not mean that the service has permanent attractions for them. Most come to Britain to enhance their professional standing and then return to their own country—few intend to remain in Britain permanently.

At this point, Mr. President, I can anticipate what many of my distinguished colleagues might say. "What has this got to do with the Anderson amendment?" they might ask. "We are not talking about socializing medicine in the United States. We are simply discussing a modest plan for financing the health care of the aged under social security."

I feel sure my colleagues are in good faith when they say this. Yet, I have seen a number of remarks quoted in various publications which make me uneasy. I read in "New America," the official publication of the Socialist Party-Social Democratic Federation, a statement by R. W. Tucker, chairman of the Socialist Party's committee on medical economics. He was talking about the Forand bill, which was the forerunner of the Anderson amendments. He said:

Once the Forand bill is passed, this Nation will be provided with a mechanism for socialized medicine, capable of indefinite expansion in every direction until it includes the entire population. And it is already evident that there will be massive pressures in favor of such expansion.

Mr. Tucker must be presumed, as a Socialist, to have expert knowledge of what a mechanism for socialized medicine really is.

FOOT-IN-THE-DOOR GOAL

I remember that former Representative Aime Forand said of his bill:

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

I remember that Walter Reuther, president of the United Automobile Workers, said during hearings before the House Ways and Means Committee:

It is no secret that the UAW is officially on record on backing a program of national health insurance. But even if we were against national health insurance, we would favor passage of the Forand bill.

He went on:

A strong case could be made that this bill should go much further into the range of care provided and the duration of its benefits.

I remember that Ted Silvey, an AFL–CIO lobbyist said, "We will come back for more and more—and more," when asked what his organization would do if the Forand bill were passed.

The Forand bill was not passed, of course. But it was succeeded by a milder version, the King-Anderson bill, and the proponents of the one are still the proponents of the other. We must now consider a variation on the same theme—the Anderson proposal. An innocuous sort of measure, on the face of it.

Or is it? Can this be a younger, more harmless looking tiger cub?

Something over a year ago my friend, the Senator from the great State of Nebraska [Mr. CURTIS] was questioning Wilbur Cohen, the Assistant Secretary of HEW. He asked this question—and I quote from the record of the hearings of the Committee on Finance:

If compulsory health insurance was extended to everybody, the total payroll tax would be up to 19 or 20 percent. If it was a 20-percent rate, the self-employed rate would be 15 percent. With a $9,000 taxable wage base, the maximum tax on the employee and employer would be $900 each, and the maximum tax on a self-employed person would be $1,350, if we do what you advocated today plus what you advocated in 1946.

Do you feel that as much of that man's earnings of $9,000 as a Federal tax source should be devoted to this one single program of social security as is available to help finance all other activities—the functions of the Government, the paying of the national debt, and the defense of our country?

Mr. Cohen replied simply:

Yes, I do, Senator.

I believe this exchange is as thought-provoking as any I have heard in recent years. Mr. Cohen gazes untroubled at the distant vistas. He is not at all appalled at the prospect of a Federal program which would cost more than all other Government functions and expenditures combined, financed by a total tax without any exemptions of 20 percent on all earnings up to $9,000.

I urge Senators to ponder this conversation before they let any legislative proposal get its foot inside the door. Bureaucrats are busy plotting for empires—and they will have them, too, if we allow it. In December 1960, the Department of Health, Education, and Welfare had 64,847 employees. By April of this year, that number had risen to 74,901, for an increase of 10,054 employees in 16 months.

Where do we go from here, Mr. President?

We now face the Anderson amendments. I have read them—twice. I have encountered similar proposed legislation in the Senate Finance Committee and may be presumed, therefore, to have a closer acquaintance with such proposals than some of my colleagues in the Senate. But, I can only remark that the amendment's sponsors were wise in routing it directly to the Senate instead of following orderly procedure. Conceivably, they hope to railroad this proposal past the Senate if they can work quickly enough.

MACHINEGUN IN VIOLIN CASE

But few Senators would vote "yea" on such a measure if they thought their way through it, phrase by phrase, section by section. For what we have here is a machinegun in a violin case, a bomb in a grandfather's clock.

Perhaps some Senator has done more homework than I, and has somehow managed to read this amendment thoroughly enough to understand it. I confess that portions of it baffle me completely. Perhaps some Senators have had time to think through the far-reaching implications of this proposal by now. I confess that I would prefer more time for study. Perhaps some Senators feel that hearings on such a technical and complex measure are a waste of time.

Perhaps it is on the old theory of "My mind is made up; don't confuse me with the facts." They might feel that our proper course is to pass this proposal before it becomes an issue in the fall elections. I wish that we, as Senators, could hear expert opinion from the people it would affect.

I would think the testimony of physicians, hospital administrators, insurance experts, nurses, actuaries, and even taxpayers would be pertinent to our decision. We are, unfortunately, unable to call these witnesses, because time is running out between now and the fall elections.

We must deal with a tax increase, of course. It would amount to 69 percent of the present rate for employers and employees and 68 percent of the present rate for the self-employed in the next 6 years.

A worker earning $4,800 today pays $150 a year in social security taxes. His employer pays the same amount. A self-employed person earning at least $4,800 pays $225.60 a year. The social security tax is already scheduled to rise to $222 each for employee and employer in 1968. To the self-employed person, that will mean a rise on schedule to $331.20, without adding the medical benefits.

By 1968, the combined employer-employee tax will reach 9¼ percent while the tax on the self-employed will rise to 6⅘ percent. Add medical care to these retirement benefits—a mere quarter of 1 percent for employer and employee—and the difference seems trifling. But increase the wage base from $4,800 to $5,200, together with the additional amount required to pay for old-age benefits, and both employer and employee will be paying $253.50 each by 1968, with the self-employed person paying $379.60, compared with the present amounts of $150 for the employer and the employee, and $225.60 for the self-employed.

It hardly seems to me, Mr. President, that a tax increase of these proportions is an unimportant thing—particularly when it is to be used to pay for service benefits instead of cash benefits. That change of approach alone sets a precedent which deserves examination. What happened to the concept of using social security benefits as a floor of protection? Must we now cover our floor with an Oriental carpet?

GROWTH OF SOCIAL SECURITY TAXES

The time is rapidly approaching when many of this Nation's wage earners will be paying a higher social security tax than a Federal income tax. By 1968, under the proposed plan, the total social security tax for a self-employed man who earns $4,000 a year and has three dependents will be $292. The same man would pay only $245 in income taxes at the present rates.

Implicit in the amendments, therefore, is a drastic reorganization of our tax structure, with increasing burdens to be borne by those least able to afford it. For as I pointed out before, some 40 percent of the national income will make no contribution to this financing plan whatsoever, based upon a social security payroll tax. Are Senators prepared to go along with so important a revision in our taxing system without thorough study?

How sound are the actuarial studies on which the Anderson amendments base the tax increase and collections? I do not pretend to know, Mr. President, not having been given time to find out, nor has the Committee on Finance been given time to find out.

I can say, however, that the Forand bill would have cost an identical amount, according to its sponsors, for different benefits.

And I can say that the King-Anderson bill would have cost the same amount, with different benefits.

Does the Anderson amendment tailor its benefits to the amount of the tax increase? Or does it tailor the tax increase to the benefits it will provide? Are the benefits the amendment proposes the proper benefits for our aged population, assuming, for the sake of argument, that they are needed at all? And if these are the proper benefits, in ideal balance in terms of health and expenditure, what is the sponsors' authority of believing so?

Will this single tax increase be sufficient to cover the benefits promised? I remember the King-Anderson bill of last year, which called for an increase of one-half percent on employer and employee and an increase in the tax base from $4,800 to $5,000. Between the time the bill was introduced and the time hearings were held in the House Ways and Means Committee, that tax increase had already gone out of date. Said the Social Security Administration's Chief Actuary, Mr. Robert J. Myers:

We're sorry that tax increase won't quite do it. We'd better raise the tax base another couple of hundred dollars.

There is also the fact that one of HEW's top researchers reported that the HEW cost estimates for the King-Anderson bill were about one-fourth of the probable costs. I am informed that this researcher's speech was canceled and his full report never issued, but that HEW was never able to stop the circulation of an abstract of it.

WHAT WOULD THE BILL COVER?

Thus I feel that we have a right to find out on what basis this tax increase was figured. How did the actuaries determine the cost of hospital care, for instance? Will not the cost of hospital care continue to rise, as all the authorities say it will? The amendment will cover diagnostic tests, but what diagnostic tests is it talking about? Blood tests? Cancer tests? The GI series? The answer to those questions surely affects the cost of this benefit, but the amendment offers no enlightenment.

The amendment provides some sort of insurance option for the beneficiary, but as it is probable that no insurance policy extent embraces precisely the benefit pattern called for, I cannot help wondering whether the insurance option is really an option at all.

Mr. President, I understand that the authors of the amendment are still wrestling with the language of that section, which relates to insurance options, and when the bill actually comes before the Senate the language may be changed. Such changes may be made as the whole amendment was written without the opportunity for committee study.

Certainly I see no mention of the word "premium" in any part of the Anderson amendment. From this I can only conclude that none are involved. I hazard the theory that rather than receiving premium payments for the individuals it insures, the insurance carrier would simply be reimbursed for the amounts it pays to the providers of services for the authorized benefits.

In other words, the carrier would merely be acting as a middleman, or fiscal agent. However, I have been told that the Senator from New York's [Mr. JAVITS] proposed amendment to the Anderson amendment will presumably rectify this.

I cannot speak with any detailed knowledge, however, on any particular of the bill. I have heard it said that the King-Anderson bill is the least understood piece of legislation in the current Congress. I dispute this. The Anderson amendment will, I predict, succeed to that title. For at least the House Ways and Means Committee held hearings on the King-Anderson bill, and some of us have had an opportunity to scan the record of testimony.

A FEW QUESTIONS

I ask, however, that I be allowed to pose just a few of the questions which should be answered as factually as possible before the Senate acts on the Anderson amendment. I ask these questions because we have not been given time to develop the answers through committee hearings, and because I feel the answers are of major importance.

Despite the disclaimers, will the Secretary of Health, Education, and Welfare be given the power to regulate the Nation's hospitals and some of its nursing homes?

Does the nursing home care covered in the amendment amount to as much as 5 or 10 percent of the nursing home care available?

Can it really be said that this measure would not affect the patient's freedom of choice—of hospital or doctor?

Would its passage lead to overuse of our hospitals?

Would this in turn lead to overcrowding of our hospitals?

What would this amendment do to the quality of medical care?

Is passage of such legislation necessary in the first place?

Is there indeed across-the-board need for health services among our aged? Is the health of our older population as bad as the amendment's proponents tell us? And are our aged in the straitened circumstances they are pictured to be?

On what basis have costs been figured? Will those costs increase?

Can the social security system withstand the added burden of a program to change the present pattern and setup and to provide services instead of cash benefits?

Is it wise to set such a precedent?

Do the services, which are estimated to provide less than 25 percent of an older person's health needs, have a predictable cost in the first place?

What would passage of such a measure do to private health insurance and other prepayment mechanisms?

What are the moral byproducts of such a bill when measured in terms of the decline, and perhaps the demise, of voluntary efforts at the community level?

Is it wise to provide benefits to millions of people who are capable of meeting their own health care problems, and who are doing so now?

Is it sound thinking to base a Government program on age instead of need?

What effect would passage have on the traditional Judeo-Christian teachings of individual and family responsibility?

I pause at this point to return to the comment that I made earlier. Based upon a study made by the U.S. News & World Report, those who think that by adopting the proposed program they would prepay the medical care benefits for their own retirement are being sadly misled. Whether they realize it or not, children would have to take care of their parents, only they would not do so directly on a personal basis. They would do it by paying for medical care a generation late.

What is to be gained by eliminating the States' historical responsibility in a vital area of government, and by further diminishing the States' authority?

What pressures will develop to expand and enlarge the benefits and coverage of the bill?

Would not the Anderson amendment, by reason of its very inequities, require broadening?

If costs cannot be controlled, would services be curtailed?

These and other questions occur to me, Mr. President. I hope they will be answered in the course of this debate, as limited as that will be in view of our obligation to settle this matter before it becomes an issue in the fall election, in view of the fact that we now have a limitation of time which has been agreed to by the Senate.

POLITICS BEFORE PUBLIC WELFARE

For myself, however, one puzzling question remains:

Why this unseemly haste when our aged population will receive no benefits under the program until January 1, 1964? I suppose the answer to this must be the unsatisfactory reply that we must vote on this amendment before it becomes an issue in the fall elections.

Meanwhile, however, the amendment has been cynically tacked on to the welfare bill, upon which millions of Americans are depending for help.

Passage of the welfare bill will therefore be delayed, Mr. President.

Perhaps that delay will also become an issue in the fall election.

And now, Mr. President, I would like finally to take up the question of the method in which this amendment bypasses the traditional committee system of the Senate. To me that is the one unanswerable argument against consideration of the measure at the present time, and under the present situation here on the floor of the Senate.

First, let me say that I think the administration's attempt to bypass the Senate Finance Committee on this legislation is just one more example of an alarming trend within the present administration of either circumventing Congress or circumventing the normal congressional procedures. In its effort to obtain back-door financing for major programs, in its move earlier this year to get the Urban Affairs Department bill out of committee before the committee had finished its work, in its effort to transfer all power over international trade from Congress to the executive branch, this trend has been obvious. Earlier this year Congress indicated its unwillingness to surrender its traditional processes to the President in the name of expediency; I hope we will do the same in the case of the bill now before us, and that even these Senators who might favor the bill in principle, if it had been worked out with due deliberation by a Senate committee, will vote against it for procedural reasons out of respect for the Senate's traditional mode of operations.

Let me emphasize that what I am anxious to protect here is not merely a meaningless tradition. There is a very sound reason for the tradition of committee consideration of technical bills, as every Member of this body knows.

We have no better example of this than the tax bill which has been before the Committee on Finance since early April, and on which we are still working in committee.

Only one who has sat through hundreds of hours of testimony on social security bills can appreciate how complex such legislation of necessity must be. During the hearings on legislation such as this, questions inevitably arise which

require further research, further study by the staff, further investigation by the administration. To consider such legislation on the floor without the benefit of committee consideration is folly.

Since its inception, the committee system in the Senate has functioned to the benefit of the Nation. It has reduced, if it has not eliminated, error. Are we to junk the Senate's time-honored procedure everytime we are urged to hasty action by an administration concerned more with political profit than with sound laws? I submit, Mr. President, that we cannot afford to do so.

Yet we are being asked to leap before looking, to vote before knowing the facts of a matter which has far-reaching importance to the destinies of every American, a matter which has had no study by any committee.

COMPLEXITY OF BILL

The pending bill, H.R. 10606, is a good example of just how complex social security legislation can be. The measure, which is 102 pages long, would amend four titles contained in the Social Security Act. Originally introduced as H.R. 10032 by the administration, the bill was subject to 3 full days of hearings—mornings and afternoons—by the House Ways and Means Committee.

Forty-seven witnesses, familiar with various aspects of the proposal, appeared before the committee to deliver their expert testimony. In addition, 113 others submitted statements on the bill.

Having weighed these arguments pro and con, the House Ways and Means Committee amended the original bill so drastically that a new bill, H.R. 10606, was reported out and sent to the floor.

As is the custom, the Committee report explained in detail exactly what each provision of H.R. 10606 would do. Ample time was then given to each Member of the House to study the Committee report and the 697 pages of the printed hearing.

However, as is the custom in the House, the legislation was considered under a closed rule because of its technical nature, and after 4 hours of debate was passed by a vote of 319 to 69.

During the debate, a number of Members of the House indicated their regret that amendments could not be offered.

When the bill, now 81 pages long, was referred to the Finance Committee, it received 4 more full days of hearings, morning and afternoon. Thirty-six witnesses appeared before the committee. Fifty-six additional statements were filed with the committee.

And after due consideration of all the arguments presented, the Finance Committee reported the bill with a number of important amendments.

WELFARE BILL NOW IMPROVED

The welfare bill has now been refined, and I think improved. It has thus far gone through two searching studies and a House debate prior to its consideration by the Senate.

If enacted, it will help many of our citizens who are in need of help.

In addition to providing increases in cash benefits, the bill continues the increased Federal participation in medical care costs incurred by those receiving old age assistance—a participation provided by Public Law 87-31, enacted a little over a year ago. Further, the bill continues the increased Federal participation in medical care costs incurred by those participating in the medical assistance for the aged program, which authorizes liberal Federal contributions to the States to provide medical care for those of the aged who, while able to meet the cost of everyday living, may have difficulty in meeting some of their medical expenses. This law, as the Senators will recall, was acted late in 1960.

My point, Mr. President, is this:

Complicated legislation can only be understood, changed, improved, and properly refined when the responsible committees of Congress subject it to hearings.

In this case, H.R. 10606 comes before the Senate after such hearings. Its substance has been altered, its provisions have been weighed, its implications and ramifications have been duly explored by those committee members entrusted with that responsibility. And this is as it should be. The Senate can now consider the endproduct of these deliberations in depth in full confidence that the measure before them has been subjected to the closest possible scrutiny beforehand.

Let me contrast now a departure from that orderly procedure.

If the entire social security law can be characterized as complex and technical, and it can, there is no question whatsoever that title II, the Old Age and Survivors Disability Insurance programs, is its most complicated part.

The King-Anderson bill involves amendments to that program. As the Senators know, this bill would provide certain hospital and nursing home benefits, plus a few other health services, to those persons 65 years of age or over who are eligible for OASDI coverage.

To call this bill "controversial" is to utter the understatement of the year. Perhaps "embattled" would be a better word, for the proponents and opponents of this type of legislation have argued it in and out of the Nation's press, on television and radio, in speech and debate, on editorial pages and in town meetings, in magazines and over the backyard fence, ever since Former Representative Aime Forand first threw its predecessor, H.R. 4700, into the legislative hopper.

The bill's power to evoke heated controversy is a byproduct of its far-reaching importance—an importance recognized at first glance by tens of millions of Americans. However, the sparks of controversy have been deliberately fanned into flame by the leaders of labor and their allies within the administration—this, in my opinion, in the hope that public pressures will force the Congress to legislate on the basis of emotion rather than reason.

RECORD OF FORAND BILL

Thus far, the Congress has remained firm. The Forand bill—similar to H.R. 4222, in that it too sought to provide health care services to OASDI recipients through the social security financing mechanism—was given 5 days of hearings in 1959 by the House Ways and Means Committee. The committee then voted, by an overwhelming majority, to retain the bill in committee.

The Senate Finance Committee also conducted hearings on the Forand bill and voted to hold the measure in committee. Despite this, an attempt was made—as the Senators remember—to amend the Kerr-Mills proposal by tacking on the Forand bill. This effort, sponsored by Senator ANDERSON, of New Mexico, and the then Senator but now President of the United States, John F. Kennedy, was defeated also.

However, Mr. President, aside from the Senate Finance hearings on the Forand bill, our committee has held no hearings on the legislation which succeeded it—H.R. 4222.

It has not done so for the good and sufficient reason that action on the bill is still being considered by the House Ways and Means Committee.

Is it suggested, Mr. President, that the Senate Finance Committee has thereby been derelict in its duties? I can assure the Senators that this is not the case. I cannot remember when the Senate Finance Committee has been busier than it has this year. We have held hearings on the President's new tax bill; the public welfare bill now before us; two tax extension bills; the debt limit bill; the sugar bill; and the extension of the Renegotiation Act.

I do not think that the Senate Finance Committee can be accused of dilatory behavior in the discharge of its responsibilities; nor do I think that my friend, the distinguished senior Senator from Virginia, need apologize for his own or his committee's application of maximum effort.

Yet, as I have pointed out, the Senate Finance Committee has given no consideration to H.R. 4222. Recognizing the need to proceed in an orderly fashion, the committee earlier this year voted 10 to 7—not on the merits of the bill, but on the procedure involved—to delay consideration of the King-Anderson bill until the House had had the opportunity of taking action. Thus, not one word of testimony from the public has yet been taken on the administration's proposal by the Senate committee assigned by law with the responsibility for dealing with this sort of legislation.

Mr. KERR. Mr. President, will the Senator yield?

Mr. BENNETT. I yield.

Mr. KERR. Is it not true that the Committee on Finance included in its action a definite statement of its purpose to conduct hearings on this measure as soon as it had come from the House to the Senate, in the event it did so?

Mr. BENNETT. The memory of the distinguished Senator from Oklahoma, who is the ranking majority member of the Committee on Finance, is eminently correct. The committee, by its vote, pledged itself to hold hearings on this proposal when it was constitutionally proper for it to take such action.

Mr. KERR. Has the Senator from Utah analyzed the amendment which is before the Senate to determine the extent to which it is a revenue-raising measure?

Mr. BENNETT. It is obviously a revenue-raising measure, because it would add to the social security tax an amount of at least one-half of 1 percent.

Mr. KERR. Is the Senator aware of the fact that if the measure were passed, it would increase the taxes collected under the social security program approximately $810 million in 1963; more than $2 billion in 1964; and then an increasing amount each year thereafter?

Mr. BENNETT. The Senator from Utah, earlier in his statement, covered that field in terms of percentages and the cost per person participating in the system, but had not used the particular figures supplied by the Senator from Oklahoma. I appreciate having them in the RECORD.

Mr. KERR. So the measure would be not only a revenue-raising measure but, so far as the Senator from Oklahoma is concerned, it would be a measure intended to raise more new revenue than any other tax measure that I know of which has been passed in some years.

Mr. BENNETT. This is true; and it is interesting to comment, in passing, that we should be asked in this bill to increase the take from the individual taxpayer at a time when the President of the United States is suggesting that individual taxes must be reduced in order to get the economy moving again.

Mr. KERR. The remark of the Senator from Utah is very appropriate, and, I think, of partciular significance in view of the fact that one of the authors of the amendment has been making a number of public statements to the effect that it was a matter of great concern and, in his opinion, perhaps of necessity, that Congress take action to reduce taxes, while, so far as I know, he has proposed no legislation to reduce taxes but is vigorously sponsoring a measure which provides for the increase of taxes by a minimum of $2 billion a year beginning in 1964.

Mr. BENNETT. That is true. He is probably obeying the Biblical injunction not to let his right hand know what his left hand doeth. But the net effect upon the taxpayer would be to destroy any value of any tax cut of a similar size that may come before the Senate in the next few months, and for which there are very vocal proponents.

Mr. KERR. Certainly the group who would be affected by this measure—that is, the group who would be required to pay the taxes called for by the measure—would individually suffer the effects of a more substantial increase in the amount of taxes they would have to pay than they would benefit under any provision that has yet been suggested for a tax reduction.

Mr. BENNETT. That is the impression of the Senator from Utah. I should like to reemphasize that if the argument is made that the social security tax is for the benefit of the future, and therefore has a moral justification, it is still a tax that has to be paid out now and will have an effect upon the individual taxpayer, as the Senator from Oklahoma has well said.

Mr. KERR. I thank the Senator from Utah. I congratulate him upon the statement he has made, because it is very lucid, appropriate, and accurate, one which I believe to be of great significance. I express my appreciation to the Senator for the work which has gone into the preparation of the statement and for his effort in making it.

Mr. BENNETT. Mr. President, I am grateful for those words of approval and approbation.

As I have already said, the Committee on Finance has given no consideration to the House bill or to the King-Anderson amendment. Earlier this year, the Committee on Finance voted, 10 to 7—not on the merits of the bill, but on the procedure involved—to delay the consideration of the King-Anderson bill until the House had had an opportunity to take action. Thus, not one word of testimony from the public has as yet been taken on the administration's proposal by the Committee on Finance, which is charged by the rules of the Senate with the responsibility for dealing with this sort of proposed legislation.

We must now cope, the administration suggests, with a radically amended variation of H.R. 4222, without benefit of committee study. We are asked to legislate in haste regardless of whether this entails repenting at leisure.

LEGISLATION NOT STUDIED BY SENATORS

I find it inconceivable, Mr. President, that the Senate of the United States should be asked to pass legislation which few—if any—of its Members had seen prior to July 2, 1962—only 8 days ago.

Personally, I take it as an affront to a committee that has worked long and hard on major portions of the administration's program; and to one of the hardest-working members of the committee—its chairman, the Honorable HARRY F. BYRD, of Virginia.

To my mind, this challenge to the committee system is justification enough to vote down this amendment.

I ask the sponsors of this proposal whether they now consider themselves an ad hoc committee of the Senate, empowered by this body to bypass the Finance Committee when, as, and if it suits the demands of political expediency.

Let there be no doubt on one thing, Mr. President:

This amendment has been drafted and is being handled in this way with the deliberate intention of winning votes.

CONGLOMERATE OF PROPOSALS

I regret that I have not had sufficient time to study this proposal—the King-Anderson amendment—in minute detail. But I have not. Neither have its sponsors. Neither has any other Member of the Senate.

I have, however, reviewed the amendment to the degree possible since its introduction, and I can tell the Senators this:

The amendment seeks to be all things to all men, and succeeds in being a jerry-built conglomerate of proposals glued together with the single purpose of promising something for everyone. A more cynical, a more frivolous, a more irresponsible effort to stampede the Senate into precipitous action has never been encountered, and it is a pity that we are now compelled to spend our time—time which could be used to much better advantage—time which should have been spent in committee—in the consideration of such a legislative monstrosity.

I say to the administration that if they want a law rather than a campaign issue, let them follow the regular procedure for making the law. Let them follow the Constitution and the law of the land, which give the House of Representatives the power to initiate this kind of legislation. Let them use the appropriate committees of Congress in order that the public be heard. Let the administration recall that it is the executive's responsibility to propose laws to the Congress but the responsibility of Congress to the people of this Nation to draft the laws thoughtfully, to the best of its ability, and with the people's freedoms and best interests in mind.

If we follow that course, Mr. President, we will vote down the hastily prepared and hastily considered Anderson amendment, and will consider this legislation in the deliberate and careful manner in which such important legislation should be considered.

I urge the Senate to defeat the Anderson amendment.

EXHIBIT I

THE UNTOLD STORY OF YOUR SOCIAL SECURITY

This is to be the untold story of your social security. It concerns the pension to which you are entitled in retirement, or if disabled, and to payments to your survivors in event of death.

Social security is a vast system. Old age and survivors insurance alone in this year will involve benefit payments of more than $13.2 billion. And the total is to grow steadily over the years ahead.

In 4 of the last 5 years, payments to persons drawing benefits have been exceeding income from payroll taxes. Some alarm has been expressed about this deficit between outgo from the social security reserve fund and income into the fund.

That, however, is not the story to be told.

Payroll taxes rose on January 1. They go up again on next January 1. Money flowing into the reserve fund, as a result, once again will begin to total more than money flowing out. Fears about the safety of the fund will subside.

A fact—and questions: A hard and little-understood fact, however, will remain to raise questions.

The fact is this: Benefits promised to people now covered by old age and survivors insurance total an estimated $624 billion. Reserves now on hand total around $22 billion. Taxes to be paid by people now covered by social security to support pensions are to be an estimated $282 billion.

That leaves $320 billion in benefits to present "policy holders" to be paid by someone else. Who will that be?

The answer, in simple terms, is that this deficit, if it is to be paid, will have to be paid by future workers at tax rates now in the law. Otherwise, persons now in the pension system would have to pay sharply higher taxes.

Pension bargains for people of the present are to become pension burdens for workers of the future.

These workers of the future will pay substantially higher taxes on their earnings—taxes earmarked for social security. They will work over a longer span of life, paying higher taxes all the way, in order that the 68 million others now covered by social security can enjoy pensions and other promised benefits.

One more windfall: It now is proposed that hospital insurance for retired persons be added to the social security system. Once again, if this type of insurance is added, older people will get a bargain. Those retired when the plan would take effect would become entitled, at no cost, to hospital and nursing care valued at thousands of dollars.

Here would be a windfall for persons now retired and those who will retire in years shortly after the plan takes effect.

The tab for the cost would be picked up—as it is being picked up for old age and survivors insurance—by employers and by those who go on working. In the end the cost would fall on employers and on generations not yet working.

In a word: social security programs, to date, represent a gigantic bargain for persons retired, soon to be retired, or fairly well along in years.

For relatively small payments these people are assured of an income on retirement. Men are assured that, when they die, their wives will go on getting an income. There is further assurance that minor children will get checks in event of the man's death. A binding promise is made of a monthly check in event of total disability.

Once the hospital-care program is in the law, pressure will grow to cover hospital costs for all persons covered by social security, whether working or retired. The final step might possibly be to cover doctor bills as well.

Idea—pay later: In each case, planning rests on the idea that future generations will get and pay much of the bill for those who are getting, or stand to get, the bargains of the present.

All of this is part of the strong trend toward special advantages for older people at the expense of the Nation's younger people.

Young people with children to educate, with a house to furnish and pay for, with saving to do if there is to be any venturing, with insurance payments to make, get few favors. Payroll taxes, increased eight times in the past 13 years, will be increased three more times for old age and survivors insurance. Hospital insurance would mean another tax. Then, at some point, there will be unpaid bills from social security promises to meet.

Old people, all of the time, are getting more and more advantages. People age 65 and older get a double exemption on personal income tax. If retired, they get a special retirement credit against income tax. The social security pension—for which they paid little—bears no tax. All their bills for medical and hospital care are deductible for income tax purposes.

All of this raises the question whether young people with more votes than old people will go on giving the breaks to the elderly.

For young alternatives: Two courses would be open to them if ever they wanted to get out from under what is to be a growing burden.

1. Inflation of prices can be accepted while a determined effort is made to keep individual pension benefits from rising. In this way, inflation could be used to reduce the pension burden, since pensions would represent a smaller part of an inflated national income.

2. Taxes could be used to take away some of the advantages enjoyed by retired persons. One tax "reform" now under study calls for taxation of social security income. There is some pressure to end many other special deductions extended to older people.

However, experience in the United States and Europe indicates that old people will go on getting their bargains and young people will continue to bear their rising burdens. In Europe there is a strong trend toward shifting to employers a larger and larger part of the social security burden.

The generous attitude of young people is attributed to two factors.

One of these factors is the realization that sometime they, too, will be old and will want some favors.

The other factor is that the young people see social security as a means of spreading the risk that comes from being forced at some point, for most, to care for their own parents.

As it's done abroad: To fill out the untold story of social security, U.S. News & World Report asked its staff members in Europe to explain how those countries—with long experience—have met the rising burden of welfare programs.

West Germany: The idea of national pension plans got its start in Germany. Two world wars, ending in two defeats and destruction of currency, destroyed the pension systems. Yet each time these systems have come back stronger than ever.

To finance old-age pensions, employers and employees each contribute 7 percent of the gross wage. For health insurance they each contribute an added 4.8 percent. An added 0.7 percent goes for sick pay, special leaves, family allowances. On top of it all, employers contribute an average of 16 percent for other fringe benefits. Payroll additions for social security amount, overall, to approximately 45 percent.

Benefit payments in recent years have been adjusted to compensate for price rises. Young people do not appear to object to the burden they carry.

Great Britain: Welfare costs now account for more than a third of all government spending. Workers covered by welfare programs and their employers pay special taxes that pay less than half of welfare costs. In the case of health insurance, three out of every four dollars come from general taxes.

Government subsidizes the whole welfare program, and political pressure is constantly on the side of larger benefits. There is pressure to cut down defense spending so welfare can expand.

Sweden: A 6-percent sales tax was introduced in Sweden 2 years ago to help meet the skyrocketing costs of welfare. Social security benefits now account for 15 percent of national income, compared with 7 percent before World War II.

In 1960, goverment, central and local, carried 69 percent of welfare expenses, workers 20 percent, and employers 11 percent. Now the pressure is to increase the employers' burden.

France: Social welfare in France extends from maternity grants, family allowances, rent allowances, and hospitalization to old-age pensions and death benefits. The expense falls mainly on employers, who pay about 30 percent on their payrolls. The employee contributes about 6 percent on maximum pay of $1,920 a year.

Italy: Social security in Italy includes old-age pensions, unemployment insurance, health insurance, maternity benefits, family allowances, and some subsidized housing. The Government contributes 25 percent to the retirement pension fund.

Employers' contributions amount to a tax of about 50 percent of payrolls. Workers contribute approximately 11 percent of their earnings.

In Western Europe as a whole, social security benefits now approximate 15 percent of national incomes. The range, according to official figures, is 12.6 percent in the Netherlands to 16.4 percent in France.

The trend in Europe is toward more and more social services, with heavier and heavier taxes on employers, plus larger contributions by the Government out of general revenues. This suggests that, in the United States, as the years go on, the Government, too, will be called upon to support the pension fund in addition to the payroll taxes that now are scheduled.

Mr. KERR. Mr. President, will the Senator from Utah yield?

Mr. BENNETT. I yield.

Mr. KERR. Was the Senator in the Chamber the other day when the distinguished Senator from New Mexico [Mr. ANDERSON], one of the cosponsors of the amendment, and the distinguished Senator from New York [Mr. JAVITS] were discussing one provision of the amendment and made it quite clear, with reference to section 1716, beginning on page 45, that the sponsors of the amendment had agreed in principle upon what the language of the amendment should be, but were still discussing among themselves the question as to what the language should consist of and provide if and when it were voted upon?

Mr. BENNETT. I was not then on the floor, and did not hear that debate. This is a process which may be safe in committee, up to a certain point; but after we discuss proposed legislation in principle on the floor of the Senate and after the Senate finally votes on it, there is no time, later, to correct the language, except in conference; and inasmuch as this bill has the unique distinction of having originated in the Senate, there is no assurance that it will go to a conference. I understand that some Senators who are joining in support of this measure are still considering changes in the language of their own amendment—changes which probably will be offered to us from time to time, as the debate continues.

Mr. KERR. The Senator's remarks are very appropriate. In fact, when one of the proponents was discussing the amendment, he was asked how many persons would be affected by it; and he had to have considerable consultation with a member of the staff before he was able to determine whether 2½ or 17 million persons would be affected by it—all of which would seem to indicate a real necessity for the Senate to have an opportunity to have one of its committees learn who would be affected by it and what language it would contain, before the Senate takes final action on it.

Mr. BENNETT. It seems to me that this may be one of the bills with attractive titles, and the proponents are anxious to have the bill passed on the basis of the attractiveness of its title, and are not too much concerned about the details of the bill itself.

Mr. KERR. No doubt the Senator is aware of the fact that approximately 75 pages of legislative matter are involved in the amendment, as it was submitted;

and, furthermore, in view of the remarks by the sponsors, it seems likely that many additional pages of language will be included in the amendment before its sponsors will be able to agree upon what the language of the amendment should be when it is voted on.

Mr. BENNETT. Yes, I am aware of that. If this measure had been handled in the regular committee process, the business of reworking the language would have occurred in committee, and we might have had another 75 pages of amendments. However, if such amendments had been worked out in the committee, they would have been carefully considered, and would not have been hastily put together on the floor of the Senate in order to attract a vote here and a vote there or to satisfy a question raised by one Senator or another.

Mr. KERR. And if the committee reported it, the bill would be accompanied by a report which would disclose with great clarity the contents of the proposed legislation.

Mr. BENNETT. Yes; and certainly that is one of the things which it is impossible to have under the process under which we have been working.

Mr. President, in addition to the material which I have previously asked to have printed in the RECORD, I shall ask unanimous consent to have printed in the RECORD, at the conclusion of my remarks, several items.

First, I submit a statement of policy regarding the position of the American Farm Bureau on the administration's medical care program.

The American Farm Bureau Federation has consistently taken a firm position against the inclusion and liberalization of benefits which would require an increase in social security taxes.

To bring myself up to date on this matter, I checked with the American Farm Bureau Federation, and was informed that its attitude on this modified bill is adequately presented in an editorial statement released last year by President Charles B. Shuman; and it appeared in Nation's Agriculture for November 1961. This statement is based on the policies adopted by the elected voting delegates in recent annual meetings, and reflects the thinking of more than 1,600,000 farm families in America.

The most recent policy was approved December 14, 1961, and I quote it: "Social security taxes should not be increased to pay medical costs for any portion of the population."

I now ask unanimous consent to have printed in the RECORD the following:

An editorial, from the Nation's Agriculture, dated November 1961, and entitled "Socialized Medicine."

An editorial, from the Wall Street Journal of May 22, 1962, entitled "One Sunday Afternoon."

An editorial, from the Wall Street Journal for June 11, 1962, entitled "A Warning From Mr. Roosevelt."

An editorial, from the Deseret News of Salt Lake City, Utah, dated July 2, 1962, entitled "The Road to Socialized Medicine."

An editorial, from the Salt Lake Tribune, dated June 5, 1962, entitled "A Back-Door Plan To Get Medicare Law."

A news release, dated July 9, issued by the Blue Cross Association, stating its opposition to the "patchwork" Anderson amendment.

There being no objection, the statement, editorials, and release were ordered to be printed in the RECORD, as follows:

[From Nation's Agriculture, November 1961]

STATEMENT OF POSITION OF AMERICAN FARM BUREAU

The next session of the Congress will be brought under great pressure to adopt legislation for the inclusion of medical care for the aged in the social security system. This emotion-charged issue is the entering wedge for national compulsory Government health and medical care—socialized medicine.

One of the original proponents of Government-managed medical care, ex-Congressman Forand, frankly admitted as much when he said: "If we can only break through and get one foot inside the door, then we can expand the program after that."

The current scheme provides for an increase in social security taxes by raising both the tax rate and the amount of earnings subject to tax. The higher revenues would be used to pay for doctor, hospital and nursing home expenses for all aged persons who are on social security regardless of need. The Secretary of Health, Education, and Welfare would develop regulations, determine whether charges were reasonable and, in effect, approve doctors and hospitals of the Nation.

Is there a real need for this new step toward welfare state socialism? In 1960 legislation was enacted providing Federal grants to the States for medical assistance for older people with low incomes.

A recent survey reveals that less than 15 percent of the aged are unable to provide the finances for adequate medical care from their own resources. Approximately 130 million people in the United States are now protected by voluntary prepaid hospital expense insurance. Surgical and medical expense protection for all age groups is being added to this coverage at a very rapid rate.

With this evidence of limited and rapidly diminishing need, why are the proponents of this step toward socialized medicine so insistent on taxing workers to pay the medical bills for the millions of older people, most of whom are able to help themselves?

The answer is obvious. The Government interventionists do not believe that the people are capable of spending their own money wisely. They believe that Government bureaucrats and planners will make better decisions on how to spend the income of the workers than the individuals who earn the money. Furthermore, the more money the Government has to spend, the greater is the power of the politicians in charge.

The vast majority of farmers believe in the maximum possible freedom of choice, competition, and opportunity. They do not want to be assigned to a Government doctor whose income depends on his political standing rather than upon his competence.

Farmers believe in taking care of their own but, when assistance is needed, it should be administered by local government—not a remote Washington agency. They are alarmed by the potential cost of the constantly expanding social security system—the social security tax rate is already scheduled to rise to almost 10 percent of the payroll base by 1969. They also understand that socialism is government management of individuals and their spending.

Farmers challenge the theory that government "can do it better" or spend more wisely. Government-run schools and hospitals are not superior to private institutions; the Department of Agriculture does not store or market grain as efficiently as the private trade; electricity from public powerplants is usually more costly than from private utilities when hidden costs and tax advantages are considered; government-controlled medicine would be expensive and unsatisfactory.

[From the Wall Street Journal, May 22, 1962]

ONE SUNDAY AFTERNOON

Since the days of the ancient Athenians one of philosophy's often expressed fears about democracy has been that its political leaders would yield to the demagogic clamor of the crowd. In our own country's beginning there were men who prophesied that would cause our ending.

Well, we've had our share of demagogues—in our own time Huey Long and Townsend come readily to mind—who made political capital of social discontent. Sometimes, as Congress did back in the thirties on the soldiers' bonus, our political leaders have yielded to the clamor.

But on the whole we have been lucky. While President Roosevelt was responsive to the people's mood, he didn't try to create discontent where none existed before; he opposed not only the soldiers' bonus but also Huey Long and the Townsendites.

So we come to last Sunday afternoon.

Across the land there were 33 great rallies for a bill which, so it is said, is going to take care of the medical bills of all the Nation's old people with hardly any cost to anybody at all. These rallies were sponsored by the administration and arranged by an organization called the National Council of Senior Citizens for Health Through Social Security, created for this purpose. The biggest of these rallies was held in Madison Square Garden in New York under the stage managership of Z. J. Linchtenstein, a professional organizer who learned his business organizing anti-Communist efforts in his native Poland.

All these rallies were addressed by important people, Vice President Johnson spoke in St. Louis, Secretary of the Interior Udall in Kansas City, Secretary of Commerce Hodges in Boston. And so on, with President Kennedy himself at Madison Square Garden, from which his speech was carried to the Nation over three television networks.

President Kennedy's speech, which set the tone for the others, wasted little time on the specifics of the King-Anderson bill; in fact, in all the day's outpourings there was hardly any serious discussion of the problem itself or of any alternative proposals that have been made. Mr. Kennedy's theme was that the people were demanding this particular bill, would have no other, and that it was being blocked only by the wicked machinations of the American Medical Association.

At the Garden, from which the circus had just moved out, there were some 15,000 people, mostly old people in shirt sleeves, come to hear the President's promises and enjoy the entertainment. Bert Parks was master of ceremonies, there was a full-sized symphony orchestra, LaVern Hutcherson and Avon Long did a medley from "Porgy and Bess," and the stars included Robert Merrill of the Metropolitan Opera and Mitch Miller with his Sing-Along group.

It was a very hot day in New York, but the air was festive, and as the old people filed out afterwards most of them were smiling and happy. We suppose it was the same all over the country, where the other

rallies could follow the show in New York through an elaborate television hookup.

Such being the mood of the day, there seems little point in our indulging either in any serious discussion about this promise of the Government to take care of us in our old age. It was hard to keep our minds on that anyway, as our thoughts drifted off in another direction.

If it were true, as everybody was saying, that there was already an irresistible clamor from the people for this program, why was it necessary to have this 33-ring circus? Could it be true that the men in Congress who come from our cities, hamlets, and farms have really been so deaf to the voices back home that they have not heard the spontaneous cry for the Government to give us this boon?

And our thoughts wandered even further afield. Like the philosophers of old, we know that it is sometimes difficult for statesmen to resist the cry for bread and circuses. But at the moment we could not recall another occasion, at least in our own country, when all the leading statesmen of the Nation joined the bands and the performers on the stage to urge the crowd to raise a clamor for what they had thought up to give them.

A quarter of a century ago we sat under a hot California sun and heard some simple people dazzled by promises of ham and eggs and $30 every Thursday. The memory seemed very vivid last Sunday afternoon.

[From the Wall Street Journal, June 11, 1962]

A WARNING FROM MR. ROOSEVELT

When Franklin Roosevelt proposed establishment of the social security program in 1935, he was careful to warn Congress against "extravagant action." If the program were "too ambitious," the President said, "its whole future would be endangered."

As the years have gone by, the program has certainly grown a great deal more ambitious, and now there's this enormous political pressure to push it into the field of medical care. The House Ways and Means Committee is scheduled to take up the administration medicare bill this week.

Now we realize that any criticism of the 27-year-old American social security institution is regarded in some quarters as somehow suspect, if not downright unpatriotic. Nonetheless, it's time we paused to ponder the meaning of Mr. Roosevelt's words.

In terms of its later growth, social security got off to a slow start. Farmworkers, domestic employees, and a number of other groups were excluded from coverage. Benefits for the aged were to range from $10 a month to $85, and no payments at all were to be made until 1942.

But this initial design was soon altered. Even before the first social security taxes were collected, organized labor was pressing for a liberalization of benefits. In 1939, Congress responded by broadening the program to include dependents and survivors of the aged and, in addition, advanced the date of first benefits to 1940 from 1942. And so it has gone from that time to this, with benefits and coverage being steadily enlarged and expanded, especially in election years.

How has Congress provided for payment of these growing benefits? In the beginning the plan was to build a giant reserve fund, invested in Government bonds, so that eventually interest income would shoulder a large part of the benefit burden. Taxes were to start at 1 percent each on employees and employers, based on the first $3,000 of each employee's wages, and were to rise to 1½ percent in 1940 and then by stages to an "ultimate" rate of 3 percent by 1949.

But politicians aren't anxious to boost taxes on voters if they think there's any way around it. And with tax receipts running far ahead of benefit payments in the early years of the program, Congress couldn't see anything urgent about tax boosts at all. As a result the tax rate didn't rise to 1½ percent until 1950, a decade behind schedule.

Soon things began closing in on social security and its manipulators. With reserve funds shrinking fast, Congress found that both old and new benefits called for new taxes. So the maximum tax on each employee now is $150 a year, compared with the $90 that the lawmakers first thought would be the "ultimate."

And the end isn't even remotely in sight. The reserve fund, in any real sense, is no longer any reserve at all. Its interest earnings each year now equal only about 2 percent of benefits. To keep the program stumbling along on a hand-to-mouth basis, even without the added burden of medical care, tax rates are slated to rise by nearly 50 percent in the next 5 years. It's certain there will be pressure for more benefits, whether medical care or something else. That's the way politicians have been using social security for 27 years.

If the pressures continue to bring action, even higher taxes than those now envisioned will be needed to keep the system from sliding into insolvency. Ironically, the taxes bear hardest on the lower-income groups; as things stand now, earnings above $4,800 aren't touched. Yet the benefits, because they are tax-exempt, are most helpful to the wealthy. To a person in the 20-percent-tax bracket, $800 of social security payments is equal to $1,000 in taxable income. To a 60-percent-bracket taxpayer, the $800 payment is equal to $2,000—twice as much.

There are other inequities. Middle-aged and older workers who entered the plan in its early years had the prospect of getting back a good deal more than they put in. But an average worker under 40 who enters the plan now, with tax rates so high and rising, has little prospect of receiving benefits worth even as much as the taxes he paid. Not to mention that the more inflation we have the less his benefits will buy.

As time goes on, the people at work will take on more and more of the burden of paying growing benefits to people already retired. Is there no limit to the load America's active work force will accept?

For the average American, even now, social security is a costly way of buying insurance. That's because a true insurance system operates with a reserve fund, a fund that generates interest income to carry much of the load. Americans, especially labor union leaders who negotiate pension fund agreements, are becoming increasingly familiar with this principle. Will there, at some point, be a public outcry against the high cost of social security?

There is another worry, and this is one that should have special significance for an administration which so often voices concern about the rate of economic growth. To speed growth, the Nation must have more savings and investment. And social security cannot help but divert funds from savings, since it takes over many burdens that otherwise would be carried by insurance. When savings go into regular insurance companies, they are invested in productive enterprise. When funds go to the Government, they merely fuel nonproductive Government spending. Is there no limit to the diversion of savings the Nation can weather?

Entirely aside from all the social implications of expanding social security, the economic questions must be considered now. For the financial planning of most Americans centers on social security, and the system should not be lightly sacrificed for political gain.

In these Democratic days in Washington, you'd think there would be someone willing to listen to Mr. Roosevelt's warning.

[From the Deseret News, Salt Lake City, Utah, July 2, 1962]

THE ROAD TO SOCIALIZED MEDICINE

The way the controversial King-Anderson bill on medical care for the aged is being watered down looks like a sure sign that it is in trouble in Congress, as it ought to be.

This makes a mockery of the earlier rosy assurances from the bill's supporters that the measure had overwhelming support and virtually nothing could stop it. If that were really the case, they would not be offering to compromise on certain provisions.

But if what happened to the administration's ill-fated farm bill is any indication, the proposed compromises on the "medicare" measure won't help it much. The parallel between the farm and medicare proposals is this: At the last minute several "sweeteners" to the farm bill were offered in an attempt to make its harsher provisions more palatable to Congress, but since they didn't alter the bill's basic flaws, it was defeated.

The same thing seems to be the case with the medicare measure. That is, the suggested medicare compromises do meet certain objections—but in the process they create new ones, besides which they do not go to the heart of what's wrong with the medicare bill.

The basic trouble with the proposed compromises is that they try to be all things to all men. Thus, the major changes made in working out the compromise would:

Permit States to set up their own health care plans by sending the participating State a lump sum to provide the basic health care for its aged. This, of course, raises the time-worn objection that it's wasteful and inefficient to raise tax funds in the States, send it—or, rather, part of it—back to the States again.

Place the medical care money in a trust fund separate from the rest of the social security fund: That might not be a bad idea since the social security fund is in such poor fiscal condition. But if that's done, what's the sense in tying the medicare program to social security in the first place?

Cover about 2.5 million persons not under social security. (The original bill would have covered only those persons participating in social security.) The trouble with this is that social security participants evidently would have to shoulder the extra burden of paying for the medical care of those not covered by social security, which would be manifestly unfair.

Permit participants to continue their private insurance plans, with the Government paying for part of the premiums instead of receiving the payments directly from the Government. But since the Government could argue with some justification that it should set standards to determine which private insurance firms would qualify to participate, this might well open the door to further Federal regulation of this particular segment of free enterprise.

Beyond these objections, the compromise medicare proposal is still a scatter-gun approach to the problem. Three-fourths of the population already has some form of medical insurance. Of those over 65, more than half have medical coverage. Moreover, coverage has been growing steadily—so why meddle with progress?

Still another danger is that if the Government is to provide, on a compulsory tax basis, medical services for one age group, why shouldn't it do the same for other groups? The end of this road is clear—socialized medicine.

What it all adds up to is that combining Government and medicine creates an unhappy mixture that would best be left alone.

[From the Salt Lake Tribune, July 5, 1962]

A BACK-DOOR PLAN TO GET MEDICARE LAW

The administration is making a strenuous effort to get congressional approval of its

social security medicare program by roundabout, and questionable, Senate action.

Stymied by inability to blast the King-Anderson bill out of the House Ways and Means Committee, administration forces have attached the bill as an amendment to a bill already passed by the House for extension and increase of certain Federal welfare payments to needy persons and dependent children.

Many Senators object to attaching such a vital piece of legislation as medicare as a rider to an unrelated bill. This threatens to destroy, or at least delay, vital legislation on which there is general agreement. The aim is to swing votes to the controversial rider in order to get the initial bill passed.

In this case the welfare bill must be passed promptly or some of these aid programs cannot be continued. Authorization for some of the funds expired June 30. The States, which administer the aid programs, are concerned—which may explain in part why 19 State Governors in their 54th annual conference voted for a resolution favoring the administration's social security medicare program.

Senator ANDERSON, one of the sponsors of the King-Anderson bill, has made certain changes in consultation with Senate opponents of the original measure which he hopes will gain enough votes to get it through the Senate.

But the compromises do not touch the heart of the matter, which is the tying of medicare to social security.

The medical profession opposes this because the doctors are convinced that once health care is tied to social security, it will inevitably expand until most, if not all, health care is brought under Government control and financed through federally imposed taxes.

Walter Reuther, head of the United Auto Workers, who has advocated many socialistic causes, made this very clear in his testimony before Congress. He said: "If we can get the principle established, we want to build on that principle." President Kennedy himself has described the King-Anderson bill as just a start.

Once health care of even the limited kind spelled out in this bill is tied to social security, we do not doubt it will inevitably expand, first to give a better level of care to older citizens, then to extend social-security health care to other age brackets.

It may be that the people of the United States want to adopt a scheme of socialized medicine such as is in effect in Britain and in many European countries.

But if so, it should be with eyes open, and after full debate, not by a foot-in-the-door subterfuge based on first establishing the principle and then building on it to accomplish full social-security financed health care.

The Tribune does not believe this country wants socialized medicine. We do not believe social security should be distorted by paying for health services rather than paying pension benefits based on previous earnings.

Furthermore we do not think a fair test has been given the aim of providing adequate medical care for the aged through the Kerr-Mills law, or through further extension of the voluntary health insurance programs which have already done so much to bridge the medicare gap.

It is regrettable that this whole problem has become such a political issue, charged with emotionalism, and characterized by misinterpretation and subterfuge.

Social security medicare is too vital a decision to be slipped through the back door as a rider on unrelated legislation. It should be decided on its own merits, with full understanding of where advocates of this foot-in-the-door program intend to take it in the years ahead, once Mr. Reuther's principle of social-security health care is established.

CHICAGO, July 9.—The financing of health care for the aged with Government participation is too important a matter to be resolved by patchwork compromise or expediency, said Walter J. McNerney, president of the Blue Cross Association, today.

In a statement relating to current discussions in Washington, Mr. McNerney said:

"There have bene many references to Blue Cross during the current debate in the U.S. Senate on the compromise proposal to finance health care for aged citizens. It is stated that the providers of services may select an organization, such as Blue Cross, to represent them in dealing with the Federal Government and that the Secretary of Health, Education, and Welfare may enter into an agreement with the agency so sellected to perform some of the administrative functions of the program. Just how this would work out is not clearly defined, but at best it seems that Blue Cross would serve largely as a conduit for money and instructions from the Department of Health, Education, and Welfare to the providers of the services. In our view this is not the most efficient and realistic way in which to utilize the assets and capabilities of Blue Cross plans. It is unfortunate that this and other provisions of the compromise plan have been advanced without the thorough examination warranted by so complex a subject.

"The member plans of the Blue Cross Association are on record to the effect that many retired aged persons need Government assistance to enable them to purchase health protection through the voluntary system. Based on extensive experience in covering more than 5 million aged persons and long standing relations with the Nation's hospitals in every State, the plans feel that the Government assistance to the aged should be related in amount to income levels; that legislation should state benefits only in broad categories so that the realities of changes in medical science and revenues could be reflected; and that Government's relations with Blue Cross should be on an underwriting basis rather than a cost plus basis; i.e., Blue Cross, to the extent that it is involved, should assume the risks at a given rate for a given period of time. The scaled income provision would help those aged who need it the most; it would encourage preservation of present coverage; and it would avoid a means test. Furthermore, an underwriting basis would enable the Congress and the administration to determine annual costs in advance, and would preserve to the highest possible degree the concept of local responsibility through local plan administration.

"Our estimate is that the income from the revenues provided in the amendment proposed in the Senate is not sufficient to cover the benefits described. Furthermore, it is doubtful that some of the benefits could be produced by providers of services because of shortages of skills and facilities in many areas.

"The voluntary system is undergoing an orderly progression in covering disadvantaged groups such as the aged. The control, underwriting and cost relations developed are effective and getting stronger continually. It is hoped that the Congress will do nothing to retard continued progress in this area."

Mr. BENNETT. Mr. President, the Senate has been very patient with me, this afternoon; and I appreciate the opportunity to present these views on the proposal before us. I am afraid I shall have other views to present, and no doubt before the end of the debate I shall again take the floor, to expand on my views on some of these problems. But at this time, in closing my remarks now, I urge the Senate to reject the Anderson amendment.

PUBLIC WELFARE AMENDMENTS OF 1962

The PRESIDING OFFICER. The unanimous-consent agreement with respect to the public assistance and welfare bill (H.R. 10606), comes into effect at this time.

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. MANSFIELD. Mr. President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator will state it.

Mr. MANSFIELD. What is the pending question?

The PRESIDING OFFICER. The pending question is on agreeing to the amendments offered by the Senator from New Mexico [Mr. ANDERSON] for himself and other Senators to the public assistance and welfare bill.

Mr. MANSFIELD. A further parliamentary inquiry, Mr. President.

The PRESIDING OFFICER. The Senator will state it.

Mr. MANSFIELD. It is my understanding that, while the Anderson amendments are the pending question, they will not be voted upon until next Tuesday, at a time certain, and that in the meantime other substitutes or amendments may be offered under a time allocation. Is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. ALLOTT. Mr. President, I send to the desk an amendment and ask for its immediate consideration.

The PRESIDING OFFICER. The amendment offered by the Senator from Colorado will be stated.

The CHIEF CLERK. It is proposed, on page 75, to strike out, beginning with line 3:

Mr. DIRKSEN. Mr. President, will the Senator yield?

Mr. ALLOTT. I yield.

Mr. DIRKSEN. May I inquire whether the distinguished Senator from Colorado has one or more amendments, and whether he expects record votes on them?

Mr. ALLOTT. The Senator from Colorado has several amendments, but does not anticipate asking for a record vote.

Mr. DIRKSEN. Can the Senator from Colorado give us some intimation as to how much time he will require on them?

Mr. ALLOTT. The Senator from Colorado thought he would probably offer about four amendments this afternoon.

Mr. DIRKSEN. Very well. I thank the Senator.

The PRESIDING OFFICER. The amendment offered by the Senator from Colorado will be stated.

The LEGISLATIVE CLERK. It is proposed, on page 75, to strike out beginning with (3) on line 10 through the word "Act" on line 12.

Mr. LAUSCHE. Mr. President, will the Senator from Colorado yield me 3 minutes from the time on the bill?

Mr. ALLOTT. Mr. President, I ask unanimous consent that I may yield the distinguished Senator from Ohio 3 minutes from the time on the bill, with the understanding that I shall not thereby lose my right to the floor.

The PRESIDING OFFICER. Is there objection to the request of the Senator from Colorado? The Chair hears none, and it is so ordered.

Mr. LAUSCHE. Mr. President, I send to the desk, for printing under the rule, an amendment which I intend to offer. The amendment would deal with the Health Insurance Benefits Advisory Council which would be created under section 1712, on page 37, of the Anderson amendments.

The section would provide that there be created a Health Insurance Benefits Advisory Council, consisting of 14 members. The 14 members would be appointed by the Secretary of the Department of Health, Education, and Welfare. The section provides, in part:

> Not less than four of the appointed members shall be persons who are outstanding in the fields pertaining to hospitals and health activities.

My amendment contemplates identifying 12 of the prospective appointees by way of occupation. My amendment would provide that:

> Of the appointed members, not less than three shall be actuaries, not less than three shall be persons who are outstanding in the fields pertaining to hospitals and health activities, not less than two shall be members of the medical profession, not less than two shall represent management, and not less than two shall represent labor.

The purpose of my amendment is to have on the Advisory Council persons who are members of professions which are directly interested in the sciences and arts connected with the program. I would provide for the appointment of three actuaries. In my opinion, actuaries are vital to the efficient operation of the Advisory Council. I would provide for three members who are acquainted with the management of hospitals. I believe such appointments are vital. I would provide that not less than two members shall be members of the medical profession, that two shall represent management, and that two shall represent labor.

Under the language of the Anderson amendments only four persons would be identified as persons having experience in hospital management. I think the presence on the Advisory Council of actuaries is absolutely needed to insure that fiscally the system, if it is adopted, will be efficiently operated.

I thank the Senator from Colorado for yielding me this time.

The PRESIDING OFFICER. The amendment will be received and printed, and will lie on the table.

The Senator from Colorado has the floor.

Mr. ALLOTT. Mr. President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator will state it.

Mr. ALLOTT. How much time have I remaining on the amendment?

The PRESIDING OFFICER. The Senator has yielded 4 minutes. The Senator has 26 minutes remaining.

Mr. ALLOTT. I thank the Presiding Officer.

Mr. President, we are considering today a health care proposal which, if enacted, would destroy America's unique system of competitive medicine and could bankrupt the social security system.

It would dilute the quality of medical care to the detriment of the patient. It would drastically change the original concept and purpose of the Social Security Act. It would shamefully exploit our elderly for political purposes. It would tax many of the poor to provide health care for many of the rich. It would encourage dependency rather than independency.

Mr. President, this proposal relies on compulsion and denial of freedom; it proclaims the state superior to the individual; it violates Judeo-Christian teachings because it rejects the divinity of man.

The measure before us was hastily conceived. It is nothing more than an expanded version of what is known as the King-Anderson bill. The bill is basically bad. The cloak of compromise does not change its defects or conceal its inherent dangers. It is still "a medicare wolf in sheep's clothing."

Yet, Mr. President, Congress is being asked to abandon its customary rules and traditional procedures and to hastily approve a proposal which would not become effective until January 1, 1964. Let us not be stampeded into making a hasty decision on a hastily conceived measure.

That great American, Abraham Lincoln, once said:

> If we could know first where we are, and whither we are tending, we could better judge what to do and how to do it.

There are many questions still unanswered.

It is often generalized that the elderly of this Nation are unable to pay their medical bills and that most of them are in poor health. But as far as I have been able to determine, there are no facts or figures as to how many—I repeat: how many there are over 65 who need and want medical and hospital care and do not get it.

I am certain, however, that the health care problems of the aged definitely are not of the magnitude as represented by some wishing to exploit them for political purposes.

No one wants anyone, regardless of age, to suffer from the lack of medical care.

But the problem before us is to determine the most sensible way to help those who need help without sacrificing the present high quality of medical care available to the Nation and without starting this Nation down the road to socialized medicine.

The measure now before us proposes to provide health care to everyone over 65, whether it is needed or not. Somebody might need it; so everybody gets it. This is a shocking disregard for the taxpayers' money.

This health care proposal is based on the false premise that most of the aged are ill and poor.

A quick sampling of surveys and studies made in various sections of the country indicate the problem of our aged citizens is an overexaggerated one.

For example: The Fort Wayne, Ind., News-Sentinel recently reported that "a documented survey—see reference one—provides indisputable evidence that Indiana's senior citizens are, for the most part, in position to finance their own health needs. Of the 445,510 Hoosiers age 65 or over, 94 percent are caring for themselves either out of private income, savings, insurance, pensions or other nonwelfare sources."

The survey pointed out that 300,560 of the aged group own their own homes and 367,000 are eligible and covered for health and accident insurance by commercial insurance companies, Blue Cross, Blue Shield, or by veterans' benefits.

The survey also revealed that out of 4,357 hospital admissions for those over 65 only 84 patients, or 1.93 percent, were unable to pay or make arrangements for payment of their hospital bills.

Another study was made in Greene County, Mo.—see reference two—where the residents are described as being in the middle-to-low income group, with farming and small manufacturing the basis of the economy.

One portion of the study included patients of 18 physicians doing mixed family care and specialty practice. The survey disclosed that patients over 65 are responsible for only 9 percent of the unpaid bills.

A 100-bed, general medical and surgical hospital also was surveyed. A study of the unpaid bills at this hospital revealed that the 65-and-over group has the best record for payment of hospital bills. Of the 857 elderly patients treated during an 11-month period, only 15 percent failed to pay their bills.

A survey conducted—see reference three—at the Billings, Mont., Deaconess Hospital disclosed that almost 95 percent of the hospital bills of 559 aged patients were paid within 6 months.

Spot surveys by three Blue Cross plans—see reference four—indicate that the majority of hospitalized persons 65 and over either are having the cost of hospitalization paid by health insurance or are paying the cost from personal resources.

Results of the 1-day surveys in Texas, Oklahoma, and northeast Ohio showed:

First. Eighty-three percent of the 2,596 persons 65 or older who were in 60 northeast Ohio hospitals last February 7 were covered by health insurance or had the resources to pay their bills.

Second. 61.2 percent of the 1,300 aged persons in 44 Oklahoma hospitals last March 14 had health insurance or private resources, and the remaining 38.8 percent were receiving either old age assistance or medical assistance to the aged through the Kerr-Mills law.

Third. 70.9 percent of the 5,701 aged patients in 480 Texas hospitals on April 11 had some form of health insurance coverage.

A survey—see reference 5—of 296 patients, aged 65 or older, who were treated at Staats Hospital in Charleston, W. Va., in a 1-year period showed that only 1.5 percent did not pay their bills.

Patients over 65—see reference 6—at the Tucson, Ariz., Medical Center had a far smaller percentage of uncollectable bills than patients under 65, according to a study by M. G. Wolfers, president of the Arizona Hospital Association.

This study, which included 1,960 patients 65 or over, revealed that only 0.36 percent of their hospital bills were unpaid.

In the State—see reference 7—of Vermont, which I am told has a higher percentage of its population over age 65 than any other State, a survey showed that 80.7 percent of the aged said they would pay doctor bills through health insurance, from savings, or with current income.

The fact is that there is considerable evidence that the majority of people over 65 are able to finance their own health care.

Additional evidence is found in the studies made by the Conference of Catholic Charities in three lower-middle-income parishes in St. Louis, Cleveland, and Buffalo.

The report stated:

> When asked who would pay for hospitalization if it were necessary, between 80 percent and 90 percent of all the aging in all studies said they had hospitalization insurance, savings, or potential help from children and relatives. The Buffalo study, which had the only further analysis of this kind, found 7 percent who would turn to welfare organizations and 5 percent who said they did not know what they would do.

Of the approximately 65,000 persons age 65 or over in the State of Montana—see reference eight—about 6,500 require assistance through public welfare and the remaining 58,500 are able to provide their own living expenses and medical care through investments, savings, current employment, pensions and health insurance.

Studies show that the overwhelming majority of aged patients in Delaware—see reference nine—can and do pay their hospital care. Of the aged admissions in Delaware hospitals, 86.2 percent paid the hospital bill in full.

These are only a few examples of studies conducted by various groups, but they provide proof that the problem has been blown out of proportion. There are some of our aged who are needy, or near needy, but to generalize about a group of 17 million on the basis of a relatively few individual cases is exploitation.

The Right Reverend Monsignor A. C. Dalton, director of Catholic hospitals, archdiocese of Boston—see reference 10—told the Senate Subcommittee on Problems of the Aged:

> From all that I have observed, heard, or read, it is my opinion that the problem of our aged citizens is an overexaggerated one. Reliable authorities appear to be unanimous in stating that the vast majority of those 65 years and over present no special problem; they can handle their own situations well or have them handled satisfactorily by those near and dear to them. It is with regard to the minority that any problem exists * * *. Public interest focuses upon this minority all out of proportion. This is no doubt due to the rapidly increasing number of these aged citizens and the fact that such an increase was neither foreseen or well prepared for. The result is a certain amount of confusion and not a little hysteria in trying to arrive at a sane and sensible solution.

Aged persons value their independence and may be resentful if ready-made plans for their welfare are thrust upon them, according to a study conducted by the Catholic—see reference 11—University of America's Bureau of Social Research among 466 aged residents of Wilmington, Del., and among 130 persons 60 years of age or older living in Wilmington suburbs.

The bureau concluded that while there is a minority of aged persons who are "desperately poor or seriously ill," Wilmington's senior citizens as a group appear to be financially independent, socially well adjusted, and in good health.

The study showed that more than two-fifths of both men and women surveyed believe they are financially able to provide comfortably for themselves the rest of their lives. Another two-fifths can pay ordinary expenses. Nearly 62 percent of the men and 54 percent of the women own their own homes or apartments.

Some 71 percent of the men and 67 percent of the women either had not been confined to bed, or had been confined 6 days or less by illness in the preceding year.

More than two-thirds of all respondents spent either nothing or less than $100 for medical care in the preceding year. Approximately four-fifths had been attended by private physicians rather than at hospital clinics for minor illnesses in the preceding 5-year period.

More than two-thirds said they would pay for long-term hospitalization through hospital insurance and/or savings.

"The most striking feature of this whole analysis," the bureau said, "is the relative economic independence of such a very high proportion" of both men and women.

A study of a random cross-section of all older persons in the United States disclosed that the health care problems of the aged definitely are not of the magnitude they have been purported to be.

This study, conducted by the National—see reference 12—Opinion Research Center of the University of Chicago, revealed that only 9.6 percent of persons aged 65 and over said they could pay a medical bill of $500. More than 90 percent said they have available means to meet such a bill.

Findings of the Federal Reserve Board disclosed that the liquid assets of persons 65 and over are up and are growing faster than the assets of any other age group during the last decade.

G. Warfield Hobbs—see reference 13—a New York banker and chairman of the National Committee on Aging, said he believed the whole country will vote more effectively and intelligently and with less emotion on health care legislation if the people are more aware of the financial facts of life concerning our aged citizens. He pointed out that our present indigent aged are diminishing both by numbers and by proportion, and are being replaced with the newly aged who are increasingly able to care for themselves.

Mr. Hobbs has warned that if sentiment or politics carries us overboard on a permanent basis to solve the temporary financial problems of a segment of the aged population, "we may find in the future that we are providing perhaps more than necessary for a very large and self-supporting aged group at the expense of other age groups."

As proof that the new generation of older citizens is attaining better financial independence, Mr. Hobbs cited figures showing that the number of aged receiving public assistance reached a high of 2,789,000 in 1950, but 9 years later there was a decrease to 2,394,000, despite the fact there were 3 million more in the aged group. The reduction continues at a rate of about 3,000 a month in spite of a net gain in the number of aged of about 30,000 a month, he said.

Dr. Willard C. Rappleye—see reference 14—in his report as president of the Josiah Macy, Jr., Foundation said:

> Planning for the long-term future under conditions which exist then should be given more consideration rather than creating permanent legislation for a temporary phase of our economy.

Some economists believe that in the not too distant future old-age assistance will have been reduced to an insignificant proportion, and that a great majority of our elderly will be self-respecting and financially independent based upon a combination of social security benefits, private pensions, private savings and insurance, and wider homeownership.

Today, those over 65—see reference 15—account for about 9 percent of our total population, and, despite the retirement majority, they still receive about 8 percent of all personal incomes.

In many respects, the aged are better off than any other group. In addition to having higher liquid assets and higher percentage of homeownership, their financial obligations are significantly less and they enjoy tax advantages not available to younger citizens.

I am sure most of us have heard the statement that 60 percent of our aged have incomes of $1,000 a year or less. This figure, while accurate, is totally misleading. It includes dependents, many of whom have no individual incomes of their own. It would be equally accurate, and just as misleading, to say that nearly 65 percent of all Americans had incomes of $1,000 or less a year. Facts are of little significance until they are examined and interpreted by reason.

The report—see reference 16—of the planning committee for the White House Conference on Aging estimated the total income of the over-65 population in the United States from all types of private investments at from $4,300 to $8,300 million a year, or approximately 17 to 28 percent of the total cash income of the group. This includes dividends, interest on savings, annuities, rents, royalties, and the like. Thus, at a conservative estimate, a total of from $75 to $150 billion worth of income-producing assets would appear to be owned by this age group.

This is a healthy figure, especially in view of the fact that it does not include such non-income-producing assets as homes occupied by the elderly or the value of businesses in which the over-65 age are still actively engaged.

There are two facts that must be kept in mind in evaluating the economic status of the aged:

First. Income alone is not a valid yardstick for measuring the financial situation of the aged.

Second. Our elderly are not a homogeneous group from either a financial or health standpoint.

To generalize that the aged are in poor health is just as misleading as to state that most of the elderly are on the brink of bankruptcy.

Doctors tell us that most older people are in good health. They explain that there are no such things as diseases of the aged. There are diseases among the aged, just as there are diseases to be found in any age group.

It is true, however, that there is a greater degree of chronic illness among older people. But it is important to understand what is meant by the term "chronic illness." It means a recurrent condition, or one that persists over a period of time.

It is significant to note that only 14 percent of the aged with chronic ailments experience any significant limitation of activity. Only 5 percent have major limitations of mobility.

There are many examples of the chronically ill who lead perfectly normal lives. Several years ago a diabetic represented the United States on the Davis Cup team. He was chronically ill, but with the help of insulin he led a normal life. President Franklin Delano Roosevelt was chronically ill as the result of polio. I need not comment on the active life he was able to lead.

Just as there has been misunderstanding about the financial status of the aged there also has been confusion about the health of our aged. Chronic illness has been interpreted by some to mean that most older people are sick and debilitated. It is false to assume that the majority of our aged required constant medical attention. We would be less than honest with ourselves if we enacted legislation on the premise that most of our aged are ill and unable to pay for medical care.

A study conducted by the National Retired Teachers Association and American Association of Retired Persons among the organizations' members revealed that 87 percent consider themselves in reasonably good health. Eighty-six percent of the 150,000 members reported that they had medical or hospital insurance.

Voluntary health insurance and prepayment plans, which permit persons of all ages to protect themselves against the cost of unexpected illness and accidents, have made a phenomenal growth. This growth has been referred to as one of the great social advances of our time.

Health insurance is now available to all aged everywhere. Today, more than 9 million, or 53 percent, of the aged already have health insurance. The number covered has tripled in the last 10 years and the elderly are purchasing health insurance at a faster rate than any other age group.

In 1937, less than 4 percent of the population of the United States had any form of health insurance. Ten years later in 1947, about 30 percent were covered. Today, an estimated 75 percent of the total population have some voluntary health insurance coverage.

The PRESIDING OFFICER. The time of the Senator from Colorado has expired.

Does the Senator from Tennessee wish to yield time?

Mr. GORE. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. How does the Senator from Tennessee wish to dispose of the time consumed in the quorum call?

Mr. GORE. Mr. President, I ask unanimous consent that the time consumed in the quorum call not be charged to either side.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. HUMPHREY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HOLLAND rose.

Mr. HUMPHREY. Mr. President, how much time remains on this amendment?

The PRESIDING OFFICER (Mr. METCALF in the chair). The Senator from Minnesota has 30 minutes in opposition.

Mr. HUMPHREY. How much time does the Senator from Florida desire?

Mr. HOLLAND. I could conclude in from 5 to 8 minutes.

Mr. HUMPHREY. Mr. President, I yield 10 minutes to the distinguished Senator from Florida.

Mr. HOLLAND. Mr. President, I appreciate the courtesy of the acting majority leader in yielding time to me. I am not speaking in favor of any single amendment or in opposition to any single amendment. I am speaking in opposition to the absurd procedure under which we find ourselves operating at this time, and in an effort to show that we are wasting our time in considering the important question of medicare for the aged in the way it is now being considered.

The bill before the Senate relates to important amendments to the body of our welfare legislation. It is a bill of many pages. The report of the Committee on Finance, which gave consideration to the various proposals which are embodied in the public welfare amendments of 1962, as the measure is styled, is 82 pages in length. That bill and the report relating to it are based upon hearings held by the Committee on Finance, as shown by the printed hearings, consisting of 603 pages. The hearings represent 4 full days of intensive work in the Committee on Finance and the study of the proposed measures by the many witnesses who appeared before that committee, including, of course, the official witnesses who are charged with the administration of the welfare acts.

Prior to the time the Committee on Finance considered the bill, it had been discussed at great length in the House of Representatives. Long hearings had been held upon the bill in that body, also. I do not have before me the volumes of the printed record of the hearings held by the House committee, but I understand they were even longer, both in terms of duration of the hearings and the extent of the printed record, than is the case with the Senate committee documents on the subject. I have already stated that the printed hearings of the Senate committee comprise 603 printed pages, and that the Senate report comprises 82 printed pages.

But, Mr. President, we now find that, notwithstanding the fact that none of those printed pages had to do with the subject of medicare, which was being handled in separate proposed legislation, subjected to long hearings in the House committee, but which has not yet come up for hearings in our own Finance Committee, we are confronted with four long amendments—as well as various shorter amendments to each of them—which have to do with the subject of medicare.

The first is the amendment proposed by the distinguished Senator from New Mexico [Mr. ANDERSON], for himself and a group of our colleagues; and that amendment alone consists of 79 printed pages; and it existed for the first time as a proposal at the time when it came to us in the form of this amendment, representing, as it did, a compromise between the ideas of its distinguished authors—that is to say, the Senator from New Mexico [Mr. ANDERSON] and various other authors; and, so far as I know and believe, the bill had never seen the light of day until a few hours before the time when it came here as a proposed amendment to the Welfare Act amendments of 1962. Yet, Mr. President, though it has not been subjected as a unified measure to hearings, either in the House committee or in the Senate Finance Committee—and I repeat that no hearings on this general subject have yet been held in the Senate Finance Committee—we are expected, on the basis of the debate on the floor of the Senate, and notwithstanding our committee duties and our other duties, and without the benefit of comment by the administrative agencies and all others who have very vital interests in connection with this measure, to decide upon it and pass upon it—each of us from the background of his own experience—and determine whether the provisions contained therein are wise.

To complicate the matter further, there are three other proposals on this subject. One of them has already been voted upon; it is the amendment proposed by our colleague, the distinguished Senator from Kentucky [Mr. MORTON]. A second voluminous amendment has been proposed by the distinguished Senator from Massachusetts [Mr. SALTONSTALL], on behalf of himself and other Senators; and a third has been proposed by the distinguished Senator from Connecticut [Mr. BUSH], on behalf of himself and certain other Senators. But, Mr. President, not one of those four measures is identical with any of the others. Not one of them is exactly like anything else that has ever been considered before by the Senate. Not one of them is exactly like the proposal which has been subjected to hearings before the House committee—and again I comment on the fact that our own Finance Committee has not heard testimony on any of these measures, nor has it given us the benefit of its consideration and its recommendations in regard to any of them. Notwithstanding all these important facts, we are expected to emerge from debate of this kind with a wise answer to a question which transcends in importance and in public interest all the other proposals included in the amendments to the Welfare Act of 1962 put together.

My own mail—and I am certain this is also true of the mail of other Members of the Senate—on the subject of medicare is several hundred times greater than the amount of mail I receive upon the various other important items included within the purview of the pending bill—that is to say, the amendments to the Welfare Act of 1962. Furthermore, the amount involved in increased taxes is greater, and the amount involved in burdens upon certain employed taxpayers is greater. Yet, Mr. President, without the benefit of any study, we are expected to arrive at a wise answer to this problem, which is a question of first impression to most Members of the Senate.

I do not challenge the principle or the high purpose of any of the distinguished Senators who have offered these amendments; but I call attention to the fact that whereas they may have had a chance individually to study this subject and to come forth with these long, involved proposals as to what they think we should do in the field of medicare, that opportunity has not been afforded all 100 Members of the Senate; and the proposals now before us have not been supported by a study by our Finance Committee and by its recommendations directed to all of us.

So, Mr. President, I cannot think of anything more absurd than for us to attempt out of such a situation to arrive at a wise or defensible answer; and, therefore, so far as I am concerned, I do not propose to vote for any of the proposed amendments dealing with the field of medicare. I feel that if I did vote for any one of them, I would be voting without the guidance and without any kind of recommendations or advice from those who, under law, are charged with administering laws in this field, and also without the recommendations and advice and guidance of the Members of our own body and our colleagues at the other end of the Capitol who, as members of an appropriate committee, are charged with bringing forth proposed legislation in this field.

Thus, Mr. President, I shall not vote for any of these amendments.

Furthermore, Mr. President, it seems to me that Senators who are offering these amendments——

The PRESIDING OFFICER (Mr. PELL in the chair). The time yielded to the Senator from Florida has expired.

Mr. HOLLAND. Mr. President, will the Senator from Minnesota yield additional time to me?

Mr. HUMPHREY. Mr. President, I yield 5 additional minutes to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida is recognized for 5 more minutes.

Mr. HOLLAND. I thank the Senator from Minnesota.

I was about to say that it seems to me that Senators who are offering these amendments are practicing what is referred to in the Constitution as "cruel and unusual punishment," not only upon Members of the Senate who have to listen to this long and involved debate, regardless of whether they must run, this year, for reelection, but particularly upon the Members of the Senate and the Members of the other body who must run for reelection this year, because this is probably the most controversial subject matter to be discussed by the people of the United States in recent years; and certainly this question is entitled to, and must have, the careful study and consideration, not only of the respective committees of the Senate and the House, but also of those who are learned in this field and who have devoted a large portion of their lives to finding out the answers to the question of what is the best way to take care, under democratic principles, of the undoubted need of many older persons in our country who do not have sufficient means to assure themselves and their loved ones of hospitalization, medical care, and surgical care.

I realize that not all of these measures go that far, and perhaps none of them covers all of these fields. However, these proposals are submitted as the answers to the undoubted need of millions of older U.S. citizens for hospital

care, medical care, nursing care, and care by doctors and surgeons. Such subject matter is entitled to better handling and more serious handling than this, especially in view of the fact that we know that the body at the other end of the Capitol is not likely to give serious consideration to a measure which originates here as a rider, and particularly when it knows that this proposal has not been studied by our committee. I would think much less of those who represent the legislative arm of our Government at the other end of the Capitol if I thought they would regard with great seriousness a measure which would come out of debate of this kind and out of proposals so carelessly advanced as those which are now before us.

So, Mr. President, I hope the Senate will reject these amendments, will insist upon handling this subject in the regular manner, and will insist that this subject matter is of sufficient seriousness and gravity to be entitled not only to ordinary handling by our committees, but also to the most careful handling by them—the most careful handling possible for so delicate, complicated, and difficult a subject.

Therefore, Mr. President, I hope the Senate will, in a showing of wisdom in connection with so controversial a subject matter, refuse to place the stamp of its approval upon any of the four proposed amendments which deal in a general way with the subject of medicare for our aged.

I thank my distinguished friend, the Senator from Minnesota, for yielding to me; and I now yield the floor.

Mr. HUMPHREY. Mr. President, how much time is left on this side?

The PRESIDING OFFICER. Fifteen minutes remain.

Mr. HUMPHREY. What is the pending question?

The PRESIDING OFFICER. The pending question is the amendment of the Senator from Colorado to the Anderson amendment.

Mr. HUMPHREY. Mr. President, I shall make a brief comment. The amendment, as I understand, strikes item (3) in line 10 through line 14, which includes item (4) of the bill, H.R. 10606, "Part E—Miscellaneous Provisions, Studies, and Recommendations."

The Senator from Colorado seeks to strike out the following language:

> The feasibility of providing additional types of health insurance benefits within the financial resources provided by this act; and the effects of the deductibles upon beneficiaries, hospitals, and the financing of the program.

It is my view that the language which the Senator from Colorado seeks to strike out should be sustained and maintained in the bill. These provisions went through committee hearings in both the House and the Senate. Careful consideration was given to the provisions. It seems to me the purpose is merely to provide additional information to the Congress and to the executive branch, within the limitations set down in items (3) and (4).

I am particularly concerned about the language which affects the deductibles upon beneficiaries, hospitals, and the financing of the program.

I am hopeful the amendment of the Senator from Colorado will be rejected.

The PRESIDING OFFICER. Does the Senator from Minnesota yield back his time?

Mr. HUMPHREY. Yes.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Colorado to the Anderson amendments.

The amendment was rejected.

Mr. ALLOTT. Mr. President, I ask unanimous consent that the pending Anderson amendments be temporarily laid aside and that the Senate proceed to the consideration of the amendment which I now send to the desk.

The PRESIDING OFFICER. Without objections, it is so ordered. The amendment offered by the Senator from Colorado will be stated.

The LEGISLATIVE CLERK. It is proposed on page 33 to strike out the matter appearing on lines 7 through 12 and insert in lieu thereof the following: "and for each of the succeeding fiscal years' "

Mr. ALLOTT. Mr. President, I want to express my sincere appreciation for the remarks of the distinguished Senator from Florida. I concur wholeheartedly in his approach to this question, and, as I shall develop in later portions of my amendments and speeches, I also think this question should be considered by the Finance Committee.

As I stated earlier when I spoke on my previous amendment, 11 times as many persons are protected against hospital expense as there were in 1940; more than 24 times as many have surgical insurance; and more than 30 times as many are protected against medical expense other than surgical.

By far the most rapidly growing part of this health insurance picture is the growth in coverage of the elderly. And most of this growth has occurred in the past 10 years.

A survey conducted in 1952 disclosed that 26 percent of all persons past 65 had some form of health insurance protection. Today, 53 percent of the aged are protected.

This growth is even more impressive when we consider that an estimated 25 percent of those 65 and over are not even in the market for health insurance, since their health care is financed in other ways. If we subtract this group, who either do not need or do not want health insurance, we find that 68 percent of those over 65 who want this protection already have it.

It is known that some 13 percent of the aged are eligible to receive health care as beneficiaries of Federal-State old-age assistance or medical assistance to the aged programs. There are many others who do not need, desire, or believe in health insurance. This group includes those being cared for by the Veterans' Administration, by medicare, by general assistance, or by other local public and private agencies. There also are those whose private incomes and resources are sufficiently large to make it unnecessary for them to have insurance coverage.

The number of our elderly who will have health insurance coverage will increase because of the trend by insurance companies to allow and encourage persons to continue their health insurance on an individual basis when they retire. This fact, coupled with a continuing expansion in coverage among the total population, means that more and more individuals will be reaching 65 with health insurance still in force.

It has always been an important provision in Blue Cross and Blue Shield contracts that subscribers who desire to do so may elect to continue their coverage after leaving their groups, or after reaching age 65.

In 1951, 5 percent of Blue Shield enrollment, or about a million members, were 65 or older. Today, Blue Shield subscribers over 65 total more than 3,250,000. There also are more than 5 million Blue Cross subscribers over 65.

In the past 10 years, total Blue Shield enrollment increased 133 percent, but the number of persons over 65 covered by Blue Shield increased 225 percent.

A survey made 2 years ago by the Health Insurance Institute showed that 7 out of every 10 workers covered under group policies can retain their coverage after retirement.

A few years ago most hospital policies sold by private insurance companies terminated at age 65. Today, more than 60 policies or programs offered by major insurance companies are guaranteed renewable for life.

In recent months there has been a dramatic increase in the number of individual and group health insurance contracts being made available to persons over 65.

A report issued in January of this year by the Health Insurance Institute contained not a complete list, but a representative selection of the policies from which noninsured over-65 persons can select health insurance protection. More than 70 programs, covering a wide range of benefits, were listed in this report.

A major medical expense program developed in Connecticut, in which private insurance companies in the State pooled resources and risks, offers comprehensive coverage for a variety of services to anyone over 65 in that State. This pioneering venture is now spreading to other States.

In January of this year the National Association of Blue Shield Plans announced a new, national low-premium plan, providing a broad scope of medical and surgical benefits in hospitals and nursing homes for the aged. I am told that as of this date 66 of the 70 Blue Shield plans have approved participation in the new plan, and 53 of these already have received their local medical society's approval and cooperation.

This brief summary of the growth of voluntary health insurance in this country should indicate to all that the number of aged in this country who need but

do not have health insurance comprise a group that is steadily shrinking. Congress should not adopt any program that would lead to the decline, if not the demise, of voluntary health insurance in this country.

The measure we are considering would substitute a compulsory system of Government health care financing for a private voluntary system that has shown phenomenal growth and an ability to provide a financial cushion against medical expenses for millions of Americans.

Our voluntary health insurance programs are versatile enough to offer a wide selection of policies to meet the needs and pocketbooks of most citizens; they are available now to all who need and want them, and they are adequate enough to meet the needs of this Nation.

Fastest growing of all types of coverage is major medical expense. These plans provide payment—after a deductible amount—for 75 to 80 percent of virtually all expenses incurred as a result of catastrophic illness, up to limits as high as $10,000 or $15,000. In just the last 8 years, the number of persons protected under these programs has grown from 2 million to more than 35 million—a 1,700-percent increase.

Not only has there been a great growth in the quality of coverage, but also in the quality of coverage. A study published by the Brookings Institution showed that health insurance covers 88 percent of all hospital expenses incurred by beneficiaries, and 81 percent of all surgical expenses.

Other studies—the latest made in 1960—bear out these percentages.

Mr. President, it is important for us to consider in our deliberations here today that the vast majority of our aged population is neither disabled by illness nor verging on bankruptcy. There are some who are, but programs are available to provide for their health care needs.

In 1960 this Congress wisely enacted the Kerr-Mills law to provide medical care for those who need it and cannot afford to pay for it. This law is now on the books and is being rapidly implemented. It enables individual States to guarantee to every aged American who needs help the health care he requires. The law also is designed to benefit older persons who are paying their day-to-day living expenses, but who could not afford to meet the cost of a serious or prolonged illness.

As I pointed out earlier, the problems of the aged vary with the individual States. The Kerr-Mills law enables each State to pattern its program to meet its own particular needs.

The growth of health insurance in this country has been little short of phenomenal in the past quarter century. A variety of health insurance policies are available now to all who are able to purchase them. The Kerr-Mills law already is available in most States to help those who need help.

Msgr. John O'Grady, secretary of the National Conference of Catholic Charities, has said that too many workers in the field of aging are, in effect, not seeing the forest for the trees. By concentrating on the small minority of our aged who represent an extreme situation—medically, emotionally, socially or economically—they are winding up with a distorted picture.

They have magnified the problems of a minority segment to such an extent that their image of the total group has become blurred.

Each year those who reach retirement age are better equipped financially to live self-sufficiently. The aged are bringing with them, into their years of retirement, the protection of pension plans, which an ever-increasing number of employers are setting up. And, as most of them have carried health insurance during their working lives, they have learned to value its protection and continue it after retirement.

The problem of financing the health care of our older nonindigent people comes closer and closer to solution each day.

The problem is a diminishing one. The dramatic change in the economic status of the aged is most noteworthy. Only 14 percent of the aged over 65 receive public assistance today, whereas 22 percent were receiving public aid in 1950.

Economists predict that this improvement will continue at an accelerating pace. We are dealing with a diminishing problem. There is no crisis. There is no need to make a hasty decision now on a hastily conceived proposal.

I should like to digress for a moment from my prepared remarks to say that there is no need at this time to make a hasty decision on a proposal now offered to the Senate as an amendment to the public welfare bill, which in itself exceeds 75 pages, which the Senate Committee on Finance has had no opportunity to hear.

I should like to comment on this phase of the question later. Anyone who knows of the workings of the U.S. Senate must recognize that the entire work of the U.S. Senate depends upon the slow and perhaps painful but also logical consideration of measures which come before it. Members of the Senate are required to a great degree to depend upon the logical, objective and thorough consideration which the committees of the Senate give to questions which come before us.

Despite the propaganda, the problem is a constantly diminishing one. It is a diminishing problem because it is being met by self-reliant individuals, by sympathetic families, by health insurance, and by private agencies and public programs such as the Kerr-Mills law.

The medical care system in this country has been largely responsible for the ever-increasing length of life expectancy. It has given millions a chance to live when they might have died a few years ago.

More and more people are passing the 65-year milestone into the era we commonly call old age. Only 1 person in 10 born in 1900 could expect to live to age 65, and then only to live 3 or 4 years longer. But today more than 66 percent will survive beyond age 65 and not for 3 or 4 years but for 15 or more additional years.

More than 4,400,000 Americans are living today who would have died if the 1937 death rate had continued at that level.

Our system of medicine has known no peer in history. Yet, if we adopt this health care proposal now before us we will be taking the first big step toward replacing our system with government medicine which has been tried and found wanting in country after country.

Similar health care proposals have been before Congress in the last three decades, but each time they were blocked by an upsurge of public protest.

I add at this point, Mr. President, my own mail on this question over a period of months has been running in excess of 90 percent against the medicare proposal.

I am sure my esteemed colleagues are aware of the present public sentiment on this issue as evidenced by the mail Members of Congress have received.

The most recent Gallup poll also confirms the fact there is a rising tide of sentiment against the proposal for financing medical care for the aged through an increase in social security taxes.

In his latest poll released this month, Mr. George Gallup, director of the American Institute of Public Opinion, said:

> The last few months have been a dropoff in public support for the administration's proposed social security financing of such health benefits. Since March, an increased number of voters have swung over to the belief that such aid for the Nation's older citizens could be better handled privately.

A year ago the Gallup poll reported that 67 percent of the people favored the administration's plan over private programs. In March of this year, the poll showed that 55 percent favored the social security approach. In the latest poll, announced this month, only 48 percent of the people favored the King-Anderson bill over private programs. This is a substantial shift in sentiment away from the administration position.

It is clear that this proposal is losing ground as more people understand it and what it really would do to them individually and to the Nation as a whole.

A survey conducted by the American Press magazine among newspaper editors and announced in the publication's April 1962 issue showed that 78 percent of the editors opposed the King-Anderson bill and that 84 percent favored a private program over a Government plan. It is reasonable to assume that most of these editors reflect the majority opinion of their readers.

The June 1962 issue of Nation's Business magazine reports the results of a survey of students in 17 public and private medical schools throughout America.

The magazine said the study showed:

> Greater Federal activity in health care would cause many young Americans to abandon the study of medicine. * * *
>
> All but a small number of the students interviewed feel that more Government interference would drag down the quality of treatment available to the public, impede medical research, reduce incentives for top performance by doctors and discourage

many bright young people from entering the profession. * * *

The survey showed that medical students overwhelmingly oppose proposals for providing medical care for older citizens under the social security system.

One of the principal reasons why many are opposed to the King-Anderson bill is the fact that the proposal would force the workers and employers of this country to pay increased taxes to provide health care for millions of the elderly who are financially able to pay for these services themselves.

Mr. President, I have used the term "King-Anderson bill" because, as I explained earlier, the Anderson-Javits amendment now pending before the Senate is a slightly disguised and modified version of the original King-Anderson bill, no matter how it is attempted to be interpreted.

There has been considerable confusion about how much additional payroll taxes wage earners and employers would be compelled to pay if this proposal became law.

At the present time, a worker making $5,200 a year is paying 3⅛ percent on a wage base of $4,800 or $150 a year. His employer is paying the same amount. Starting January 1, 1963, the worker will pay 3⅝ percent on $4,800 or $174 a year and again his employer will match it.

The King-Anderson bill calls for a double-barreled tax increase—a tax increase of one-fourth of 1 percent for employees and employers alike, three-eighths of 1 percent for the self-employed, plus a $400 boost in the tax base from $4,800 to $5,200.

By January 1, 1964, when the King-Anderson bill—or the Anderson-Javits amendment—would go into effect, the worker making $5,200 would pay 3⅞ percent on the new wage base or $201.50. Again his employer would match it with another $201.50. The tax increase for this measure would be $27.50 a year for each worker and the same amount for his employer—a total of $55.

This amounts to a 16-percent tax increase for employee and a like increase for employer.

Two more social security tax increases already are approved and scheduled to go into effect in 1966 and 1968.

The tax jumps to 4⅛ percent for the worker, matched by employer, in 1966, and to 4⅝ percent in 1968.

If the King-Anderson bill—or the Anderson-Javits amendment—becomes law hiking the tax base to $5,200, every social security tax boost now scheduled and all future increases will be paid on that new base.

And these figures are based on the lowest estimated cost of the proposed plan. No nation which has tried similar medical care programs ever has been able to estimate the cost correctly, and some insurance actuaries believe the estimates for the King-Anderson proposal are unrealistically low.

The young man entering the labor market at age 21 would be forced to pay this tax for at least 44 years, while today's retired, many of whom are well-to-do and who have not contributed a dime to the program, could get the benefits free.

This social security approach places the burden of meeting the cost of the program only on low-income workers and then on a gross income up to $5,200. The secretary earning $5,200 a year would pay the same social security tax as her boss earning $52,000 a year.

It has been estimated that 40 percent of taxable income in the United States is not subject to social security tax.

If medical care for the aged is a national problem, it should be financed from general revenues as provided in title VI of Public Law 86–778.

There has not been time to fairly assess the Kerr-Mills program or the many new private insurance plans for the elderly. They deserve a fair trial.

The Federal grant-in-aid program for the medical care for the needy and near-needy is designed to help those who actually need help—not to arbitrarily established groups. It preserves voluntarism, permitting the nonneedy to take care of themselves. It follows the traditional Federal-State organizational structure of our Nation. And it places administrative responsibility and authority where it belongs—on the local government, which understands and is close to local problems.

The Kerr-Mills law does not waste tax dollars on aged people who are perfectly willing and able to take care of their own medical care costs. It preserves the high quality of medical care now available in this country by maintaining the patient's free choice of doctor and the doctor's freedom to treat his patients in an individual way.

To adopt the King-Anderson bill—or the Anderson-Javits amendment—would be to meddle with the free practice of medicine—a system that has given this Nation the best medical care in the world. It would be the beginning of an irreversible program that eventually would expand until it covered every man, woman and child in this country.

We cannot strengthen this Nation by copying medical systems under which one country after another around the globe has lost leadership in science and medicine. We cannot strengthen this Nation by substituting medical failure for medical success. I urge you to reflect on the consequences of such a radical measure and to heed the lesson taught in England. The British have given us a history lesson we cannot afford to ignore.

Mr. President, I ask unanimous consent that there be printed in the RECORD at this point a table of references keyed to the remarks I have made, showing the sources and authorities for the figures and statistics I have given.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

REFERENCES

1. Fort Wayne, Ind., News-Sentinel, January 16, 1962, page 1. Survey by Commission on Aging, Indiana State Medical Association.

2. New Medical Materia magazine, May 1962, page 58.

3. Reported in the AMA News, March 5, 1962.

4. Reported in the AMA News, May 14, 1962.

5. Reported in the AMA News, December 28, 1959.

6. Reported in the AMA News, April 17, 1961.

7. Reported in the AMA News, July 11, 1960. Survey by Vermont State Medical Society's Committee on Aging.

8. House Ways and Means Committee hearings, July 24–August 4, 1961, page 578.

9. House Ways and Means Committee hearings, July 24–August 4, 1961, page 1220.

10. October 14, 1959.

11. Reported in the AMA News, May 14, 1962.

12. Financial Resources of the Aging by National Opinion Research Center, University of Chicago, released November 1959.

13. Reported in the AMA News, May 16, 1960.

14. Reported in the AMA News, May 16, 1960.

15. "Our Changing Economy," syndicated column by Maurice H. Stans.

16. Britannica Book of the Year—1961.

17. Modern Maturity magazine, June–July 1961.

Mr. ALLOTT. Mr. President, I should like to propose a parliamentary inquiry at this time.

The PRESIDING OFFICER. The Senator will state it.

Mr. ALLOTT. Is it in order for me to withdraw the amendment which I have proposed?

The PRESIDING OFFICER. It is in order for the Senator to do so.

Mr. ALLOTT. How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 5 minutes remaining.

Mr. ALLOTT. I withdraw the amendment which I previously proposed.

The PRESIDING OFFICER. The amendment is withdrawn.

Mr. ALLOTT. Mr. President, I send to the desk an amendment to the Anderson amendment and ask that it be read.

The PRESIDING OFFICER. The amendment will be stated.

The LEGISLATIVE CLERK. In the Anderson amendment, identified as "6–29–62—A," it is proposed to strike the language beginning on line 1, page 1, through line 25 on page 74.

Mr. ALLOTT. Mr. President, much has been said and is being said on the subject of medical assistance for our elderly citizens. Yet for some reason we seem no closer to the truth today than ever before. The amendment I have offered would strike the so-called Anderson-Javits amendment. I venture to suggest that the large bulk of confusion has been induced by a deliberate effort to confuse, that the entire matter has become submerged in a morass of conflicting testimony that appeals to the emotions rather than to reason.

Much of what I will say today has been said before but if we are to understand this problem in its entirety and the effect of our actions not only upon the aged of our country but on future generations as well, the time we spend in reviewing the facts will be time well spent.

The subject of medical care of our senior citizens is a grave and complex

one, and cannot be dismissed with a few pat, cavalier statements. Neither is it a subject that should be charged with emotionalism, arbitrarily resolved in accordance with the whims of an administration that seeks only to enhance its power regardless of the harm that will be done. This administration seems to be more concerned with the means rather than the end and I propose therefore to set the record straight.

In order to set the record straight we must first define the problem. The problem concerns the individual, the community and the country as a whole. The problem needs to be examined with regard not only to the plight of our elderly people, but with respect to the role that is played by the family, various institutions and the government of the States in assisting the elderly to meet the growing costs of medical care. This problem is in danger of becoming, and has indeed become, a political football and it is time we cried "enough." The administration is so emotionally involved in trying to get its way with this matter, that it refuses to concede that the problem is already in a fair way being solved.

Rather than give the law of the land a chance to work, the administration would prefer to hold up the legislative processes concerning other important problems still to be solved by the Senate and the House, while it drags red herrings across our path. As a result the time we spend here will serve to delay needed legislation further.

At the same time through a lack of cooperation from the administration the law of the land which was enacted to provide the assistance that the elderly most desperately need is not being implemented with the deliberate haste that it deserves and the elderly of certain areas of our country are being deprived of the assistance they require.

It apparently matters not to this administration that our senior citizens are being deprived of their rights as long as the majority gets its own way with them. I suggest, Mr. President, that when the results of this recalcitrant attitude of the administration are weighed in the balance, that they are found wanting.

None of us are insensible to the needs of our senior citizens. All of us are gravely concerned regarding the problems of those who arrived on this earth before us and to whom we owe so much. We who are their sons and daughters have benefited from their labor and sacrifices on our behalf. They provided for us in our early years with the sweat of their brow; they watched over us and they guided us; they nursed us through our illnesses in the far watches of the night and through dark hours of despair. They saw to our education to the best extent of which they were capable, doing without in order that we might have advantages which they to a large degree could not afford themselves.

Even those who were childless were joined with our parents in achieving the scientific breakthroughs, the medical progress, the engineering marvels, the great strides in transportation, in education, in every phase of our modern life, so that we came into a life of advantages far greater than they themselves had enjoyed.

Who are the elderly of today but the workers, the scientists, the engineers, the teachers, the ministers, of yesterday? And now as they reach their sunset years, and as others reach them tomorrow, next year, and the years to come, their security and dignity is on our conscience. Now in the twilight of their years, some of our senior citizens are in need of assistance and it is and will continue to be the responsibility of all of us to see that they get it. We must see to it that they enjoy their remaining years in peace and dignity, not as wards under the benevolent despotism of an all-powerful Federal Government, but as free citizens able to live their own lives in gracious fulfillment.

Many of the facts and tables from which I will quote are from already published reports, but if we are to bring this problem to light in its true perspective, then these facts will bear repetition.

The problem is simply this: How many of our senior citizens need assistance in meeting the costs of medical care; what kind of medical care do they need; how much do they need; what will it cost; how is the required assistance to be given to them?

It is a well-known fact that since the early part of this century the proportion of the population which represents people of age 65 and over has doubled and that by 1980, about 10 percent of our population, something over 24 million people, will be 65 years of age or older. At the same time, that is, by 1980, the proportion of the population of working age will be less than it is today. So, whatever the cost, and rising as it will, to take care of an ever-increasing quantity of people in the elderly bracket, payment for those costs will have to come from an ever-diminishing group of wage earners.

Further factors bearing on the problem are that the majority of the aged are women and this proportion increases with age, the proportion of married persons drops with increased age and the proportion of the population age 65 or over varies not only State by State but further by county within States. To summarize, the essential facts are that our aged population is increasing with greater longevity among women and an uneven geographical distribution.

By the beginning of 1964 Social Security Administration estimates the total population 65 or older will be about 9 percent or approximately 17,900,000 persons. As I said a moment ago, not only the oldest age group, but also the youngest, will grow faster than the rest of the population. Between 1950 and 1960, while the number of persons 65 years of age or older increased by 34.7 percent, the number of those under 20 years of age increased by 34.4 percent. At the same time the increase in the group 20 to 64 years old was only 6.9 percent. This latter is the age group, of course, in which are the vast majority of those actively employed.

To interpret this information in another way, it might be said that while the younger group is growing very fast and those in the oldest group are growing very fast, those in the middle group, who would have to provide the money to pay for this program, are not increasing nearly so fast.

As I have said, the increase in the group 20 to 64 years old was only 6.9 percent. This latter is the age group, of course, where we find the vast majority of those actively employed. It represented 57.9 percent of the total population in 1950 and only 52.3 percent of the population in 1960. In this same decade there was an actual decline of 9.2 percent in the number of persons 20 to 29 years old. This is the age group which was made up of persons born during the prewar years when the birth rate was low.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD two tables published by the Bureau of the Census. One shows the total U.S. population and population age 65 and over for the years from 1920 to 1980. The second depicts the shifting percentage composition of the population by age group.

There being no objection, the tables were ordered to be printed in the RECORD, as follows:

Total U.S. population and population age 65 and over, 1920–80

Year	Total population (millions)	Population age 65 and over	
		Number (millions)	Percent of total population
1920	106.0	4.9	4.7
1930	123.2	6.6	5.5
1940	132.1	9.0	6.9
1950	151.3	12.3	8.2
1960	179.3	16.6	9.2
1970	208.2	19.5	9.4
1980	245.4	24.5	10.0

Source: U.S. Bureau of the Census: U.S. Census of Population: 1960, vol. I, for 1920 to 1960 data; "Illustrative Projections of the Population of the United States by Age and Sex, 1960 to 1980," series P–25, No. 187 (Nov. 10, 1958), p. 16, for 1970 and 1980 projections. Projected data are series III of the 4 series prepared and are based on an assumption of relatively high birth rates. The projections exclude data for Alaska and Hawaii.

Percentage distribution of U.S. population, by age, 1900 to 1960

Year	Percent of population			
	Total	Under 20 years	20 to 64 years	65 years and over
1900	100.0	44.3	51.4	4.1
1910	100.0	41.9	53.6	4.3
1920	100.0	40.8	54.6	4.7
1930	100.0	38.8	55.8	5.5
1940	100.0	34.4	58.7	6.8
1950	100.0	34.0	57.9	8.2
1960	100.0	38.5	52.3	9.2

Source: U.S. Bureau of the Census, U.S. Census of Population: 1960, vol. I. Because of rounding, items may not add to totals.

Mr. ALLOTT. Mr. President, a steady increase in the proportion of the aged group in the population during the last 60 years is apparent. The proportion of the population that is under 20 has not followed a consistent pattern. Predictions for this segment of the population over the next two decades are difficult because this birth rate depends on economic developments, social trends, and changing attitudes regarding the desired

size of families but I think that it is safe to say that the proportion of the working age group will be less in 1980 than it is in 1960. Factors that are inhibiting the growth of this age group are military service and the emphasis on higher education which reduces the number of those available for employment.

I believe the two tables which I have just placed in the RECORD support this conclusion adequately.

It should be further noted at this point that the greatest relative increase among the over-65 population has been at the upper end of the age scale. Data from the 1960 U.S. Census of Population show that, among the aged, the older the group, the greater has been its proportionate growth. Between 1950 and 1960 the following increases in population were registered in the specified age groups:

Increase in population from 1950 to 1960

Age group:	*Percent*
65 to 69 years	24.8
70 to 74 years	38.6
75 to 84 years	41.1
85 years and over	60.8

The geographic distribution of the aged is also worthy of note. In 18 States at least 10 percent of the population was age 65 or over on April 1, 1960. The heaviest proportionate concentrations of aged persons were in the Plains States and New England. Iowa and Missouri respectively had 11.9 percent and 11.7 percent of their populations age 65 and over. Florida, with 11.2 percent, had the largest ratio of 65 and over persons of any State outside these regions. In only eight States, Alaska, Arizona, Hawaii, Nevada, New Mexico, North Carolina, South Carolina, and Utah, was less than 7 percent of the population in the age group with which we are here concerned. The highest rate of growth in the aged population took place in Florida and Arizona. Here, the number of persons age 65 or over more than doubled between 1950 and 1960. California and Nevada have had rises in their aged population of over 50 percent in each of the past two decades. However, because of the rapid growth in the total population in Arizona, California, and Nevada, the proportion of the total represented by the aged has not changed significantly. Indeed, the proportion over 65 in Nevada declined from 1950 to 1960.

An excellent examination of the economic factors affecting our elderly people can be found in a report prepared by the Blue Cross Association and the American Hospital Association. This report is based on factual data supplied from a number of sources, including the U.S. Bureau of the Census, the Social Security Administration, and others.

Mr. President, I ask unanimous consent that this statement may be printed at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. ALLOTT. Mr. President, I believe we should now turn our attention to medical developments and changing health patterns as they affect the people with whom we are concerned. For many reasons of advances in medical science and improvements in our environment there has been a marked increase in life expectancy from 1920 to 1960. For example, in 1920 male babies could be expected to live for an average of 53.6 years. In 1960 male babies could be expected to live an average of 67 years. At the same time there has been an increased exposure on the part of the aging population to chronic disease.

The decline in the death rate is in great measure attributable to the enormous advances made in the control and elimination of infectious diseases but the pattern here is that while pneumonia and influenza, tuberculosis, and diarrhea and enteritis are all but conquered we now find ourselves faced with increasing incidents of heart disease, cancer, and cerebral vascular diseases.

It has been said, then, that chronic illness, in contrast to acute illness, is much more prevalent among the elderly than among those under 65.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD a table showing the percentage of persons having chronic conditions, by age and sex, in the United States, July 1957–June 1958.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

Percentage of persons with chronic conditions, by age and sex, United States, July 1957–June 1958

Chronic conditions	Males			Females		
	All ages	Under 65 years	65 years and over	All ages	Under 65 years	65 years and over
Percent of persons with at least 1 chronic illness	39.1	36.0	75.2	43.5	39.8	80.6
1 chronic condition only	23.1	22.9	26.2	22.8	22.4	26.9
2 chronic conditions	9.3	8.3	21.3	10.7	9.8	19.9
3 or more chronic conditions	6.7	4.8	27.7	10.0	7.6	33.8

Source: U.S. National Health Survey, "Limitation of Activity and Mobility Due to Chronic Conditions, United States, July 1957–June 1958," U.S. Public Health Services Publication 584–B11 (July 1959), cited in Mortimer Spiegelman, Ensuring Medical Care for the Aged, Pension Research Council Publication (Homewood: Richard D. Irwin, Inc., 1960), p. 51.

Mr. ALLOTT. Mr. President, what is the outlook for the future? While it is difficult to forecast accurately, there is very good reason to believe that science will continue to improve the state of the medical art, and that our people will live longer; and it is, therefore, likely that a greater portion of the population will live to older ages than even now are extrapolated.

In examining the needs of our elderly, we must consider the costs of medical care and must note the increase that has taken place within the past several decades. While the consumer price index rose 70 percent from 1929 to 1959, the medical care index rose 105 percent; and from 1950 to 1960, the percentage rise in the medical care index was approximately twice that of the overall index, and more than that of any other major CPI component. There are many reasons for this, of course. Inflation has taken its toll here, as it has everywhere else. There are other factors, also. While a manufacturer can automate with machine tools to offset the rise in labor costs, a hospital can automate only a small part of its clerical functions. The surgeon must still perform the surgery; an anesthetist cannot be replaced by a punched card; a scrub nurse cannot be replaced by a conveyor belt. In addition, science has introduced into the medical world an ever-widening scope and an ever-increasing complexity of services. Labor costs have risen significantly, through the correction of extremely low wages, shorter workweeks, the increase in hospital personnel, and the higher costs of personnel who are better trained, in order to be more efficient and skillful, and who can meet the demands of today's medical science for higher standards of care. In the factories, new techniques often result in smaller labor forces in specific areas, while in the hospitals, new techniques and services result in the need for more and better trained personnel and equipment, rather than less. As an illustration, I request unanimous consent to have printed at this point in the RECORD a news report from Time magazine.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

FREEZING FOR PARKINSON'S

The movies that Manhattan's Dr. Irving S. Cooper showed to the American Medical Association last week were heart rending even to medical men familiar with the ravages of disease. There were pictures of adult victims of Parkinson's disease, or "shaking palsy"—men who could not stay the agitated tremor of their rigid, half-clenched hands, or could not walk except in jerky petits pas. There were children suffering from nerve disorders similar to Parkinsonism. During an attack, a pretty girl of 11 was doubled up, her whole body distorted and shaking. A boy the same age was bent backwards; eventually, said Dr. Cooper, his back and legs might arch until his head touched his heels.

All those pictures were of people who had not yet been operated on by Dr. Cooper. Next, the inventive neurologist paraded the same grateful postoperative patients before the professional audience. Ex-Coal Miner Arnold Smith, 46, has been so completely freed of the palsy that he has taken up a new career as a physiotherapy aid at the Whitesburg Memorial Hospital in Kentucky. Remarkably erect Joan Harris, now 15, of Larchmont, N.Y., is doing well in school. The boy, 13, is as straight as a spruce, and supple as a birch. But there were still more surprises to come. These patients, like famed Life photographer Margaret Bourke-White, were operated on by techniques that Dr. Cooper, 39, now considers outmoded. The patients he really wanted to show off

were the next to be presented: a housewife and a schoolgirl on whom he operated by freezing a pea-sized portion of the brain.

CROSSED CONNECTIONS

Parkinsonism (the cause of which is unknown in most cases) is a disorder of nerve cells near the thalamus deep in the brain. The affected nerve cells keep on firing impulses for muscle contraction when the contractions are not necessary. Effective treatment consists of somehow interrupting these misfiring nerves.

Dr. Cooper's first approach, back in 1952, was to sever an artery supplying the nerve-cell complex. Though many patients got relief, several died, and an equal number were left worse off than before their operation. Next he tried injecting absolute alcohol into part of the brain near the thalamus. Then Dr. Cooper put the alcohol into the thalamus, as in Photographer Bourke-White's case.

THREE IN ONE

But the neatest, cleanest way to kill a specific segment of tissue in a living body is by rapid deep-freezing. Dr. Cooper's newest technique, used in almost 200 cases in the past year, is to put the patient on the operating table under a battery of X-ray machines. Using a local anesthetic, he saws out a dime-sized piece of the skull, then inserts a three-in-one tube, only 2 millimeters (less than one-twelfth inch) in diameter. The tube slips painlessly through the insensitive brain to the deep-lying thalamus. The tube's outer layer is a vacuum insulator; the innermost bore carries liquid nitrogen supplied at minus 196° C.; the middle layer is for warmed and gaseous nitrogen to escape.

When the X-rays show that the tip of the tube is in the thalamus, Dr. Cooper lets in enough liquid nitrogen to drop the tip temperature to zero or minus 10° C. This knocks out the nerves, but does not destroy them. He asks the patient to raise an arm, or leg, or both: If the patient has full control of his limbs, with no tremor remaining, the tip is in the right place.

Then Dr. Cooper admits more liquid nitrogen, to drop the tip temperature to minus 40° or minus 50° C. In less than 5 minutes, this rapid freezing kills the offending, misfiring nerve cells. If the freezing extends a bit too far and the patient becomes unable to move his arm satisfactorily, Dr. Cooper has 30 seconds in which to correct the error and rewarm the thalamus. Most patients can be out of bed the same day and out of the hospital within a week.

Now that nitrogen injection kits are being manufactured, other neurosurgeons, still skeptical, will try to duplicate Dr. Cooper's results. Awaiting the benefits of his bold pioneering are at least 300,000 U.S. victims of Parkinsonism, a lifelong affliction, of which doctors say: "Patients don't die of this disease—they die with it."

Mr. ALLOTT. Mr. President, it has been reported that the small special equipment developed for the operation referred to in the article which I have submitted for the RECORD would cost $5,000 per unit, certainly not an overwhelming figure when we think of the misery and agony such equipment will do away with, but, nevertheless, an illustration of the fact that every step of progress is costly.

Not only must we be concerned with the increasing cost of rendering hospital services of one sort and another; another factor in those costs is the increase in the per capita use of hospitals. As further improvements in medical science are inaugurated, we can expect that they will spur continued growth in the demand for health services. Hospitals and doctors are doing their best to maximize the result per dollar cost, by introducing efficiencies in their procedures and organization; but even as these are improved, we can expect the standards of care to be raised, the scope of services to be expanded, and consumer demand to continue to grow.

At this point I should like to state that in my personal conversations with the superintendents of many hospitals, and particularly in my conversations with the superintendents of hospitals in my own State, I have been impressed by the very great efforts they have made to try to find ways to reduce hospitalization costs. Some of the plans they have thought of and have considered show a maximum of objective thinking in their attempts to deal with this problem. They know what the problem is. But it is not possible to place, as I have stated, hospital patients on a conveyor belt and, by placing a screw here and a nut there, expect to have them repaired.

So it is obvious that hospitalization costs will constantly increase. But I should like to make very clear that, in my opinion, the personnel involved—the hospital superintendents and all the other administrative personnel of the hospitals—are devoting their best energies in the endeavor to find new ways to prevent further increases in hospitalization costs.

As examples of the kind of costs I am talking about, it is well to consider that while we gratefully hear of someone whose life has been saved through the use of an artificial heart, or that a cancer has been arrested through the use of a cobalt machine, very few of us know that an artificial heart-lung machine costs about $45,000, a cobalt machine about $30,000, and X-ray movie cameras cost from about $20,000 to $50,000. As these newly developed machines are added to the hospital inventories, they require more, rather than less, people to operate them. True, the equipment is expensive; but the outstanding cost for these new services is that for the new, trained personnel to operate the equipment.

These costs will continue to rise as medical science continues to develop, because as fast as the new services and equipment are developed, the public or the consumer demands that their use be made available to him. So as time goes by, medical care will become more complex and more costly.

Let us now take a look at what these costs mean to the individual consumer. In 1958, the annual per capita gross expenditures by noninstitutionalized citizens for personal health care was $177 for persons 65 and over, and less than half this amount, or $86, for persons under 65. The Department of Health, Education, and Welfare recently estimated that the total public and private annual expenditures for health care of the aged was nearly $5 billion. Total health expenditures for all persons in the United States in the year ended June 30, 1960, were $26.5 billion—$20.3 billion private expenditures and $6.2 billion public expenditure. It would appear, then, that the health bill for persons 65 and over, although they constitute less than 10 percent of the total national population, represents almost 20 percent of total national expenditures for health. Not only are the health-care expenditures for aged persons greater than those for their younger counterparts, but in recent years they have been increasing at a greater rate. A Health Information Foundation study compared two 12-month periods—1952–53 and 1957–58. Between the two periods, the gross per capita expenditures for elderly persons increased by 74 percent, while for all persons the rise was only 42 percent.

One of the difficulties apparent here is that the higher per capita health-care expenses incurred by the aged come at a time when family income has declined. As a result, health-care costs take a disproportionately large part of the elderly family's income.

As of 1958, hospital-care expenditures represented a greater proportion of the total health-care outlays for the aged than for those under 65. From 1952–53 to 1958 the greatest absolute increase among the types of medical expenditures for the elderly was for those for hospital services. For all major types of physicians' services—home calls, hospital calls, office calls, and surgery—expenditures for aged persons are substantially higher—from 26 to 105 percent higher—than those for all individuals.

In addition, hospital care for the elderly costs much more than that for younger persons. If we examine the history of hospitalized persons, we find that those over 65 incurred an average expenditure of $352, compared with an average of $168 for persons of all ages who were hospitalized. These figures are for the years 1957–58.

The PRESIDING OFFICER. The time available to the Senator from Colorado has expired.

Mr. HUMPHREY. Mr. President, has the Senator from Colorado used all of the 30 minutes available to him on the amendment?

The PRESIDING OFFICER. That is correct.

Mr. HUMPHREY. Let me inquire whether the Senator from Colorado wishes to have additional time made available to him. I think so highly of my friend that I wish to cooperate in every way possible.

Mr. ALLOTT. I am very grateful to the Senator from Minnesota, even though I do not seem to have impressed him this deeply before. So I shall be grateful to have additional time made available to me.

Mr. HUMPHREY. Would an additional 10 minutes be helpful to the Senator?

Mr. ALLOTT. Of course.

Mr. HUMPHREY. Then, Mr. President, I am glad to yield 10 additional minutes to the Senator from Colorado.

The PRESIDING OFFICER. The Senator from Colorado is recognized for 10 additional minutes.

Mr. ALLOTT. I would like now to turn to the utilization of health facilities and services by the aged. Aged persons utilize most health-care services to a

considerably greater degree than the population as a whole. They are admitted to hospitals more frequently and stay longer. They are the predominant users of nursing homes and other long-stay institutions. They require and use a greater volume of physicians' services. They spend more on drugs. They do spend less for dental service than the population as a whole.

How is the financing of health care for the aged managed? A National Health Survey provides the most recent and comprehensive nationwide data on hospital insurance coverage. The survey was conducted during the period of July 1958 to June 1960.

The study showed that two-thirds of all persons discharged from short-stay hospitals met at least some of their hospital charges through insurance. Half of the aged discharged patients had some part of their bills covered by insurance. Some portion of hospitalization charges was covered by insurance for 63.3 percent of the persons age 65 to 69; for 53.9 percent of those between 70 and 74; and for 37.5 percent of those 75 and over.

Among all persons discharged from short-stay hospitals who received some insurance benefits, 75 percent had at least three-fourths of their bills paid by insurance. Of those 65 and over who received insurance benefits, 59.2 percent had at least three-fourths of their hospital charges covered.

The net result is that among the discharged patients, at least three-fourths of the hospital bill was covered by insurance for 51.3 percent of the persons of all ages, 30.3 percent of the persons 65 and over, and 20.2 percent of those 75 and over. It is interesting to note that hospital insurance coverage, particularly for the aged, is largely dependent upon employment. In a 1957 study of aged persons, it was found that less than 4 out of every 10 persons 65 and over had some form of voluntary health insurance. Almost all of those with health insurance had hospitalization, approximately two-thirds had coverage for inhospital doctor visits, and about one-fifth had coverage for physicians' home or office visits. Fifty-seven percent of all aged persons with health insurance had first obtained such coverage through a job, either their own or their spouse's.

About one-sixth of the elderly persons studied were uninsured but had been insured in the past. Nearly half of the formerly insured persons had obtained insurance through their work. The principal reasons given for terminating insurance were retirement from employment, belief that coverage was too expensive, and dissatisfaction with the benefits offered.

Half of the aged who had no health insurance said that they would be interested in obtaining such insurance, but felt that they either could not afford it or could not obtain it. The rest of the uninsured group either did not want insurance or were not interested.

A study of the uninsured in 1958 indicated that persons who did not have health insurance were more likely to be found among these groups: nonwhites, unmarried individuals, full-time housewives, retired persons, members of low-income families, residents of rural farm areas, and the aged. For 12 percent of the uninsured persons of all ages, coverage could be obtained through work by either the uninsured individual or other members of his family. However, only 1 percent of the uninsured persons 65 and over could obtain coverage in this way, and no coverage was possible through work for approximately 99 percent of the uninsured aged.

A 1957 survey by the Bureau of Old-Age and Survivors Insurance showed insurance paid at least part of the hospital, surgeon, and inhospital physician costs for 54 percent of the OASI beneficiary couples with a member hospitalized in general hospitals and 48 percent of the hospitalized single beneficiaries. Slightly more than 30 percent of the hospitalized beneficiaries had at least half of these costs paid by insurance; 7 percent had all these costs so paid.

The survey also found that the percentage of those who received hospital care during the year was higher among those who had insurance—14.2 percent—than among those who did not—8.8 percent.

A 1958 study indicated that average hospital bills increase with patients' age and, moreover, that older persons pay a larger proportion of such charges out of pocket without the help of insurance. The data also suggested that not only do fewer of the aged than of the young have health insurance, but that those who do have insurance have poorer protection than their juniors.

Data provided by Blue Cross plans show that between 4.3 and 5.1 million persons age 65 and over are covered by Blue Cross. Some 24 percent of all Blue Cross group subscribers are now included in enrolled groups that have provisions for continuing retirees as part of the groups. Provisions for employer contributions toward the cost of this arrangement are increasing. Some 25 percent of all Blue Cross subscribers are persons who have left employment where they were covered on a group basis, or who enrolled as individuals—a large segment of this group are persons 65 or more.

About 4 to 4¼ million persons age 65 and over are covered by commercial health insurance. Of these, 750,000 are insured under group plans and about 1 million are covered under mass enrollment programs. The remaining aged—about 2.5 million—covered by insurance companies have individual policies.

There are many programs of private health insurance which are of assistance to the aged. Coupled with these, as I will later show, the Kerr-Mills law is being made a workable solution to the problem of assisting the elderly to obtain and pay for the assistance they need.

What, then, is the problem? A few of the major points are these:

Half of the aged persons in the United States have money income of less than $1,000 a year. Although the older persons have somewhat higher than average asset status when compared with younger persons, much of their assets are difficult to convert into purchasing power. A mortgage-free home is a fine thing to have, and actually represents a type of income, because the owner does not have to pay rent; but such assets are difficult to convert into purchasing power.

The aged have higher medical expense. They use hospital and medical services more. On the average, the aged spend considerably more than the rest of the population for hospital care and significantly more for all the other elements of medical care except for dental care. Like all of us, they face rising medical costs, and these costs have been rising faster than any other item in the Consumer Price Index. Because of the nature of medical science, it is likely that medical care costs will continue to rise faster than other items in the Consumer Price Index. We know that, as among all age groups, the costs of medical care fall unevenly and unpredictably; that while some have few medical expenses in a given year, others have very high expenses. We know that the incidence and prevalence of illness are greater among the aged, and we know that once the aged become ill, they are more likely to remain ill.

We know that fewer of the aged are covered by prepayment or insurance than persons below 65. We know that the coverage of the aged is of lesser benefit quality, in general, than the coverage of younger age groups. We know that in the past few years, prepayment and insurance have made impressive strides in coverage of the aged and in removal of many restrictions. Various public programs such as those covering free or reduced rate mental and tuberculosis care, are widely available. It is not only the aged who experience low income, high medical expenses, and low protection. To a lesser extent, the younger population contains persons in a similar plight. But more of the aged are caught in the problem of low income and high medical expenses, and their economic position is unlikely to change, a hope that is not denied to the younger. Because of their fixed position, they are more vulnerable to the costs of inflation.

The PRESIDING OFFICER. The additional time of the Senator from Colorado has expired.

Mr. HUMPHREY rose.

Mr. ALLOTT. Does the Senator have in mind speaking on this particular amendment?

Mr. HUMPHREY. The Senator primarily has in mind cooperating with the Senator from Colorado.

Mr. ALLOTT. I shall be pleased if the Senator will yield me another 10 minutes.

Mr. HUMPHREY. I am glad to yield the Senator 5 minutes at this time.

Mr. ALLOTT. I am glad to have it. I appreciate the Senator's courtesy.

The PRESIDING OFFICER. The Senator from Colorado is recognized for an additional 5 minutes.

Mr. ALLOTT. Mr. President, what are the requirements, then, of a health assistance program? The requirements can be simply stated. It should be based on free enterprise and freedom of choice

which, God willing, will always be the posture of Americans. It should be established on a sound and reasonable basis for providing assistance to individuals over 65 who otherwise would experience difficulty in paying for medical care.

Mr. President, it is important to repeat that latter phrase—"who otherwise would experience difficulty in paying for medical care." There are many who are able to take care of their own problems quite satisfactorily in their own way without any assistance from anybody, least wise the Federal Government.

Such a program needs to be administered at the State and local level, where the problems of the people within the State are better understood and more efficiently handled.

And finally, such a program should be made financially feasible for the States in order that they can implement it.

Mr. President, I now propose to show that the Kerr-Mills law meets the requirements better than the proposal which we have before us today.

Mr. President, if I may have the attention of the distinguished acting majority leader, I have in mind offering another amendment. This is a convenient time for me to interrupt my discourse. If the Senator wishes to reply to the argument on the amendment, to use the remainder of his time, I inform the Senator it is my intention to withdraw the amendment.

Mr. HUMPHREY. I suggest that the Senator proceed according to his announcement and withdraw his amendment. I know the Senator has strong convictions on these matters and wishes to express those convictions, as he has done so well today. We can proceed to consider the other amendments. I shall be more than happy to yield back any remaining time I have on this particular amendment. If the Senator will withdraw the amendment, we can proceed to consideration of other amendments.

Mr. ALLOTT. Mr. President, if the Senator has yielded back his remaining time——

Mr. HUMPHREY. I yield back my remaining time.

Mr. ALLOTT. I withdraw my amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

Mr. HUMPHREY. Does the Senator intend to offer another amendment?

Mr. ALLOTT. Mr. President, I offer the amendment which I send to the desk, and ask for its immediate consideration.

The PRESIDING OFFICER. The amendment will be stated for the information of the Senate.

The LEGISLATIVE CLERK. It is proposed to strike out the language beginning on line 18, page 57, and ending on line 15, page 75, of the Anderson amendments.

KERR-MILLS ACT

Mr. ALLOTT. Mr. President, as I have suggested, I now intend to discuss certain provisions of the law relating to the Kerr-Mills Act.

It has been the custom under the present administration, as well as in past administrations, to hold White House Conferences, in which experts in a particular field are called together in an effort to work out recommendations for solving some of the problems facing the Nation. One such conference was called, for a meeting in January of 1961 to discuss the problems, potentials, and challenges of an aging population. For 4 days, more than 2,500 delegates met in Washington, D.C. The results of that conference cover a variety of subjects.

We are fortunate that on May 15, 1961, the Special Committee on Aging of the U.S. Senate, under the able guidance of my good friend and colleague, the Senator from Michigan [Mr. McNAMARA], issued a document which I now hold in my hand. It is the committee print of the White House Conference on Aging, and I would call special attention to page 37 of the committee print, which is entitled "Policy Statement and Recommendations—Institutional Care." Since the recommendations by the experts on the subject of our senior citizens deals directly with the matter under consideration by the Senate, I should like to read from the report.

On page 37, after a preliminary statement, the Report by the White House Conference on Aging says:

> Adequate care cannot be provided without sufficient financing, both for construction and for provision of services. Costs should be kept to the lowest possible level consonant with high-quality care, through planning, efficient management and economical use of facilities. No needed care should be denied because of inability to pay, nor should the financing mechanism create impediments to the proper utilization of the various types of facilities, including the home. Everything possible should be done to encourage voluntary prepayment groups to expand and broaden their coverage for aged individuals, and further, to extend such coverage over the whole institutional care spectrum, and to care in the home. Local, State, and Federal Government financing will be required in increasing amounts to supplement individual resources and voluntary prepayment. Existing Federal State, matching programs will provide effective, economical, dignified medical care for our elderly citizens who need help. The implementation of such programs should result in the high quality of medical care desired. Compulsory health care inevitably results in poor quality health care.

I repeat, "Compulsory health care inevitably results in poor quality health care." I would like to point out, for the benefit of any of my colleagues who might have entered this Chamber toward the end of my statement, that I was not reading from the Republican platform of 1960. I was reading from the committee print published by the Special Committee on Aging, listing the recommendations of the White House Conference on Aging of January 1961.

The minority views hold to the contrary, and urge what is tantamount to medical care under social security, although it is not specifically referred to as such. It is worth noting that in July of 1962, just as in the early days of 1961, the people of this country continue to hold steadfastly to the view reflected by the majority in the White House Conference. My mail has been running overwhelmingly against the King-Anderson-Javits approach, that is to say, medical care for our senior citizens under social security.

It appears to me that in the deliberations which are now taking place in this Chamber we are disregarding the considered judgment of experts as well as the wishes of the majority of the people in this country. From my State of Colorado there was a delegation to this White House Conference which included Robert L. Knous, our Lieutenant Governor, the chairman of the Governor's Commission on Aging. In addition, the following persons were also in attendance:

Dr. Albert H. Rosenthal, District Regional Director of HEW; Mr. Riley Mapes; Dr. William T. Van Orman; Miss Charlene J. Birkens; Dr. Roy L. Cleere, head of our State medical office; Dr. Franklyn Ebaugh; Dr. Richard Haney; Dr. Heber Harper; Mr. Samuel Janzen; Mrs. Ray Landis; Mr. Archie G. Maine; Mr. Herrick Roth; Mrs. Edith M. Sherman; Dr. Lennig Sweet; Mrs. Leslie E. Taylor; Mr. Franklyn Stewart; Mr. Bernard Teets, Director of our State Department of Employment Security; Mr. Lindsay E. Waters; Dr. John Zarit.

The severest critics of the Kerr-Mills approach to medical care for those over 65 point to the fact that the act has simply not accomplished the purpose. Apart from the fact that I consider it ill-reasoned to expect a program of this magnitude to be functioning at peak performance 22 months after enactment—just as unreasonable as criticizing our space program for its inability to reach the moon in the relatively short time it has been in existence—there is also the fact that the executive branch has not been pursuing the implementation of Kerr-Mills as assiduously as the program warrants. During the hearings before the House Subcommittee on HEW Appropriations, Secretary Ribicoff made the following statement:

> Now, administratively, we want to get results. One important task was the problem of getting out the results of the White House Conference. Thirty-seven separate publications have been issued.

On the other hand, and as I will point out in just a moment, the Department of HEW, with appropriated funds at its disposal, has not been moving forward in an effort adequately to put Kerr-Mills into full operation as the Congress intended. I commend the Secretary for disseminating the results of the White House Conference, and find myself only disappointed that the recommendations have not been followed, at least as they apply to Kerr-Mills.

At this point I must go outside my prepared statement and remark upon one of the great failures and frailties of the Congress and the great structure of Government that we have. An hour or so ago the Senate voted upon an amendment proposed by the distinguished Senator from Wisconsin which would provide for a commission to study manpower needs and the assets available for our space program.

His amendment provided for the appointment of a council to make such a study. I voted against the amendment, not because I am not convinced that

there is a need. There is a great need for such a study. I voted against the amendment because the council would meet, much money would be expended, and then even before a report of the study was published or before the council had arrived at a conclusion, the chances are about 90 to 1 that the people in the space agency, the Congress and the administration, would go galloping off without paying any attention to what the council had reported anyway.

We have followed such a procedure on the question of taking care of our aged. I am astounded that we in the Congress again and again appropriate money to various commissions, agencies, and bureaus to investigate aspects of certain questions, and then before even a report of the study is prepared, we pass impressive and extensive legislation involving hundreds of millions of dollars which does not even take into consideration the findings of the various commissions so appointed, because the commissions have not yet reported.

In the present instance, we are asked to do it again, and we shall repeat the process again and again. I wished to refer particularly to the vote today on the amendment of the Senator from Wisconsin, because I think it is perfectly obvious that while the need the Senator from Wisconsin had in mind is very great, the results from such a study would never have seen the light of day. If they did see the light of day, they would wilt as fast as a fresh violet plucked from a mountain meadow.

Mr. HRUSKA. Mr. President, will the Senator yield?

Mr. ALLOTT. I am happy to yield to the distinguished Senator from Nebraska.

Mr. HRUSKA. First, the Senator from Colorado is making a fine contribution to the discussion at hand. He handles his material well and shows that he has become a student of no mean knowledge on the subject.

I should like to ask the Senator from Colorado whether or not it is true that on occasion, instead of overstudying a subject or a pending measure, we do not get into it enough by way of our legislative process, and the measure which is before the Senate—the so-called King-Anderson-Javits proposal—is probably a good example of that point. No committee hearings have been held. There has been no documentation of the various points of view or of the provisions of the bill. No estimate of cost that I know of has been formulated by any Government authority which would normally be consulted on the question. Would the Senator have any comment upon that particular aspect of the proposed legislation to which his amendments are directed?

Mr. ALLOTT. I certainly do have. I wish to thank the distinguished Senator for his contributions. It is true both ways. I was particularly interested in the fact that while we paid attention to what the White House conference for the aged did, we have turned around and pursued the most inconsistent, illogical, and almost immature approach to a question like the one pending before the Senate, which would affect the lives of most of us, God willing, and certainly the lives of many individuals. We would do so by seeking to jam through the Senate an amendment which would take the social security approach to the health care for the aged.

It is a measure which would have great tax consequences for every employer and employee, and its provisions are completely inadequate. Sometime within the next few hours I shall probably get to that aspect of it. It is completely inadequate for the needs.

We are asked to commit hundreds of millions of dollars to a program in a field which is already adequately serving or could adequately serve the people, and yet we would do so without even letting the measure go to the Senate Committee on Finance, the committee upon which we must depend to study these questions and make recommendations. We are asked to act on the measure without a report or a recommendation from that committee.

Mr. HRUSKA. Mr. President, I thank the Senator for yielding to me.

Mr. ALLOTT. I thank the Senator. His thoughts have been most helpful.

In recognition of the fact that among our senior citizens, there are those unable to meet the costs of medical, hospital and other related treatment, the Congress, in 1960 passed the Kerr-Mills bill which, in essence, provides for a Federal financial participation in State programs established to meet these needs. To provide for those 65 and over already covered by old-age assistance, the bill would increase those benefits to cover the medical aspects.

While I shall discuss that point later, I think it is only appropriate to call attention now to the fact that the Anderson-Javits amendment, which we are now considering, would provide no medical care outside of a hospital or certain designated nursing homes. For those over 65 not covered by old-age assistance, the Kerr-Mills bill authorized medical coverage in specified amounts.

Kerr-Mills has the benefit of the customary legislative process, and was accorded complete committee hearings and consideration—culminating in a report by the Senate Committee on Finance dated August 19, 1960.

Mr. President, each of us who was here at the time had an opportunity to study that report. It was Report No. 1856, 86th Congress, 2d session. It stands as a tribute to the unanimity of feeling regarding the bill, that the vote on final passage was 91 to 2 in favor of passage. And yet, scarcely has the time elapsed in which to implement this legislation, and the Senate is now being asked to junk it and start afresh.

What is proposed is that we pile this monstrosity on top of it. If we do so, we will have a real situation on our hands.

Opponents of Kerr-Mills urge that the act be set aside, almost before the ink is dry, despite the fact that better than 24 States have enacted legislation in reliance upon its permanency. It is difficult to conceive how a program, concurred in by 91 Members of this body, only 22 months ago should now become unworkable or, as the Special Senate Committee on Aging concluded:

> It proves that Kerr-Mills cannot, of itself, solve that problem which our committee has found to be the most persistent and frightening one confronting millions of older people and their children in all parts of the country—the problem of assuring economic access to medical care for all our older people on a decent, self-respecting basis.

Before this body relegates to the ashcan a program upon which a substantial number of States have relied, a program which a number of States have implemented by legislation, a program which was and is dedicated to fulfilling the needs of our senior citizens, it would be very useful to examine the act in detail in order to clear the air of misunderstandings and have clearly in mind what the objectives of the Kerr-Mills bill are, and what its accomplishments have been in the brief period it has been law.

The Senate Finance Committee, reporting on H.R. 12580, the social security amendments of 1960, said as follows:

> In this 25th anniversary year of the Social Security Act, the committee has examined proposals relating to almost every title of the Social Security Act. As a result of our consideration, the committe is reporting a bill which makes changes and improvements in all of the programs encompassed by this legislation. The major issue presented to the committee this year has been the increasing cost of adequate medical care for older people. The evidence presented to the committee indicated that these costs derive, to a large extent, from the fact that impressive improvements have been made in medicines and medical technology, which assist in better diagnosis and treatment, and from improved hospital and other facilities and their wider availability to the public. The knowledge that these costs are unpredictable and sometimes very heavy, especially for our older men and women living on reduced retirement incomes, has been a matter of grave concern to this committee. As a result we are recommending a program of Federal assistance in providing through the cooperation of the States, an expanded program of medical care for persons aged 65 and over. Under this proposal, the Federal share of existing old-age assistance plans will be substantially increased to encourage States to strengthen their medical programs for these people or to initiate new programs. In addition, Federal money will be made available, on a generous matching formula, to assist the States in aiding those aged persons, many of them otherwise self-sufficient, who need help only in meeting the costs of medical care of a very expensive nature.

In the event that the successful implementation of Kerr-Mills has not proceeded with such dispatch as its detractors would wish, the responsibility must, in part, at least, be borne by HEW. Under questioning by Representative MELVIN LAIRD and Chairman JOHN E. FOGARTY at recent hearings of a House Appropriations Subcommittee, Secretary Ribicoff admitted he had hired only one professional staff member, although Congress had provided $145,000 to em-

ploy a staff of 18. Further questioning also brought out that little has been done by the Department to implement the 600 recommendations of the White House Conference on Problems of the Aging. One of them, dealing specifically with medical care for the aged, I discussed a moment ago.

Mr. President, I ask unanimous consent to insert in the RECORD at this point in my remarks an excerpt from the hearings before the House Committe on HEW appropriations on January 30, 1962.

There being no objection, the excerpt was ordered to be printed in the RECORD, as follows:

REFERENCE TO APPROPRIATE HOUSE HEARINGS BEFORE THE SUBCOMMITTEE ON HEW APPROPRIATIONS, JANUARY 30, 1962—PART I

Pages 104 and 105:

"Mr. FOGARTY. What did Mr. Kent [works for the Secretary, studying the Conference recommendation and developing legislation to carry them out] originally ask of the Bureau of the Budget?

"Mr. KELLY. In his supplemental request?

"Mr. FOGARTY. Yes.

"Mr. KELLY. I am going to have to act from memory, Mr. Chairman. My memory is we went over there with a request for 21 additional positions, and we came up to the Congress with a request for 18 positions. And we have an operating plan for utilizing 14 of those jobs that the Congress gave us, and we are requesting 3 additional positions in 1963.

"Mr. FOGARTY. How much did you get; how much did the Congress give in that supplemental last year?

"Mr. KELLY. They gave us the whole 18 positions as requested.

"Mr. COHEN. Yes. I think $145,000, if I recall correctly.

"Mr. FOGARTY. And how much of it was put in reserve, if any?

"Mr. KELLY. Well, I know it was four positions. I do not recall the amount. But out of the 18 positions, 4 were withheld.

"Mr. FOGARTY. Percentagewise, that is a pretty good clip.

"Mr. KELLY. Yes, sir. We had to save eight jobs in the Office of the Secretary. Four of them were in the special staff on aging.

"Mr. FOGARTY. Four out of eighteen?

"Mr. COHEN. I think, while there is a tremendous need there, Mr. Chairman, I might say I worked with Mr. Kent on trying to recruit some of these people——

"Mr. FOGARTY. I understand he has had problems. But I think I am going to find the same fault I found with everybody over the past 10 or 12 years. I do not think you are going fast enough or far enough."

Pages 105 and 106:

"Mr. FOGARTY. You gave me a breakdown but I have forgotten. About how many people have been added to the special staff on aging, and when were they added?

"Mr. COHEN. I have here the two additional people in the information branch reporting to duty on January 29. One person has been recruited to the field operations branch, reporting to duty in February. A fourth person on research and training branch has been recruited and reporting to duty in March.

"Those are the four professional positions in the increase.

"Mr. FOGARTY. What year are you talking about?

"Mr. COHEN. This year, sir. Right now.

"Mr. FOGARTY. January 29, you mean yesterday?

"Mr. COHEN. Yes, sir. Reported to duty yesterday. That is January 29—two of them.

"Mr. FOGARTY. Well, I would not brag about that kind of action, would you?

"Secretary RIBICOFF. Well, it is pretty hard to find people sometimes."

Pages 106 and 107:

"Mr. FOGARTY. What are you going to do, give up?

"Mr. COHEN. No, sir.

"Secretary RIBICOFF. We are keeping on trying.

"Mr. COHEN. We are keeping on trying. Mr. Kent is going ahead. I talked to him several times.

"And we have now prepared a position description for each of these positions and we are advertising them and circularizing so we can see if we cannot get some more people interested in them. I think there is a great need in this area, and I would hope we could expand it.

"Mr. FOGARTY. That is what I was hoping for, too, when Mr. Kent was named. I do not see that he is doing much better than those before him. There is, and has been, a lot of talk about this for years as you well know.

"You have been talking about it, but as of today, January 30, nothing much has been accomplished with that supplementary appropriation. That is a fair statement, is it not?

"But the White House Conference came up with about 600 recommendations, and how many of those recommendations have been put into effect?

"There was a lot of talk at that conference about a blueprint for action.

"Mr. COHEN. Wnat we have done, of course, has been a continual exploration of this problem. Over on the Senate side, in connection with the Senate hearings, we have moved wherever there were some legislative recommendations.

"Mr. FOGARTY. Was there ever an advisory committee appointed?

"Secretary RIBICOFF. No. An advisory committee has not yet been officially appointed, but——

"Mr. FOGARTY. I think last August was the last time I talked with you.

"Mr. COHEN. Yes.

"Mr. FOGARTY. And you told me it was right around the corner.

"Mr. COHEN. We have been clearing the people and discussing them. I would hope that we can formally appoint them very shortly.

"Mr. FOGARTY. What do you call 'shortly'; a month from now or next year?

"Mr. COHEN. Before the end of this year.

"Mr. FOGARTY. The fiscal year or the calendar year?

"Mr. COHEN. Fiscal year."

Page 107:

"Mr. FOGARTY. What happened to the Federal Council on Aging?

"Mr. COHEN. The Federal Council on Aging has been more or less inactive, and I think it is Mr. Kent's intent to reactivate the Federal Council.

"Mr. FOGARTY. There is nothing being done now, is there? They have not met in a long time?

"Mr. COHEN. I think we have had one meeting. I think there has been one preparatory or one planning meeting to see what they worked out."

Pages 108 and 109:

"Mr. FOGARTY. Well, the thing I am after and have been after for 10 or 12 years is action.

"I was just amazed to find that the first man hired under last year's supplemental appropriation was put on yesterday."

Page 109:

"Mr. LAIRD. You have been passing that money around, though. You have been looking for anybody who would like to do a little consulting work, have you not?

"Secretary RIBICOFF. I have not. I know Mr. Kent is sincere and hard working and a self-starter; and I have the utmost faith in him. If you give Kent a reasonable period of time, he will have a staff that you will be proud of, Mr. Chairman. And I would like to see where Mr. Kent stands next September, frankly.

"Mr. FOGARTY. You call a reasonable length of time——

"Secretary RIBICOFF. Well, I would say that the moneys available in October, I would like to see the results next September 1.

"Mr. FOGARTY. How long has Mr. Kent been on the job? How long has he been in office?

"Mr. COHEN. I think he came something like July 1. * * * As the Secretary stated, I hope you will wait until he has an opportunity to appear before you, Mr. Chairman.

"Mr. FOGARTY. Oh, I will. He will be given every opportunity, of course. He will not be shut off. He can talk as long as he wants to.

"But from what I already know, I am still afraid I am going to be disappointed in the action so far."

Pages 1084 and 1085:

"Mr. FOGARTY. We thought this was a real important program last summer. When you asked for a supplemental appropriation we were led to believe it was ncessary and needed. In fact, I thought more was needed.

"Now tell us what you have done with these funds.

"Dr. KENT. At present, on our supplemental, we have 14 positions—7 professional, and 7 clerical. The seven clerical were easy to fill and we filled five. We have not filled the other two because we will wait until we have the complement of professionals. In terms of professionals, we have filled four; for two more we have tentative acceptances and two that we are negotiating for, which includes one vacancy on the regular staff.

"Mr. FOGARTY. You think you have done as well as you could but I think a better job could have been done. I think if I were in your position, when you came down here last summer, that I would have known that these jobs were hard to come by. There is a general impression around from the groups that I have talked to, and I have talked to a great number of them, that there is no real program in aging. Every group that I have talked to has been disappointed in the lack of action to initiate one."

Mr. ALLOTT. Mr. President, geared as it is to the needy, Kerr-Mills Act is designed to authorize Federal participation in approved State plans which provide medical assistance first, on behalf of aged recipients of old-age assistance; and, second, for aged persons not on old-age assistance whose incomes and resources are not sufficient to meet the costs of necessary medical services. The act has the following provisions:

MEDICAL ASSISTANCE FOR THE AGED WHO ARE NOT RECIPIENTS OF OLD-AGE ASSISTANCE

Under this program, States can receive Federal funds to help pay the cost of medical services for persons aged 65 and over who are not recipients of old-age assistance, but whose income and resources are insufficient to meet such costs. States may choose among a broad scope of medical services, but the services for which they pay the costs must include those of both an institutional and noninstitutional character. The law is specific in outlining the scope of care and services that may be provided including: inpatient hospital services; skilled nursing-home services; physicians' services; private-duty nursing services; physical therapy and related services; dental services; laboratory and X-ray services; prescribed drugs, eyeglasses, dentures and prosthetic devices; diagnostic, screening and preventive services; and any other medical care or remedial care recognized under State law.

In considering the merits of these two proposals we must consider what is now offered by present law and the paltry,

parsimonious, limited benefits that would be offered under the King-Anderson-Javits amendments.

However, as under the law before the 1960 amendments, there can be no Federal participation in payments with respect to medical services furnished an inmate in a nonmedical public institution or to a patient in a mental or tuberculosis institution. Persons with a diagnosis of tuberculosis or psychosis may be covered for 42 days of care in a general hospital.

To qualify for Federal matching grants, State plans for medical assistance must meet certain requirements already in the act and still applicable to old-age assistance as well as the new program—the requirements, for example, that the program be in effect in all political subdivisions, provide for financial participation by the State, and insure proper and efficient administration. In addition, under a State plan for medical assistance for the aged, no enrollment fee or charge may be imposed as a condition of eligibility, and under regulations prescribed by the Secretary the State must furnish assistance to State residents absent from the State. Reasonable standards for determining eligibility and the extent of medical assistance are required. There must be a provision that no lien can be imposed during a recipient's lifetime on account of payments under the plan—except pursuant to a court judgment concerning incorrect payments—and that adjustment or recovery is permitted only after the death of the recipient and spouse. A State may not impose an age requirement higher than 65, and no resident of the State and no citizen of the United States may excluded. Federal Government participation in the total amount expended by the States for medical assistance for the aged under a Federal matching percentage will range from 50 to 80 percent under a formula based primarily on per capita income.

MEDICAL CARE FOR RECIPIENTS OF OLD-AGE ASSISTANCE

Under the amended title I of the Social Security Act, as formerly, there is no Federal requirement as to the scope of medical services that the States provide for old-age assistance recipients. However, the Kerr-Mills Act made additional funds available to the State for expansion of such services for recipients of old-age assistance.

An additional plan requirement for old-age assistance under title I is the same as one that applies to medical assistance for the aged—the State plan must include reasonable standards for determining the eligibility for patients in a medical institution as the result of diagnosis of psychosis or tuberculosis for 42 days after such diagnosis is permitted for old-age assistance as well as for medical assistance. The law, continues, however, to exclude from the matching provision money payments of such patients. Before the amendments the maximum average monthly payment for old-age assistance in which the Federal Government would participate was $65. This amount included both money payments to the individual and vendor payments for his medical care. The Federal Government will continue as before to share in such expenditures for old-age assistance up to four-fifths of the first $30 of the average monthly payment, with variable matching ranging from 50 to 65 percent in the remainder up to $65 based on the relationship of the State's per capita income to the national per capita income.

For States with average monthly payments of more than $65, the 1960 amendments provide for Federal participation in additional expenditures except that such participation will be limited to the amount of the average vendor medical payments up to $12 a month, or the amount by which the total average payment exceeds $65, whichever is less, with the Federal share ranging from 50 to 80 percent based on per capita income. For States with average monthly payments of $65 or less the Federal share in average vendor medical payments up to $12 a month will be an additional 15 percent over the usual Federal percentage applicable to the amount of payments falling between $30 and $64. This percentage, when added to the usual Federal percentage for the second part of the formula for payments, will give a total Federal share of 65 to 80 percent. The additional Federal share of 15 percent will also be available to States with average monthly payments of more than $65, when it is advantageous to them as an alternative to the method described above. The Federal Government also pays 50 percent of the cost of administering State plans under the Kerr-Mills Act.

Kerr-Mills is legislation designed to accommodate the two pressing problem areas—namely, by providing those persons over 65 who are covered by programs of old-age assistance with an expansion of medical coverage and by also providing medical assistance to those persons who have reached 65 but who are not recipients of old-age assistance. Of the more than 17 million persons in these classifications, the Senate Finance Committee figures indicate that approximately 10 million persons might meet eligibility requirements. The number actually affected will depend upon the number of States participating, and the eligibility standards formulated by such States. Each year, after all State plans are in full operation, an estimated one-half to 1 million persons among these 10 million may become ill and require payments. The number of recipients per year 1961–63 as listed in the budget, fiscal year 1963, is: 1961, actual, 80,400; 1962, estimate, 495,500; and 1963, estimate, 729,300.

The argument is often made that Kerr-Mills is inadequate and insufficient to meet the pressing needs as they exist today. The Finance Committee figures do not give umbrage to such a position. It should be borne in mind in the coming year better than 72 percent of those senior citizens who will require medical attention will be taken care of under Kerr-Mills—and this assumes no further implementation on the part of the States not presently participating. When there is taken into account the fact that the establishment of such a State program cannot be accomplished overnight, every indication suggests that Kerr-Mills is doing the job which the Congress felt should be accomplished, and rapidly. At this point, it would be well to have a list of the States which are participating in the Kerr-Mills program. They are as follows:

Alabama, Arkansas, California, Connecticut, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Washington, West Virginia, Guam, Puerto Rico, and the Virgin Islands.

THE MEANS TEST

In an effort to discredit the Kerr-Mills Act, the oponents have resorted to emotionalism. There is a tendency to cloud the real issue by casting adjectives about and thus attempt to discredit what is a perfectly proper administrative aspect of the program in terms of the purpose which it was intended and does serve. Kerr-Mills came to grips with a problem which faced us, namely, how to provide adequate medical and hospital care to our senior citizens incapable of providing it themselves. In reporting the bill, the Committee on Finance called attention to the purpose of the medical assistance aspect for the aged not receiving old-age assistance:

> The bill would amend existing title I to make it clear that States may extend their assistance programs to cover the medically needy. The bill would give the States a financial incentive to establish such programs where they do not exist or to extend such programs where they are not adequate in coverage or comprehensive in the scope of benefits. Benefits under a State program may be provided only for persons 65 years of age or over to the extent they are unable to pay the cost of their medical expenses. Under this program, it will be possible for States to provide medical services to individuals on the basis of an eligibility requirement that is more liberal than that in effect for the States old-age assistance programs.
>
> It would cover all medically needed aged 65 and over; it would cover every such person including those under the social security system, railroad retirement system, civil service system, or any other public or private retirement program whether such person is retired or still working, subject only to the participation in the program by the State of which they are resident; it would cover the widows of such workers as well as their dependents who meet the age 65 requirement and are unable to provide for their medical care. There are many individuals who have not worked under the social security program or any other retirement program for a sufficient time to ever become eligible for retirement benefits; this is another needy group which would be able to receive medical assistance under the health plan endorsed by the Finance Committee.

The report to the Special Committee on Aging, in discussing the means test, uses descriptions such as "humiliating," "degrading." The act, itself, has two provisions covering this subject, one of which applies to a State plan which includes old-age assistance and the other to a State plan which includes medical assistance. Section 2(10)(A)—the State

agency shall, in determining need for assistance, take into consideration any other income and resources of an individual claiming old-age assistance; (B) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; section 2(11)(D), include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; (E) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan—except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual—and that there shall be no adjustment or recovery—except, after the death of such individual and his surviving spouse, if any, from such individual's estate—of any medical assistance for the aged correctly paid on behalf of such individual under the plan.

There is nothing onerous, nothing degrading, humiliating in these requirements. There is nothing in that language suggestive of a pauper's oath; and any such suggestions are eminently unfair to the purposes and objectives of the program. Quite obviously, if an individual is capable of taking care of his or her medical needs, then in the American tradition, such individual would want to do so. But, it should be borne in mind that the people this legislation is trying to help are those without adequate funds to help themselves. Does it not stand to reason that an inquiry of one sort or another must of necessity be made, in order to arrive at a determination as to the applicant's eligibility? It was never the intent of Congress to oblige anyone seeking this assistance to be embarrassed, and certainly no one would condone such treatment outside the realm of emotionalism, leading to the unavoidable conclusion that, since the act was intended for the needy, some determination of this need must be made. Since those who are going to be helped are of modest means, does not a fair and reasonable test have to be applied in order to make that determination? It should be remembered that there are Federal and State funds involved, and there is the duty upon those charged with administering the program to see that the funds are properly applied.

The charge that the means test is demeaning is not well documented. However, if experience were to show that, in reality, an undue hardship is being placed upon those persons seeking assistance, then the obvious remedy is to amend the requirements, not discard the program. The minority report to the Special Committee on Aging carries the suggestion that one way to remedy this, if a problem in fact exists, is through an amendment to the present law stipulating that a simple statement setting forth details of the individual's finances, submitted under oath, by the applicant for aid would be presumed valid in determining eligibility.

In an effort to bring all the facts into their proper perspective, it should be noted that Kerr-Mills was designed to provide assistance to senior citizens as and where needed. The need factor cannot be too strongly underscored. Approximately 2.5 million, or 16 percent of our population, at the 65 age level or above, receive public assistance. Beyond that there are those having incomes adequate to cover living expenses, but inadequate to take care of hospital and medical expenses of a protracted nature. But, regardless of numbers, it is the needy who must be considered, and it is just that purpose which Kerr-Mills, in its full and complete implementation, will accomplish.

Kerr-Mills was intended to supplement, not supplant. In this connection, Dr. Vetalis V. Anderson, president of the Colorado State Medical Society, wrote to me recently, outlining the society's proposal to implement the medical assistance for the aged portion of Kerr-Mills. Dr. Anderson does point out that the plan has been submitted to the Colorado General Assembly Legislative Council for study. I ask unanimous consent that Dr. Anderson's letter be printed at this point in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

COLORADO STATE MEDICAL SOCIETY,
Del Norte, Colo., May 1, 1962.

Senator GORDON L. ALLOTT,
U.S. Senate,
Washington, D.C.

DEAR SENATOR ALLOTT: The Council on Governmental Relations of the Colorado Medical Society, working closely with Mr. John J. Vance of Colorado Blue Shield, has drafted a proposed method implementing the medical assistance to the aged portion of the Kerr-Mills law (Public Law 86-778). In the hopes of obtaining passage of this plan or some revision thereof, at the next session of the Colorado General Assembly, we have submitted our plan to the assembly's legislative council for study.

We believe that you will also be interested in knowing something about our proposed implementation of the medical assistance to the aged portion of the Kerr-Mills law in Colorado. The object of implementing this portion of Public Law 86-778 is to help those persons in Colorado who are over age 65 and acknowledged to be presently, or potentially, medically indigent, and who for one reason or another are not eligible for the OAP medical care program.

Our proposed medical assistance to the aged program recognizes the first dollar needs of the very indigent, but mainly its help is directed at the catastrophic expenses which can represent financial hardship to even the reasonably affluent aged members of society.

The program would not replace the benefits available through the many voluntary prepayment plans in existence, but is designed to encourage self-help and enrollment in such plans, and to supplement them through an extension of benefits. We propose that certain base plan benefits be established, the cost of which constitutes a deductible feature which must be borne in whole or in part by the medical assistance to the aged recipient. When the medical assistance to the aged recipient finds the benefits of his base plan are exhausted, or when similar services have been paid out-of-pocket by the recipient with no base plan coverage, then the protection of this medical assistance to the aged extended benefit approach becomes applicable.

It is recognized that the potential medical assistance to the aged recipients vary in degree of medical indigency. Each can help himself to some degree and self-help is the foundation of this approach, although recognition is given to the extreme indigency status of some classes of medical assistance to the aged recipients.

The base plan constitutes the deductible services, the cost of which the individual must bear, either through membership in prepayment plans or as an out-of-pocket expense at the time the service is incurred. In the case of real indigency, the cost of the base plan would be subsidized by medical assistance to the aged.

Any voluntary hospital-medical prepayment plan would be eligible to underwrite the base coverage at whatever rates the individual organization felt were warranted, providing the plan offered the precise benefits set forth by the Colorado Department of Public Welfare, administrators of the plan, on a noncancellable basis, and were approved by the Colorado Insurance Department as reputable firms.

We propose that the base plan coverage include complete hospital benefits up to 30 days per year; outpatient service; nursing home benefits of 30 days[1] a year at an allowance of up to $5 per day when under the care of a physician in a licensed nursing home; home nursing service during any 30-day convalescent period each year with daily visits if necessary at an allowance of up to $3 per nursing visit; medical-surgical benefits in the hospital or doctor's office and home calls by a physician at a rate of up to two calls each year during a 30-day convalescent period following hospital care.

The medical assistance to the aged is proposed in the form of subsidization of the cost of the base benefits for the very indigent, thereafter in extended hospital and medical benefit protection, applicable only after the base benefits are exhausted. The medical assistance to the aged program would renew the base benefits (except for the nursing home care) as often as medically necessary, with each renewal after the first subject to a minimal payment by the recipent on the basis of his financial condition. Our proposed program omits convalescent nursing home services, in the belief that such service beyond ,that provided in the base plan, is of a custodial rather than of a medical nature, and is therefore a cost of living, not a medical cost.

There are some unknowns in our cost estimates of the proposed program, but we feel that this is not an insurmountable obstacle. Much of the cost of base benefit renewal can be ascertained from OAP experience, which discloses in the last fiscal year that only 860 cases out of 20,754 admissions required more than 30 days of acute hospital care. We believe that a liberal estimate of the cost of this program would be $3 million of State money to be matched by Federal funds under the Kerr-Mills law.

We hope this rather lengthy explanation of our proposed medical assistance to the aged program will give you some idea of what we believe can be done for Colorado's needy and near-needy aged. We feel that this is the proper solution to the medical care problems of this aged group in Colorado and could be adapted by every State in the Nation.

Sincerely,

V. V. ANDERSON, M.D.,
President.

Mr. ALLOTT. Mr. President, my State has already in effect an old-age pension, health, and medical care pro-

[1] In addition to the 30 days of convalescent nursing home care, provision is made for an additional 12 months extended care in a person's lifetime.

gram which it adopted in 1956. At that time, a limitation of $10 million was placed upon the funds to be earmarked for carrying out the program. Therefore, while we have a good program presently operative, the constitutional limitations will have to be amended in order to adopt the MAA program under Kerr-Mills.

Mr. President, I now withdraw my amendment.

The PRESIDING OFFICER. The amendment of the Senator from Colorado is withdrawn.

EXHIBIT 1

ECONOMIC FACTORS

SUMMARY

Money income: Eleven out of every twelve persons 65 and over received some cash income in December 1960. Slightly more than half of this income came from private and the balance from public sources. Social security and other forms of public insurance accounted for the bulk of public income and employment accounted for the bulk of private income. Over one-third of the estimated aggregate income of $32 billion received by the aged was represented by earnings from employment.

Employment status: Of the elderly men who worked in 1959, 54 percent held full-time jobs for more than half the year. Over half of the elderly working women held part-time jobs, and 36 percent of them worked full time for more than 26 weeks. Employment of the aged involves a significant amount of part-time, or part-year work. The prevalence of work decreases with age and, among those who continue to work, self-employment becomes more dominant. In late 1959, the percentage of aged men looking for work was less than the rate for all men. Their length of time out of work was greater. For most aged who work, income from their jobs is only one source of total income. Often public sources are also involved.

Retirement: The number of workers covered by private pension plans in the United States increased from 2.7 million in 1930 to 20.2 million in 1959, or from 5.4 percent to 29.1 percent of the civilian labor force. The typical pension pays 25 to 40 percent of average earnings before retirement. The vast majority of pensioners are covered by Old-Age, Survivors, and Disability Insurance. Roughly, 50 percent of private retirement programs have vesting provisions and the percentage is growing. Private pensions and individual annuities represented slightly less than 6 percent of the estimated aggregate income of persons 65 and over in 1960. In 1959, as in the preceding 4 years, private pension plans took the largest single share of employer-empolyee contributions to employee-benefit plans.

Of the public income-maintenance programs, OASDI is by far the most important It now covers 9 out of every 10 workers and is paying benefits to nearly two-thirds of the aged population. In August 1961, the average individual benefits were $75.77 per month. In December 1960, average monthly benefits were $123.90 for man and wife, and $57.70 for an aged widow.

The railroad and Federal retirement systems provide higher pension benefits than the OASDI program. Benefits paid by State and local governments vary widely. These programs generally require direct participation by the employee.

Two types of public benefits based on demonstrated need and derived from general tax revenues are old-age assistance benefits and payments to wartime veterans for nonservice-connected disabilities. The former vary considerably by State, ranging in July 1961 from $35.32 to $114.26 a month. The national average was $67.99. Veterans 65 or over are eligible for monthly pensions based on disability, unemployability, and low income. The benefits range from $40 to over $150 a month.

Distribution of money income among the aged: In 1960, less than $1,000 in total money income from all sources was received by 52.7 percent of all noninstitutionalized aged individuals; 27.1 percent of the men and 73.9 percent of the women were in this income group. The median income of aged persons was approximately 83 percent higher in 1960 than in 1950 as measured in 1960 dollars. Money income of $5,000 or more was received by 11.8 percent of the men and 1.7 percent of the women in 1960.

In 1959, of the 6.2 million families headed by persons 65 or older, money incomes for half were below $2,830 and for one-fourth were below $1,620. The average family comprised 2.6 members of whom three-fifths were 65 or over. Of the 3.6 million elderly persons living alone or with nonrelations in 1959, incomes of half were below $1,000 and of four-fifths below $2,000.

The per capita income of families headed by persons 65 and over, in 1958, was only 58 percent as much as that for families whose head was between 55 and 64, but it was 81 percent as much as that for families headed by persons 25 to 34 years old. The income position of the aged is more fixed than for the younger age groups. Many of the younger families are in transition to larger incomes; the aged are not.

Assets: Of the spending units with heads 65 and over, 13 percent did not report owning any liquid assets, corporate stock, equity in home, other real estate, or unincorporated business in 1960. An additional 23 percent held less than $5,000 in such assets. Approximately 40 percent had assets valued at $10,000 or more. All together, half had assets of $8,000 or more. Equity in home was the most important type of asset in terms of value. The type of asset held by the largest percentage of spending units was liquid assets. The pattern of holdings was similar to spending units with heads between 45 and 64. Younger spending units had considerably less than those headed by aged persons. In regard to aged OASI recipients alone, in 1957, 10 percent of the retired couples, 33 percent of the single retired workers, and 27 percent of the aged widows had no net worth (value of selected assets—major portion of total assets—less reported debt). On the other hand, 48 percent of the retired couples, 39 percent of the single retired workers, and 32 percent of the aged widows had a net worth of $10,000 or more. The data show quite a spread in asset position among the aged.

In regard to liquid assets, in early 1960, more of the aged spending units had no liquid assets than all spending units (30 percent versus 24 percent), but more had at least $2,000 in such assets (40 percent versus 25 percent). Twelve percent of the aged units had over $10,000 in liquid assets alone. Among the aged, those with the smallest incomes are likely to have the least liquid assets.

One of seven aged spending units had corporate stocks or bonds in 1960. The median equity greatly exceeded that of younger spending units. Most of these aged spending units also had significant bank accounts and savings bonds.

In 1959, 66 percent of the nonfarm family units headed by persons 65 or over owned their own homes. Of these homes, 83 percent were free of mortgage debt. In contrast, 58 percent of all nonfarm family units owned the homes in which they resided and 44 percent of these homes were mortgage free. In 1960, the median equity in their own homes of aged spending units who were homeowners was $9,700. Home ownership was positively correlated with level of savings and with income. For example, in 1957, among OASI beneficiaries, 8 of 10 couples with incomes of $5000 or more owned nonfarm homes, but less than two-thirds of those with incomes below $1,200 were owners.

In 1957, 56 percent of the spending units with aged heads owned a life insurance policy, compared to 79 percent of all spending units. The value of the insurance was, in general, enough to cover burial expenses.

In 1959, a survey showed that 69 percent of the aged spending units were entirely free of debt, as compared with only 32 percent of spending units of all ages. Only 11 percent of units headed by elderly persons had mortgage debt (versus 31 percent for all units), and 26 percent of the older group had personal debt (three-fifths under $200) compared to 60 percent of all spending units.

The aged tended to look upon savings and other assets as resources to be used to meet expenses only in a dire emergency. This was particularly true of housing.

Noncash income: Noncash income probably plays a more important role in the well-being of elderly people than it does in the case of younger adults. In 1957, among OASI beneficiaries four of five couples and three of five nonmarried persons had noncash income of one or more of the following types: imputed rental value of an owned home, rent-free housing, food homegrown or obtained without cost, medical care provided free or at someone else's expense. It has been estimated that the value of noncash income of the aged amounted to $3 billion in 1958.

Tax position of the aged: In 1957, 6.5 million of more than 16 million persons 65 and over filed an income tax return. Of these, 3.2 million returns were taxable. The Federal and State Governments have special tax provisions for the aged. For example, the Federal Government gives special consideration to age itself, blindness, public and private retirement benefits, and medical expenses. Certain taxes, other than those on income, may be unfavorable for the aged.

Budgetary needs: It is estimated that, on the average, persons over 65 have somewhat lower living costs than their younger counterparts. Budgets for the aged have been worked out by various government agencies. These budgets are calculated to support a modest but adequate living. They have several limitations which are noted in the text. Within these limitations, the fact that many aged fall below the threshold of adequacy is shown. It is also noted how many of the aged are well above the threshold and presumably able to meet living expenses.

The economic picture of the aged is mixed. Not all are in a difficult position. A significant segment of the aged, however, have neither the monthly income nor the capital assets to withstand protracted economic adversity. The aged who are disadvantaged differ from the younger disadvantaged mainly in the fact that their position is relatively immune to change either through prospective employment or otherwise.

Mr. ALLOTT. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MILLER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MILLER. Mr. President, I send to the desk an amendment and ask that it be read.

The PRESIDING OFFICER. The amendment will be stated.

The CHIEF CLERK. It is proposed to strike out all in line 19, page 2, after "(4)," and all of lines 20, 21 and 22, and insert in lieu thereof the following: "it

is a duty of government to provide necessary hospital and medical services for those citizens, young and old alike, who cannot otherwise obtain such services."

Mr. MILLER. Mr. President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator from Iowa will state it.

Mr. MILLER. Do I correctly understand that 30 minutes is allocated on each side of the amendment?

The PRESIDING OFFICER. The Senator is correct.

Mr. MILLER. I yield myself 30 minutes.

Mr. President, I ask unanimous consent that 3 minutes from the opposing side be extended to the distinguished Senator from Pennsylvania [Mr. CLARK] and that his remarks appear at this point in the RECORD.

The PRESIDING OFFICER. Is there objection?

Mr. HUMPHREY. Not at all; the time is gladly yielded.

The PRESIDING OFFICER (Mr. METCALF in the chair). Is there objection? The Chair hears none; and the Senator from Pennsylvania may proceed.

Second. The social security program is proposed as the vehicle for financing the program, notwithstanding the serious financial situation the social security program is in today. I propose to elaborate on these reasons in the course of my remarks.

There are a good many misunderstandings about President Kennedy's so-called medicare program, now modified and incorporated in the Anderson-Javits amendment. One of these is that my making payments into the social security program during their working years, people will be building up an insurance fund out of which their medicare needs—hospital and nursing-home care, as covered by this amendment—can be met after they reach age 65. But such is not the case. In 1959, the Supreme Court of the United States made this clear, in the case of Fleming against Nestor, in the following statement:

> Persons gainfully employed, and those who employ them, are taxed to permit the payment of benefits to the retired and disabled, and their dependents. Plainly the expectation is that many members of the present productive force will in turn become beneficiaries, rather than supporters of the program. But each worker's benefits, though flowing from the contributions he made to the national economy while actively employed, are not dependent on the degree to which he was called upon to support the system by taxation.

Note the words "not dependent." Social security benefits to those over 65 are not met by payments made during their working years, but are met by taxes paid by current active workers. This is why it is misleading to talk about this program as health insurance. It is not insurance at all. If it were, the millions of people now retired under the social security program would not receive any medicare benefits at all, because they never paid anything into the social security program for them; and the millions who are in the middle age bracket would receive only a fraction of the medicare benefits, because they would have paid into the social security program only a fraction of the taxes needed to meet the cost of the benefits. The value of the benefits of those who have paid nothing at all for them is estimated at between $10 and $20 billion. The value of the benefits in excess of taxes that will be paid in by the worker and his employer, for all present active workers is estimated at $15 to $40 billion. The result is that the young people who will be entering the labor force in the future must make up between $25 and $60 billion of benefits which the recipients have not paid for. This is not insurance at all. It is a windfall that the present generation is proposing to receive at the expense of future generations.

The statement has been made that this is desired by the younger generation in order that their older relatives may have some medical benefits. I do not question that statement insofar as it applies to our older citizens who cannot afford decent hospital, nursing home, and even doctor's care. But I certainly do question it as far as concerns those who can afford these essentials. I do not believe that our young people want to be taxed to pay for benefits for people who can afford them. And I do not believe those who can afford them are selfish enough to want a free ride on the backs of their children and our future generations.

I do not know how many of the some 15 million people 65 and over who would become eligible for these medicare benefits under this amendment can afford to pay for them. Apparently, of the 12 million 65 and over under social security now, some 1.2 million of them are excluded from benefits by reason of their earned-income receipts. But there are many, many others who are receiving pensions, rental income, interest income, and didivend income who could afford these medicare benefits too. It is common knowledge that, to protect their social security retirement pensions, many older citizens convert their self-employment income into nonworking income of the kind I have referred to. Others have built up substantial property holdings as nest eggs to cover contingencies such as prolonged illness and catastrophic disease. Others have built up accident and health insurance programs which, either in full or in part, would take care of their hospital and nursing home needs, as well as doctor bills. It is grossly unfair to give these people a windfall at the expense of younger people, with families, who are trying to make ends meet right now. The inequities of the situation which this amendment would create are aggravated by the fact that these same people can deduct for income tax purposes the entire cost of their medical needs, whereas those under 65 cannot do so. In fact, I would estimate that most of those under 65 never receive the benefit of any medical expense for income tax purposes, because the tax law is so arranged that either they use an optional standard deduction—in which those with medical expenses are treated the same as those without medical expenses—or the arbitrary 3 percent of their adjusted gross income exceeds their medical expense so that no deduction at all is received.

Note also that while the medical expenses of our older citizens are higher than those of our younger people, these younger people are beset by medical expenses for their children, clothing and education costs of their children, mortgage payments on their homes, costs of home furnishings and appliances, and automobiles. Many of these older citizens have no automobiles—they are retired and do not need one in connection with their work—they own their own homes, which have long since been furnished, their families are raised and are out on their own. Their food and clothing costs are much less. I am not suggesting that this is not as it should be. After long years of hard work, this is a financial situation which should only naturally develop. What I am saying is that, in this state of affairs, it is unfair to ask the future generations of our Nation to pay for hospital and nursing home care for those older citizens who can afford to do so, themselves. Indeed, I would suggest that those older

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

The PRESIDING OFFICER (Mr. METCALF in the chair). The Senator from Iowa is recognized for 28 minutes.

Mr. MILLER. Mr. President, I am opposed to President Kennedy's medicare program, sometimes called the King-Anderson bill, and now before us substantially in the form of the Anderson-Javits amendment. My principal objections are twofold, as follows:

First. The Anderson-Javits amendment would provide benefits to anyone over 65 years of age, regardless of his or her financial need.

citizens who can afford to do so are resentful of the appeal to selfishness which this amendment contains.

The only way to cure this amendment of this inequity is to modify it to provide for exclusion of benefits of those who can afford them, or for partial exclusion of benefits of those who can afford some of them. I suggested to the distinguished Senator from New Mexico [Mr. ANDERSON] last week in a colloquy that one approach would be to take the income-from-work test now used in scaling down or eliminating social security payments. The defect here, however, would be that people receiving income from rentals, interest, or dividends would not be excluded, and these people might well be even better able to afford their hospital and nursing home expenses than some of those receiving income from wages or self-employment. As I pointed out in my colloquy with the distinguished Senator from Kentucky [Mr. MORTON] last Friday, income from long-term capital gains which—to the extent of 50 percent—is not recognized for income tax purposes represents economic income and should be reflected in determining eligibility.

If it be suggested that all of this would be administratively cumbersome, the answer is that the States are doing this right now in determining eligibility for old age assistance and aid to dependent children; and while it may be administratively cumbersome, it is necessary to prevent taxation of people to pay expenses of others who can afford to pay for them—perhaps even better than those who are being taxed.

My colloquy with the Senator from New Mexico [Mr. ANDERSON] brought out the point that, under the Anderson-Javits amendment, the cost of catastrophic disease or illness of people under 65 would not be covered. Accordingly, I suggest that, from the standpoint of the duty of government to provide for those citizens who cannot provide for themselves, this amendment is grossly deficient. In addition to the case I referred to in the colloquy, let me give the Senate some other cases. The first three are hypothetical, but are based upon facts of actual cases given to me by a practicing physician. The fourth is quoted from a recent article in Medical Economics:

Case No. 1, Mr. A., age 40, fell at work 7 years ago and severed his spinal cord, causing permanent total paralysis of both his legs. For 2 months his insurance company assumed responsibility for his hospital bills. After that, he paid his own way until he had liquidated all his assets. He lost his home, his car, and his savings. Having become a pauper, he at last became eligible for public welfare and has been on the welfare rolls since. This injury has caused extensive hardships to the patient and his entire family. His lot has recently been somewhat improved, but only by his winning a lawsuit which was drawn out over the years and was in itself most unpleasant.

Comment: This man was working in a State (not Massachusetts) which has grossly inadequate liability laws for workingmen. Another individual with a similiar injury, but properly insured, has maintained his home intact and since his injury has had two sons graduate from college with honors. Legislation providing coverage for all individuals struck with catastrophic illness would prevent the hardship suffered by Mr. A. and his family.

Case No. 2. Mr. B., age 45, worked 20 years in a satisfactory manner for company X, One year ago he had a heart attack. After a 3-month convalescence, Mr. B. was ready to return to light work. Company X, and all others to which he has applied for work, refuses to hire him unless the doctor will certify he has returned to normal and is physically capable of doing any job in the plant. Since this cannot be done, Mr. B. is being denied his rightful employment and is being forced to do either menial odd jobs about the town or accept charity. The reasons company X will not hire him involve seniority rules and bumping rights written into their contract with the local union, and unrealistic State liability laws regarding heart disease and symptoms related to it which appear on the job.

Comment: Legislation aimed at making a place in industry for partially disabled men is sadly needed. Many companies would hire such people if they could control what type of work they did, and if liability laws were made more realistic.

Under the Anderson-Javits amendments, this person would be left out in the cold.

Case No. 3. Mr. C., age 32, was a partner in a small contracting business. His job was to operate and maintain the heavy machinery. This required extreme physical exertion, long hours, and exposure to the elements. Three years ago he developed acute Bright's disease (kidney trouble) and almost died. Convalescence was slow and painful. As time went by, it became apparent that he could not resume his previous occupation, and he was advised to learn a new trade. He applied to the State rehabilitation commission for help. For several months he went to interviews, filled out forms, and watched the bureaucrats shuffle papers. Then his wife went to work, friends loaned him money, and he went to a school for laboratory technicians for 1 year. On graduation he applied for and obtained a job as part of a research team in one of our finest hospitals. The rehabilitation commission did nothing.

Comment: Our Federal Legislature could set up a true rehabilitation (retraining) program available to anyone disabled by illness. It would be much more economical to get these people back to work than to pass out pensions, which is all our rehabilitation commission ever seems to do. The Federal Government has demonstrated what a great job it can do with the VA rehabilitation program.

I point out that under the Anderson-Javits amendments Mr. C would be left out in the cold.

Case No. 4. L. D. was a 37-year-old machinist living in Milwaukee, married, with two children. In 1956, he was crossing a street one evening on the way home from work when a car struck him and broke his hip. The driver was at fault but had minimal insurance and too few assets to be worth suing.

L. D.'s fractured hip became infected (osteomyelitis). He spent the next 3 years in a plaster cast from chest to toes, and at this writing has had more than 20 operations. He'll never walk again; he'll be in pain for much of the rest of his life; he'll need further operations approximately once a year.

L. D.'s tragedy isn't only medical, but financial. His bills are astronomical; so far he owes the hospital alone more than $25,000. His savings have vanished. His health insurance, as always in such cases, was a cruel disappointment. His earnings have stopped for good; and he worries day and night.

Comment: This is a case where the Federal Government could return this man to society at the same economic level he had reached prior to his horrible injury, if they would back everyone, regardless of age, color, etc., who is struck down by catastrophic illness.

The Anderson-Javits amendments would leave this individual out in the cold.

All of these cases are those of young people. All of them are what one might call catastrophic situations. All of them should be covered by the Government, at least after the point is reached that the people involved cannot afford to pay for their medical and hospital bills. However, the Anderson-Javits amendments would not take care of them at all.

Another unfairness which the amendments would perpetrate is that by covering everyone over 65, regardless of his financial need, the benefits going to those who are in need would inevitably be reduced. In fact, this is one reason why the benefits provided by the amendments are inadequate to take care of a catastrophic situation. If adequate coverage is to be extended, then the cost of the entire program will have to be greatly increased—if everyone is going to be covered. By limiting coverage to those who are in need, we would not face such a dilemma. Costs would be kept down, and the benefit coverage would be kept high. Indeed, I believe I speak for a great many people when I say that I am more concerned about coverage for people such as those referred to in the foregoing examples that I am about coverage for someone who happens to be over 65 years of age and who has the wherewithal to meet the costs of his medical and hospital care.

One of the most controversial features of the Kennedy medicare program, as reflected in the pending amendments, is that it is proposed to finance it by payments into the social security system. Millions of people are now working under social security and are (between themselves and their employers), making payments for what they hope will be a reasonable pension during their retirement years. Unfortunately, the purchasing power of these social security pensions has been steadily eroded by inflation. And so, Congress has periodically increased the amount of the pensions in order to preserve the purchasing power of the pensioners. The social security taxes have not been increased proportionately however. The increase in taxes has largely been scheduled to meet the increased numbers of people coming into retirement status. Accordingly, more and more of the burden of paying for these unfunded social security benefits has been shifted to future generations.

In the June 29, 1961, issue of the Wall Street Journal, an article by Mr. Ray M. Petersen, vice president of the Equitable Life Assurance Society, points out that if social security taxes had ceased in 1950, the trust fund would have covered 113 percent of the benefits promised for the future for those then in receipt of payments; but if taxes should cease in 1965, only 20 percent of the benefits for

those then on the rolls would be covered, with no provision at all for those not retired. Such a state of affairs would not exist if social security taxes had been increased in the amount needed to pay for increased benefits and for the broader coverage of workers. But they were not increased. The decision was made by Congress to shift the burden on to our future generations—the same ones, I might add, to whom is being passed a national debt of over $300 billion.

This was, perhaps, the easy way out for Congress and those now covered by social security. It would have been fairer either to have increased the social security taxes or to have appropriated the difference needed out of the general fund into which taxes paid by everyone are funneled. We are running into a similar problem now with respect to the retirement of our Federal civil service employees. In the July 2 issue of the Washington Evening Star, a timely article by Joseph Young, staff writer for the Star, calls attention to the present unfunded liability of the civil service retirement fund of $32 billion and to warnings by CSC officials that the fund will go bankrupt by 1980 if additional means of financing it are not secured. Mr. Young reports that a considerable number of Members of Congress believe the situation poses a greater threat to the civil service retirement system than any plan to coordinate the retirement system with social security as the administration is expected to advocate next year. Such a solution, of course, would merely shift the burden on to future generations. A fairer way of handling it would be to increase the amounts contributed by Civil Service Commission employees to the retirement fund, or to make appropriations from the general fund to make up the deficit, which is what we are doing today.

However, Mr. Young says that if the civil service retirement fund's liability increases to a point where the Government would have to begin to pour billions of dollars into the fund each year in order for it to meet its obligations, the Congress might then very well be in a mood to reduce civil service retirement benefits, merge it with the social security system or abandon it entirely. In the face of this financial mess of our civil service retirement system, it is now reported that the Senate Civil Service Subcommittee will approve a bill giving retired Federal workers and their survivors an immediate 10-percent increase in annuities. We will trust that the subcommittee comes up with the solution of not only how to finance this increase but how to clean up the financial mess which the increase will worsen.

Anyone can see that if the benefits are increased, someone is going to have to pay the freight. It probably will not come from increases in the contributions made to the retirement system, because that would be unpopular. It probably will not come from appropriations from the general fund, because the budget is already badly unbalanced, and the future is as bad as the present.

The quick, easy answer is to pass the whole load on to the backs of future generations by integrating the system with the social security system. That is why, no doubt, the administration is reported as planning to take this action.

I call attention to the plight of our civil service retirement system as a parallel to the plight of our social security system. The trust fund is practically used up. As graphically pointed out in an excellent article in the July 2 issue of U.S. News & World Report, entitled "The Untold Story of Your Social Security," there is now some $22 billion on hand in the social security trust fund. The value of future contributions to be made by workers now covered by social security and their employers is some $282 billion. Thus, between the balance in the trust fund and the amounts present workers will pay in, we have a total of $304 billion to fund the benefits which are to be paid to those now retired and those now working when they retire. The pension money required for this purpose, however, is estimated to amount to $624 billion, leaving a "gap," as the article puts it, of $320 billion—a deficiency to be made up by taxes to be paid by future generations of workers and employers. This is a most serious situation. It is a most unfair heritage to pass on to our future generations, and let it be made clear that this $320 billion deficiency is in addition to the $300 billion plus national debt which is also being passed on to the future generations.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. MILLER. Mr. President, I withdraw my amendment. I send to the desk an amendment and ask that it be stated.

The PRESIDING OFFICER. The amendment of the Senator from Iowa will be stated.

The LEGISLATIVE CLERK. The Senator from Iowa [Mr. MILLER] proposes an amendment to the Anderson amendments on page 2, line 13, to strike out the word "most" and insert in lieu thereof the word "some."

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Iowa.

Mr. MILLER. Mr. President, as if that is not enough, it is now reported that the administration is thinking about coordinating the civil service retirement system with the social security system, thus letting the social security system absorb the serious deficit of $32 billion in the civil service retirement fund. That would add up to a $352 billion social security debt being passed on to future generations.

Now the Anderson-Javits amendment comes along, proposing to pile another $25 to $60 billion on top of that. This is nothing less than selfishness—a free ride for people who are unwilling to pay the cost of their own program and who desire to let the future generations of the United States pay for it.

I ask unanimous consent that the U.S. News & World Report article to which I have referred be printed in the RECORD at this point in my remarks, along with the examples set forth on page 47 and the table set forth on page 48 of the article.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

THE UNTOLD STORY OF YOUR SOCIAL SECURITY

Check your own social security, and you'll probably find you are getting a bargain. Check your grandson's, and it's a different story. Reason: Pensions for this generation must be paid, in large part, by future generations.

To answer questions now being raised:

This is to be the untold story of your social security. It concerns the pension to which you are entitled in retirement, or if disabled, and to payments to your survivors in event of death.

Social security is a vast system. Old-age and survivors insurance alone in this year will involve benefit payments of more than $13.2 billion. And the total is to grow steadily over the years ahead.

In 4 of the last 5 years, payments to persons drawing benefits have been exceeding income from payroll taxes. Some alarm has been expressed about this deficit between outgo from the social security reserve fund and income into the fund.

That, however, is not the story to be told.

Payroll taxes rose on January 1. They go up again on next January 1. Money flowing into the reserve fund, as a result, once again will begin to total more than money flowing out. Fears about the safety of the fund will subside.

A fact—and questions: A hard and little-understood fact, however, will remain to raise questions.

The fact is this: Benefits promised to people now covered by old-age and survivors insurance total an estimated $624 billion. Reserves now on hand total around 22 billion. Taxes to be paid by people now covered by social security to support pensions are to be an estimated $282 billion.

That leaves $320 billion in benefits to present policyholders to be paid by someone else. Who will that be?

The answer, in simple terms, is that this deficit, if it is to be paid, will have to be paid by future workers at tax rates now in the law. Otherwise, persons now in the pension system would have to pay sharply higher taxes.

Pension bargains for people of the present are to become pension burdens for workers of the future.

These workers of the future will pay substantially higher taxes on their earnings—taxes earmarked for social security. They will work over a longer span of life, paying higher taxes all the way, in order that the 68 million others now covered by social security can enjoy pensions and other promised benefits.

ONE MORE WINDFALL?

It now is proposed that hospital insurance for retired persons be added to the social security system. Once again, if this type of insurance is added, older people will get a bargain. Those retired when the plan would take effect would become entitled, at no cost, to hospital and nursing care valued at thousands of dollars.

Here would be a windfall for persons now retired and those who will retire in years shortly after the plan takes effect.

The tab for the cost would be picked up—as it is being picked up for old-age and survivors insurance—by employers and by those who go on working. In the end the cost would fall on employers and on generations not yet working.

In a word: social security programs, to date, represent a gigantic bargain for persons retired, soon to be retired, or fairly well along in years.

For relatively small payments these people are assured of an income on retirement. Men are assured that, when they die, their wives will go on getting an income. There is further assurance that minor children will get checks in event of the man's death. A binding promise is made of a monthly check in event of total disability.

Once the hospital-care program is in the law, pressure will grow to cover hospital costs for all persons covered by social security, whether working or retired. The final step might possibly be to cover doctor bills as well.

IDEA: PAY LATER

In each case, planning rests on the idea that future generations will get and pay much of the bill for those who are getting, or stand to get, the bargains of the present.

All of this is part of the strong trend toward special advantages for older people at the expense of the Nation's younger people.

Young people with children to educate, with a house to furnish and pay for, with saving to do if there is to be any venturing, with insurance payments to make, get few favors. Payroll taxes, increased eight times in the past 13 years, will be increased three more times for old-age and survivors insurance. Hospital insurance would mean another tax. Then, at some point, there will be unpaid bills from social security promises to meet.

Old people, all of the time, are getting more and more advantages. People age 65 and older get a double exemption on personal income tax. If retired, they get a special retirement credit against income tax. The social security pension—for which they paid little—bears no tax. All their bills for medical and hospital care are deductible for income tax purposes.

All of this raises the question whether young people with more votes than old people will go on giving the breaks to the elderly.

FOR YOUNG: ALTERNATIVES

Two courses would be open to them if ever they wanted to get out from under what is to be a growing burden.

1. Inflation of prices can be accepted while a determined effort is made to keep individual pension benefits from rising. In this way, inflation could be used to reduce the pension burden, since pensions would represent a smaller part of an inflated national income.

2. Taxes could be used to take away some of the advantages enjoyed by retired persons. One tax reform now under study calls for taxation of social security income. There is some pressure to end many other special deductions extended to older people.

However, experience in the United States and Europe indicates that old people will go on getting their bargains and young people will continue to bear their rising burdens. In Europe there is a strong trend toward shifting to employers a larger and larger part of the social security burden.

The generous attitude of young people is attributed to two factors.

One of these factors is the realization that sometime they, too, will be old and will want some favors.

The other factor is that the young people see social security as a means of spreading the risk that comes from being forced at some point, for most, to care for their own parents.

AS IT'S DONE ABROAD

To fill out the untold story of social security, U.S. News & World Report asked its staff members in Europe to explain how those countries—with long experience—have met the rising burden of welfare programs:

West Germany: The idea of national pension plans got its start in Germany. Two world wars, ending in two defeats and destruction of currency, destroyed the pension systems. Yet each time these systems have come back stronger than ever.

To finance old-age pensions, employers and employees each contribute 7 percent of the gross wage. For health insurance they each contribute an added 4.8 percent. An added 0.7 percent goes for sick pay, special leaves, family allowances. On top of it all, employers contribute an average of 16 percent for other fringe benefits. Payroll additions for social security amount, overall, to approximately 45 percent.

Benefit payments in recent years have been adjusted to compensate for price rises. Young people do not appear to object to the burden they carry.

Great Britain: Welfare costs now account for more than a third of all Government spending. Workers covered by welfare programs and their employers pay special taxes that pay less than half of welfare costs. In the case of health insurance, $3 out of every $4 come from general taxes.

Government subsidizes the whole welfare program, and political pressure is constantly on the side of larger benefits. There is pressure to cut down defense spending so welfare can expand.

Sweden: A 6-percent sales tax was introduced in Sweden 2 years ago to help meet the skyrocketing costs of welfare. Social security benefits now account for 15 percent of national income, compared with 7 percent before World War II.

In 1960, government, central, and local, carried 69 percent of welfare expenses, workers 20 percent and employers 11 percent. Now the pressure is to increase the employers' burden.

France: Social welfare in France extends from maternity grants, family allowances, rent allowances and hospitalization to old-age pensions and death benefits. The expense falls mainly on employers, who pay about 30 percent on their payrolls. The employee contributes about 6 percent on maximum pay of $1,920 a year.

Italy: Social security in Italy includes old-age pensions, unemployment insurance, health insurance, maternity benefits, family allowances and some subsidized housing. The Government contributes 25 percent to the retirement pension fund.

Employers' contributions amount to a tax of about 50 percent of payrolls. Workers contribute approximately 11 percent of their earnings.

In Western Europe as a whole, social security benefits now approximate 15 percent of national incomes. The range, according to official figures, is 12.6 percent in the Netherlands to 16.4 percent in France.

The trend in Europe is toward more and more social services, with heavier and heavier taxes on employers, plus larger contributions by the Government out of general revenues. This suggests that, in the United States, as the years go on, the Government, too, will be called upon to support the pension fund in addition to the payroll taxes that now are scheduled.

Social security taxes and how they grow

	Rate paid by worker, matched by employer	Maximum paid by worker matched by employer
1937–49	1 percent on 1st $3,000 of pay	$30.00
1950	1½ percent on 1st $3,000 of pay.	45.00
1951–53	1½ percent on 1st $3,600 of pay.	54.00
1954	2 percent on 1st $3,600 of pay	72.00
1955–56	2 percent on 1st $4,200 of pay	84.00
1957–58	2¼ percent on 1st $4,200 of pay.	94.50
1959	2½ percent on 1st $4,800 of pay.	120.00
1960–61	3 percent on 1st $4,800 of pay	144.00
1962	3⅛ percent on 1st $4,800 of pay.	150.00
1963–65	3⅝ percent on 1st $4,800 of pay.	174.00
1966–67	4⅛ percent on 1st $4,800 of pay.	198.00
1968 and after	4⅝ percent on 1st $4,800 of pay.	222.00

ANOTHER INCREASE COMING?

To provide for hospitalization and nursing home care for the aged, President Kennedy now urges an extra one-quarter of 1 percent in the payroll tax. The tax base would rise from $4,800 to $5,200. The maximum tax then would be raised to $201.50 next January 1, and go on up to $253.50 by 1968.

NOTE.—The social security tax on self-employed persons, first covered in 1951, is 1½ times the tax on employees.

IS YOUR SOCIAL SECURITY A BARGAIN?—HERE ARE SOME EXAMPLES

Example A: A worker who retired in 1940 at age 65. Wife the same age. Before retirement, worker and employer had paid social security taxes for 3 years. Total tax, worker and employer combined: $180. Since retirement, this man and his wife have been drawing benefits for 22½ years. Total benefits to date: $24,973.

Example B: A worker who retired last January 1 after paying the maximum social security tax since 1937. Total tax paid by worker and employer: $2,868. Add interest at 3 percent, and this contribution to the pension fund becomes $3,714. Pension from now on will be $121 a month for the worker, plus $60.50 for his wife if she also is 65 years old. If both live out their normal life expectancy, then total benefits for man and wife: $32,074.

Example C: College graduate starts working in 1962, pays maximum social security tax until retirement in the year 2005. Total tax paid by worker and employer: $18,564. Add interest at 3 percent, and this contribution to the pension fund becomes $36,226. Pension for man and wife, after retirement, will be at a rate of $190 a month. Total benefits, normal life: $33,664.

Example D: Young man gets a job in 1968 pays the maximum tax from then until retiremen in the year 2011. Total tax, worker and employer: $19,092. With interest at 3 percent, this is worth $37,954. Assume this man is a widower, with no dependents. He lives 2 years after retirement, and dies at age 67. Total benefits, 2 years: $3,048.

Mr. MILLER. Mr. President, the backup figures or computations which support the conclusions set forth in the article I have asked to have printed were prepared by Mr. Robert J. Myers, Chief

Actuary of the Social Security Administration. They are set forth in a table showing the results of liberalizing amendments of 1958, 1960, and 1961 which I ask unanimous consent to have printed in the RECORD at this point in my remarks.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

Balance sheet cost analyses of OASDI system, 1958, 1960, and 1962 intermediate cost estimates at 3 percent interest

PRESENT VALUE OF TAXABLE PAYROLLS

[In billions]

Item	Jan. 1, 1958 1956 act	Jan. 1, 1958 1958 act	Jan. 1, 1960 1960 act	Jan. 1, 1962 1961 act
Present members	$2,876	$3,038	$3,204	$3,279
New entrants	6,795	7,202	7,583	7,747
Total coverage	9,671	10,240	10,787	11,026

PRESENT VALUE OF BENEFITS AND ADMINISTRATIVE EXPENSES

Present members	$486	$543	$587	$625
New entrants	335	377	404	431
Total coverage	821	920	991	1,056

PRESENT VALUE OF SCHEDULED CONTRIBUTIONS

Present members	$194	$231	$254	$282
New entrants	563	641	682	719
Total coverage	757	872	936	1,001

EXISTING FUND

Present members	$23	$23	$22	$22
New entrants				
Total coverage	23	23	22	22

ACTUARIAL BALANCE, SURPLUS (+) OR DEFICIT (—)

Present members	—$269	—$289	—$311	—$321
New entrants	+228	+264	+278	+288
Total coverage	—41	—25	—33	—33

NOTE.—Present members are all living persons (including beneficiaries) who have earnings credits, as of the given date. New entrants include those participating in the system at any time after the given date who had no earnings credits before that date.

Mr. MILLER. An additional table prepared by Mr. Myers discloses that the per capita deficit for present members of the social security program is $4,679. This means that, on the average, everyone in the social security program today—both retired and working members—is passing on to our future generations a debt amounting to $4,679.

I ask unanimous consent that this table be printed in the RECORD at this point in my remarks, along with a final table showing the deficit for present members as a percentage of current taxable payroll, also prepared by Mr. Myers.

There being no objection, the tables were ordered to be printed in the RECORD, as follows:

Per capita deficit for present members, 1958, 1960, and 1962 intermediate cost estimates at 3-percent interest

NUMBER OF PRESENT MEMBERS [1]

[In millions]

Item	Jan. 1, 1958, 1956 act	Jan. 1, 1958, 1958 act	Jan. 1, 1960, 1960 act	Jan. 1, 1962, 1961 act
Active workers	56.7	56.7	58.4	[2] 59.0
Retired workers	6.3	6.3	7.9	[3] 9.6
Total	63.0	63.0	66.3	68.6

DEFICIT FOR PRESENT MEMBERS

[In billions]

	$269	$289	$311	$321

PER CAPITA DEFICIT FOR PRESENT MEMBERS

	$4,270	$4,587	$4,691	$4,679

[1] Active workers taken as average of calendar year average figures for current and previous year (coverage in effect). Retired workers are primary beneficiaries in current payment status as of date given. Although survivor beneficiaries are not included in the count of "present members," all dollar figures include liabilities for survivor benefits.

[2] Average for March, June, and September 1961 (coverage in effect).

[3] Estimated, using 9.4 million actual as of end of October 1961, plus assured 100,000 monthly increase.

Deficit for present members as percentage of current taxable payroll, 1958, 1960, and 1962 intermediate cost estimates at 3-percent interest

CURRENT TAXABLE PAYROLL [1]

[In billions]

Jan. 1, 1958, 1956 act	Jan. 1, 1958, 1958 act	Jan. 1, 1960, 1960 act	Jan. 1, 1962, 1961 act
$181	$181	$202	$214

DEFICIT FOR PRESENT MEMBERS

[In billions]

$269	$289	$311	$321

DEFICIT AS PERCENTAGE OF CURRENT TAXABLE PAYROLL

[Percent]

149	160	154	150

[1] Taxable payroll for previous calendar year, e.g. calendar year 1961 for valuation of Jan. 1, 1962.

Mr. MILLER. The proponents of the Anderson-Javits amendment make considerable point over the fact that the social security tax would be increased only one-fourth of 1 percent for employees and one-fourth of 1 percent for employers in order to finance the program. I ask unanimous consent that a table showing the social security tax rate for 1962 and future years, both as now constituted and as it would be if this program were adopted, be printed in the RECORD at this point in my remarks.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

EMPLOYERS AND EMPLOYEES

[Percent]

Years	Now	Bill
1962	3	3
1963–65	3½	3¾
1966–68	4	4¼
Thereafter	4½	4¾

SELF-EMPLOYED

1962	4½	4⅛
1963–65	5¼	5⅞
1966–68	6	6⅜
Thereafter	6¾	7⅛

Mr. MILLER. It would be far more fair to our future generations if this proposed modest increase were greater, so that the program would be on a pay-as-you-go basis instead of $25 to $60 billion unfunded. If I understand this argument of the proponents, we might as well ask for an increase of one-eighth of 1 percent instead of one-fourth of 1 percent in social security tax. "This would make it easier for the present generations and who cares about how much more of a load will be placed on our future generations" is what their argument comes down to.

However, let us not be so naive as to think that this is where the social security tax increase will stop. We know from the history of the social security program that the trend is to bring more people into the program and to increase the benefits. When this is done, either the tax must be increased or the burden on future generations will be just that much greater. Social security taxes have been moving steadily upwards—although not enough to prevent the load on future generations from being increased even more. This program is not going to be able to satisfy the needs of people who are met with catastrophic illness or disease, or who have large doctor bills, and who do not have the wherewithal to pay for them. As times goes on, these areas of need will be covered, and this will mean a further boost in the social security tax—unless benefits to those who do have the wherewithal to pay for their medicare costs are dropped from coverage.

Mr. Wilbur J. Cohen, Assistant Secretary of the Department of Health, Education, and Welfare testified that over the next 10 years, the earnings base for social security taxes might well go from $5,200, as proposed in the amendment, to $9,000. If this were to happen, we might just as well tack the social security tax on as an addition to the individual income tax instead of having separate taxes. The rate is likely to go up too. If all people, young and old alike, were covered under a program of hospital and medical care, the rate would be at least 10 percent on employer and employee alike; and let me make it clear that such a rate is a flat rate applied against gross

salaries and wages—not against net income, as is the case with the income tax.

Some opponents of the Anderson-Javits program have insisted that the Kerr-Mills Act should be given a reasonable opportunity to work, and that if this is done, the need for coverage will be met—at least for catastrophic disease and illness cases. I would hope that implementation of the Kerr-Mills Act by the States to the point of giving it a full opportunity to become effective would rapidly take place. Doubtless it is imperfect in some respects, but a reasonable trial period will isolate these imperfections and enable the Congress to make a sound determination of what is required. Enacting legislation at this time is legislating in the dark, if we used no more than the factual data available to us in connection with the Anderson-Javits amendments.

One of the features of the Kerr-Mills Act is that it permits benefits only on the basis of need. However, one of the defects at the same time is the wide variance in need among the definitions of the various States.

In more than half of the 24 States which have so far passed enabling legislation or appropriations, or both, to implement the Kerr-Mills Act, the value of the home occupied by an applicant is disregarded. The range extends from Hawaii, with a limit of $14,000, to Arkansas, which specifies $7,500. In many States some valuations are exempt from need considerations. Differences exist in the amount of personal property allowable and that permitted to be used for business or income-producing purposes.

A single person may retain a cash reserve of $300 to $2,000, depending on his residence. A married couple may retain a cash reserve of from $600 to $3,000, depending on residence.

The face or surrender value of health insurance policies is exempt in a few States. A reasonable amount is exempt in another. Up to $1,500 may be retained by a single person, and $2,000 by a married couple in other States.

Monthly incomes allowable—in some cases the annual allowance has been divided by 12 to compute this figure—range from $83 to $250 for a single person, and from $125 to $325 for a couple. Limits differ in one State, Louisiana, depending upon whether hospital or physician services are required. In a few States the applicant's total resources are evaluated without regard to individual limits, and then compared with maintenance levels established by the State welfare department, to determine eligibility.

In a pamphlet entitled "State Finances and Medical Care Programs for the Aged," prepared for the 20th annual meeting of the National Taxpayers' Conference and Tax Foundation Conference on Federal Affairs, held in Washington, D.C., from February 3 to 7 of this year, at page 9, there apears a table showing State property-income eligibility requirements for medical assistance recipients under the Kerr-Mills provisions.

I ask unanimous consent that the table may appear at this point in the RECORD.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

TABLE 4.—*State property-income eligibility requirements for medical assistance recipients under Kerr-Mills provisions as of Feb. 7, 1962*

Legend: S=single person; M=married couple; E=exemp.

State	Real property		Personal property	Cash reserve, liquid assets, etc.	Surrender value of life insurance	Monthly income limit	
	Home	Except home				Single	Married
Alabama	E	$1,000				$100	$150
Arkansas [1]	$7,500		$2,500	S$300 M600		100	125
California	$5,000		1,200			(2)	(2)
Connecticut [3]	E	S$900 M1,300		M1,300	(4)	129	183
Hawaii	14,000	300		Yes	Yes	Yes	Yes
Illinois	Yes	Yes	Yes	Yes	$1,000	150	200
Kentucky	E	E		S$750 M1,000		100	150
Louisiana	E	1,000 [5] 5,000	[6] E (7)	S1,000 M1,500	S1,500 M2,000	[5] 250 [8] 125	[5] 325 [8] 175
Maine	E	S500 M800	[5] S1,000 [5] M1,500	S500 M800	S500 M800	125	175
Maryland	E	$2,500				95	130
Massachusetts	E	E		S2,000 M3,000	E	150	225
Michigan	[9] E	E	1,000	S1,500 M2,000	E	125	166
New Hampshire	E	4,000		S500 M800		100	150
New York	E		E	S1,050 M1,550	500	150	217
North Dakota	E	$2,500				100	150
Oklahoma [10]	8,000		[11] 1,500 [5] 2,500	S700 M1,000	[12] 1,000 [12] 2,000	125	166
Oregon	E	1,500		S1,500 M2,000		125	166
Pennsylvania	[13] E	[7 9] S1,500 [7 9] M2,400				125	200
South Carolina	E	E	E	S500 M800	[12] 1,000 [12] 2,000	83	170
Tennessee	[14] 10,000			S1,000 M1,500		83	125
Utah	10,000			S1,000 M2,000		110	170
Washington	[15] E	[15] E	(15)	(15)	(15)	(15)	(15)
West Virginia	$4,000			S1,000 M1,500		125	250

[1] Residence required: 3 out of last 5 years. All other States have no durational requirement.
[2] Not to exceed medical, personal, and home and certain debt costs.
[3] Program to begin Apr. 15, 1962.
[4] Reasonable amount exempt.
[5] Income producing.
[6] Maximum allowable for hospitalization benefit.
[7] Automobile exempt.
[8] Maximum allowable for physicians' services.
[9] Plus furnishings.
[10] Plus certain other agricultural/domestic exemptions.
[11] Tools of trade.
[12] Face value.
[13] Liens executed after death of recipient.
[14] Or equity of $4,000.
[15] Excess considered as available to meet medical expenses.

NOTE.—Data for Idaho not available.

Mr. MILLER. The point to be drawn from this table is that one of the defects under the Kerr-Mills Act is the wide variance between various States in the definition of "need." That does not mean that the Kerr-Mills Act could not be improved; nor does it mean that the Anderson-Javits amendment could not be improved, by cranking in a need factor along the lines of the colloquy which I had with the Senator from New Mexico [Mr. ANDERSON] last week.

A great many people have been fearful that implementation of the amendment would result in a medical system or a Government health program in the United States which would be not unlike the one in Great Britain—not necessarily overnight, but over a period of time; in other words, that sooner or later we would get into a system such as the British people have been suffering under for the last several years.

Dr. John R. Seale, a member of the medical profession of Great Britain, made an address before the House of Delegates of the California Medical Association in San Francisco on April 24 of this year, in which he discussed the operations and the defects, as well as some of the benefits, of the British National Health Service.

Mr. President, I ask unanimous consent to have printed in the RECORD at this point the address delivered by Dr. John R. Seale.

There being no objection, the address was ordered to be printed in the RECORD, as follows:

THE BRITISH NATIONAL HEALTH SERVICE—THE WINDS OF CHANGE

(By John R. Seale, M.D.)

My purpose in visiting with you is to clarify the current debate on the part Government should play in the control and finance of medical care in a democracy. This is merely an extension of what I am trying to do in my own country. There is no place for an Englishman to tell American citizens what they should or should not do—not since the Boston Tea Party—but I may be able to illuminate some of the issues involved. This is my third visit to the United States, and as I lived near Boston for a whole year when I was at Harvard in 1958, I have for long taken a particular interest in events in your country.

There is a book on the British National Health Service which is to be published in London at the end of April by one of our Conservative Members of Parliament who is also a physician. He states, in passing, that the medical system in the United States is by no means perfect—in no country is it perfect—but he goes on, "If my history of the British National Health Service can help the Ameri-

cans to avoid some of the pitfalls into which we in Britain have so clearly fallen, then my efforts in the writing of this book will have been worth while." If my talk to you has the same effect then it also will have been worth while.

The organization sponsoring my visit to your country is the American Medical Association. I am myself a member (though, of course, not a representative) of the British Medical Association, and as I am a physician it is appropriate that my talk should be sponsored by an association of physicians. I have no particular interest in, or knowledge of, the details of the present proposals for financing medical care for the aged in the United States, which represents a domestic political issue which as an Englishman is no concern of mine. On more general issues, however, I believe that my views coincide with most of the American medical profession, and also with most doctors in other nations of the Western World.

I have been witnessing for several years what I believe to be the progressive destruction of the excellence of the medical profession in Britain as a result of excessive control of the profession by the state, and it would appear that the British experience is revelant to other countries. I have no doubt that in the long run not only does the medical profession suffer from total nationalization of medical care, but the people themselves suffer also.

The AMA has often used events in the British Health Service as propaganda against Government intervention in medical care. In doing so it has nearly always painted a uniformly black picture which being both inaccurate and lacking in analytical profundity has in my opinion weakened its case in the United States and has caused much offense in Britain. I hope that I shall be able to show from a review of trends in Britain that although the state has a part to play in medical care the extent of its intervention should be strictly limited.

Before turning to the British National Health Service I wish to draw your attention to the fundamental difference between the National Health Service, as I shall call it, and the medical care provided by it. The failure to draw this distinction has caused endless confusion in discussion about the National Health Service on both sides of the Atlantic. The National Health Service is an organization for financing, administering and distributing medical care. It is not the medical care itself.

Let me illustrate. When I was a senior resident in internal medicine at St. Mary's Hospital in London an American was admitted to the ward suffering from a coronary thrombosis. He was particularly impressed with the excellence of the nursing care he received, which is considerably better than that usually available in American hospitals. He assumed, incorrectly, that this excellence was evidence of how good the National Health Service was. He did not know that the high quality of the British nursing profession had been built up from almost nothing in the 100 years that followed the pioneering efforts of Florence Nightingale, and the National Health Service took over this profession with its high standards and ideals—it did not create it. The National Health Service is not the nursing profession, it is not the doctors, it is not even the hospitals, nearly all of which were built long before it was thought of. It is only a financial and administrative organization, although the structure of the organization does, in the long run, affect the quality of medical care provided by it.

You will find that I am highly critical of the national health service because, in my view, it is damaging the health professions and the quality of medical care available to the people of Britain. Doubtless many of you will have heard, quite correctly, of the excellent care received by many people under the national health service, but before you assume that my analysis is inaccurate, once again let me remind you that this excellence which does exist may do so in spite of, and not because of, the national health service.

Medical care of all forms is provided in Britain through the health service which is operated by the state and was created in 1948 by the Labor government in power at the time. The state provides medical care free of direct charge to the entire population irrespective of income, thus relieving the individual of much of the financial hardship associated with illness. All hospital and specialist care are free, all the services of general practitioners are free, and there are only nominal charge of 30 cents for prescribed drugs, and small charges for dental treatment. The act of Parliament laid upon the Central Government the responsibility of providing these services itself, and to enable it to do so the private and city hospitals were nationalized, the state pays specialists a salary, and it pays general medical practitioners a modified form of salary. Although the health service is partly financed by compulsory insurance payments, nearly 80 percent of the cost has been covered by general taxation.

To make available to all the medical care they require, free of charge, is a very attractive proposition to the people, although a utopian intention, because what is required is largely a subjective concept. Certainly there was immense support from the general public and from the national press for a health service of this type at the time, and in many ways it has remained popular over the years. The climate of the times in Great Britain in 1946 when the National Health Service bill was passed by Parliament was favorable to extension of the activities of the state. Emerging from a world war which had lasted 6 years we had come to accept a degree of control of the individual by the state from which we have since moved away in almost all fields, except for health. In recent months, however, several of our economists have been questioning the basic arguments for nationalizing medicine, but even more important, signs of strain in the state service are now developing which suggest that it contains fundamental defects. There is a growing awareness that the wholesale nationalization of medical care 14 years ago was a mistake and the damage done may take a long time to repair.

The provision of free medical care does, of course, reduce the risk of financial ruin for the individual through illness, a highly desirable objective. But a system which provides it brings new problems. Although the patient does not pay directly for medical care at the time he consumes it, nurses, doctors, dentists, and other health workers still have to receive an income in return for the services they provide. These incomes are no longer derived from the people as patients paying fees or voluntary insurance premiums—they come from the people as taxpayers. The problem of paying directly for medical care as a patient is merely shifted to the problem of paying taxes—and taxes are no more popular than direct payments for medical care. Furthermore, if the taxes are entirely raised by the central government, then it, through the Department of the Treasury, tends to exercise direct control over the hospitals and the health professions.

Although the cost of the service to the taxpayer has worried both the public and the Government ever since it started, a new, more complex, and more important problem is developing—the quality of medical care available in the Service. So much attention has been devoted to keeping down costs that the effects on quality—indeed the importance of quality—have been inadequately perceived. But the quality of medical care received is vital for if it is not high the patient may lose his health, happiness, and sometimes his life. If a child dies during an appendectomy because the surgeon is inadequately trained, or the anesthetist is inexperienced, or the intravenous pentothal is defective, the fact that the operation is performed free of charge is little consolation to the bereaved parents. Direct payment for medical care does not by itself guarantee high quality, but neither does provision by the state.

Ever since the state service started successive governments have thus been faced with a dilemma and I fully appreciate the difficult position in which they are in. On the one hand the Government has attempted to provide medical care of the quality and quantity acceptable to the electorate; on the other hand they have tried to limit expenditure of tax funds as much as possible. Although the two objectives tend to be mutually exclusive, the issues are not of minor importance to the Government. The whole nation is intensely interested in the level of taxation, and in the effectiveness of its state-operated health service, almost the only channel through which it now obtains medical care—money and life interest us all a great deal. If the cost is too high or if the quality of medical care available is too low then a government could fall from power. Troubles in the health service strike at the very heart of political activity.

So far, as the most articulate public critics of nationalized medicine have leveled their attacks at high cost rather than low quality, the politicians and the health departments have naturally done likewise. We must not forget that the Government tends to do what the people want in a democracy, even though the wishes of the people may be harmful to themselves in the long run if their opinions have been based on inadequate information. Democracy itself can be no more than a facade if the people are not well informed. To lower public expenditure the Government can either increase the share of cost borne by the patient and private insurance, or cut down expenditure on the service itself. It has been considered politically inexpedient so far to raise substantially the cost to the patient, and little serious thought has been given to encouraging the expansion of private health insurance. Great efforts however have been directed to curtailing total expenditure on the service itself with a success which is not generally realized.

How has cost been kept down over the last 10 years or so? By efficiency in the use of material and human resources? Economy with efficiency have been the aims of the state authorities for 10 years and in principle they are highly desirable objectives. However, economy in practice often means cheapness and this carried too far tends to impair efficiency.

The easiest way to economize is to cut capital expenditure. Capital was the first casualty in the economy campaign in the hospitals. It should be recalled that one of the primary arguments in favor of nationalizing the hospitals in 1946 had been the view that capital expenditure on them under the old system before the war had been inadequate, and that after the damage and neglect of the war years only the state could afford the huge investment required to modernize them. Nevertheless, according to a Government sponsored report on the cost of the health service, annual capital expenditure on the hospitals in the first 6 years after nationalization, at constant prices, was only one-third of that spent in the 1930's. The proportion of the total capital investment of the nation devoted to hospitals, already so low in 1949, fell substantially for 8 years and has only been rising since 1957. It was not until 1962, 14 years after the state monopoly was created, that detailed plans for a

major rebuilding of the hospitals have been put forward. Because most of the capital which has been spent has gone toward patching and mending old buildings few entirely new hospitals have been completed since the end of the war, although another 20 or so are now under construction. To economize on capital in the hospitals, in which labor is the major item of cost, and in which much of the plant is already obsolete, is contrary to the principles of sound management. Much of the energy of doctors and nurses has, as a result, been wasted as they work in inefficient surroundings which have been perpetuated by an excessively narrow pursuit of economy.

A policy of stringency tends to lower the incomes of those who work in any organization dominated by this aim. For doctors in a nation where the state has a virtual monopoly in medical care, it comes almost the only buyer of their services, because private practice is of necessity severely curtailed. Most people believe that governments spend their money raised by taxation very lavishly, but it should not be forgotten that the state is not always generous. The state has in fact used its immense power over doctors, nurses, and other health professions, to obtain their services inexpensively. These professions are particularly vulnerable when faced with a monopoly employer because they will not harm their patients by striking against their employer.

I shall not trouble you with the details of the prolonged struggles over earnings between the medical profession and the state. According to the English economist, D. S. Lees, in his recent book, "Health Through Choice," between 1950 and 1959 the real incomes of general medical practitioners fell by one-fifth while those of the community in general went up by about as much. Even with the much publicized increase in doctors' pay in 1960 they are still no better off than they were 10 years ago. This can be said of few other sections of the British working community and contrasts strongly with the trend of medical incomes in most other countries in the Western World.

The fall in the earnings of doctors in hospitals has been more complex. All are paid salaries and many grades of hospital doctors receive considerably lower real incomes today then they did in the early days of the National Health Service. Probably more important than the fall in real incomes of any particular grade, however, is the rapid expansion of medical appointments with low salaries compared with expansion of those with high salaries. This was not so in the first 4 years of the Service, but between 1953 and 1960 the number of senior, relatively well-paid specialists increased by 8 percent while the number of residents and interns increased by 21 percent. In the case of general surgery in the last 9 years the number of senior specialists has actually been reduced. The result has been that surgeons have remained in junior posts as residents on low pay for many years—indeed often till middle age. For the purpose of this paper I define middle age as the age of 40. During the long years as a resident the surgeons have often been undertaking, according to a recent Government sponsored report, the same work as a consultant. But the salary of a resident is only about half that of a consultant. Increasingly the demand for doctors in the nationalized hospitals has been for those who are willing to provide their services for low prices.

Is the policy of economy in doctors' earnings have any effect on the quality of medical care available in the nationalized hospitals? Many young doctors are showing themselves unwilling to accept the prices offered for their services by the state and they dislike the rigidity, and the impairment of their professional freedom, in the system in which they work. The rigidity and restriction of their freedom does, I believe, follow necessarily upon finance and responsibility being vested in the hands of central government. With the state virtually a monopoly employer of doctors they must either accept the terms offered by the state, or leave the country, or leave their profession. Large numbers have left the country. In the 10 years of the 1930's, that is, before nationalization, an annual average of 27 doctors with British degrees registered for practice in Australia according to official Australian sources. But in the last 5 years the annual rate has been 225. The 1959 figure of 256 in the 1 year was almost equal to the total for the entire 10 years of the 1930's. In the last 8 years an average of over 200 British doctors emigrated to Canada each year according to the Canadian Department of Immigration. In the 1 year, 1960, more doctors (162) trained in England and Ireland passed their State boards examination in the United States than did in the whole 10 years of the 1930's. In short, in the last 10 years the number of British doctors going to Australia and North America has been well over five times the rate prevailing in the 1930's, is over five times the general rate of emigration, and the total of 600 a year is equivalent to one-third of the annual output of the British medical schools. The reasons for their departure is, in my opinion, that in Australia and North America the professional freedom of doctors is greater, the opportunity to practice medicine well, particularly in general practice, is greater, and the financial rewards are more appropriate to the years of study, the long hours of work, and the heavy responsibility which doctors carry.

To sustain the large loss of doctors by emigration there has not been a correspondingly high output from the British medical schools. The number of medical students in training has fallen continuously from 14,200 in 1950 to 12,300 in 1959. In spite of the steady fall in the early years of the 1950's a committee recommended a further 10 percent cut in the intake of students in 1957. As a result the number of students in training is now no greater than it was before World War II in spite of a rise in population and in spite of the increased complexity in medical practice which has characterized the last quarter of a century.

To aggravate the shortage of doctors in Britain due to high emigration and low recruitment, the rate of retirement of elderly doctors is now rising steeply. This reflects the uneven age distribution of British doctors—an unusually large number of men entered the medical profession after the end of the First World War in 1918 and these are now reaching retiring age. In the next 5 years about 60 percent more doctors will reach the age of 65 as did in the last 5 years.

As the supply of doctors with British degrees has been falling the hospitals have relied increasingly on doctors from overseas to take temporary posts. By 1960, 41 percent of all junior hospital posts in England were filled by doctors trained outside the British Isles (nearly 4,000 doctors from overseas), and the proportion is rising rapidly. Most come from India and Pakistan. The total number is now equivalent to well over 2 years of output of the medical schools. In the region around Sheffield, an area in the north of England, 26 of the 74 hospitals have no doctors at all below the grade of consultant (that is under the age of about 40) who were trained in Britain. Increasingly the medical staff of the hospitals is a rapidly shifting labor force recruited from abroad, most of which does not intend to settle in Britain. These young doctors from overseas arrive with little experience, but once they have become highly competent they return to their own lands.

The effect on the quality of medical care in hospitals was described by several of the speakers in the now famous debate in the House of Lords on the shortage of doctors on November 29 last. There is no system whereby the hospitals are made to keep within specified standards for the training of postgraduate doctors from overseas. Large numbers of these, instead of receiving training and experience under supervision at the postgraduate institutes for which Britain is famous, are being used for what in economic terms, might be described as inexpensive medical labor.

Difficulty in language is one of the major problems because of the short time many remain in Britain. Not only do some of the doctors have the greatest difficulty in communicating with their patients, they also have difficulty in talking with other doctors. The language difficulties of interns from abroad has been a problem in U.S. hospitals, but the American Hospital Association has imposed a compulsory linguistic test which now insures a knowledge of English before a hospital appointment is made. In Britain there is at present no such test though doubtless one will soon be imposed.

I have spoken a good deal about how the nationalization of medicine has affected the earnings and conditions of work of the doctors. But again how has it affected the patient, without whom the doctor has no function? Up until the present the patients have been cared for satisfactorily, particularly those who have been acutely or severely ill. Now there are signs that a crisis has been reached, particularly in the emergency departments of the hospitals, and in the maternity services. This has been extensively documented recently in Britain in official and nonofficial publications, and doubtless many of you will have read of it.

I have concentrated on troubles in the supply of doctors because they are the most essential of the skilled personnel providing medical care. If the supply fails then there is real trouble ahead and I should remind you that the future supply of doctors in your country is by no means assured. However, the effects of the national health service are also beginning to show in the nursing profession and in other health professions with unhappy consequences for the patients. The cumberous administrative structure of the health service, described by our present Minister of Health as "lumbering Leviathan," often impedes the efforts of the individual in it to work well. I have stated on many occasions in my publications that the undoubted success of much of the state health service up till the present in providing medical care of high quality has been due to the abundant stock of human, moral, and material capital which it inherited in 1948. British doctors, and British nurses have for long had a world-wide reputation for excellence. Few will doubt that the material capital—that is the hospital buildings and equipment—has been allowed to run down. It is now becoming apparent that the human and moral capital of the health professions has also been consumed but only partially replenished. Until recently there has been no clear evidence of declining quality of medical care, but this is the problem which is now emerging in nationalized medicine which is as yet only imperfectly appreciated, but which will dominate the medical care field in Britain in the 1960's. The national health service, which started with such high hopes and great expectations, is now moving into a phase which has many of the characteristics of high tragedy.

I think there are some lessons of general interest to be learned from these recent occurrences. It has been an error to assume that the major problem in medical care is cost. If the burden of payment is removed from the patient then all will be well was the oversimplified approach of the 1940's. This is just not true. Of equal or greater importance is quality of medical care avail-

able. This is a complex concept, and somewhat intangible, just as the concepts of freedom and patriotism are, but their compiexity and their intangibiiity makes them no less important.

It would be absurd to suggest that cost is of no importance. But surely the objectives one wishes to attain in any form of heaith system is, first, to insure that there is available in a nation medical care of high quality, second, to insure that no individuai shaii be unable to obtain medical care for financial reasons, and, third, to insure that he shall not be financially ruined because of medicai expenses alone. In the United States, possibiy in no country, have these objectives been achieved. But they can be approached by a great variety of means, and it was certainly not necessary to nationaiize all the medical facilities and personnel, and provide all medical services free, as happened in 1948. This achieves the last two objectives, but impairs the achievement of the first. The state has an important part to play—in your country for instance the treatment of mental disease and of tuberculosis and many other health problems have for long been a function of public authorities—but the individuai also has a part to play. It is the preservation of a reasonable balance between the right and duties of the state and of the individuai which is the hallmark of a free but responsible society. In my country, this deiicate balance has been disturbed in the field of heaith but we shaii be making efforts to restore it. The realization that some change is needed is just beginning to dawn.

In the United States also the winds of change are blowing strongiy. With an aging population the probiem of financing medical care for the elderly becomes more important, and the citizens of a prosperous nation do not wish to be exposed to the risk of reduction to penury by iii heaith. There is no easy soiution, there is no complete solution, but do not fali into the error of assuming that the state, by usurping the responsibilities of the individuai, will provide all the answers.

You may think from what I have said that medicine in Britain is in trouble. Indeed this was precisely what was said by the British Medicai Journai in its leading article commenting on the now famous debate in the House of Lords last November. But to assume that this is all there is to be said about the situation would be erroneous. The British may be siow to change their minds but once they realize that change is necessary they are weli able to bring it about. Furthermore, it is when they see that a situation is particuiariy disastrous that they are at their best.

You may be wondering why I shouid be here to tell you of these troubles in my own country. It is only in part because I hope you wiii avoid some of the errors which we have made. It is aiso because I do not wish you to misunderstand what is happening in Britain as you read reports of further events in the health service in the years ahead. My three strongest emotions are love of my country, of my family, and respect for my profession, and I do not wish you to underestimate the potentialities of my country to remedy an unfortunate situation.

I can only remember dimly as a child the episode in 1938 now known as Munich. At that time the vast majority of my fellow countrymen was behind Mr. Chamberiain, the Prime Minister, in his policy of peace—at almost any price. We now accept this was a mistake. Few British thought at the time, that there would be war, and none wanted it. But as events unfolded in the early months of 1939, as we perceived the abyss toward which we were heading, then a great change came over the people and we moved toward war in September as if we had always known that it was coming. It was, however, only after the shattering defeat of our armies in France in May 1940, that we reaiiy showed our worth. All the rest of the world, all informed opinion in the United States, wrote us off as finished. The Germans even demobilized some of their fighting divisions. Yet in England we took it entirely for granted that we would continue to fight alone against Nazi Germany. This we did for more than a year until the United States came to our assistance and together we marched forward to final victory.

So if you think that the British wiii never change their nationalized heaith service because they like the state to provide free medical care for aii, and if you think that because medicine is in trouble we shall not remedy it, then I suggest that you think again. When my feiiow countrymen come to reaiize from the course of events that they have taken a wrong turning, changes will be made, and if we are in real troubie then we wiii get out of it. After ali—we have done so before.

Mr. MILLER. Mr. President, I think it well to point out that some of the benefits which are claimed for the British National Health Service are not those that came about as a result of that program. They were those which were already in existence at the time the program was started.

Some people talk about their friends in Great Britain thinking that the medical care which they receive under the national health service is satisfactory. Then they attempt to justify the program which is being presented to Congress on the basis of the fact that things are satisfactory over in Great Britain.

The only reason why they have been as satisfactory as they have been thus far has been the fact that these are benefits which have carried over from the system that existed prior to the national health service. Since the national health service has gone into effect, according to those who know, the medical program furnished to the people of Great Britain has deteriorated. They now have a situation whereby they cannot get enough persons to go to medical schools for training as doctors. The level of medical students today is about the same point as it was back in the 1930's, even though the population has been increasing steadily. They have been bringing doctors in from overseas. This is not a good situation.

Then, of course, there is the problem of the doctor-patient relationship, which is a precious and important heritage in the medical profession of the United States.

Mr. President, the situation with respect to the number of medical students in British medical schools is something that has given much concern to members of the British Government. One reason why the situation has arisen has been that under the British National Health Service the Government has what most people would consider to be socialized medicine. In my arguments against the Anderson-Javits amendment or the Kennedy medicare program, I have refrained intentionally from using the phrase "socialized medicine." To be fair about it, I think it can be pointed out that there could be a great difference between the British National Health Service as now constituted and the situation which would exist in the United States if the program of the Anderson-Javits amendment were implemented. However, that does not make it right. Whether the Anderson-Javits program is socialized medicine or is not socialized medicine is not, in my judgment, the question.

The points, as I have already emphasized, are first, that under the Anderson-Javits amendment we would drain off the benefits from those who need them, dilute those benefits, and tax the people for benefits for those who can afford them. I think that is unfair; and second, the social security system would be used to finance the program although it is already in a very shaky financial condition. It will not get any better, and it will get much worse if we keep putting more burdens on the backs of future generations by increasing the coverage and the benefits under this program. I think it would behoove the people who are so eager to have the social security system embrace all of the proposed new coverages and benefits to watch out lest the social security system become bankrupt some day, or lest the coverage and the benefits be reduced.

When future generations come into the heritage we are leaving them and begin to run Congress, I wonder whether they will be satisfied with the heritage the present generation will have left to them. They could cut back the benefits, scrap the program, or have an entirely new program financed out of general taxation, any of which would be fairer than what we will be passing on to them by the actions we have been taking in the last several years.

I do not know whether a majority of the people in my State of Iowa favor the Anderson-Javits amendment or not. On the basis of the correspondence I have received, my guess is that a substantial majority of them are opposed to it.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD an article entitled "Hospital Care for Older People," published in Wallaces Farmer for February 17, 1962.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

HOSPITAL CARE FOR OLDER PEOPLE—IOWA FARM FOLKS SPLIT ON LINKING HOSPITAL CARE TO SOCIAL SECURITY

Should the social security tax be raised to pay hospitai biiis for foiks 65 or over? This is one of the projects the present Congress is arguing over.

What you pay the doctor is not an issue here. If the biii is passed, it would oniy help on hospital expenses. Patients would use Biue Shieid or private insurance policies to help with medical expenses.

About half of Iowa's farm families carry some kind of hospitai insurance. What older folks sometimes worry about is the prospect of a serious illness that would not be covered by limited hospital insurance. And the ones that have ro insurance are naturally stiii more concerned over the health hazards of advancing years.

The Wallace's Farmer poll asked Iowa farm people what they think about the sociai security proposal. Those who had heard about it were asked:

"President Kennedy is urging that a hospital insurance plan be added to the social security program. The plan would help pay hospital costs for men and women when they reach 65. Social security payments would be increased to cover cost of the plan. On an income of $3,000 a year, the added social security payment would be $11.25 a year. * * * Do you approve or disapprove this proposal?" Here are the results:

[Percent]

	Men	Women	Total
Approve	44	39	41
Disapprove	39	39	39
Undecided	17	22	20

Last year's bill provided for hospital care up to 90 days. The patient would pay the first $10 of hospital costs per day for the first 10 days. After that (up to 81 days for a single illness), the social security insurance would pay all the hospital bills.

Cost of nursing home service was also covered, up to 180 days.

The new 1962 bill hasn't been worked out in detail yet. Costs may differ a little, but the betting is that the benefits will be about the same.

Older men, as you might expect, liked the plan better than younger ones:

[Percent]

	24 to 34 years	35 to 49 years	50 to 64 years
Approve	28	44	57
Disapprove	44	42	32
Undecided	28	14	11

Farmers with gross incomes of less than $5,000 a year liked the plan better than did those with more money. But men with gross incomes of $10,000 or more still gave the bill an approving vote of 42 percent.

Farm women voted much as the men did except that very few young women (21–34 years) were undecided. They divided almost evenly for and against the plan.

One young farm woman in Buena Vista County wondered if the plan would hold together until she was 65. She said: "I'll have to pay for it but I sure want some security that my hospital bills will actually be paid when I'm 65."

The mother of a young farmer in Taylor County said emphatically. "No: Take my son. He doesn't get as big an income as his dad and he still has to pay more for social security than he can afford."

There was a family split on a farm in Wright County. The man, now getting social security payments, approved the hospital plan. But his wife said:

"I'm over 65 but I disagree. I think it's putting an awful burden on the young people. If we can afford to pay for our own, we should."

A middle-aged farmowner in Webster County said: "I'd approve hospital insurance for old people on social security. Goodness knows they can't afford it at present."

A young man in Greene County said: "I just wonder how much hospital insurance you can really get for that money. Maybe they'll have to increase the tax more."

Blue Cross, Blue Shield, and other private organizations are moving to provide help for older people without bringing in social security. Blue Cross, for instance, is talking of a plan whereby folks of 65 or over would pay $10 or $12 a month for hospital insurance providing 60 days of hospital care a year.

Blue Shield suggests a $3 a month fee for older people to cover medical expenses. This would be open to couples with incomes below $4,000 a year.

In each case, special provisions of some kind would be made to help those with incomes so low that they could not meet these monthly charges for Blue Cross and Blue Shield.

Wallace's Farmer will report details on these and other plans as they develop. The new social security bill will assume definite form soon and farmers will know in more detail what the administration proposes. Until then, many farmers will be like the man in Jackson County, Iowa, who said: "I would need to know more before I vote yes or no.

Mr. MILLER. Mr. President, the article contains the results of a poll taken among Iowa farm people. It is not a complete coverage, but it is a poll of a type which quite often adequately represents a good cross-section of the thinking of Iowa farm people. It points out that there is an almost even split between those who approve and those who disapprove with about one-fifth of those polled being undecided. I suggest that on the basis of the way the questions were asked, the people who voted in the poll, both for and against the proposal, did not have a good background of the facts behind the questions which were asked. I am well satisfied that if they knew the facts, if they knew that the program would pay benefits to those who can afford them as well as to those who are poor and cannot afford them, they would not have voted for the program.

In fact, my mail is running about 10 to 1 against this program. I am trying to weed out of my mail those letters and other communications which are prompted by pressure group action. I am trying to arrange the correspondence on the basis of spontaneous opinion. To date it is almost unanimously opposed to the proposed program, although many persons would favor some kind of program to cover catastrophic situations.

The State of Iowa, which I have the honor to represent, has passed an enabling law with respect to the Kerr-Mills Act. Unfortunately, the legislature was not able to appropriate any money to implement that act. What will be the action on this subject in the next session of the legislature is difficult to forecast; but I assume, on the basis of results in other States, and if Congress does not go off the deep end and pass the type of program that is envisaged by the Anderson-Javits amendment, that not only the Iowa Legislature, but also a great many other legislatures, will find a way to pass a reasonable appropriation to implement the Kerr-Mills law, so that catastrophic situations can be covered.

Mr. President, the problems of my State in connection with the consideration of this subject in the last session of the legislature are well set forth in an article entitled "Should Iowa Aid 'Medically Needy'?" published in the Waterloo Daily Courier of February 28, 1961. I ask unanimous consent that the article be printed at this point in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

SHOULD IOWA AID "MEDICALLY NEEDY"?—ASSEMBLY PONDERS FEDERAL AID PLAN

(By Dave Dentan)

On the last legislative day before the recess, the House Committee on Public Health filed a bill in Des Moines to authorize participation in the Federal matching program for medical aid to those past 65 who are not indigent but are living on small incomes.

The bill is primarily an enabling act, since it carries no appropriation and does not establish the minimum of income and savings which would make a citizen eligible for the aid.

The program involved is the "medical aid for the aged" (MAA) authorized by the Kerr-Mills bill which passed the last session of Congress. Six States already have programs in operation, using Federal grants which pay from 50 to 60 percent of the cost.

The bill filed in the Iowa House would make the State board of social welfare and county welfare boards the administrators of the program, subject to advice from a council representing various professional associations, such as the Iowa State Medical Society and the Iowa Hospital Association.

All Iowa residents over age 65, with one exception, would be eligible for the aid, according to the bill, if such a resident "has not sufficient income or other resources of his own, or available to him to provide himself with such needed medical care and services."

The one exception is that the beneficiary under this program could not be a recipient of old-age assistance. Iowa already provides medical (doctor's fees and outpatient laboratory services) care for those receiving old-age assistance.

This care has been costing on the average $7.48 a month per recipient. This could be increased to $12 a month under another provision of the Kerr-Mills bill if Iowa wants additional Federal matching funds for this purpose.

Some officials also argue that if hospital and surgical care is to be given to the "medically needy" in their home towns, the same benefits should be given to the "medically indigent" (the recipients of old-age assistance). This latter group receives hospital and surgical care, except for emergencies, at University Hospitals, Iowa City.

The MAA program for the "medically needy" is intended to aid those aged who, after a lifetime of hard work and rearing a family, are able to support themselves in their old age except for unusual medical care—particularly the lengthy and costly catastrophic illness.

A program for a large part of this group would be needed even if the program of President Kennedy for compulsory hospital insurance under the social security program were adopted by Congress this year.

Iowa has approximately 325,000 residents past age 65, of which 35,000 are receiving old-age assistance and 215,000 are receiving retirement benefits under the social security program.

This leaves an estimated 75,000 who are receiving neither. About 65 percent of these, if they are typical of the older group generally, would have incomes of less than $1,500 a year.

Various estimates may be obtained of the probable need for the individual in any group ruled eligible for the MAA program. The Health Insurance Institute lists $177 as the average actual yearly expenditure for medical care for those 65 and over.

Medical care standards would improve, however, if more financial resources were made available. On the other hand, some deductible feature might be incorporated in the program under which the individual would contribute the first $100 to $500 of cost of an illness, perhaps depending on income.

On a different basis, the Iowa Department of Social Welfare estimates that some 42,403 Iowans (including many receiving social security retirement) would apply for aid under an MAA program and might need an average of $250 each. (This would be the actually sick group, so the average would be higher than for all old persons.)

If this estimate were used, the program would cost some $10,600,750 a year, of which the Federal Government would pay 58.48 percent.

A more moderate and limited program could be devised. There are about 178,709 persons past age 70 in Iowa who are not receiving old-age assistance. According to a recent study of the elderly, 30 percent would have no resources for an emergency. If the average assistance were $100 for each of these 53,613 medically needy persons, the total cost would be $5,361,300 a year, of which the Federal Government would pay 58.48 percent.

The figures for this calculation were furnished by R. J. Quackenbush, executive secretary of the Iowa Nursing Home Association.

Governor Erbe in his budget message suggested that surpluses in the fund accumulated to pay the Korean bonus could be used to finance a beginning on the program. Such use would hinge on a determination, either by the attorney general or the courts, that the money could be legally used.

Some legislators indicate a desire to delay enactment of the MAA program until Congress determines what action it will take on the Kennedy hospitalization program under social security. But others point out that some program will be needed for needy Iowans not receiving social security benefits and that the proportion of Iowans in this category is considerably higher than the national average.

In any case, the bill introduced in the House is written in such broad terms that it could be used (1) to let the board of social welfare prepare a program based on the amount of money available or (2) permit the attachment of amendments to define more precisely the rules of eligibility.

The Journal of the Iowa State Medical Society declares that a State appropriation of at least $2,500,000 is needed to get the program underway.

Mr. MILLER. Mr. President, in the Des Moines Register of May 22 there appeared an excellent article entitled "Doctors Say It Does Not Meet Needs"—referring to President Kennedy's medicare program. I ask unanimous consent that the article be printed at this point in the RECORD, in connection with my remarks.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

DOCTORS SAY IT DOES NOT MEET NEEDS—SEE A STEP TOWARD BRITISH SYSTEM

NEW YORK, N.Y.—Leaders of the American Medical Association, Monday, denounced President Kennedy's medical care for the aged plan as a cruel hoax aimed at establishing welfare state medicine for everyone.

"Don't mistake it," an association official declared in a paid, national televised reply to Mr. Kennedy's Sunday speech here.

"England's nationalized medical program is the kind of thing they have in mind for us eventually."

Mr. Kennedy urged passage of the King-Anderson bill, commonly known as medicare. It would pay some hospital and other medical bills through social service taxes. Doctor bills generally would not be covered.

The AMA representatives said the public was in danger of being blitzed, brainwashed and bandwagoned into swallowing a plan that would disrupt health services and turn individual patients into impersonal numbers.

ELEMENT OF NEED

The plan would cover millions who don't need it and ignore millions of others who do, said Dr. Edward R. Annis of Miami, Fla., a surgeon who is chairman of the AMA national speakers bureau. He added:

"Our fees are not involved. Our practice of quality medicine is. Your health is."

In an impassioned plea, he urged viewers to consult the "one they know and trust—your doctor" about what the Kennedy plan would do to American medicine.

"There are only a few things which touch so close to God and the relationship between a doctor and his patient is one of them," he said, charging that the Kennedy plan seeks to undermine it.

CROWDLESS GARDEN

The doctors' reply to Kennedy was filmed in Madison Square Garden, the same place where Mr. Kennedy Sunday addressed a cheering crowd.

But instead of a crowd scene for a backdrop, the AMA spokesmen appeared in an empty, silent arena, its vast expanse littered with paper, broken balloons and decorations left from the Kennedy rally.

An association spokesman estimated cost of the show, carried on paid time over the National Broadcasting Co. network, at $75,000. The group had asked for equal time to reply to Mr. Kennedy's half hour address, but was turned down. Mr. Kennedy's speech was carried free.

AMERICAN SYSTEM

Dr. Leonard D. Larson of Bismarck, N. Dak., association president, spoke briefly. He said the administration's program would deprive older people of "the American system of medicine, based upon the private doctor treating the private patient."

In the last 20 years alone, he said, this system has "added 10 years to the life of every American."

Dr. Larson said the King-Anderson bill would not cover 3 million over-65 people not eligible for social security benefits, and thus probably most in need of medical aid.

At one point, Dr. Annis held up a copy of the King-Anderson bill and said: "This bill is a cruel hoax and a delusion."

ADDED TAX

He said it would add as much as 17 percent to the working American's payroll tax to give medical care to "the rich, the well-to-do and the comfortable, as well as those of low income.

"Whether they need it or not; whether they want it or not—they'd be in," he said.

"Now, there is some more interesting reading in here for those on social security who genuinely need medical aid. Just what would you get under King-Anderson? You can read it as we did. For a hospital room containing one, two, or three other people—it would still cost you $10 a day for the first 9 days of your hospitalization. That's $90.

"After you left the hospital or nursing home, you wouldn't be eligible for further hospital benefits for at least 3 months. Don't have a relapse or get sick again. To get into the hospital you'd apply in writing and get the certification of a doctor.

PAY DOCTOR

"You'd have to pay for your doctor, and you'd have to pay for a private duty nurse if needed. And you can also read if your illness required hospitalization for more than 30 days, it'd have to be passed on by a special committee who'd have to consider a lot of other people too, don't you know. After all, the Government has to treat everyone fair and equal, don't you know.

"They know all about how to make things exactly alike—like human illnesses. Like a broken toe * * * and cancer. A bed is a bed. Thirty days is thirty days. Your doctor won't decide. The committee will decide—when it meets.

"Do you know that you'd have to pay the first $20 of each diagnostic study you'd get at the hospital as an outpatient?

"Do you know that the only drugs that would be paid for are those you'd get at the hospital or nursing home—and that many important drugs used today do not appear on the list approved for hospitals and that a prescription made out by your doctor in his office or your home is not covered by the King-Anderson bill? Do you know that in order to get into a nursing home for your maximum of 150 units of service—you'd have to go to the hospital first?

DOCTOR BILLS

"Maybe some of you are still thinking in the back of your heads, what are the real reasons the doctors are so dead set against this King-Anderson bill? You may believe that it must have something to do with doctors' fees * * * our income.

"But, do you know what? The King-Anderson bill doesn't even cover most private doctor fees. Doctors would probably make more money, not less, under King-Anderson * * *. Anyone knows there is more money in mass production.

"But that is beside the point. The American system of medicine is a system of quality medicine * * * not mass production medicine. It is a system of private medicine, practiced by private doctors treating private patients, free to make decisions based on the patient's specific medical needs—and nothing else."

KERR-MILLS ACT

Dr. Annis claimed that the Kerr-Mills medical aid for the aged law, passed by Congress in 1961, provided means for caring for the elderly who need financial assistance in meeting medical costs.

The Kerr-Mills law, he said, "is a desirable supplement" to "one of the greatest social advances of our generation—the spectacular growth of private, voluntary health insurance systems to which millions of Americans already belong."

MEANS TEST

In reply to charges that obtaining aid under the Kerr-Mills plan requires submitting to a "means test" that is "degrading and undignified," Dr. Annis said: "When you apply for the low rent benefit of public housing—don't you have to prove that your income is below a certain level? This is a means test. A test of your means.

"And when you apply for social security, aren't you asked to prove that your wage earnings are below a certain amount? Is this degrading or undignified? Well, that's a means test, isn't it?—a means test for social security itself.

"A means test is a desirable protection for those who are really needy, as against those who are merely greedy."

The King-Anderson bill would not repeal the Kerr-Mills Act. If the King-Anderson bill were passed, the Kerr-Mills Act could continue to provide medical care for needy persons not covered by social security, in those States that fully implemented the act. (Iowa has passed an enabling act, but has not provided any money to put it into operation.)

IOWA HOSPITALS OPPOSE MEDICARE

The Iowa Hospital Association has reaffirmed its stand against any plan to provide medical care for the aged under the Federal social security program.

The association in 1960 voted to oppose the plan and reaffirmed this stand at a meeting of the board of trustees and officers last Friday in Spirit Lake.

An association statement, made public Monday said:

"We are convinced that the solution to the medical-care-for-the-aged problem can be found within the framework of this country's existing system of private voluntary health care.

Mr. MILLER. Mr. President, in the March 1961 issue of the Iowa State Medical Society Journal appeared an interesting and timely article entitled "Colorado's Plan for Administering Medical Aid for the Aged." I ask unanimous consent that the article be printed at this point in the RECORD in connection with my remarks.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

COLORADO'S PLAN FOR ADMINISTERING MEDICAL AID FOR THE AGED

In Colorado, a medical service plan for elderly people with little or no income has been administered throughout the past 3 years by Blue Cross and Blue Shield, under contract with the State welfare department. The arrangement—virtually identical with that which is being proposed by several of the groups that will furnish services under the MAA program in Iowa—meets with the enthusiastic approval of all the parties involved.

EVERYONE IS PLEASED WITH THE ADMINISTRATION

As a part of a study that a team of investigators made last year for the Health Information Foundation, an instrumentality of the commercial (non-Blue Cross-Blue Shield) health insurance companies,[1] about 100 participants in the Colorado program—physicians, hospital administrators, welfare officials, pensioners, and Blue Cross-Blue Shield executives—were interviewed individually. Every single one of them declared that the administrative arrangement has worked well.

"With Blue Cross administering the program," a county welfare director explained, "we have no problems with hospitals—no difficulty about admissions and no time-consuming conferences about charges and the like."

An orthopedic surgeon stated: "Physicians' acceptance of this program was largely due to its use of Blue Shield. If the same program had been set up through a State bureau, we would have had a completely different reaction to it."

A State welfare official declared: "By using the existing channels—Blue Cross and Blue Shield—we avoided any conflict with physicians and hospitals and held down our paperwork, too."

A hospital administrator observed: "Existing Blue Cross and Blue Shield controls have held abuses to a minimum in this program—far less than would be found in a Government program."

THE SCOPE OF THE PROGRAM

Before we present an outline of the administrative setup, a brief sketch of Colorado's payments and service benefits is in order. In September 1937, every indigent beyond 60 years of age, in that State, began receiving a pension. The amount has been raised several times since then, and is now $107 per month, less other income. On January 20, 1957, the Colorado medical care plan for pensioners went into effect, and an amendment to the State constitution decreed that $10 million per year—no more and no less—should be budgeted for its support. All pensioners are eligible for its benefits.

Originally, patients were allowed 30 days of hospitalization per admission, and readmission might succeed discharge without the patient's stepping outside the door and reentering it. Last fall, in what may have been only the first in a series of curtailments, the limit was reduced to 21 days per admission, and unless the attending physician requests an extension, a period of 30 days must elapse between discharge and readmission. Emergencies are given special consideration, thus preventing hardship, and it is thought that the change in rules is helping to stem overutilization.

Pensioners entering nursing homes agree to pay the proprietors $100 per month, retaining for themselves just enough money to pay for their clothing and incidentals. The State makes direct payments to the nursing homes in varying amounts, depending upon the facilities and services that the institution is able to provide, and upon the type of care that the particular patient must have. These sums may not exceed $95, and at present average $67 per patient per month. From the pensioner's relatives, the proprietor may collect additional amounts, provided that the total from all sources does not exceed $250 per month for any particular patient.

Pensioners are provided surgery and inpatient medical care much as they would be if they held Blue Shield service contracts. Those in nursing homes are provided two doctor's calls per month, and as many as two more when they are acutely ill. Those who live at home are entitled to a noncumulative, two office or home calls per quarter at State expense. Consultants' and surgical assistants' fees are covered, as in Blue Shield contracts.

Prescription drugs, except cortisone and its compounds, are furnished to patients at State expense, but dietary supplements, household remedies, and personal care items are not. In many instances, because Colorado has counties without hospitals and even without doctors, its elderly people must travel long distances to obtain health care. In such cases, the plan covers transportation.

THE FUND'S "DEFICIT" IS A BOOKKEEPING FICTION

The pensioners' medical care plan in Colorado is proving more costly than was anticipated, and as has already been mentioned, curtailments of benefits have been undertaken in an effort to curb overutilization. The annual budget for the fund was permanently set at $10 million 3 years ago, and expenditures over that amount are technically "deficits" that Federal grants under the provisions of the Kerr-Mills Act cannot formally erase. But when, by dipping into general funds, Colorado spends Kerr-Mills money for its eldercare program, during this and ensuing years, only the most rigid purist can say that it is spending improperly.

ADMINISTRATION HAS A MINIMUM OF COMPLICATIONS

Blue Cross and Blue Shield began administering the Colorado hospital-care and physician-service arrangements on February 1, 1958, less than a month after the inauguration of the medical care plan, and they have continued doing so ever since. Payments for nursing home care and for transportation of patients are made directly to the vendors by the welfare department. Drugs are purchased direct from retail pharmacies, and claims from druggists are audited by a committee of independent pharmacists.

A medical advisory committee containing representatives of the State medical society, the osteopathic association, the pharmacal association, the hospital association, the dental association, the State department of health, the State association of county commissioners, the National Annuity League, the State chamber of commerce, the League of Women Voters, and the county welfare directors' association was set up by the State welfare department to guide it in implementing and perfecting the program.

Blue Cross and Blue Shield were selected to administer the bulk of the old-age pensioners' medical care program partly because they already had the machines and personnel to do the job. They could carry out the details of the program for less money than the State welfare department could do the work in its own offices. And just as importantly, less paperwork would devolve upon the suppliers of services.

Each of the eligibles receives a card resembling a Blue Cross-Blue Shield identification, and he presents it to his doctor when he seeks medical care outside the hospital, and presents it at the hospital when his doctor has requested his admission there. The hospital's paperwork is limited to (1) confirming the patient's eligibility, since despite the card, the patient may no longer be entitled to service; (2) billing Blue Cross when the patient has been discharged; and (3) notifying the local welfare office by post card when the patient has left the institution. Normally, the physician whose patient has been hospitalized has only one form to complete—a standard statement for services rendered, which he sends to Blue Shield. If the patient needs an extension of his hospitalization, the doctor must fill in another form, which goes to the director of medical services at the State welfare department. The doctor must send individual billings to Blue Shield for his visits to nursing-home pensioners and for visits to or from pensioners who live at home.

Blue Cross and Blue Shield must keep their lists of eligibles current, and must see to it that the billings that are presented to them are for covered services and that their amounts conform with the fee schedules that have been negotiated between the suppliers and the welfare department. They pay the hospitals and doctors, and bill the welfare department, adding their administrative fees to the sums that they have paid out, and attaching an IBM card for each pensioner-patient and a list of all disbursements.

The State welfare department determines the financial eligibility of each elderly applicant, passes upon requests for extensions of hospitalization and for readmission within 30 days after discharge, provides the nursing home, drug, and transportation parts of the program, and reimburses Blue Cross and Blue Shield.

CONCLUSION

The Colorado State Department of Welfare retains ultimate responsibility for its pensioners' medical care program, and its management contracts with Blue Cross and Blue Shield would not prevent it from imposing new controls, if such seemed desirable.

Since Blue Cross-Blue Shield administration has saved money, lessened paperwork and promoted good relations between the welfare department and the suppliers of health services in Colorado, it is probable that a similar arrangement would work advantageously in Iowa.

Mr. MILLER. Finally, Mr. President, I wish to point out that a study of the frequency of hospital admissions of major and minor economic importance in the old and the young was conducted by Dr. J. Robert Browning, of Plymouth, Mass. The study represents a compilation of data by the staff of the records room and the business office of the Jordan Hospital, in Plymouth, Mass. I believe the conclusions of the study merit the attention of the Senate; and they are as follows:

[1] Reich, William T., and Anderson, O. W.: Colorado's Medical Care Program for the Aged, Health Information Perspectives No. a2, Health Information Foundation, 420 Lexington Avenue, New York City 17, 1960.

First. Catastrophic illness occurs in significant numbers in both young people and old people.

Second. Most periods of hospitalization are of minor economic importance, regardless of age group.

Third. True need for aid is related to economic severity of illness, rather than age.

Fourth. Further data analysis in a similar manner is needed from other areas of the country.

Fifth. If confirmatory data is obtained, a reappraisal of the approach to the solution of current medical problems is needed.

Mr. President, let me say, in conclusion, that I do not question the motives or the desire for a better society which prompt those who have submitted this amendment but I think it is a waste of the time of the Senate, for it is common knowledge that if the amendment is adopted by the Senate, it will not be adopted by the House. As recently as last week, we heard arguments to the effect that we should not take action on bills or amendments which will not be acted on by the House. Yet we are consuming many days of valuable time of the Senate in working on a measure which will not be dealt with by the House. I think that is most unfortunate.

However, since it has been decided that this matter will be brought to a head in the Senate, I wish to say that, since this measure will not be passed by both Houses at this session of Congress, regardless of predictions by some who like to indulge in wishful thinking, I desire to have it clearly understood that one benefit will come from this debate—namely, the American people will receive a full disclosure of the arguments in connection with this problem.

I hope that what I have said this afternoon will assist in formulating public interest along the right lines in connection with this most important problem.

The PRESIDING OFFICER. The time available to the Senator from Iowa has expired.

Mr. MILLER. Mr. President, I yield the floor.

The PRESIDING OFFICER. Does the Senator from Iowa withdraw his amendment?

Mr. MILLER. I do.

The PRESIDING OFFICER. The amendment of the Senator from Iowa has been withdrawn.

Mr. JAVITS. Mr. President, I rise to propound a parliamentary inquiry.

The PRESIDING OFFICER. The Senator from New York will state it.

Mr. JAVITS. Is the pending question on agreeing to the Anderson amendments to the bill?

The PRESIDING OFFICER. That is correct.

Mr. JAVITS. Mr. President, I call up my amendment which is identified as "6–29–62–B." I offer the amendment on behalf of myself, the Senator from Kentucky [Mr. COOPER], my colleague [Mr. KEATING], and the Senator from California [Mr. KUCHEL].

The PRESIDING OFFICER. The amendment will be stated.

The LEGISLATIVE CLERK. It is proposed to strike out section 1716, and insert in lieu thereof the following:

"CHOICE OF BENEFITS

"SEC. 1716. (a) Any individual entitled to health insurance benefits under section 1705 may elect, in lieu of the health insurance benefits provided in other sections of this title, to receive payment of insurance premium benefits.

"(b) For the purposes of this section 'payment of insurance premium benefits' means payment to the insurance carrier to premiums on a private health insurance policy of which such individual is the beneficiary, but such payment shall not exceed $100 per calendar year.

"(c) The term 'private health insurance policy' means a health insurance policy which (1) conforms with standards established by regulations promulgated by the Secretary, (2) is offered by an insurance organization licensed to do business in the State wherein such policy is offered, (3) is guaranteed renewable at the option of the insured individual, (4) provides benefits which the Secretary determines to be of a value which is not less than the value of the health insurance benefits provided in other sections of this title, and (5) provides that such organization will, after the expiration of the usual grace period, notify the Secretary of any lapse in payment of premiums on such a policy by any individual eligible to receive health insurance benefits under this title. Such term shall include, with respect to any individual eligible to receive such benefits, any group policy if (i) such policy otherwise conforms to the requirements prescribed by the preceding sentence, and (ii) such individual has been covered by such policy for a period of not less than one year immediately preceding the date he attains 65 years of age.

Mr. JAVITS. Mr. President, I give notice that I shall substitute another amendment for this one; and I ask unanimous consent that immediately after the morning hour tomorrow, I may proceed in accordance with the unanimous-consent agreement.

Mr. HUMPHREY. Mr. President, will the Senator from New York withhold his request for a moment?

Mr. JAVITS. Yes, Mr. President.

Mr. HUMPHREY. As the Senator from New York may recall, immediately after the morning hour tomorrow, the nomination of Matthew H. McCloskey, of Pennsylvania, to be Ambassador to Ireland, will be called up; that has already been ordered. Therefore, will the Senator from New York modify his request accordingly, so that following the vote on that nomination, the Senator from New York may proceed?

The PRESIDING OFFICER. Let the Chair state that the Parliamentarian informs the Chair that when the bill is laid down tomorrow, unless the Senator from New York uses the time available to him tonight, he will automatically have that time tomorrow.

Mr. JAVITS. And will I be entitled to recognition to speak upon my amendment at that time, before the recognition of any other Senator to speak on my amendment?

The PRESIDING OFFICER. As the Chair understands, under the unanimous-consent agreement the Senator's amendment is the pending business; and on tomorrow, if he then seeks recognition, he will be entitled to it.

Mr. JAVITS. As soon as the unfinished business is laid before the Senate?

The PRESIDING OFFICER. Yes.

Mr. JAVITS. Mr. President, I thank the Chair; and I announce that I wish to proceed in that way. I gather that that has the concurrence of the acting majority leader.

Mr. HUMPHREY. Yes.

Mr. President, I appreciate the action of the Chair in clarifying the situation, so that the Senator from New York fully understands his rights under the agreement. As I understand, after the Senate acts tomorrow on the nomination of Mr. McCloskey to be Ambassador to Ireland, the Senator from New York will be entitled to the floor.

The PRESIDING OFFICER. Yes; after the Senate acts on that nomination and after the unfinished business is laid down, the Senator from New York will then be entitled to address himself to his amendment.

PUBLIC WELFARE AMENDMENTS OF 1962

The PRESIDING OFFICER. The Chair lays before the Senate the unfinished business.

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. MORTON. Madam President, there is some apprehension in the State of Kentucky that the existing arrangements for placement of children in foster home care may be upset by the provisions of H.R. 10606. The welfare functions in Kentucky have been reorganized on a number of occasions. Until recently the Department of Child Welfare, which has had responsibility for placement of children in foster homes, has been in a separate agency from the one which administers aid to dependent children under title IV of the Social Security Act. Within the past few months a State statute has been passed which places both of the former departments, along with a number of other State agencies, in what is termed a Health and Welfare Agency. In view of the fact that there have been a number of organizational changes within recent years some persons question whether even this arrangement is likely to be a permanent one, believing that the chance that it will not is such that proper safeguards to maintain existing practices in the field of child welfare should be considered in relation to this bill.

It is my understanding from the Department of Health, Education, and

Welfare that insofar as can be determined, the new Health and Welfare Agency would be considered a single State agcncy responsible for both the administration of the aid to dependent children program and of the child welfare services program. Under such circumstances, no problem would arise.

Public Law 87–31 of this Congress deals with the subject of foster home care of certain children and its provisions in this respect would be made permanent by H.R. 10606. Among those provisions is one for "use by the State or local agency administering the State plan, to the maximum extent practicable, in placing such a child in a foster family home, of the services of employees, of the State public welfare agency referred to in section 522(a)—relating to allotments to States for child welfare services under part 3 of title V—or of any local agency participating in the administration of the plan referred to in such section, who perform functions in the administration of such plan." This provision would seem to assure that so long as the health and welfare agency is responsible for the administration of both the aid to dependent children program and the child welfare services program that there would be maximum utilization of the child welfare services program and that there would be no threat to existing arrangements.

Moreover, the Senate Committee on Finance adopted an amendment to H.R. 10606—section 155 of the bill under consideration—which permits the responsibility for placement and care of children in foster homes to be the responsibility of an agency other than the agency responsible for the administration of aid to dependent children if such agency is a public agency which has in effect an agreement with the agency administering title IV, the aid to dependent children program, which assures a suitable plan for the children. This latter section would be in effect for 1 year ending with the close of June 30, 1963. For that year and on a continuing basis if the section is continued, the role of the child welfare services agency would seem to be assured whether it remains a part of the health and welfare agency of the State or if some further reorganization should take place, since maximum utilization would be required for the services of the Department of Child Welfare under section 408 and even though separate from the agency responsible for administering aid to dependent children it would be authorized to operate under an agreement with such agency if the amendment adopted by the Committee on Finance becomes law. Under these circumstances, it is unthinkable that a traditional responsibility for placement by the child welfare services agency would be upset by the enactment of this legislation.

WHAT PRICE FOR MEDICARE?

Mr. BENNETT. Madam President, this discussion of providing certain health-care benefits to our senior citizens has not to date adequately touched upon what I regard to be one of the significant points with which this body should be concerned. We have heard discussion of the needs of our senior citizens and we have had presented to us a number of proposals for accomplishing this purpose. I repeat, however, that the most essential factor has been missing in all the discussion of the last few days. I refer to the cost of providing benefits of the type proposed by the Senator from New Mexico and several of his colleagues.

The Social Security Administration, and particularly its Actuary, whom we have all long since come to admire for his ability and knowledge in the area of forecasting costs of providing social security annuity coverages, has no firsthand knowledge of the cost of providing health-care benefits. While it is true that the social security program has a history of workability, never has it been tested with a provision of handling health care on a service basis. I take exception, therefore, to the statement that we can rely upon the tried and tested social security mechanism. This mechanism has never been either tried or tested in an area such as we are discussing today.

COSTS ARE UNPREDICTABLE

The uncertainty of the costs of providing these health-care benefits is shared by the Chief Actuary of the Social Security Administration. In a document published last July by the Department of Health, Education, and Welfare, this uncertainty of predicting costs for medical-care benefits is stated in concrete terms. Let me quote a few key phrases of this Actuarial Study No. 52. In this document the following is stated:

> Long range actuarial cost estimates, by their very nature, can present the general range of costs but cannot be a precise forecast of future experience.

The report states:

> Nonetheless, precise estimates are not possible because of such unknowns as the extent of hospital utilization by persons who have not had insurance in the past, but who would have benefit coverage under the provisions of the bill.

Further:

> Another major difficulty in making costs estimates for hospitalization benefits is the extent to which hospital costs will rise in the future.

These qualifications which the chief actuary has been careful to spell out, and I commend him for this, have been lost sight of as we glibly talk about providing health care benefits at a cost of one-half or 1 percent of a $5,200 payroll base.

In view of the lack of experience of the Social Security Administration in this particular area, are we risking a serious blow to the social security mechanism without careful examination of the true cost level? Is there any group which has adequate experience in providing health care benefits, and has such a group made such experience available to the Congress?

There is, of course, such a group. I refer to the health insurance business, including insurance companies as well as the Blue Cross and other such plans. Health insurance has been provided to the American public, in one form or another, since before the turn of the century. Currently, some 136 million Americans of all ages have some form of voluntary health insurance and in many instances a major portion of the premium for such protection is provided by the employer. In fact, in excess of 9 million of our current senior citizens have this protection and this 9 million figure is 3 times what it was several years ago.

INSURANCE INDUSTRY VERSUS GOVERNMENT ESTIMATES

Now, what does the insurance business say about the true cost of providing benefits such as are contained in the amendments proposed by Senator ANDERSON and his colleagues? Last July, in an appearance before the House Committee on Ways and Means, the insurance business presented detailed actuarial cost estimates for these benefits. They were testifying, of course, with respect to H.R. 4222. Since the benefits proposed by the junior Senator from New Mexico with respect to the OASI population are essentially the same as those contained in H.R. 4222, these estimates are applicable.

Let me recite the nature of the dollar differences as well as the tax requirements as between actuaries experienced in providing medical insurance benefits and Government statisticians with no such experience.

First. Benefits provided under H.R. 4222 would cost $2.2 billion in 1963 as compared with the administration's estimate of $1 billion. In 1964, with the nursing home provision available for the entire year, the total cost would rise to $2.5 billion. The administration's estimate for this year is again $1 billion.

Second. By 1983, the anual cost of H.R. 4222 would be $5.4 billion while the administration has estimated that by 1990 costs will reach only $2½ billion.

Third. The level premium costs of H.R. 4222, as defined by the Social Security Administration, are 1.66 percent on a $5,200 taxable earnings base while the administration's estimate is only 0.66 percent. While it is not strictly comparable, the administration estimates this level premium requirement basis. In our judgment, this is unrealistic.

The insurance companies' estimates are based upon the actual claim experience of insurance companies as well as Blue Cross and Blue Shield plans gathered by the New York State Insurance Department. Its long experience would indicate that this substantial actual data is far more reliable in predicting cost than is unverified data obtained from household interviews of a limited sample of the aged population as is the case of the data of the administration.

ADMINISTRATION'S ESTIMATES UNREALISTIC

In the opinion of insurance actuaries, the administration has greatly overestimated the effect of the deductible.

Further, the administration's estimate of cost has not made an adequate allowance for future increases in hospital and related health care costs.

Furthermore, it is believed that the administration's cost estimates have not

been realistic as to the ultimate costs of the skilled nursing home benefits.

As the Senate is well aware, OASDI taxes prior to this year are scheduled to reach 9¼ percent in 1968. Within 6 years it is the estimated cost of H.R. 4222 added to the 9.25 percent tax rate, workers earning up to $5,200 per year would, jointly with their employers, be subject to total OASDI taxes of 10.91 percent. Secretary Ribicoff has indicated that a 10 percent total social security tax rate appears to be about the maximum which should be imposed. Based on these estimates, the addition of health care benefits would result in a total OASDI tax which would exceed this practical limit.

It is well to observe that this estimated tax of nearly 11 percent would cover only those benefits provided and beneficiaries presently eligible under H.R. 4222. Once enacted, pressures would be engendered to remove the present deductible provision, to cover more forms of health care to provide care for longer periods of time, and to lower the age limit.

Although I am no actuary, I have spent time in a careful reading of the actuarial appendix filed by the insurance business. This analysis is based, as I have indicated, upon actual claim experience of insured lives under both insurance company policies as well as those of Blue Cross and Blue Shield plans. Such experience indicates a hospital utilization rate per aged person per year ranging from 2.6 days at the lower ages to 6.0 days at ages 80 and over. According to the American Hospital Association, the average cost per day in a hospital in 1960 was about $32. Hospital costs have been rising annually at an average increase of about 7 percent. Assuming that such per diem costs increase by only 5 percent between 1960 and 1964, the cost per day in a hospital should be about $38 in that year. A projection of the cost per day and the aforecited hospital utilization by the aged produces the estimated costs predicted by the insurance business.

The Government's statisticians, on the other hand, have used a hospital per diem of about $29, and let me call your attention to the fact that this per diem that they have used is even less than the actual costs in a hospital today, let alone what it will be by 1964. The Government's statisticians have based their hospital utilization on information obtained in a survey conducted 6 years ago among some 5,000 OASI beneficiaries. In that survey, such persons were asked how frequently they went to a hospital and how long they stayed. Statistical experts tell me that the range of sampling error, memory error, and other such factors make surveys of this type, for purposes of predicting hospital utilization, completely unreliable. This is one major reason why the insurance business believes that the Government has underestimated the true costs of the health care benefits.

COSTS THREE TIMES PREDICTION

There are a number of other reasons why the true cost will be about three times what some Government statisticians predict. Again, the Government people have used household interview material, and in this instance, a survey among about 600 persons, to measure the financial effect of the up to $90 deductible contained in the health care benefit provisions. The insurance business, on the other hand, utilized actual claim experience with deductible provisions. They note with exactitude that the financial effect of the deductible will be considerably less than that predicted by the administration. This represents a second reason for the understatement of the Government's estimates.

A third reason for the understatement rests in the fact that there will always be a certain amount of what insurance actuaries call "extra utilization and longer hospital stays" under a governmental program as compared with a program of insured lives. Governmental programs in Saskatchewan, British Columbia, Great Britain, and elsewhere, have all experienced considerable increases in utilization over what existed prior to the organization of the plans. The insurance business, in developing its estimates, added an allowance of 5 percent for such extra utilization. There is no evidence that any similar allowance was provided for by the Government's statisticians.

A fourth and perhaps the most significant reason why the half of 1 percent is not realistic lies in the area of future hospital costs. The cost per day in a hospital, as I have indicated, has been rising by some 5 to 7 percent a year. All knowledgeable authorities in the hospital field predict a continuance of this yearly percentage increase for the foreseeable future. In fact, Assistant Commissioner of Health, Education, and Welfare Wilbur Cohen, himself, has testified before a governmental body to this very effect. Built into the insurance business' estimate therefore is an allowance for future increases in the cost of a day in hospital. No similar allowance is contained in the Government's estimate of the cost of these benefits. In fact, and I repeat, the hospital per diem amount used by the Government is actually less than what is being charged for a day in hospital today.

ANDERSON PROPOSAL INADEQUATELY FINANCED

There are a number of other reasons contained in this actuarial study which make me feel that the cost aspect of these health care benefits is an overwhelmingly important matter for the Senate to consider. If this amendment to H.R. 10606 with its present proposal of financing the benefits of a half of 1 percent is passed, I predict that within a short period the administration will be back with a request for an increase in the tax, or else benefits will be paid out via further deficit financing.

My comments to this point have been concerned with only that portion of the proposal of the Senator from New Mexico which have to do with the OASI aged population. The Senator proposes to provide these same health care benefits to the non OASI aged at a net cost to the Government of $50 million per year. I have studied this figure with some care and I cannot conceive of such a small amount. Where he predicts a gross cost of a quarter of a billion dollars, I have good reason to feel the gross cost will approach half a billion dollars per year with a net cost of about a third of a billion dollars. I have equally good reason to feel that this third of a billion dollars which will have to be paid out of the Treasury each year will not wash itself out in a few years but will continue into the indefinite future. Let me recite the reasons why I feel this aspect of the cost of H.R. 10606 is equally unsound.

ERRORS IN ANDERSON'S ESTIMATES

With respect to the cost of providing benefits to non OASI eligibles, the Senator from New Mexico—CONGRESSIONAL RECORD, June 29—assumes a cost of $250 million to provide coverage to "2½ million aged people." The Senator indicates that the net cost of covering such aged persons would be only $50 million in that the Government would derive a savings of some $200 million via lesser payments under public assistance and veterans programs. These estimates are totally unrealistic for reasons outlined below.

The Senator's estimates are erroneous because:

First. He has understated the number of aged persons not eligible for either OASI or railroad retirement benefits.

Second. He has understated the cost of providing health benefits to those eligible under this provision of his amendment.

Third. He has overstated the savings which the Government would realize under its public assistance and veterans programs.

With respect to the number of aged who would be eligible, the Senator from New Mexico derives his figure as follows. As of January 1964, there will be 17.9 million aged persons. Of this number, he says, a quarter of a million, while not eligible for either social security or railroad retirement, would be covered under the Federal civil service governmental health insurance plan. Subtracting this quarter of a million, he incorrectly arrives at 17½ million. He then indicates that about 15 million aged persons are eligible for either social security or railroad retirement, leaving a remainder of 2½ million aged persons who would require health care benefits to be financed from general revenue. According to the Social Security Administration, Department of Health, Education, and Welfare, there will be 17.9 million persons at age 65 and over on January 1, 1964.

Excluding the quarter of a million Federal civil servants—even this figure may be high—leaves a remainder of

17⅔ million—17½ million. According to the same governmental sources, there will be 14.4 million aged persons eligible for OASI and an additional quarter of a million for railroad retirement benefits—not already include under OASI. By subtraction, there remains 3 million aged persons not covered by either OASI, railroad retirement, or having benefits by reason of being Federal civil servants, who would qualify for health care benefits from the general revenue.

SAVINGS OVERESTIMATED

The junior Senator from New Mexico estimates that the cost of caring for each non-OASI eligible would be $100. The insurance business has presented detailed actuarial cost estimates to the effect that the cost per OASI eligible should approximate $141 in 1964. The non-OASI aged population is, according to governmental estimates, a significantly higher age group than is the OASI aged population. This being the case, the cost per person among the non-OASI aged should be even higher than $141. Apart from this, and using a base cost of $141 per person, with an allowance of 10 percent for the cost of administering these benefits, the cost in 1964 for providing health benefits to the non-OASI eligible population should approximate $465 million—compared with the Senator's estimate of $250 million. We are unable to substantiate the basis for the Senator's estimate that this aspect of his proposed program would result in a savings of $200 million.

There is a presumption that such an estimate is unduly optimistic. According to the Social Security Administration, public assistance expenditures for general hospital care in 1960 totaled $100 million. Such expenditures were for aged persons under old-age assistance of which about one-third are also covered under OASI. If it is assumed that the OASI and non-OASI public assistance recipients used hospital care at about the same amounts, then about $67 million was expended by both Federal and State Governments to provide general hospital care in 1960. The Federal Government's share of this $67 million approximates $45 million, or two-thirds. In 1960, the Veterans' Administration spent $165 million for general hospital care. It is to be noted that the very large majority of veterans are covered under OASI. The saving to be derived by way of this program is, therefore, questionable.

Apart from the above, and accepting the $200 million savings—as indicated this is very likely too high—we estimate the net cost to the Federal Government, for providing health benefits to the non-OASI aged population, to be $265 million in 1964 with the likelihood that this figure could well be in excess of one-third of a billion.

NOW OASI AGED COSTS WILL CONTINUE

One other aspect of the Senator's estimate is open to question. The Senator indicates, in the aforestated CONGRESSIONAL RECORD, that the "annual cost of the provision would drop sharply—and eventually wash out altogether." It is difficult to accept this statement in light of the fact that, according to the Social Security Administration, there would still be by the year 1980, 217 million aged persons not eligible for OASI benefits. By that year, according to the insurance business' estimate of the cost of providing such health care benefits, the cost per person will be in excess of $200. Thus, 16 years from now the Federal Government would still be providing, from the general revenue, approximately one-third of a billion dollars to provide coverage to this group of the aged population.

Madam President, the Senate of the United States has a history of careful thought prior to approving any piece of legislation. Since the Anderson amendment is a fiscally unsound proposal, I urge its rejection by this body.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from New York [Mr. JAVITS].

Mr. JAVITS. Madam President, I send to the desk a modified amendment and ask that it be stated.

The PRESIDING OFFICER. The modified amendment of the Senator from New York will be stated.

Mr. JAVITS. Madam President, I ask unanimous consent that reading of the amendment may be dispensed with, and in lieu of reading, that an explanation of the amendment be printed as part of my remarks.

The PRESIDING OFFICER. Without objection, reading of the amendment is dispensed with, and the amendment and explanation may be printed in the RECORD.

The modified amendment is as follows:

On page 14, line 17, insert "after December 1963" after "month".

On page 15, lines 8 and 9, strike out "(as defined in section 210(i)".

On page 23, between lines 11 and 12, insert the following:

"States and United States

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

Beginning with line 1, page 45, strike out all to and including line 5, page 49, and insert in lieu thereof the following:

"OPTION TO BENEFICIARIES TO CONTINUE PRIVATE HEALTH INSURANCE PROTECTION

"SEC. 1716. (a) In lieu of payments to a provider of services under an agreement under this title, payments may be made to an eligible carrier under an approved plan with respect to services, for which payment would otherwise be made under the preceding provisions of this title (hereinafter in this section referred to as 'reimbursable health services'), which are furnished by such provider of services to any individual entitled to health insurance benefits under this title if such individual elects to have payment for such services made to such carrier.

"(b)(1) An individual may make an election under subsection (a) with respect to the approved plan of an eligible carrier only if he was covered by an approved plan of such carrier (or an affiliate thereof) continuously during whichever of the following periods is applicable—

"(A) if the month in which such individual becomes entitled to health insurance benefits under this title is any month in 1964 or January, February, or March of 1965, the 90-day period ending with the close of the month before such month, or

"(B) if the month in which he becomes so entitled is April 1965 or a subsequent month, the period beginning January 1, 1965 and ending with the close of the month before the month in which he becomes so entitled or, if shorter (i) in the case of a plan meeting the requirements of clause (A), (B), (C), or (D) of subsection (c)(5), the one-year period ending with such close of such month, or (ii) in the case of a plan meeting the requirements of clause (E) of such subsection, the 2-year period ending with such close of such month.

"(2) An individual may make an election under subsection (a) in such manner and within such period as the Secretary may prescribe, but in no event more than 3 months after the month in which such individual becomes entitled to health insurance benefits under this title; and an individual shall be permitted only one such election. An election so made may be revoked at such time or times and in such manner as may be so prescribed, and shall be effective at the end of the 90-day period following such revocation or, if later, the end of the benefit period (as defined in section 1704(c)), if any, of the individual during which such revocation is made or, if a benefit period begins during such 90-day period, the end of such benefit period.

"(c) To be approved for purposes of this section with respect to an individual, a plan must—

"(1) be an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement provided by a carrier for the purpose of providing or paying for some medical or other type of remedial care;

"(2) with respect to the period before an individual becomes entitled to health insurance benefits under this title, include provision of, or payment for the cost of—

"(A) inpatient hospital services, with no greater deductible and limitations than are applicable in the case of inpatient hospital services which constitute reimbursable health services, or

"(B) in the case of a plan meeting the requirements of clause (A), (B), (C), or (D) of paragraph (5), inpatient hospital services to the extent provided in subparagraph (A), but without application of the deductible under section 1704(a)(1) and with a limitation of forty-five days on the duration of such services;

"(3) with respect to the period during which an individual is entitled to health insurance benefits under this title, include provision of, or payment to providers of services for the cost of—

"(A) all reimbursable health services, or

"(B) in the case of a plan meeting the requirements of claus · (A), (B), (C), or (D) of paragraph (5), such reimbursable health services, but without application of the deductible under section 1704(a)(1) and with a limitation of forty-five days on the duration of inpatient hospital services;

"(4) include provision of, or payment for part or all of the cost of, some additional medical or other type of remedial care not included as reimbursable health services; and

"(5)(A) be a group plan, or a continuation of a group plan which is available to individuals on conversion of a group plan after their separation from the group, or (B) be issued by a corporation, association, or other organization which is exempt from income tax under section 501(c) of the Internal Revenue Code of 1954, or (C) be a prepayment group practice plain, or (D) be a plan which the Secretary determines, on the basis of available data, is likely to result in a ratio of acquisition costs to payments with respect to the cost of medical or any other type of remedial care which is not greater than the ratio of such costs to such payments in the case of most of the group plans approved under this section, or (E) in the case of a plan which does not come within clause (A), (B), (C), or (D), be issued by a corporation, association, or other organization which (i) is licensed in the 50 States and the District of Columbia to issue insurance covering all or any part of the cost of medical or any other type of remedial care and, in the most recent year for which data are available, has made payments with respect to the cost of such care aggregating at least 1 percent of all such payments in the 50 States and the District of Columbia, or (ii) is determined by the Secretary to be national in scope, or (iii) is licensed to issue insurance covering part or all of the cost of such care in the State with respect to which it requests eligibility hereunder and, in the most recent year for which data are available, has made payments with respect to the cost of such care aggregating at least 5 percent of such payments in such State.

"For purposes of paragraph (5)—

"(6) a 'group plan' issued in any State is a plan which meets the requirements established by the law of such State for such plans or, in the case of a plan in a State in which there is no State law establishing requirements for such plans, which—

"(A) is issued to employers for their employees, or to unions for their members, or to other associations for their members who are bound together by a single, mutual interest other than insurance, and

"(B) covers at least 10 persons in the group;

"(7) the 'acquisition costs' of a plan are costs directly related to the sale of coverage under such plan to individuals, including costs such as costs of advertising, commissions and salaries of agents, and salaries and other expenses of field staff directly involved in the sale of coverage under the plan.

"(d) A carrier shall be eligible for purposes of this section if it—

"(1) is a corporation or other nongovernmental organization which is lawfully engaged in issuing plans described in subsection (c)(1) in the State with respect to which it requests eligibility under this section;

"(2) agrees that any information provided in connection with any approved plan will be accurate and complete;

"(3) agrees, in the case of any individual who has made an election under this section with respect to an approved plan and who revokes such election (including termination of such coverage by such individual or the carrier), to continue to make payments under such plan with respect to him until his revocation is effective (or would be effective if such termination were considered a revocation) as provided in subsection (b)(2);

"(4) agrees to provide the Secretary, on request, such reports as may reasonably be necessary to enable him to determine the amounts due, under any plan with respect to which an election has been made under this section, on account of reimbursable health services and the administrative expenses of the carrier in connection therewith, and agrees to permit the Secretary to determine the accuracy of such reports;

"(5) agrees to make payments for reimbursable health services to providers of services, or to provide reimbursable health services, with respect to individuals who have made an election under this section in the same amounts, under the same conditions, and subject to the same limitations as are applicable in the case of such services for which payments are made under the preceding sections of this title; and

"(6) agrees not to impose any fees, premimums, or other charges with respect to reimbursable health services for individuals entitled to health insurance benefits under this title.

"(e) If a plan ceases to be approved under this section or a carrier ceases to be an eligible carrier or ceases to do business, any individual who has made an election under this section and is covered by such plan or by a plan of such carrier shall be deemed to have revoked his election under this section and such revocation shall, notwithstanding subsection (b)(2), be effective immediately upon such cessation; except that the limitations applicable under such plan shall apply with respect to the benefit period (as defined in section 1704(c)), if any, of such individual existing at the time of such cessation.

"(f)(1) An eligible carrier shall be paid from time to time amounts equal to the payments made or the cost of services provided by it for reimbursable health services under approved plans with respect to individuals who have made an election under this section, and in addition, such amounts as the Secretary finds to be the administrative costs of such carrier which are reasonably necessary to the provision of or payment for the cost of reimbursable health services for such individuals under an approved plan, except that such additional amounts for any year may not be more than 50 per cent greater than the comparable part of the cost of administration of this title.

"(2) In the case of a plan to which subparagraph (B) of subsection (c)(3) is applicable, the limitations and conditions of payment for reimbursable health services under the preceding sections of this title shall be modified in accordance with such subparagraph; and for such purposes the maximum units of reimbursable health services (within the meaning of section 1704(b)) for which payment will be made under this title shall be 105 units."

The explanatory statement submitted by Mr. JAVITS is as follows:

EXPLANATION OF THE (JAVITS, COOPER, KUCHEL, KEATING) AMENDMENT TO THE ANDERSON AMENDMENT TO H.R. 10606, STRIKING AND INSERTING A NEW SECTION 1716 "OPTION TO BENEFICIARIES TO CONTINUE PRIVATE HEALTH INSURANCE PROTECTION"

The purpose of this amendment is to offer the individual an opportunity to purchase or continue a private health care plan which would give him the statutory benefit of 90 days of hospitalization with a deductible, or under group and similar plans 45 days of hospitalization with no deductible, in addition to other health care benefits.

The amendment permits any individual entitled to health insurance benefits for the aged, under proposed title XVII of the Social Security Act, at his option to elect to have payment for those benefits he uses be made to an eligible private carrier under an approved plan.

An approved plan must include the benefits under the statutory plan plus some other health care benefits to be provided by the private carrier. Except that as an option in place of the 90-day hospital benefit with a deductible of $10 a day for 9 days, specified private plans could offer a 45-day hospital benefit with no deductible.

Qualified to offer the option of either the 90-day hospitalization benefit with the deductible, or the 45-day hospitalization benefit paying "first costs," would be group insurance plans, prepayment group practice plans, nonprofit plans, and plans (generally "mass enrollment" plans) having acquisition costs comparable to those of approved group plans. Other nongraup plans must offer the 90-day hospital benefit, and could qualify if the carrier did business in the 50 States and wrote at least 1 percent of the health insurance business, was determined by the Secretary to be otherwise national in scope, or did at least 5 percent of the health insurance business within a State in which it sought to write business under this bill.

Private plans must include medical or other health benefits in addition to those reimbursed by the Government. No fee, premium, or other charge to the individual could be made for the reimbursable benefits. The carrier would be paid the reasonable administrative costs of providing the reimbursable benefits, but not to exceed 150 percent of Government costs for the same functions.

An individual must make the election to continue a private health plan within 3 months after becoming entitled to health insurance benefits, and is permitted one such election; he may later revoke that election if he desires. He must have been covered by the approved plan for 1 year prior to becoming eligible for health insurance benefits in the case of group and nonprofit plans, and for 2 years in the case of commercial individual policies (except that coverage for 90 days is sufficient for those becoming eligible prior to April 1965, and coverage beginning January 1, 1965, is sufficient for those becoming eligible in or after April 1965, if less than 1 or 2 years).

The private plan is required to include only the 90- or 45-day inpatient hospitalization benefit during the period before the individual becomes eligible under the program; after he becomes eligible, the plan must also provide all auxiliary benefits such as skilled nursing facility, home health, and outpatient hospital diagnostic services.

Mr. JAVITS. Madam President, the amendment would amend the Anderson amendments which are pending before the Senate, and is the definitive

provision for an option to beneficiaries to continue private health insurance protection, which has been under discussion for a number of days, to replace that part of the bill which relates to the subject.

The reason for submitting the amendment at this time is to perfect the Anderson amendments, in view of the fact that it is well known to all Senators that the Senator from Massachusetts [Mr. SALTONSTALL], the Senator from Connecticut [Mr. BUSH], and perhaps other Senators will be proposing complete substitutes for the consideration of the Senate. It is therefore important that the Senate have before it the definitive provisions of the measure offered by the Senator from New Mexico [Mr. ANDERSON] when it considers substitutes. It is my belief that the amendment which I am submitting is acceptable to the Senator from New Mexico [Mr. ANDERSON]. Obviously there will be adequate opportunity to debate its merits pro and con as we go along and to debate the amendments of the Senator from New Mexico. I therefore hope that I may make a brief explanation of my amendment. As I understand, the Senator from Massachusetts [Mr. SALTONSTALL] is prepared to present his substitute.

Mr. ANDERSON. Madam President, will the Senator yield?

Mr. JAVITS. I yield.

Mr. ANDERSON. I wish to say to the Senator from New York that I appreciate very much his consideration of the amendment. I appreciate the many long hours he has put into it, along with many of us. This is the matter having to do with options. If the Senator from New York is agreeable, I would be happy to modify my amendment to include the text of the amendment that he has submitted as his amendment.

Mr. JAVITS. I ask only that the Senator from New Mexico indulge the Senator from New York for about 10 minutes while I explain my amendment. Then I shall be glad to have the Senator do that.

Mr. ANDERSON. Will the Senator permit me to make two other modifications?

Mr. JAVITS. Certainly.

Mr. ANDERSON. Madam President, I also send to the desk an amendment to the Anderson amendment identified as "6–29–62—A," which reads:

On page 21, lines 17 and 18, strike out "decision of the physician members" and insert in lieu thereof "finding (after opportunity for consultation to such attending physician) by the physician members".

On page 23, line 10, insert "(after opportunity for consultation to such attending physician)" after "finding".

On page 28, line 6, insert "(by the physician members of the committee or group)" before "pursuant".

The amendment would make it clear that the patient's physician would be consulted before the hospital staff committee or other groups reviewing utilization makes a finding that the patient's continued stay in a hospital or skilled nursing facility is not medically necessary. It was expected that such consultation would take place as a matter of course. However, so that there can be no question or misunderstanding, my amendment is modified to that extent.

I also send another amendment to the desk. This is an amendment to the Anderson amendment identified as "6–29–62—A" which reads:

One page 75, line 13, insert "and use of the option" after "deductibles".

I modify my amendment to that extent. I am very happy to accept the language of the Senator from New York.

I modify my amendment further by striking' the original language and putting in the option language which has been the result of many hours of thoughtful and faithful consideration of this problem in an attempt to encourage free enterprise as much as possible. I thank the Senator from New York and his associates for the many hours of work that they have devoted to the preparation of the option.

Mr. JAVITS. Madam President, I yield myself 10 minutes. Unless other Members of the Senate desire to be heard in connection with the amendment which I have sent to the desk, at the conclusion of my remarks, I will yield back the balance of my time, because I understand the Senator from Massachusetts [Mr. SALTONSTALL] desires to proceed.

Madam President, the health care insurance bill in which I and my Republican colleagues have joined with Senator ANDERSON is the inclusive and most comprehensive bill on medical care for the aging to come before the Congress. It goes far beyond the original King-Anderson proposal and incorporates the essential principles which my colleagues and I have been working for and which are consistent with the declarations of the 1960 Republican platform.

Madam President, I should like to emphasize to the Senate that "this is it," so far as the Anderson proposal is concerned. This is the definitive package which we hope the Senate will accept.

Madam President, what has been achieved? First, all persons who are 65 years of age and older are now entitled to health care benefits under the bill, including those who are not presently covered by social security. This brings into the programs an estimated 3 million persons who would have been excluded under the old King-Anderson bill.

Of great importance, too, is the new provision establishing a separate medical trust fund for purposes of financing this program. We shall be able, then, to see exactly how much has been collected, how much paid out for this medical care program, and how much it is costing the social security system.

A third principle which I have maintained refers to State administration, and a measure of such State participation has also been provided as well as private administration of the Government program.

An opportunity is also given to individuals to select or continue their private insurance plans.

This amendment may be termed the "freedom of choice" amendment. It gives private enterprise a considerable share on a voluntary basis in the health care program, by substantially liberalizing the option to beneficiaries in section 1716 of the bill now before us and by offering a choice of hospital benefit programs which a beneficiary thinks is best suited to his needs.

In addition, this private health insurance protection, which would give the individual much more than the statutory benefits, would actually cost the individual much less than he would otherwise have to pay for such increased protection because the carrier would not be permitted to charge a premium for that part of the health insurance benefit which is reimbursable by the Government.

The amendment introduced by my Republican colleagues strikes out the present section 1716 in the pending amendment and substitutes under the same heading another provision. It adds to the private insurance option for individuals now in the bill, which must contain the same benefits as the statute makes generally available, an alternative preventive care benefit program. This is a truly preventive care option which has as its base the actuarial equivalent of the proposed statutory benefits and is offered to groups, mass enrollment and nonprofit plans; it features 45 days of hospital coverage without any deductible.

This is in addition to other benefits.

I cannot emphasize too strongly the critical importance of what has been accomplished.

Thus the individual has the freedom to choose between continuing his private insurance protection with a choice of benefit programs or the standard proposed statutory benefits program. The private insurance carrier has an unprecedented opportunity to provide as an addition—for a fair premium—a well-rounded preventive care health program. A policy could be written to contain the following as sample benefits, according to reliable estimates:

For a premium of $7.50 a month per person, built upon the basic coverage which will be provided by the bill, there can be added to the basic coverage any number of doctors' visits at home or office, for which the carrier will pay $6 toward the office visit, and $4 toward the home visit.

Also, there will be provided, in addition, diagnostic, X-ray, and laboratory fees on a schedule of items costing from $2 to $50.

Also surgery in or out of the hospital, from $350 on a schedule of items.

Also specialist consultation of $15 to $25.

Madam President, based upon the same estimates, for only $3.30 a month. the carrier could offer on a similar basis:

Out-of-hospital diagnostic services.

Surgery.

Medical care in the hospital.

These extremely generous programs, which have been prepared for me by a health insurance organization, carry out the geriatrics emphasis on preventive care and could thus result in a substantial reduction in the hospital utilization—and subsequent lower cost to the Government—if participated in on a

large scale. They preserve the doctor-patient relationship, provide for competition and give private enterprise a tremendous incentive to participate in this vast health care effort. Let no one regard the benefits program I have outlined as the last word. Even it can be improved, and I think that private enterprise has the creativeness to come up with many different kinds of valid benefits that are possible in this context.

Since this bill would go into effect on January 1, 1964, the individual beneficiary must hold his private insurance or group plan for at least 3 months prior to the time he becomes eligible for social security benefits during the first year and quarter after December 31, 1963, or for 1 year after March 1965.

After the individual becomes entitled to social security benefits or reaches age 65, if he is not covered by social security, his private insurance plan would also have to provide all the other statutory health benefits, such as skilled nursing facility, home health services and outpatient hospital diagnostic benefits. If the beneficiary become hospitalized, the Government would reimburse the carriers for the cost of the statutory benefits or the equivalent 45-day hospital plan. The carrier would also be paid for its reasonable administrative costs in connection with the benefits for which it is reimbursed but not over 1½ times the estimated cost of administration to the Federal Government. No premiums or other fees would be charged to beneficiaries in connection with these reimbursable health services.

This amendment thus makes it possible and attractive for private enterprise to take a substantial role in this great nationwide effort. It means, further, that health care insurance is not going the road of socialized medicine, as its critics have charged, nor in fact a road comparable in substance to that pursued in other countries.

The proposal now before the Senate is a distinctly American approach to a problem which all of us recognize. The fact is—and it cannot be repeated too often—that our older citizens need more medical care at a time when their incomes and earning power are too low for them to be able to afford the kind of care they need.

With this amendment in the bill we stand on the threshold of a new era in American health care. It is tremendously gratifying to me that we have reached this point. For many years I have supported a program of health care insurance for the aging, because I believe it is an urgent domestic need which we can no longer delay meeting.

I have contended for the very program, in essence, which the Senator from Massachusetts [Mr. SALTONSTALL] will place before the Senate today. But I have accepted the social security approach to finance this program because I am convinced that that is the way to have the program enacted into law, and also because I believe the American people want to pay for it in this way.

Madam President, this is the essence of my presentation to the Senate. I do not wish to run down any other plan. But I am now convinced that this is the only way in which we will get anywhere. I am also convinced that it is essential if we are to get anywhere, at long last, in this field.

On another occasion I shall argue that two points have been raised with respect to adding the health care program to the public welfare bill. I am particularly aware of the fact that there has been what is tantamount to the most comprehensive inquiry and investigation of this whole subject which it is possible to have in American public life—perhaps not directly in the hearings on the bill, but certainly in what has taken place in this field within the past 3 or 4 years. I have on my desk, by way of physical exhibits—and Senators are welcome to a mimeographed summary of the documents which I have before me—a sample of the hearings, investigations and reports which have taken place within the last 3 or 4 years on the subject of health care for the aged. This subject has been reviewed as few other subjects in American public life have been reviewed. The evidence is all before us.

In addition, the precedents are overwhelming and complete to the effect that the Senate has absolute constitutional policy and power to do precisely what it would be doing if it were to adopt the Anderson amendment.

The other day it was said that I made certain statements in the debate in 1960. I shall quote what was quoted to me in connection with my views. The Senator from Oklahoma [Mr. KERR] quoted me, and I again quote the statement:

> Mr. President, I think the hard nut of the issue is: Do we wish to inaugurate in the social security system what is for all practical purposes a health care scheme? I would not say that it is exactly what the British do, but it is very much like it. The point is that we would for the first time inaugurate a system by which we would have a national responsibility for the health care of the people.

I wish to make it very clear that what has been done by the amendment which is incorporated in the amendment of the Senator from New Mexico [Mr. ANDERSON] is exactly what I hoped to accomplish in 1950. We are no longer inaugurating a British-type system; we are inaugurating an American-type system, because under this system we are opening the whole plan to the winds, to the effect of competition. We are giving the individual a choice which is thoroughly American. We are giving him the choice of being under either a Government administered plan or a privately administered plan. The choice is his. I believe that that proposal definitely negates the principal concern, which I expressed, quite properly, in 1960.

Finally, with respect to the advocates of social security financing, I said at that time:

> I hasten to refute any idea that a social security approach is "un-American." Of course it is not. I only point out that the question of context, of the way in which we live, our national attitudes, is an important consideration in making what is really a fundamental and a very important sociological decision. I wish to emphasize that point. I shall not go to Bermuda, nor will grass grow in the streets, if the Congress decides that way, but I think it would be a profound and important departure from anything we have ever done before, with great sociological implications. I therefore urge my colleagues who are thinking about it, and I know many are, to consider it in those terms as well.

Madam President, because there is universal coverage in the Anderson proposal, because there is a completely open option in respect to the private enterprise system, I urge the Senate today, to consider the plan as a thoroughly American plan, entirely congenial and wise for our institutions, and entirely necessary in the public interest. I pointed out—and I shall do so again—that this is a completely Republican approach, one which should be extremely congenial to Senators on this side of the aisle. It is what we contended for in 1960. Our idea is now incorporated in what has been presented. This can never again be termed a partisan issue. There is now a bipartisan approach, one which does credit to the issue, credit to the elder citizens, and credit to the political processes of the Nation.

I salute my colleagues and friends, the distinguished Senator from New Mexico [Mr. ANDERSON], the distinguished Senator from Kentucky [Mr. COOPER], the distinguished Senator from New York [Mr. KEATING], and the distinguished Senator from California [Mr. KUCHEL], for seeing the direction which this health care program must take.

Mr. KEATING. Madam President, will the Senator yield?

Mr. JAVITS. Madam President, I yield 3 minutes to my colleague from New York.

Mr. KEATING. Madam President, I commend my colleague from New York for all his work in this field, and specifically for the work which he and other Senators have done to help to produce the new amendment.

The amendment which has been offered would provide an even greater opportunity for free enterprise to work hand in hand with Government. The expansion of this free enterprise option will make it much more attractive for group health associations, corporate health plans and private insurance companies to write large numbers of comprehensive health insurance programs for the elderly. If anything, it will increase the number of health care policies held by people over 65. It should also encourage younger people to join good group health plans before they retire, because they will now be guaranteed that this coverage will continue to be available to them at a limited and reasonable cost after they reach age 65.

The five major changes which we have made largely obviate the problem or fear of Federal control. Private companies are encouraged to cooperate. The amendment specifically says that no attempt shall be made to interfere with the traditional free practice of medicine by physicians. State and local control, AMA–AHA certification of hospitals and other related revisions in my

mind clearly refute the unfounded charge by those who contend that no material changes have been made. The fact is that this proposal is vastly different from the original King-Anderson bill which we had before us.

The new proposal retains the social security principle of financing. It is true that it has added many important features. It is evidence of the kind of cooperation and progress which is needed in this field if we are to move forward with legislation, rather than try to devise some political issue.

I congratulate not only my distinguished senior colleague from New York, but also the distinguished senior Senator from New Mexico [Mr. ANDERSON], for the time, perseverance, patience, and personal attention which they have so generously devoted to the bill and to the long, careful, and helpful meetings which have been held on the modifications which are now included in it. I sincerely hope the bill will have the support of all Senators.

Mr. JAVITS. Madam President, I yield 4 minutes to the distinguished Senator from Kentucky.

Mr. COOPER. Madam President, I join with the distinguished junior Senator from New York [Mr. KEATING] and other Senators in commending the senior Senator from New York [Mr. JAVITS] for the leadership he has shown in developing amendments to the original proposal of the Senator from New Mexico [Mr. ANDERSON]. I also pay my tribute to the Senator from New Mexico for the willingness he has shown to consider the amendments which have been proposed, and to accept them.

To me, at least, the amendment which we now offer adds great strength to the original amendment offered by the Senator from New Mexico, in which several of us joined as cosponsors. The amendment in which we joined a few days ago provides the option that a person eligible for health insurance benefits may make the decision to rely solely on the benefits provided by payments that can be made under the bill. These benefits are, first, up to 90 days' hospitalization, but with a $20 to $90 charge; second, up to 180 days in a skilled nursing facility; third, up to 240 home visits by a public or private nonprofit home health agency; and, fourth, outpatient hospital diagnostic services, with a $20 charge during any month.

Or, the individual can choose, in place of the means provided by the bill, to subscribe to or continue a private insurance policy, or to join a prepayment group practice plan, which offers medical, surgical, or other benefits in addition to the benefits provided by the Government program—for the Government share of which no premium could be charged.

Under the amendment we have offered today—again developed under the leadership of Senator JAVITS—individuals could also choose group or nonprofit plans providing a 45-day hospitalization benefit with no deductible charge against the individual, for which the Government would reimburse the private plan.

I point out that it has not been claimed that the hospitalization and other benefits provided by the original Anderson amendment can meet the full medical costs of most older persons. Perhaps only 40 to 50 percent of medical cost would be met. The remaining medical costs must be met out of pocket, through private supplemental insurance through Kerr-Mills, by the charity of doctors and through higher charges by hospitals and doctors to those who can pay—or else they will not be met. Our amendment integrates needed private insurance protection with the Government program, and does so in a way that makes it possible for these additional health needs to be met, and in a much better way than the original administration proposal would do.

To those who are concerned about the role of Government in guaranteeing a degree of protection for older persons against the high costs of their medical care, I answer that this bill—with the changes and improvements which have been secured by the Senator from New Mexico [Mr. ANDERSON], together with the leadership of the Senator from New York [Mr. JAVITS] and the cooperation of other Senators—brings into the program all types of private health insurance plans, will permit them to handle needs which they cannot now cover at a cost which older persons can well afford, and provides an opportunity for individuals to secure through private plans a broad range of benefits and a useful choice of benefits.

Madam President, I also address myself to the point referred to by the Senator from New York at the conclusion of his remarks; that is the real question involved in this debate, which revolves around the question of whether we should support a program financed through the social security system. I say frankly that this matter has been on my mind ever since I have been in the Senate. When I first came here, the Senate was then discussing in 1947 and 1948 a health program; and after all these years, I have accepted this method for a health insurance program, as I have accepted it for the existing social security retirement and other benefits. The persons who pay the compulsory payroll deduction are eligible for benefits from the social security trust fund. Under this bill, persons who pay into the health insurance trust fund will receive benefits from the trust fund, through hospitals and other providers of health services.

The real issue we are called upon to decide is whether it is possible to provide for the minimum health needs of persons over 65 in any other way. I do not think so.

And I do not think it is necessary to study statistics in order to reach that conclusion. I only need to travel through my own State and my own county, and to visit people's homes; I do not need any great mass of statistics. I can draw upon my own experience and can use my own eyes. I have come to the conclusion that there is no other possible way to provide for the minimum medical care of the great mass of people over 65 years of age.

The services of doctors, often free in the case of many in need, and the increasing use of private insurance plans—valuable as they are, and they will continue—will not meet the needs of millions who are deprived of the opportunity to obtain the same extent of hospital care and nursing care as those in more fortunate financial circumstances.

I think it proper that these people should have an opportunity to provide for their future care, by payments into the health insurance trust fund of the social security system during their working years. Medical care is important to persons over 65 years of age—and often is as important as housing, food, clothing, and security from dependency, all the purpose of the social security system.

That is my basic reason for supporting the bill.

Madam President, so far as I am concerned, after all these years, I have made up my mind. And I have made my decision on the basis that these human needs should be met.

Mr. JAVITS. Madam President, I yield 2 minutes to the Senator from California [Mr. KUCHEL].

The PRESIDING OFFICER. The Senator from California is recognized for 2 minutes.

Mr. KUCHEL. Madam President, my purpose in rising is to pay a highly deserved tribute to a great American and a great Senator. Some of us on this side of the aisle will not turn our backs on the need of so many people at this time and in the future; and we on this side of the aisle, under the leadership of the Senator from New York [Mr. JAVITS], have had conferences with the Senator from New Mexico [Mr. ANDERSON], in the effort, not to reap partisan advantage, but to solve this problem as Senators and as American citizens.

So I rejoice in the progress which has been made by us under the leadership of the Senator from New York, and I have cooperated fully and will continue to cooperate fully with him; and at the same time I compliment the Senator from New Mexico [Mr. ANDERSON] for the completely unpartisan fashion in which the bill has been improved to the point where it merits approval by the overwhelming majority of Members of the Senate.

Mr. JAVITS. Madam President, I yield myself 1 minute.

The PRESIDING OFFICER. The Senator from New York is recognized for 1 minute.

Mr. JAVITS. Madam President, I ask to have printed in the RECORD, as part of my remarks, a list of the volumes which are available to demonstrate the manner in which this matter has been given the most detailed attention and study by a number of committees in the past few years.

There being no objection, the list was ordered to be printed in the RECORD, as follows:

Problems of the aging

Number of volumes	Year	Title	Committee
1-13	1961	Hearings: Problems for the Aging	Subcommittee on Federal and State Activities of Special Committee on Aging.
1-3	1961	Hearings: Nursing Homes	Subcommittee on Nursing Homes, Special Committee on Aging.
1-4	1961	Hearings: Retirement Income of Aging	Subcommittee on Retirement Income of Special Committee on Aging.
1-5	1961	Hearings: Housing Problems of Elderly	Subcommittee on Housing for Elderly of Special Committee on Aging.
2-14	1959	Hearings: Aged and Aging in the United States (pt 1 exhausted—summary attached).	Subcommittee on Aged and Aging of Labor and Public Welfare Committee.
1-14	1960	Background Studies Prepared by State Committees for White House Conference.	Do.
1	1959	Hearings: Federal Programs for the Aged and Aging	Do.
1	December 1960	Report: Aging Americans—Their Views and Living Conditions	Do.
1	1960	Study: Condition of American Nursing Homes	Do.
1	1960	Report: Directory of Voluntary Organizations in Field of Aging	Do.
1	1960	Report: Aged in Mental Hospitals	Do.
1	1960	Hearings: Aged and Aging in United States (S. Res. 65). Report: Aged and Aging in United States.	Do.
1	1959	Survey: Major Problems and Solutions in the Field of the Aged and Aging.	Do.
1	1959	Hearings: National Organizations in the Field of Aging	Do.
1	March 1961	Report: Action for the Aged and Aging	Do.
1	July 1959	Hearings: Hospital, Nursing Home and Surgical Benefits for OASI Beneficiaries (H.R. 4700).	House Ways and Means Committee.
1	April 1960	Testimony: Health Needs for the Aged	Subcommittee on Aged and Aging, Labor and Public Welfare Committee.
1	Nov. 1959	Analysis: Rising Costs of Public Education Trends in the Supply and Demand of Medical Care.	Joint Economic Committee.

Mr. JAVITS. Finally, Madam President, I thank my friends and colleagues—and I assure Senators that I am not now indulging in rhetoric—for their trust and their very real and most helpful support. This result could not have been obtained without it. I am most grateful to them. Furthermore—and this is even more important—I believe the people of the United States should be very grateful to them for having achieved, together with me, the very marked advance which we have recorded today.

At this time I yield to the Senator from New Mexico [Mr. ANDERSON].

Mr. ANDERSON. Madam President, I do not wish to use any great amount of the time available to those on this side. I merely wish to announce that I accept the amendment of the Senator from New York, and modify my amendment accordingly.

The PRESIDING OFFICER. The amendment of the Senator from New Mexico will be modified accordingly.

Mr. SALTONSTALL. Madam President, I call up my amendments identified as "7-9-62—N", to House bill 10606. I offer the amendments on behalf of myself, the Senator from Vermont [Mr. AIKEN], the Senator from Pennsylvania [Mr. SCOTT], the Senator from Hawaii [Mr. FONG], the Senator from Delaware [Mr. BOGGS] and the Senator from Vermont [Mr. PROUTY].

The PRESIDING OFFICER. The amendments will be stated.

The LEGISLATIVE CLERK. On page 1, in line 4, it is proposed to strike out "Public Welfare Amendments of 1962" and insert in lieu thereof "Public Welfare and Health Insurance for the Aged Amendments of 1962".

On page 100, line 16, strike out "II" and insert in lieu thereof "III".

On page 100, line 18, strike out "201" and insert in lieu thereof "301".

On page 100, line 23, strike out "202" and insert in lieu thereof "302".

On page 100, between lines 15 and 16, insert the following:

TITLE II—HEALTH INSURANCE FOR THE AGED

SEC. 201. This title may be cited as the "Health Insurance for the Aged Act".

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

"TITLE XVII—MEDICAL BENEFITS FOR THE AGED APPROPRIATION

"SEC. 1701. For the purpose of assisting the States to improve the health care of aged individuals of low incomes by enabling them to secure, at cost reasonably related to their incomes, protection either against the expenses of preventive and diagnostic services and short-term illness treatment or against long-term illness expenses, there are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine. The sums made available under this section shall be used for making payments to States with State plans submitted by them and approved under the title.

"State plans

"SEC. 1702. The Secretary shall approve a State plan under this title which—

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

"(b) provides that each eligible individual (as defined in section 1705(a)) who applies therefor (and only such such an individual) shall be furnished whichever of the following he may elect:

"(1) preventive, diagnostic, and short-term illness benefits, which, for the purpose of this title, shall consist of payment on behalf of an eligible individual of the cost incurred by him for the following medical services rendered to him to the extent determined by the attending physician to be medically necessary (but subject to the limitations in section 1706)—

"(A) inpatient hospital services for not to exceed twenty-one days in any enrollment year, except that at the request of the individual days of skilled nursing-home services may be substituted for any or all of such days of inpatient hospital services at the rate of three days of skilled nursing-home care for one day of inpatient hospital services;

"(B) physicians' services furnished outside of a hospital or skilled nursing home, on not more than twelve days during any enrollment year;

"(C) ambulatory diagnostic laboratory and X-ray services furnished outside of a hospital or skilled nursing home to the extent the cost thereof is not in excess of $100 in any enrollment year;

"(D) organized home health care services for not more than twenty-four days in any enrollment year; and

"(E) such additional medical services as the State may elect (subject to the limitations in clauses (E) (vi) and (vii) of paragraph (2) and to the limitations in section 1708); or

"(2) long-term illness benefits, which, for purposes of this title, shall consist of payment on behalf of an eligible individual of 80 per centum of the cost above the deductible amount incurred by him for the following services (hereinafter in this title referred to as 'medical services') rendered to him to the extent determined by the attending physician to be medically necessary (but subject to the limitations in section 1706)—

"(A) inpatient hospital services for not to exceed one hundred and twenty days in any enrollment year;

"(B) surgical services provided to inpatients in a hospital;

"(C) skilled nursing home services;

"(D) organized home health care services;

"(E) such of the following services as the State may elect (subject to the limitations in section 1708)—

"(i) physicians' services;

"(ii) outpatient hospital services;

"(iii) private duty nursing services;

"(iv) physical restorative services;

"(v) dental treatment;

"(vi) laboratory and X-ray services to the extent the cost thereof is not in excess of $200 in any enrollment year;

"(vii) prescribe drugs to the extent the cost thereof is not in excess of $350 in any enrollment year; and

"(viii) inpatient hospital services in excess of one hundred and twenty days in any enrollment year; or

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

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

"(d) provides for payment of enrollment fees, payable annually or more frequently, as the State may determine by eligible individuals applying for long-term illness benefits or diagnostic and short-term illness benefits under the plan, the amounts of such fees to be determined by a schedule established by the State and approved by the Secretary as providing fees the lowest of which is equal to not less than 10 per centum of the per capita cost for the enrollment year involved of the benefits provided and the remainder of which vary in relation to the

come (as defined in section 1705(b)) of the individuals;

"(e) includes provisions for individuals who, for the enrollment year involved, would not be eligible individuals but for the provisions of section 1705(a)(2);

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

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

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

"(3) methods relating to collection of enrollment fees for long-term illness benefits or diagnostic and short-term illness benefits under the plan, except that the State may not utilize the services of any nonpublic agency or organization in the collection of such fees, and

"(4) methods for determining—

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

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

for which expenditures are made under the plan;

"(g) sets forth criteria, not inconsistent with the provisions of this title, for approval by the State agency, for purposes of the plan, of private health insurance policies;

"(h) provides that no benefits will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2, aid to dependent children under the State plan approved under section 402, aid to the blind under the State plan approved under section 1002, aid to the permanently and totally disabled under the State plan approved under section 1402, or aid or assistance under a State plan approved under title XVI (and for purposes of this paragraph an individual shall not be deemed to have received such assistance or aid with respect to any month unless he received such assistance or aid in the form of money payments for such month, or in the form of medical or any other type of remedial care in such month (without regard to when the expenditures in the form of such care were made));

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

"(j) includes (1) provisions, conforming to regulations of the Secretary, with respect to the time within which individuals desiring benefits under the plan may elect for any enrollment year between the types of benefits available under the plan and may apply for the benefits so elected for such year and (2) to the extent required by regulations of the Secretary, provisions, conforming to such regulations, with respect to the furnishing of benefits described in paragraph (1) or (2) of subsection (b) to eligible individuals during temporary absences from the State;

"(k) provides for establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for any persons, institutions, and agencies, providing medical services for which expenditures are made under the plan; and

"(l) provides that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports. Notwithstanding the preceding provisions of this section, the Secretary shall not approve any State plan under this title unless the State has established to his satisfaction that the medical or any other type of remedial care, together with the amounts, if any, included in old-age assistance in the form of money payments on account of their medical needs, for recipients of old-age assistance under the State plan approved under title I will be at least as great in amount, duration, and scope as the diagnostic and short-term illness benefits included under the State plan under this title;

"(m) makes provision (1) authorizing employees' pension or welfare funds to contribute to the payment of enrollment fees under the plan for or on behalf of eligible members or beneficiaries of such funds, (2) authorizing employers (including the State or any political subdivision thereof when acting as an employer) to contribute to the payment of their employees' enrollment fees under the plan, and (3) permitting any employee, or member or beneficiary of an employees' pension or welfare fund, to authorize his employer (including the State or any political subdivision thereof when acting as an employer) or trustee or other governing body of such fund to deduct from his wages or from such fund, as the case may be, an amount equal to his enrollment fees under the plan and to pay the same to the State agency administering the plan.

"Payments

"SEC. 1703. (a) From the sums appropriated therefor, each State which has a plan approved under section 1702 shall be entitled to receive, for each calendar quarter beginning with the quarter commencing July 1, 1963, an amount equal to (1) the Federal share for such State of the total amounts expended during such quarter by the State under the plan as long-term illness, diagnostic and short-term illness, or private insurance benefits, plus (2) one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

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

"(c) For purposes of subsection (a), (1) expenditures under a State plan in any calendar year shall be included only to the extent they exceed the amount of the enrollment fees collected in such year under the State plan, and (2) expenditures under a State plan for preventive diagnostic and short-term illness benefits or for long-term illness benefits in excess of $128 multiplied by the number of individuals enrolled for benefits under such plan in such year shall not be counted.

"Operation of State plans

"SEC. 1704. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of any State plan which has been approved under section 1702, finds—

"(1) that the plan has been so changed that it no longer complies with the provisions of section 1702; or

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

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

"Eligible individuals

"SEC. 1705. (a) For the purposes of this title, the term 'eligible individual' means, with respect to any enrollment year for any individual, an individual who—

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

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

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

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

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

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

"(2)(A) his income did not exceed $3,000 in the case of an individual who, at the beginning of such enrollment year, was unmarried or was not living with his spouse, or

"(B) the combined income of such individual and his spouse did not exceed $4,500 in the case of an individual who, at the beginning of such enrollment year, was married and living with his spouse.

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

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

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

"(3) Veterans' pensions.

Determinations under this section shall be made (in the manner prescribed by the Secretary by regulations) by or under the supervision of the State agency administering or supervising the administration of the plan approved under section 1702.

"Benefits

"SEC. 1706. Subject to regulations of the Secretary—

"(a)(1) Except as provided in paragraph (2), the term 'medical services' means the following to the extent determined by the physician to be medically necessary:

"(A) Inpatient hospital services;

"(B) Skilled nursing-home services;

"(C) Physicians' services;

"(D) Outpatient hospital services;

"(E) Organized home care services;

"(F) Private duty nursing services;

"(G) Therapeutic services;

"(H) Major dental treatment;

"(I) Laboratory and X-ray services; and
"(J) Prescribed drugs.
"(2) The term 'medical services' does not include—
"(A) services for any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases; or
"(B) services for any individual who is a patient in a medical institution as a result of a diagnosis of tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution, as a result of such diagnosis, for forty-two days.

"Inpatient Hospital Services

"(3) The term 'inpatient hospital services' means the following items furnished to an inpatient by a hospital:
"(1) Bed and board (at a rate not in excess of the rate for semiprivate accommodations);
"(2) Physicians' services, nursing services, and interns' services; and
"(3) Nursing services, interns' services, laboratory and X-ray services, ambulance service, and other services, drugs, and appliances related to his care and treatment (whether furnished directly by the hospital or, by arrangement, through other persons).

"Surgical Services

"(c) The term 'surgical services' means surgical procedures provided to an inpatient in a hospital, other than those included in the term 'inpatient hospital services', including oral surgery, and surgical procedures provided in an emergency in a doctor's office or by a hospital to an outpatient.

"Skilled Nursing-Home Services

"(d) The term 'skilled nursing-home services' means the following items furnished to an inpatient in a nursing home:
"(1) Skilled nursing care provided by a registered professional nurse or a licensed practical nurse which is prescribed by, or performed under the general direction of, a physician;
"(2) Such medical supervisory services and other services related to such skilled nursing care as are generally provided in nursing homes providing such skilled nursing care; and
"(3) Bed and board in connection with the furnishing of such skilled nursing care.

"Physicians' Services

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

"Outpatient Hospital Services

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

"Organized Home Health Care Services

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

"Private Duty Nursing Services

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

"Physical Restorative Services

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

"Dental Treatment

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

"Laboratory and X-Ray Services

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

"Prescribed Drugs

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

"Hospital

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

"Nursing Home

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

"Miscellaneous definitions

"SEC. 1707. For purposes of this title—

"Federal Share

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

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

"(3) As used in paragraphs (1) and (2), the term 'United States' means the fifty States and the District of Columbia.

"Deductible Amount

"(b) The 'deductible amount' for any individual for any enrollment year means an amount equal to $175 of expenses for medical services (determined without regard to the limitations in clauses (A) or (E) (vi) or (vii) of section 1702(a)(2)) which are included in the State plan and are incurred in such year by or on behalf of such individual, whether he is married or single, except that, in the case of an individual who is married and living with his spouse at the beginning of his enrollment year, it shall be an amount equal to $300 of expenses for medical services (so determined) incurred in such year by or on behalf of such individual or his spouse for the care or treatment of either of them, but only if application of such $300 amount with respect to such individual and his spouse would result in payment under the plan of a larger share of the cost of their medical services incurred in such year. Subject to the limitations in section 1708, the $175 amount referred to in the preceding sentence may be reduced for any State if such State so elects; and in case of such an election the $300 amount referred to in such sentence shall be proportionately reduced.

"Enrollment Year

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

"Private Health Insurance Policy

"(d) The term 'private health insurance policy' means, with respect to any State, a policy, offered by a private insurance organization licensed to do business in the State, which is approved by the State agency (administering or supervising the administration of the plan approved under section 1702), which is noncancelable except at the request of the insured individual or for failure to pay the premiums when due and which is available to all eligible individuals in the State.

"Cost

"(e) The per capita cost of long-term illness benefits or diagnostic and short-term illness benefits for any year or other period shall be determined by the State, in accordance with regulations of the Secretary, on the basis of estimates and such other data as may be permitted in such regulations.

"Election of medical services to be provided by State

"SEC. 1708. Any election by a State pursuant to the provisions of clause (E) of paragraph (1) or the provisions of paragraph (2) of section 1702(b) or of the second sentence of section 1707(b) shall be valid for purposes of this title for any enrollment year or other period determined by the Secretary only if an election is also made by the State under the other of such provisions so that, in the judgment of the Secretary, the per capita cost of benefits under paragraph (1) of section 1702(b) and the per capita cost of benefits under paragraph (2) of such section for such period after such elections bear the same relationship to each other as the per capita cost of benefits under each such paragraph for such period without such elections bear to each other.

"Advisory Council on Health Insurance

"SEC. 1709. (a) There shall be in the Department of Health, Education, and Welfare an Advisory Council on Medical Benefits for the Aged (hereinafter referred to as the

'Council') to advise the Secretary on matters relating to the general policies and administration of this title. The Secretary shall secure the advice of the Council before prescribing regulations under this title.

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

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

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

"Savings provision

"SEC. 1710. Nothing in this title shall modify obligations assumed by the Federal Government under other laws for the hospital and medical care of veterans or other presently authorized recipients of hospital and medical care under Federal programs.

"Planning grants to States

"SEC. 1711. (a) For the purpose of assisting the States to make plans and initiate administrative arrangements preparatory to participation in the Federal-State program of medical benefits for the aged authorized by title XVII of the Social Security Act, there are hereby authorized to be appropriated for making grants to the States such sums as the Congress may determine.

"(b) A grant under this section to any State shall be made only upon application therefor which is submitted by a State agency designated by the State to carry out the purpose of this section and is approved by the Secretary. No such grant for any State may exceed 50 per centum of the cost of carrying out such purpose in accordance with such application.

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

"(d) Appropriations pursuant to this section shall remain available for grants under this section only until the close of June 30, 1964; and any part of such a grant which has been paid to a State prior to the close of June 30, 1964, but has not been used or obligated by such State for carrying out the purpose of this section prior to the close of such date, shall be returned to the United States.

"(e) As used in this section, the term 'State' includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

"Technical amendment

"SEC. 1712. Effective July 1, 1963, section 1101(a)(1) of the Social Security Act (as amended by section 541 of this Act) is amended by striking out 'and XVI' and inserting in lieu thereof 'XVI and XVII'."

Make appropriate changes in the table of contents of the bill.

Mr. SALTONSTALL. Madam President, I ask for the yeas and nays on the question of agreeing to my amendments.

The yeas and nays were ordered.

Mr. SALTONSTALL. Madam President, on behalf of myself and Senators AIKEN, SCOTT, FONG, BOGGS, PROUTY, and COTTON, I have called up the amendment which we offer as a substitute for the Anderson amendments. Except for minor technical changes, this amendment is similar to S. 937 which nine Senators, including myself, joined in cosponsoring last session. The only significant change is that, on the basis of information furnished by the Department of Health, Education, and Welfare, the deductible feature applicable to one of the three options in the bill has been reduced from $250 to $175 for a single person and from $400 to $300 for a couple.

My colleagues and I offer this proposal because we believe it offers the most constructive approach to providing a sound, voluntary medical care program for our older citizens. It would supplement the Kerr-Mills plan which is geared to providing assistance to the medically indigent, by offering a medical program to those aged persons of modest incomes not eligible under Kerr-Mills.

As our older citizens have come to constitute a larger percentage of our population, increasing attention has understandably been devoted to the special problems which confront them. The life span of the American people has increased 20 years since 1900, largely as a result of advances made in the fields of medicine, drugs, and hospital care. The 1960 census reported 16.6 million Americans 65 or over, and it is estimated that by 1970 there will be more than 20 million in that age group.

One reflection of our concern for this segment of our population is the increasing attention which is being given to the difficulties some of these citizens encounter in meeting their medical costs. The sharp increase in longevity has been accompanied by serious budgetary problems for many individuals required to finance those extra years after relinquishing full-time jobs. This financial situation has been aggravated by rising costs of medical care. Hospital costs have tripled in the last 15 years and people over 65 years of age spend, on the average, more than 2½ times as long in the hospital as those under 65. It has been estimated that hospitalization which cost $8 or $9 per day in 1947 has risen to $30 and $35 today. It has become virtually impossible for many of our older citizens to finance the medical treatment they require. The question is not whether such a problem exists, but how it can best be met. We are debating the question of who should receive help in meeting their medical expenses and how this help should be paid for.

The enactment of the Kerr-Mills Act in 1960 provided tangible evidence of congressional interest in helping to relieve some of the financial medical burden of our elderly. It marked a significant step forward and all of us are indebted to the senior Senator from Oklahoma [Mr. KERR], for his leadership in advancing that legislation. Kerr-Mills has been implemented in 24 States, Puerto Rico, Guam, and the Virgin Islands, and is in the process of being approved in 10 other States. As of April 1962, 96,000 persons were participating in the program. Massachusetts was one of the first States to participate in the program and its benefits are among the most liberal. In fact, as of April, Massachusetts along with three other States received 90 percent of the total payment issued by the Federal Government under the present law.

Kerr-Mills is helpful legislation. I believe, however, that a further medical assistance program is needed to supplement it, to help persons who, although not meeting the "medically indigent" criteria of Kerr-Mills, possess modest incomes insufficient to enable them to meet their basic medical demands. The amendment presently before us, would, in my estimation, provide such a program.

Like the Eisenhower administration medicare bill, which I sponsored in 1960, this amendment embodies the following essential principles: First, it is a voluntary program and not one based on compulsory social security financing; Second, it involves Federal-State matching and State administration; Third, it offiers benefits to meet the specific needs of an aged participant; and, Fourth, it requires some participation on the part of the individual participating in the program.

Our amendment provides 3 optional plans from which participants can select the one they best feel is suited to their individual needs. Total costs of $100 to $128 per person per year would include a modest enrollment fee paid by the individual participant and Federal-State matching based on the per capita income of the State.

OPTIONS

The three options offered to participants would be as follows:

PREVENTIVE CARE PROGRAM

First, a diagnostic and short-term illness plan emphasizing preventive medicine. The minimum program offered under this plan is estimated to cost an average of $100 per person per year and would provide: first, 21 days of hospitalization—or equivalent skilled nursing home services; second, 12 physicians' visits in home or office; third, diagnostic laboratory and X-ray services up to $100; and, fourth, organized home health care services up to 24 days.

States could also expand this preventive plan to include a maximum package which would provide, first, 45 days of

hospital care or equivalent nursing home care; second, physicians' services for 12 home or office visits; third, total costs for ambulatory diagnostic laboratory and X-ray services; and, fourth, 135 days of home health care services. It would also include any other type of medical services provided for by the State plan. Aside from the enrollment fees, the Federal and State Governments would contribute to the cost of this maximum program up to a combined total of $128. Any cost in excess of $128 would be borne by the State.

Statistics show that preventive care is needed more by aged persons than long-term hospitalization, which is emphasized in the Anderson proposal and which encourages the overutilization of already heavily burdened hospital facilities. In our opinion, it is desirable to emphasize preventive features in a health program. It is wiser and less costly to seek to keep a man healthy and ambulatory than to wait until he becomes chronically ill.

No deductible is included in this diagnostic and short-term illness plan, although participants would pay an enrollment fee expected to range from $10 to $12.80.

MAJOR ILLNESS PROGRAM

The second alternative is a long-term major illness plan which contains a deductible feature of $175 for an individual or $300 for a couple. The basic plan would provide, following the deductible, 80 percent of the costs of, first, 120 days of hospitalization; second, up to 365 days of nursing home services; third, surgical services provided in a hospital; and, fourth, full home health care services. The minimum program which could be provided here is estimated to cost $100 per person per year.

A State could expand this long-term illness plan to include 80 percent of the following costs after payment of the first $175: First, 180 days of hospital care; second, full nursing home care; third, full home health care services; fourth, surgical services in hospital, office or home; fifth, first $200 laboratory and X-ray services; sixth, first $350 of prescribed drugs; and, seventh, other physicians, major dental and private duty nurse services. Again, the Federal and State Governments would contribute to the cost of this maximum program up to a combined total of $126 per person per year.

This second comprehensive package would benefit an individual or a couple who are worried about a major illness which would hospitalize them for a long period of time. The inclusion of surgery, physicians, major dental and private duty nurse services provides a more attractive long-term plan than the Anderson amendment.

PRIVATE INSURANCE PROGRAM

The third option encourages the purchase of a private insurance plan by enabling the Federal Government and the State to share up to one-half of the cost of an insurance premium purchased by an aged person up to a maximum of $60 per year. The total cost is not limited so that the individual retains a wide choice of plans.

Many insurance firms have been expanding and improving their programs for the aged and should be encouraged to formulate more liberal policies for the elderly at moderate rates. In fact, one salutary result of the continuing discussion of this important subject has been to stimulate private health plan groups to accelerate their efforts to improve and expand their programs.

In Massachusetts, Governor Volpe recently signed into law the Massachusetts-65 program which enables insurance carriers to pool their resources in developing new forms of insurance protection for our senior citizens. Connecticut, New York, and Mississippi have also authorized this type of pooled action. It is also my understanding that Blue Cross-Blue Shield is working on a low-cost medical program for the aged which it may submit next fall.

ELIGIBILITY

Eligible for benefits under our amendment would be all persons aged 65 or over who did not pay a Federal income tax in the preceding year or whose income for Federal tax purposes in the preceding year was $3,000 or less—$4,500 for a couple—and who are not receiving medical care under old-age assistance or other Federal medical assistance program. Under our substitute means test, a person will not have to pauperize himself to receive assistance, yet only those persons who are financially in need can qualify. This is in contrast to the Anderson proposal which allows participation regardless of income or wealth. It is estimated that 12.3 million aged persons would qualify under our program. HEW estimates that, based on 75 percent anticipated participation, the annual cost would be about $1 billion.

ADMINISTRATION

Administration of this program would be vested in the States after the Secretary of Health, Education, and Welfare confirmed that a State plan met the standards set forth in this amendment and approved those provisions for which specific standards are not stipulated. I believe this medical program should be State administered and not federally oriented, because by being closer to the needs of its people, a State is able to tailor its program more effectively to meet the requirement of its senior citizens. In addition, a State-administered program would avoid cumbersome Federal control and extensive regimentation over the plan's services and payments.

FINANCING AND ENROLLMENT FEE

A basic feature of our substitute is that it would be financed out of general revenues—except for the enrollment fees—on a Federal-State matching basis rather than under a compulsory social security system. The Federal share would be based on the per capita income of each participating State but would be no less than 33⅓ percent nor more than 66⅔ percent of the cost in any State. The Federal Government would also pay one-half of a State's administrative costs. In addition, each participant would be required to pay a small enrollment fee—$10 to $12.80 yearly minimum. This enrollment fee would be determined by the State and would be based on a minimum of 10 percent of its average per capita cost of the program. Payment of this fee by employers or under welfare or pension funds is permitted.

To my mind, the question of how the funds are raised to implement a program of health benefits is crucial. I am opposed to the social security method of financing and therefore I am opposed to the Anderson-Javits amendment.

Many improvements have been made in S. 909—the administration bill—as it has been modified by the efforts of a bipartisan group of Senators, of whom the Senator from New Mexico [Mr. ANDERSON] and the Senator from New York [Mr. JAVITS] have been the leaders. All are to be commended for their efforts to strengthen the original measure and for the success they have achieved. The Senator from New Mexico [Mr. ANDERSON] and the Senator from New York [Mr. JAVITS] have worked particularly hard to this end and they deserve recognition for their contribution. Those of us who have joined together in the substitute I am now offering are also glad to acknowledge our heavy debt to the Senator from New York [Mr. JAVITS].

Despite the improvements which were made in the original Anderson bill during the deliberations of the bipartisan group to which I have referred, the bill remains predicated on a feature which I find objectionable: the program is to be financed largely by means of taxes levied on our social security system.

The administration proposal would be financed by increasing the social security tax on employees, employers, and self-employed persons and by raising the tax base from $4,800 to $5,200. Under present law, an employer and employee pay 3⅛ percent or $150 apiece per year in social security taxes. By 1968 this tax will increase to 9¼ percent and will cost employee and employer $222 apiece per year. If the administration proposal is approved, another one-half of 1 percent will be added to the tax and each would be paying $253 in 1968. At the same time, a self-employed person who is now contributing $225 in social security taxes will be paying $331 in 1968. If the administration plan is adopted, he will be paying a total of $379 instead of $331. This is an alarming increase over a span of 6 years in social security taxes. Where will it stop?

Everyone who has worked to come up with a satisfactory plan in this area knows how difficult it is to prevent certain inequities from creeping into any system which can be devised. But it seems to me that a socal security based system of medical care contains a major, glaring injustice. Unquestionably it is a regressive tax. It is not based on ability to pay whch is the traditional way in which we have distributed the tax burden but rather places a far greater relative burden on persons with limited incomes. Percentagewise, the worker earning $5,200 would be paying a greater percentage of his gross income in support of the program than would a person earning in excess of this figure. Use of the general revenue approach, on the

other hand, means that the costs will eventually be borne by those most able to pay. I firmly believe this is the preferable way of raising the money.

It has been said in debate that citizens seem to prefer a social security based system and that therefore it should be supported. There is increasing evidence that the Nation is having second thoughts about this method of financing. To cite one example, the most recent Gallup poll on the subject notes a rather sharp decline of 7 percentage points since March in support of a social security based system. Among the people most directly involved in the matter—those citizens aged 60 and over—the decline in support was even greater—9 percentage points. The gap is thus rapidly being narrowed.

VOLUNTARY VS. COMPULSORY

I also object to the compulsory health care financing of social security. I much prefer our traditional democratic principles of voluntary participation and free choice. The initiative of our citizens and our Federal, State and local governments has helped make us probably the healthiest Nation in the world today. Our facilities and know-how are unsurpassed and people come from all over the world to take advantage of them. We can continue best to contribute to the greatness of our country by helping resolve the medical needs of our elderly in the true American spirit—putting our shoulders to the wheel and solving this problem through voluntary programs and methods. I submit that the support of the medical profession is likely to be much more enthusiastic in connection with this voluntary participation plan than under a social security based program.

SUMMARY

In summary, our amendment calls for a voluntary program rather than one based on compulsory social security financing. It places the financial burden on those most able to pay rather than establishing a regressive tax which falls most heavily on those income groups least in a position to pay the costs. It provides options so that an idnividual may select the plan which best meets his needs. It involves Federal-State matching and State administration. It requires some participation on the part of individuals enrolled in the program. I hope it will prevail.

I hope the amendment may be substituted for the Anderson amendments.

I yield 20 minutes to the Senator from Hawaii.

Mr. FONG. Madam President, I commend the distinguished senior Senator from Massachusetts for his very clear, direct, and excellent statement on the substitute amendment, which I am privileged to cosponsor with the distinguished senior Senator from Vermont [Mr. AIKEN], the distinguished junior Senator from Pennsylvania [Mr. SCOTT], the distinguished junior Senator from Delaware [Mr. BOGGS], the distinguished junior Senator from Vermont [Mr. PROUTY], and the distinguished senior Senator from New Hampshire [Mr. COTTON].

Of all the health insurance measures offered in this Congress, I am firmly convinced the best by far is the pending plan.

At the outset, I pay tribute to the senior Senator from New York [Mr. JAVITS], whose yeoman work produced this plan 2 years ago and whose constant endeavors continued to improve it since then. We were proud to join him as cosponsors of the earlier versions. I for one deeply regret we must part company with our colleague, Senator JAVITS, a pioneer in the health insurance field who is now cosponsoring the social security plan of the junior Senator from New Mexico [Mr. ANDERSON].

We thought the Javits plan was best 2 years ago, and we still hold those views.

Our plan offers medical benefits most closely tailored to the special needs of those age 65 and over.

Our plan offers the greatest protection against Federal encroachment upon the practice of medicine.

The cost of our plan is moderate, and the Federal share of costs is widely and fairly distributed among all taxpayers in accord with their taxable income.

Our plan provides for States, rather than the Federal Government, to establish and administer medical plans which must meet minimum benefit requirements.

Our plan permits and encourages continuation of private health insurance plans for those 65 and over who prefer such protection.

Our plan permits freedom of choice—freedom to individuals to select the benefit package which best fits their individual circumstances; freedom to choose their doctor; freedom to choose their hospital; and freedom to participate or not to participate in the program.

Our plan is the only proposal which places the emphasis where it belongs—that is, on preventive care and on medical care, rather than preponderantly on hospital care.

Under the Saltonstall amendment, persons 65 and over of modest income would have three benefit packages to choose from: a preventive, diagnostic, short-term illness plan; a long-term so-called catastrophic-illness plan; and private voluntary insurance.

Covered by our plan would be some 12 million persons 65 or over. These are substantially all the aged persons who may need assistance toward their health care costs.

Persons qualifying for old-age assistance medical care or Kerr-Mills medical care would be covered by existing programs. Of the estimated 17 million persons in the 65-and-over age bracket more than 2½ million are receiving old-age assistance and an estimated 1 million more are eligible for Kerr-Mills medical assistance.

Eligibility provisions of the Saltonstall amendment are very liberal. There is an age requirement of 65 years or over. There is a residence requirement in that a person would be permitted to enroll in a plan under the State in which he had resided at the beginning of the enrollment year.

There is an income requirement which is very liberal and which will avoid a means test for the overwhelming majority of senior citizens.

Any person 65 or over would be eligible who did not pay any Federal income tax for the taxable year immediately preceding the enrollment year. As the junior Senator from New Mexico [Mr. ANDERSON] stated on the floor of the Senate last Friday, "about 80 percent of the aged have no tax liability."

Thus, 80 and perhaps 90 percent of those 65 and over would automatically qualify. It is a very simple matter to verify Federal income tax returns and there would be no need for the administrators of this program to pry into the bank accounts and assets of individuals.

Those elderly persons who have no financial worries do not constitute part of the national problem and since the well-to-do are not part of the national problem, there would be no justification for using Federal funds in their behalf.

Therefore, some ceiling on income for eligibility is necessary and is included, just as old-age assistance contains a means test; just as aid to dependent children requires a means test, aid to the blind, aid to the permanently and totally disabled, low-rent public housing, school lunch program, veterans pensions, and some veterans hospitalization for non-service-connected disability all have means tests. Yet they are not condemned for that. Indeed, this represents a prudent use of the taxpayers money in that it goes to those who most need assistance.

I want to emphasize that the income ceiling test would operate in relatively few instances. More than 80 percent of those persons 65 and over would qualify on the basis of having paid no Federal income tax for the preceding year.

The fact that relatively few investigations would be required to verify eligibility would keep down administrative costs. It would avoid many of the complaints against investigative costs incurred under Kerr-Mills.

The distinguished senior Senator from Massachusetts [Mr. SALTONSTALL] has already described the provisions of our plan. I want to say that I am in complete accord with the excellent exposition of my colleague. He has masterfully stated why we cosponsors feel compelled to offer a substitute for the Anderson-Javits social security plan.

I shall not delay the Senate by repeating terms of the amendment, but ask unanimous consent that a summary of the three options be presented in the RECORD at this point in my remarks.

There being no objection, the summary was ordered to be printed in the RECORD, as follows:

OPTION NO. 1: PREVENTIVE, DIAGNOSTIC, AND SHORT-TERM ILLNESS PLAN

1. Minimum of 21 days hospitalization a year.

2. Three days of nursing home care for each unused hospital day approved by the State.

3. Twenty-four days of home health service per year.

4. Twelve days of surgeons' and physicians' services per year, outside of hospital.

5. Diagnostic, laboratory, and X-ray services up to $100 per year.

6. No deductibility and no coinsurance; this pays for all specified costs beginning with the first dollar of such costs.

7. Permits individual to obtain protection before chronic illness should set in. The individual obtains benefits as soon as needed.

8. Benefits are fully adequate from a medical point of view for the average health care needs of the older citizens in short-term illness cases.

9. By giving priority to preventive care, we help avoid the hazard of overcrowding hospitals and other institutional facilities.

(NOTE.—These are services toward which the Federal Government would render financial assistance; States could enlarge benefits at State cost. Individuals applying for benefits would be required by the States to pay enrollment fee of at least 10 percent of per capita costs of benefits provided.)

OPTION NO. 2: LONG-TERM CATASTROPHIC ILLNESS PLAN

1. Minimum of 120 days per year in hospital.

2. Surgical services to hospital inpatients.

3. Skilled nursing home services 365 days a year.

4. Organized home health care services 365 days a year.

5. Such of the following services as the State may elect to assist up to 80 percent of cost: physicians' services; outpatient hospital services; private duty nursing services; physical restorative services; dental treatment; laboratory and X-ray services up to $200 a year; expensive drugs up to $350 a year.

6. Government pays 80 percent of the cost of above services; individual 20 percent. Deductible of $175 if single; $300 if married, each year, although the State could reduce the deductible amount in the plan it offers.

(NOTE.—These are services toward which the Federal Government would render financial assistance. States could enlarge benefits at State cost. Individuals applying for benefits would be required by the States to pay enrollment fee of at least 10 percent per capita cost of benefits provided.)

OPTION NO. 3: PRIVATE HEALTH INSURANCE

An individual might select a private health insurance policy toward which premiums the Federal Government and the States would share up to one-half, but not more than $60, each year.

Mr. FONG. Madam President, the minimum cost for either the preventive-care package or the catastrophic-illness benefits package is estimated at $100 a year. The Federal Government would be permitted to contribute toward an expanded benefit package up to a total cost of $128 per year. This feature of our health insurance plan would encourage States to expand their benefits beyond the minimum stipulated in the bill.

An example of the maximum package benefits under the preventive care option would be: physicians' services, 12 days office and home; inpatient hospital services, 45 days; unlimited ambulatory, X-ray, and laboratory services; unlimited organized home health care services; skilled and nursing home services, 135 days. States so desiring could, of course, go beyond this, but this is what could be offered if the Federal Government contributed a maximum of $128 toward preventive care services and if the States are willing to go that far.

So, for those who want preventive care and want the costs met starting with the first dollar, without any deductibles or coinsurance, there is a very good plan under this amendment, all for a small enrollment fee.

This preventive care program providing between 21 days hospital care at minimum and 45 days at maximum without any deductible and without any sharing of costs between patient and the Government, meets the real need of the great majority of the elderly. The U.S. Government statistics show that the general average hospital stay is 21 days. Ninety percent stay an average of 14 days, while only 10 percent of the aged hospitalized stay more than 31 days per year in the hospital.

Also, by providing diagnostic and preventive care starting with the first-dollar costs, early care is made available which could preclude long chronic illness stays.

For those who can take care of themselves, unless they run into a bad problem, there is a long-term catastrophic illness plan under which they pay the first $175 of costs in long illness, and 20 percent of the balance of costs, plus a small enrollment fee.

A Federal contribution of $128 toward long-term or catastrophic illness would permit such services as 180 days hospital care; 365 days skilled and nursing home care; 365 days organized home care service; surgical procedures; laboratory and X-ray services up to $200; physicians' services; dental services; prescribed drugs up to $350; private-duty nurses; and physical restorative services.

Every person hospitalized under the Anderson-Javits plan would pay a minimum of $20 up to a maximum of $90 for hospitalization care, plus all surgeons' fees and doctors' fees, plus major medical expenses. If a person decides to have protection against the latter, he would have to buy insurance under some private arrangement and pay premiums accordingly.

The Saltonstall plan more closely approximates the varying needs and varying pocketbooks of those age 65 and older than any other plan before Congress.

The costs of these benefits would be financed by Federal-State matching funds and individual enrollment fees based on a State-determined schedule with the lowest fee not less than 10 percent of per capita cost. The Federal share would be based on per capita income of each participating State, but no less than 33⅓ percent nor more than 66⅔ percent. Federal matching funds would be available to States on programs costing up to $128 per capita. States would be reimbursed for one-half of the administrative costs.

Inasmuch as persons 65 or over who desire health insurance protection would, under the Anderson-Javits bill, which does not provide surgical or doctors' costs or medical care, need to buy insurance covering doctors' fees and major medical expenses, there should be no objection to the very modest yearly enrollment fee requested of individuals under the Saltonstall plan which would be somewhere between $10 and $12.80 a year.

Furthermore, the fact that the elderly individual is contributing in some part toward the costs of the health insurance benefits—and these are very generous benefits—will give him the feeling of entitlement to these benefits, rather than a feeling that he is being given charity.

Much ado has been made about the social security principle under which each covered wage earner contributes toward the benefits he or his family would eventually derive. Because it is a contributory system, it is said, the wage earner's attitude is that he is not a charity case. He is said to believe his contributions build up rights for him to claim at such time as he or his widow or surviving children should qualify for them.

The medical insurance plan I have cosponsored, through its requirement for enrollment fees for participating individuals, also removes our plan from the category of charity. Under our plan the individual also will be buying rights, through the enrollment fee, in much the same way as wage earners do through social security taxes.

The Anderson-Javits plan has no monopoly on the concept of buying rights. The social security system has no monopoly on the concept of buying rights.

As a matter of interest, what will happen to the rights the wage earner bought when he exhausts the admittedly skimpy benefits available to him under the Anderson-Javits plan after he becomes age 65 in event illness strikes?

Somehow, he must provide for payment of doctor bills and surgeon's fees, for private nursing, for expensive drugs, and for all the other major medical expenses. Those costs may be such that he may have to ask for assistance under Kerr-Mills and be subject to the means test and all that.

The so-called rights he bought through years of contributions to the social security health insurance fund may—and I predict will—if the Anderson-Javits bill is enacted and benefits remain the same, prove to be very illusory and temporary and fleeting and not at all satisfactory.

The idea that only the social security contributory system will protect an individual's rights is fallacious. An individual also obtains rights when he pays an enrollment fee as under the Saltonstall plan and when he pays private insurance premium fees.

One of the striking features of the current controversy over medical care for the aged has been the administration's insistence upon financing through social security. Even by so doing, its health insurance plans fall far short of meeting the well-known medical cost needs of those 65 and over. Only from 18 to 30 percent of the average medical costs of the elderly would be covered by the administration-endorsed Anderson-Javits plan.

This is woefully inadequate health insurance for our Nation's senior citizens.

Why then are the benefits not greater? The answer in part is that the costs would be too great and the social security taxes on wage earners and on employers

would have to be raised too sharply at one fell swoop.

Since this is the case, why does not the administration agrees to finance the costs of a comprehensive medical plan our of general revenues and spread the cost burden among a greater number of our citizens according to their ability to pay?

Why does the administration insist on social security financing even though it hurts the low wage earner the most?

I am advised that 53 percent of the wage earners in America earn less than $5,000 a year. They need every cent for day-to-day living expenses. Why does the administration insist on taking $27.50 from them every year to pay for health insurance for somebody else?

There is another consideration regarding social security financing that is most disturbing. There is grave doubt that the proposed increases of one-fourth of 1 percent on employee and one-fourth of 1 percent on employers, plus raising the amount of taxable wages from $4,800 to $5,200, will yield sufficient revenue to make the administration's medical care program actuarially sound. Is the health insurance trust fund to be in as bad shape as the other social security trust funds? The existing social security fund faces a deficit of $320 billion. This is more than our total national debt incurred mainly in three major wars.

General revenue financing, which is proposed in the Saltonstall plan, spreads the responsibility amoung all the people who are able to pay taxes, in proportion to their ability to pay. The social security approach is practically a sales tax approach. It taxes those at the lowest end of the wage scales—in other words, those least able to pay. Why should only the wage earners pay the cost of health insurance for the aged? If this is a national problem, and it is generally agreed it is, why should not all taxpayers bear the burden?

Social security financing of health insurance for the aged means wage earners under 65 years of age will pay the costs of a medical care program for persons over 65. Meantime, of course, the under-65 wage earner must also pay out of pocket for medical care for himself and his family. Then, when he reaches age 65, he will not receive one cent of his contributions to the health insurance fund unless he becomes ill and is hospitalized. At that, the benefits under the Anderson-Javits social security plan would pay only 18 to 30 percent of average medical costs of the aged. After paying all these years, the wage earner would discover that he would still have to pay 70 to 72 percent of his medical costs after age 65.

Costs under the Saltonstall plan range from an estimated $970 million total for the minimum benefits to $1.190 billion for the maximum, assuming 9 million persons of the 12 million eligible aged participate. Of the $970 million estimated total cost for the minimum benefits, the Federal share would be $420 million. The State share would be $455 million, and enrollment fees of individuals would produce $95 million. Of the $1.190 billion dollar total cost for the maximum benefits, the Federal share would be $520 million; the State share would be $550 million; and enrollment fees of individuals would produce $120 million.

Estimates of first-year costs of Anderson-Javits range from $1.5 to $2.4 billion, which would require increases in the social security taxes on both wage earners and employers. Individual wage earners would pay the tax and then as consumers along with other consumers would pay more for goods and services produced by employers. The social security tax on employers is a direct cost of doing business and would have to be passed on to consumers in higher prices.

Thus, one of the direct effects of the Anderson-Javits social security increase will be to raise prices of things Americans buy. It will also put American products at a greater competitive disadvantage with foreign producers.

In conclusion, among the advantages of the plan I am cosponsoring with Senator SALTONSTALL, I wish to stress the following:

First, it is voluntary.

Second, it is practical, for it builds upon progress already made by mutual and private insurance organizations.

Third, it is keyed to those of the aged who need financial assistance toward adequate health insurance.

Fourth, it does not put undue strain on the Federal Treasury because it provides for State sharing of the costs and for contributions from individuals.

Fifth, it avoids Federal interference with the practice of medicine. The States would set up their separate programs in accord with the wishes of their citizens and States would have primary supervision over the structure and administration of the program.

Sixth, it places the burden of the Federal cost on all American taxpayers—unlike the Anderson-Javits plan, which puts the burden of costs all on the wage earners and employers.

Seventh, it provides benefits suited to the special health needs of the aged: namely, home, outpatient, and nursing-home care. It recognizes that different individuals have different medical-care needs.

Eighth, it conforms to our traditional American way of caring for health problems. It avoids experimentation in a new approach which is untested and untried and which is fraught with potential dangers to our customary private doctor-patient relationship and to our entire medical and health system, which up to now has made very great progress in the battle against disease and illness.

It is risky to embark upon a program which might discourage young people from entering the medical profession, which demands so many years of study and training. We do not have sufficient numbers of doctors and nurses now, under our present system of nongovernment medicine. A compulsory medical-care system financed under social security might worsen the situation. Why should we take that risk; and, particularly, why take it when there is a better remedy at hand; namely, the measure proposed by the distinguished senior Senator from Massachusetts [Mr. SALTONSTALL].

Our hospitals are strained to capacity now. Why embark on a program which emphasizes hospital care, and which can only result in greater strain on our hospitals? Especially, why do it when there is a better remedy at hand?

Even the sponsors of the Anderson-Javits plan admit the benefits of their measure do not begin to meet the needs of our elderly people? They why embark on such an inadequate program, which falls so far short of these needs? Our plan is so far superior in terms of benefits to the Anderson-Javits plan that there is no comparison.

If the Anderson-Javits amendment is adopted, many, many elderly persons will be greatly shocked to learn how little of their total medical bills is covered. They will unquestionably have to protect themselves insurance-wise against major medical and surgical costs which are the bulk of the medical-care costs confronted by our aged.

We believe the Anderson-Javits bill is an inadequate bill. It is an experiment fraught with far-reaching and perhaps undesirable consequences for young and old alike.

As my able colleague from Massachusetts said a few moments ago, there is no dispute as to the need for helping our senior citizens obtain adequate protection against the high costs of illness at a time when their incomes may be limited. There is a need which remains unmet today. The dispute arises as to how best to meet that need.

We all recognize that one of the greatest fears of the elderly is that they will be stricken with a costly illness that may wipe out their savings, rendering them destitute and possibly impoverishing their children, as well. It is a matter of uppermost concern to our senior citizens who are not wealthy; and we must respond.

We are also aware of the amazing advances in medicine over the past two decades, which have served all our people of whatever age. Medical research expenditures have multiplied, producing new medicines and drugs which have saved many lives and conquered many diseases. New equipment has been developed to give finer care for those who are stricken. All these improvements have added to the cost of medical care, in hospitals and clinics and in all fields of medicine.

More and more people have sought protection against these rising costs through private insurance, and the benefits and the coverage of these insurance plans have been greatly liberalized, especially over the past 5 years.

Two years ago Congress recognized the high cost of medical care for our elderly by enacting the Kerr-Mills program to provide Federal and State financial assistance to those persons over 65 who are otherwise self-supporting, but cannot meet the costs of medical care. The somewhat stringent means test in that law, however, leaves a gap—a health-protection-for-the-aged gap.

Today we are trying to devise a method to close that gap. Sponsors and supporters of the Saltonstall voluntary health insurance plan, now before us, believe ours is preferable to the Social Security method of closing the health protection gap for senior citizens of America.

Our plan preserves the dignity and the rights of our senior citizens.

Our plan is not disruptive of our American medical system, which is the finest in the world.

Our plan is reasonable in cost, and spreads the cost burden more equitably.

I urge the Senate to adopt this amendment.

Mr. SALTONSTALL. Mr. President, I yield 15 minutes to the Senator from Vermont [Mr. PROUTY].

The PRESIDING OFFICER (Mr. HICKEY in the chair). The Senator from Vermont is recognized for 15 minutes.

Mr. PROUTY. Mr. President, there are now almost 17 million Americans over age 65. More than 44,000 of these citizens are in Vermont. Many of them find it difficult, if not impossible, to obtain adequate medical care, because of inability to pay for it.

As earnings from employment go down, or cease altogether, most persons 65 and over must get along on limited resources. It is sad to note that a very high portion of the aged have incomes which fall far below the threshold of adequacy.

On a nationwide basis, 52.7 percent of our older people receive less than $1,000 a year in cash income; 76.4 percent of our older people have a cash income under $2,000; and 86.4 percent have annual incomes of $3,000 or under.

The median income of aged persons in 1960 was $950. Only 11.8 percent of the men and 1.7 percent of the women received $5,000 or more.

It is one of the tragedies of life that when income is at its lowest level, the incidence of illness is at its highest. The percentage of persons with three or more chronic ailments is more than four times greater for the 65-and-over category than for those below 65. The number of bed disability days a person a year is nearly 100 percent higher for older people than for those for all other age groups.

Added to these unfortunate situations is the fact that the costs of medical care have risen sharply during the past decade. In truth, the percentage rise in the medical-care index was approximately twice that of the overall index.

We have here, then, a problem national in scope and importance. It requires a national solution. It is our responsibility to find one.

The essential question facing the Senate is whether the public interest and the interest of the aged will be better served by the existing law—the Kerr-Mills Act, which perhaps has not been on the statute books long enough to make it possible to determine its efficacy—the Anderson amendment, or the Saltonstall substitute, of which I am a cosponsor.

As each Senator must, I have to ask myself which will do the most for older persons in my State and which program is devised in the most sensible and equitable manner.

The Anderson amendment, because of built-in defects, would do little to provide care for our older citizens in Vermont. The amendment gives the appearance of offering benefits in the way of nursing-home-care services, but the appearance is a mirage. In order for a nursing home to be eligible under the amendment, it would have to be affiliated with a hospital. There are only two—at most three—nursing homes of this type in the entire State of Vermont. The Mary Fletcher Nursing Home has 43 beds, and the Bishop DeGoesbriand Home has 80 beds. Both of these are now operating at approximately 75 percent of capacity.

The Thompson House, which has a tie-in with the Brattleboro Memorial Hospital, has a capacity of 32 beds. It is full at the present time, and there is a waiting list.

The other 189 nursing homes in Vermont would not qualify, even though they provide excellent nursing-home care.

It is only fitting and proper now to ascertain within the limitations I have specified just how much nursing-home care the Anderson amendment would make available to senior citizens in Vermont. We have established the fact that there are only three eligible nursing homes in Vermont. We have also established the fact that the total capacity of the three eligible homes is 155. We have further established the fact that the Brattleboro Thompson House is 100 percent occupied, and that the two Burlington nursing homes have an occupancy rate of approximately 75 percent, or 93 out of 123 beds.

Thus, Mr. President, in the entire State of Vermont, which has 44,000 persons over the age of 65, there are waiting for occupancy only 30 nursing-home beds, and there are eligible for occupancy only 155.

I think it would be well to look at the experience our State government has had to date with nursing-home care. That experience makes it unmistakably clear that the Anderson amendment falls so short of the mark that it would almost be humorous, if human life were not at stake.

I said previously that we have 44,000 persons over the age of 65 in Vermont. Of these, 5,500 are already covered under a State-administered program of nursing-home care for recipients of old-age assistance. Assuming that the health needs of the 38,500 older persons not receiving old-age assistance are similar to those of retired people receiving this assistance, a potential of some 4,000 elderly Vermonters would immediately be eligible for nursing-home care under the Anderson amendment.

So, Mr. President, excluding our old-age-assistance cases, we have about 4,000 older Vermonters who should have nursing-home care now; and the Anderson amendment provides that they can have it at Government expense if they can get in the 155 eligible beds in Vermont or in the 30 eligible nursing-home beds not occupied.

I do not like to play games with the health and happiness of any person, and I think that the Anderson amendment does precisely this with respect to 16 million Americans over age 65. It simply gives them nursing-home care with one hand, and takes it away with the other.

Since the Anderson proposal will be of virtually no help to Vermont in regard to nursing-home care, it is only appropriate to inquire about what it would do in the way of making available hospital care.

We have in the State of Vermont 23 nonprofit general hospitals, with a total of 1,791 beds; and 1 privately operated general hospital, with 24 beds—or a grand total of 24 hospitals and 1,815 beds. In view of the fact that a hospital must, for all practical purposes, be accredited by the Joint Commission on the Accredition of Hospitals, under the terms of the Anderson amendment there would, therefore, automatically be excluded 9 of Vermont's 24 hospitals. So the elderly sick people in many of these communities could expect no help from the Anderson amendment if they went to their local hospital, because the amendment would not pay their institutional room and board bill.

Tragic to say, most of the nine ineligible hospitals are in relatively smaller communities to which elderly rural people look for their hospital services. It has been estimated that among the aged in Vermont, there will be some 2.5 percent hospital confinements a month, or roughly 963 a year. This figure does not include the hospital confinement of persons age 65 and over who are under old-age assistance.

The Anderson amendment would, on the one hand, encourage hospitalization; and, on the other, it would make ineligible for participation 9 out of 24 hospitals and 251 out of 1,815 hospital beds, many of which are in areas of greatest need.

I am not satisfied with this kind of program; and I am sure that thousands of Vermonters will not be, either, when they find that their Government policy is not good at their local hospital.

We have seen, then, Mr. President, that, according to the best data made available to me, only 3 of Vermont's 192 nursing homes would be eligible for participation in the Anderson program, and over one-third of Vermont's hospitals would be ineligible.

I am proud to say that under the Saltonstall amendment, of which I am a cosponsor, all nursing homes and hospitals licensed by the State would be able to help the thousands of elderly citizens of my State who want a good hospital-care program.

To turn to another point, one of my principal objections to the King-Anderson bill was its predominant reliance on inpatient hospital services, rather than on preventive care. Eighty percent of the long-term King-Anderson expenditures were dedicated to such inpatient hospital services. I am even more distressed by the Anderson-Javits amend-

ment, whereby almost 90 percent of its long-term benefit costs would be for hospital services. In the first year, almost 98 percent of the cost would be hospital benefits.

The Saltonstall substitute places the stress where it should be: on preventive care.

If the Federal Government is going to spend a great deal of money, I think it is important that it spend the money to help older people maintain health, instead of simply spending it to cure sickness.

The cooperative-type health plans have demonstrated beyond question that when plans undertake to provide preventive medical care, they succeed in cutting down tremendously hospital utilization. This is important because hospital costs have risen about three times as fast, in the past 30 years, as have medical costs generally; and it is patently clear that the best single way to reduce expenses for medical care is to keep people as healthy as possible and out of hospital beds.

It is very interesting to compare the results achieved by cooperative-type health plans that deal in both medical and hospital services with the results from voluntary plans that simply deal with hospital care.

The facts are absolutely astounding. In 1956, Blue Cross subscribers nationally used an average of 995 days of hospital care per 1,000 persons covered. In Michigan the figure was 1,100 days per 1,000 persons covered. However, members of Group Health Cooperative of Puget Sound used only 562 days of hospitalization per 1,000 members; and at the Group Health Association, of Washington, D.C., the figure was only 546 days. On the average, 10 of each 100 Blue Shield subscribers in New York City are hospitalized each year, compared to only 8 out of 100 subscribers to the direct-service Health Insurance Plan of Greater New York.

In view of these facts, I think it is highly unfortunate that the Anderson amendment places its emphasis on hospital care.

It should be noted, also, that the Saltonstall proposal takes cognizance—but the Anderson one does not—of the fact that the needs of elderly persons vary greatly, according to their health situation, their financial situation, and the availability of institutional facilities. It does this by providing a voluntary plan for medical care for the aged which contains three options, any one of which may be selected by the individual covered. The plan would benefit all persons 65 or over who are not on public assistance and whose income is no more than $3,000 per year, for a single person, or $4,500 per year, for a married couple. It is common knowledge that about 94 percent of persons age 65 and over have a total annual income of less than $5,000. It is within this group that real health-care problems are found. The Rockefellers would not be eligible under the Saltonstall proposal; and why should they be? They would, however, be entitled to help under the Anderson amendment.

Let us look at some of the preventive health services available under the Saltonstall amendment. Under the first option there will be required, as an absolute minimum, program payment for 12 home or office visits with a physician, the first $100 of ambulatory, diagnostic, or X-ray services, and up to 135 days of visiting nurse or other home health care. There is also, under the same option, a minimum hospital and nursing home program; but the first option in the entire Saltonstall approach is one with stress on preventive care, and that will prevent our running the risk of overutilization of hospital and other institutional facilities.

For the individual who is not concerned about the first few dollars of medical-care costs, but who needs to obtain protection against long and serious illness, there is a major medical expense program with a reasonable deductible. This second option provides for an absolute minimum of 120 days of hospitalization, up to a year of full nursing-home service, and all home health-care services. Provision is also made in this option for surgical services up to 80 percent of the cost incurred after the first $250. If the States found it desirable or appropriate, they could reduce the amount of the deductible as they might see fit.

There is still another option which takes into account the sentiments and need of those who wish to choose a private health insurance policy tailored to meet their requirements. Under the third option in the Saltonstall program, an individual could receive 50 percent of his premium expense for a private policy, but the Government contribution would not exceed $60 a year.

We have seen that when a plan does not include preventive health services, hospital utilization jumps tremendously. No one can deny that the Anderson plan will do this; and the most fantastic thing of all is that it will increase utilization at the same time that it makes ineligible great numbers of nursing homes and hospitals.

In contrast, the Saltonstall proposal will take advantage of all hospital and nursing-home facilities recognized as adequate by State law, and will guard against overuse of these facilities, by helping people to stay healthy, rather than by simply curing, their sickness.

Of all the health-care proposals, the Saltonstall measure offers the wisest approach to the health needs of persons over age 65. It builds upon the foundation already laid by nonprofit and commercial insurance organizations. It allows each individual to select the option most in keeping with his own needs. It does not interfere, as the Anderson amendment does, with the standards that have been set by the States for their hospital and nursing homes. It requires cooperation between the Federal Government and the States, and only token contributions from policyholders.

Last of all—although this is one of the most important points of all—it will be financed in the soundest and most equitable manner—out of general revenues which are derived from taxpayers according to their ability to pay.

The medical-care program under the Anderson amendment would accelerate a dangerous trend which is placing a disproportionate tax burden on younger workers and is making more tenuous the relationship of tax contributions to benefits received.

Although few persons stop to think about it, the tax which would support the Anderson program would be steeply regressive. The heaviest tax burden would be placed on those least able to bear it.

In addition, it is inequitable and economically unsound to finance this program, which is national in scope and concern, from a regressive tax imposed only upon a limited segment of the economy—its working men and women.

Within recent years there has been a trend of liberalization of the old-age survivors and disability insurance system which will have the effect of greatly increasing the ratio of taxes paid to benefits received for our younger workers. The Anderson medical-care plan would not only continue this trend, but would aggravate it.

An actuarial study released by the Social Security Administration has estimated that workers over age 20 in 1958—the present members of the system—and their employers will pay, as a class, only about 42 percent—21 percent each—of the value of their benefits. On the other hand, workers who were under age 20—the so-called new entrants—and their employers will pay 169 percent—84.5 percent each—of the value of their benefits. The disparity would be much more marked, of course, if aged workers were compared to the new entrant class. Moreover, these figures do not reflect the liberalizations enacted by the 1958 and 1960 social security amendments.

It should be clearly understood that under the Anderson plan there would be no relationship between the individual's tax payment and the medical benefits he would receive or between his former earning capacity and the benefits he would receive. Moreover, there would be no relationship between the medical benefits received and the individual's need for them. A man could receive full benefits under the Anderson medical program even though he was independently wealthy, and even though he was continuing to work and to earn at his normal rate.

An increase in the regressive social security tax would place an even heavier burden on the low-income family. Such a method of taxation may be justifiable when there is a direct relationship between tax contributions and benefits payable; but it is inappropriate, and often inequitable, when applied to a benefit scheme, such as that presented in the Anderson program.

The Tax Foundation has recently concluded a study, the purpose of which was to determine the relative tax burden borne by families in various income classes. The results confirm what already was obvious: The taxes levied to support social insurance programs are the most regressive class of taxes presently imposed by the Federal, State, or local governments.

In 1958, every family with an income under $2,000 paid over 6 percent of that income to support the Federal Government's "social insurance" programs—principally social security. This is more than twice the rate paid by families with incomes between $8,000 and $10,000, and five times the rate paid by families with incomes of $15,000 or more. A table, prepared by the Tax Foundation, illustrates graphically that these social insurance taxes are far more regressive than the much maligned sales and excise taxes levied by the Federal and State and local governments.

These facts cannot be answered by the assertion that the absolute size of social insurance taxes is small. In 1958 the Federal social insurance levies accounted for almost 40 percent of the total tax burden on families with incomes under $2,000, and more than 20 percent of all the taxes, State, Federal and local, which such families paid. Moreover, the social insurance levies have the effect of unbalancing the whole tax burden, with much higher rates for those with incomes in excess of $15,000. However, the social insurance taxes tipped the scales so that families with incomes of less than $2,000 paid a higher total rate of taxes than that paid by any other class of families, except those with incomes of $15,000 or more.

Furthermore, the number of persons affected is large. In 1957, more than 12 million families and unattached individuals had incomes of $2,000 or less. Three-fourths of those were under age 65.

Moreover, I am not at all sure that all of the American people—including those who are in favor of the new medical-care program—are aware of the tax increases scheduled in the social security law which are necessary to finance the program we already have. We should keep in mind the fact that we are already committed to a 50 percent increase in the social security payroll taxes by 1969, even if we make no further liberalizations. If the Anderson proposal were accepted by Congress, the ultimate tax rate in 1969 would be nearly double the present rate. Right now, an employee making $2,000 a year pays a social security tax of $60. By 1969, he will be paying $90, even if there are no liberalizations. If the Anderson bill became law, that worker would probably be paying close to $110.

On the basis of the facts I have already given, it seems to me that the social security method of financing medical care for the aged would be both inequitable and economically unsound, and cannot be justified on the basis of a return commensurate with the burden.

We have a social security system because there is a great need for it. As a class, the aged have found it difficult or impossible to provide for their security in old age. The object of the social security system is to replace some of the wages lost because of old age, disability, or death. The object is to provide income maintenance for a group which otherwise would have insufficient income to assure a decent and dignified existence. However, the problem of low income is not restricted to persons over 65. Indeed, as I have mentioned, in 1957 about three-fourths of the families and unattached persons with incomes under $2,000 were composed of younger workers and their families. Under the existing financing arrangement, these younger workers with low incomes are the ones who must bear the heaviest social security tax burden. What sense or equity is there in increasing this burden? What sense does it make to take from one low-income group and give to another? I can see none. These younger workers with low incomes not only bear a disproportionate part of the burden of supporting the aged, but they must also find somewhere the resources with which to feed, clothe, and house their families. Moreover, they must educate their children, of whom there are several million. This must be done from income, which, according to the Bureau of Labor Statistics, would not be sufficient by half to maintain a family of four on an adequate standard of living.

Even if social security financing were not regressive, it would still be objectionable as a means of financing medical care for the aged, because it is imposed only on workers and their employers. Assuring adequate medical care for the aged is an obligation which ought to rest on the whole economy, not just on the workers.

At the present time, the issues of underemployment and national growth are much before the public. I think we should not blind ourselves to the possible adverse effects of steadily increasing social security taxes. When social security was inaugurated, the idea was to provide a basic "floor" of protection. Taxes were to be small, so that the individual would be able to retain at least a part of his freedom to save and invest as he saw fit. If the President's medical care and other proposals are accepted, we shall be heading toward a level equal to about 10 percent of the present taxable payroll, if not more.

A further question is whether steeply increasing social security taxes on employers, who pay about half of the cost, would constitute a barrier to the employment of additional workers. It is worth noting that in Great Britain, a tax similar in effect is levied, with the avowed purpose of discouraging the use of labor manpower. At the present time we are looking for ways to find more jobs, not fewer jobs. But even if we were not now experiencing what is called a recession, we should realize that social security tax rates are intended to be permanent, and that the future may hold similar fluctuations in business activity.

Our society has progressed to the point where we can no longer tolerate a lack of adequate medical care for the senior citizen. We can, and must, find a way to make up for this lack. Likewise, there are in our population other groups who have not had an equal share in the products of our affluent society. Our obligation to these other groups is no less than our obligation to the retired workers.

Even if the Anderson medical-care plan would solve the medical problems of the aged, it would do so at the cost of heaping even heavier burdens on other groups who are in no better economic straits than are the aged. The largest single source of general revenue is the progressive tax on personal income. The progressive income tax places the heaviest burdens on those best able to bear them. It excuses from paying income taxes many of the families with incomes under $2,000 per year, because it is recognized that to reduce their disposable income would be to reduce their ability to purchase the necessities of life. It seems to me that any Federal medical program for the relief of the aged must be financed out of Federal general revenue. Otherwise, we would be creating as many inequities as the ones we would eliminate.

The defenders of a payroll-tax method of financing medical care argue that even with its regressive features, it would be preferable to the general-revenue approach, because it would make the people cost-conscious. I maintain that the effect would be the opposite. The people and the Congress are being misled by talk of prepaid medical insurance and contributions. We have been conditioned to ignore the regressive characteristics, by talk of benefits earned or related in some manner to contributions. It is time that we wake up to the fact that expenditures for a medical-care program under social security would be no different from Government expenditures for any other welfare program, and that they should be evaluated in the same way.

In summary, then, Mr. President, I believe the Saltonstall amendment is far superior to the Anderson program.

The Saltonstall amendment builds upon the progress made by commercial and nonprofit insurers. The Anderson amendment makes only an empty gesture in this direction.

The Saltonstall amendment allows the individual to choose what is best for him from among three options. The Anderson proposal offers basically only one package.

The Saltonstall amendment emphasizes the maintenance of health, as well as the curing of illness; but the Anderson amendment touches only the latter, and does so in an ineffective manner.

The Saltonstall amendment would make full use of the wonderful hospitals and nursing homes we have throughout the country. The Anderson amendment would impose arbitrary standards, and in some States, such as Vermont, would declare ineligible for participation virtually every nursing home in a State.

Last of all, the Saltonstall amendment recognizes the great contributions which our senior citizens have made to this country, and imposes upon all taxpayers, according to their ability to pay, the obligation to provide decent health services. The Anderson amendment keeps the heaviest financial burden upon the low-income and middle-income workers, and lets off virtually scot free the millionaire and multimillionaire class.

For these reasons, I give my wholehearted support to the Saltonstall amendment, which is preferable in almost every way to the Anderson program.

Mr. SALTONSTALL. Mr. President, the Senator from Pennsylvania is on his way to the Chamber and will speak briefly on my side of this question.

If the Senator from New Mexico would like to speak at this time, it may be convenient for him to do so.

Mr. ANDERSON. Mr. President, I shall make a few remarks at this time.

One of the first things to which I want to invite attention to is the statement made by the Senator from Hawaii [Mr. FONG], which I find on page 13 of his prepared text:

> The existing social security fund faces a deficit of $320 billion.

I wish to deal with that question, because I think it would be too bad if over the country there should be that impression when people are paying into the social security fund and wondering if their money is reasonably well managed.

The question has has arisen, Is the social security system sound?

The answer is, "Yes." There are $20 billion in the old age and survivors insurance fund, and $2 billion in the disability fund. The OASI fund is expected to increase very sharply, reaching $79 billion in the year 1980. Under the long-range estimates, it is estimated that by the year 2000 the fund will reach $137 billion.

Social security financing is scrutinized by the Congress and checked by the executive branch of the Government.

The most recent advisory council on social security financing made a review of this question in 1959. It was composed of distinguished economists, private insurance actuaries, bankers, financial counselors and representatives of insurance and labor.

The finding in 1959 was that the "present method of financing the old-age, survivors, and disability insurance program is sound." and "based on the best available cost estimates, that the contribution schedule enacted into law in the last session of Congress makes adequate provisions for financing the program on a sound actuarial basis."

That report was submitted by a very fine group of persons.

In addition, I wish to quote a very interesting comment by Mr. R. A. Hohaus, senior vice president and chief actuary of the Metropolitan Life Insurance Co. He said:

> This financing method has proven sound because Government has been alert to the need for constant vigilance, due to the very nature of social insurance itself and the dynamic character of our society and our economy.

The reports I have given the Senate were interesting, but the Committee on Finance of the Senate, in its report on the social security amendments of 1961, also had some comment on it. By the way, that is Report No. 425, 87th Congress, 1st session:

> It can reasonably be presumed that a social insurance system under Government auspices will continue indefinitely into the future. The test of financial soundness is not then a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather the test is whether the expected future income from taxes and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs. The concept of "unfunded accrued liability" does not have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group.

Finally it said:

> The intent that the system be self-supporting (or actuarially sound) can be expressed in law by a contribution schedule that, according to the intermediate cost estimate, results in the system being substantially in balance.

That was signed by a very interesting group of members of the Finance Committee. I submit that their judgment was pretty good.

Mr. President, the distinguished and able Senator from Massachusetts and his colleagues have offered a proposal aimed at the solution of a problem that deeply concerns us all—the problem of the high health care costs of the aged. Under the Senator's proposal the Federal Government would share in the costs of State programs designed to furnish health benefits to aged persons of limited income. The aged person would pay an enrollment fee related to his income and would have a choice of long-term or short-term benefits under a State plan or payment toward an approved health insurance policy.

I respect the sincere concern of the Senator from Massachusetts about the problems aged persons face in paying for needed health care. But I believe Senators should consider carefully whether enacting a program such as that proposed by the Senator would be a realistic solution of the problem. We have on the statute books now the medical assistance legislation of 1960 which bears many similarities to the Senator's proposal. It is, as we know, a generous law. It authorizes the States to establish programs of medical assistance for the aged which could, if the States so desired, provide practically all of the benefits that would be provided under the Senator's proposal. Under this 1960 legislation, the income test that an aged person must meet in order to be eligible for health benefits could be every bit as liberal as in the Senator's proposal.

But Senators know what has happened under this legislation. Only about half of the States have taken the opportunity to establish new programs of medical assistance for the aged, and most of those which have programs in effect sharply restrict the scope of benefits provided. Only three States have plans in operation which meet the Department of Health, Education, and Welfare's definition of a comprehensive medical care program. Moreover, most of the income tests under State medical assistance programs severely limit the number of aged persons who can participate. In some instances the income limits tend to be more rigid than the tests for old-age assistance. Moreover, almost 90 percent of all medical assistance for the aged payments are made in four of the wealthiest States.

The experience under the medical assistance legislation demonstrates, I believe, that a proposal such as the Senator's is inadequate as the primary means of financing costs of health care for the aged. The simple fact is that many States simply do not have available to them the funds required to set up adequate medical assistance programs. They are unable to do so even under existing law where the Federal Government pays 50 to 80 percent of the costs. How then could they be expected to set up still another program such as the Senator proposes under which the Federal share would be only 33⅓ to 66⅔ percent?

I emphasize that I do not oppose the Kerr-Mills legislation. I supported it in committee. I supported it on the floor of the Senate. The Federal-State programs employing income tests or means tests are needed and will be with us for many years. But I believe that basic health insurance for the aged should be furnished through the social security system.

Many persons have said that my amendment is compulsory. All taxes are compulsory, whether people pay income taxes or into the social security system. It is said that financing through general revenues will be easier on the working classes. If the funds come from the general revenues, they would be taken from income taxes, where there is a sliding scale. The people know that, and they still want health insurance under social security in order that they may have these benefits as a matter of right. No amount of talking will persuade them otherwise.

The coverage of physicians' services has been a hot issue in many parts of the world, particularly in Canada at the present time, and it is left out of the Anderson amendment. It is a pretty warm issue. I do not believe the Senate wants to deal with it now. The same benefits provided under the Saltonstall proposal can be provided under the medical assistance for the aged program, and the Federal Government will pay 50 to 80 percent. Why should a State go to this new program when it gets 50 to 80 percent under present law and would get only 33⅓ to 66⅔ under the Senator's proposal?

The Gallup polls have been mentioned. It is an interesting subject.

The results of three Gallup polls dealing with the public's attitude toward financing the health care of the aged have been published since June 1961. In the first poll, respondents were asked if they would favor or oppose a social security tax increase to pay for old-age medical insurance. The results showed 77 percent favored this kind of measure and 26 percent were opposed.

In April and again in June of this year the public's attitude on the subject was surveyed again, but the question was posed in an altogether different manner. The respondents were told that two different "plans" were being discussed in Washington for meeting hospital costs for older persons and then they were asked to express a preference between the two. "One plan," it was stated,

"would let each individual decide whether to join Blue Cross or buy some form of voluntary health insurance. The other plan would cover persons on social security and would be paid by increasing the social security tax deducted from pay checks." It is impossible for anyone to determine what this first "voluntary plan" means. Of course, right now aged people can join Blue Cross or buy private insurance, but few can afford the high cost of adequate insurance. But since it was described as a "plan," it suggests that something new will be offered, and since there is no mention of financing, many respondents no doubt jumped to the conclusion that some miraculous health insurance plan had been developed that the elderly could afford without help from Government or increased taxes.

Considering the two alternatives, it is indeed remarkable that such a high proportion voted for social security. In the April and June surveys, 55 and 48 percent, respectively, voted for the social security plan as opposed to 34 and 41 percent, respectively, for the voluntary plan. But since the first alternative was so vague, the results of the two surveys cannot be said to indicate any trend, so far as I can see.

Much of the appeal which the social security program has for Americans is attributable to the fact that benefits are paid regardless of savings, pensions, investments and the like. The success of the program in preventing dependency among the older people, the disabled, and the survivors of deceased workers, is attributable to the fact that the benefits are payable without regard to any other resources that people may have. This approach enables people to supplement their basic protection afforded by the social security program with benefits under employer pension plans and whatever additional protection they can afford. It encourages them to save and to plan for their old age, so that they can expect to live their remaining years with dignity and self-respect.

I could go on at length on this question. I do not intend to do so. I only say that the program being considered is one which we have considered in the past and which has been rejected. I am sure it was rejected with sound judgment on the part of the Senate. I hope it will be rejected again.

Mr. SALTONSTALL. Mr. President, I yield 10 minutes to the Senator from Pennsylvania [Mr. SCOTT].

The PRESIDING OFFICER. The Senator from Pennsylvania [Mr. SCOTT] is recognized for 10 minutes.

Mr. SCOTT. Mr. President, the mythological Procrustes was a tidy man. Believing that his overnight guests should fit exactly into the spare bed in the guestroom, he took it upon himself to tailor the guest accordingly.

Those too short were stretched upon the rack until they were long enough. Those too tall were shortened through the simple expedient of amputating an appropriate length of the offending legs.

Uniformity was thus achieved—not enjoyably for the guest, perhaps. But Procrustes felt that the big thing in life was to find simple solutions.

I have heard the arguments which have accompanied the introduction of the Anderson and subsequent amendments, from which I have been able to draw two general conclusions:

First, every Senator believes—as I do—that the problem besetting our elder citizens of how to finance the cost of their health care, needs to be solved. We differ in terms of the means we should adopt—not the ends we are seeking.

Second, we drift easily into the error of considering the aged as an homogeneous group, all with just the same sort of problems. Upon consideration, I think we all realize that this is not true: that our older population has not a uniform need for help either in terms of health care or the means with which to pay for it.

Bearing this in mind, let us beware of Procrustean solutions.

Yet, are not the ANDERSON amendments Procrustean in their approach? I suggest that they are, Mr. President. The able junior Senator from New Mexico proceeds from the mistaken premise that the very fact of having attained an arbitrary age is proof of universal need. He argues that his own proposed package of benefits is suited to the uniform health requirements of better than 17 million people. He suggests that one master plan—a Federal plan—offers the best solution.

I ask my friend if his proposal does not share some of the drawbacks inherent in Procrustes' solution?

The problem of financing adequate health care has concerned me for many years, Mr. President. In fact, I sponsored a National Health Act as an alternative to the Ewing health plan when I was a Member of the House of Representatives. It may interest the Senators to know that this proposal was backed by the senior Senator from New York [Mr. JAVITS] and cosponsored by the Senator from New Jersey [Mr. CASE] and the Senator from Kentucky [Mr. MORTON] who were also Members of the House in 1949; and by former Vice President Nixon, then a House Member.

Our measure rested upon the common conviction that Federal and State resources were required; that membership should be made available in voluntary prepayment plans for everyone, regardless of age or financial condition; and that the beneficiary's income should determine the degree to which Government funds would be used in meeting premium costs. Even then, we believed that the benefits to be provided should be broader than institutional care, flexible enough to fit the individual's particular requirements, and extensive enough to cushion those covered against the shock of catastrophic illness.

It seems to me that these criteria are still valid and should be invoked in our search for the means whereby we can best help the aged meet the costs of their health care.

It is for this reason that I support the Saltonstall amendments.

As the Senators know, the amendments offer three options.

First, there is the basic option—a first dollar program covering up to 21 days of inpatient hospital services in any one enrollment year; an alternative of skilled nursing home services up to 63 days; 12 home or office visits by a physician; the first $100 of ambulatory diagnostic laboratory and X-ray services; 24 days of organized home health care services; and any additional health or medical services an individual State might elect to provide.

Second, there is an option designed to protect the person whose circumstances are such that first-dollar coverage is of less importance.

Under this phase of the amendments, the individual may elect to subscribe to a plan covering the major portion of a long-term or catastrophic illness. The beneficiary would pay 20 percent of the cost after a deductible of $175 for a single person, or $300 for a couple. In return he would be eligible to receive 120 days of inpatient hospital care; inpatient surgical costs; skilled nursing home services; and any of a number of other services elected by the individual State.

The third option provides that a covered individual over 65 who does not enroll in a State-administered medical plan could receive half of his premium expenses for a private health insurance policy approved by the State, this amount not to exceed $60 a year.

Instead of flatly assuming that every person over 65 is medically indigent, the Saltonstall amendments base eligibility on a realistic but generous income qualification—$3,000 a year or less for an unmarried person, $4,500 a year for a couple.

Instead of imposing a regressive tax on those least able to pay for it—the young, productive worker of modest means—the amendments propose to meet the program's cost through general revenues.

Instead of offering a rigid package of benefits, the amendments provide flexibility in every direction.

Instead of using the insurance companies as disbursing agents, the amendments include an option under which the insurance company would act as the insurer.

Instead of orienting health care to institutions—medically unsound to begin with and certain to cause overuse and wasteful abuse—the Saltonstall amendments contain the necessary alternatives to institutional care.

Instead of federally regulated health care, the amendments would allow the individual States to tailor their programs to fit the problem.

Instead of thrusting aside the Kerr-Mills law as a failure, the amendments would change and supplement the general health laws and give Kerr-Mills a chance to prove it will work if given a fair trial. Presently, some States have been sabotaging the administration of the Kerr-Mills Act, to advance the political push behind the King-Anderson bill.

Further, Mr. President, the Saltonstall amendments do not propose a revolutionary, irreversible plan susceptible to mushroom growth and bureaucratic waste. Not only do they meet the test of fiscal responsibility, but also they would preserve for the States their traditional right to care for their own in

the way their experience has proved best.

In summation, I ask the Senators to consider whether or not a more flexible program of benefits could be made available, or whether any other measure seeking to provide health care for the aged includes—as this amendment does—an emphasis on preventive care.

I urge that the Members of this body support the Saltonstall amendments for the reasons I have given and for the reasons advanced by the sponsor of the amendment.

Let us, Mr. President, tailor our legislation to fit the needs of the aged. Let us not, in haste or under the pressures of political expediency, fall into the Procrustesan error of distorting the problems of the aged to fit the rigid confines of the administration proposal.

I am for medical care for those who need it. I prefer to support a genuine bill which provides for medical as well as hospital care. The amendments are geared to meet the actual needs of those over 65 years and will not result in a system which heavily taxes all, regardless of need, for hospital services administered less ably and competently than they presently are, by indifferent Government employees, with no personal interest in the problems of the patients.

Mr. President, I yield back the remainder of my time.

Mr. SALTONSTALL. Mr. President, I yield 5 minutes to the Senator from New York [Mr. JAVITS].

The PRESIDING OFFICER. The Senator from New York [Mr. JAVITS] is recognized for 5 minutes.

Mr. JAVITS. Mr. President, it is not often that a Senator takes the floor when amendments are offered, as the amendments are offered, which were his own creation, and finds himself in a different position from the one he was in when the proposal was first developed, as this was, in August of 1961.

I am very grateful to my colleagues for the delicacy with which they have treated me in this connection. I also wish to say to my colleague from Massachusetts especially, and to others who have joined him in this proposal as a substitute, that they have helped to bring us to the pass in which we are now.

They have helped to make a major advance in respect to the proposal which I hope will become a statute on the books. For example, had I not had the necessary support for extending any health care idea to all persons over 65, whether or not on social security, which was represented by the overwhelming vote on the Republican side of the aisle in 1960, I do not believe that, with the best will in the world, the Senator from New Mexico [Mr. ANDERSON] could have swung his legions over to that idea. So already something has been accomplished.

I believe also that the opening of the door in respect of some option to admit the private enterprise system can be very heavily attributable to the kind of solid support which that measure has had on this side of the aisle. So I think that no matter what has happened, a real contribution has been made.

We ought to consider the points with respect to which we are together. First, we are together on the fact that we want universal coverage. That is being accomplished. Everyone now agrees to that.

Second, we are together on the fact that we want a trust fund. That is being accomplished. Everyone agrees.

Third, we are together on State administration. Everyone agrees to that now.

Fourth, we are together on the question of opening the program to private enterprise to some extent, which we all agree upon. Such a provision will be incorporated in whatever plan may prevail.

Where we have parted company is essentially in the method of financing and in the income test. As to an income test, it represents a compromise with the existence of the Kerr-Mills Act. The Kerr-Mills Act is the fundamental income test measure. I therefore believe it would be incompatible now to have a health plan of any kind, whether it was the measure of the distinguished Senator from Massachusetts [Mr. SALTONSTALL], the measure of the distinguished Senator from New Mexico [Mr. ANDERSON] and myself, or anyone else's, which is constructed on yet another income test.

We have one income test, which is pretty much at the discretion of the States, as the Senator from New Mexico has said. Therefore, I think whatever we now do must be relieved of the idea of an income test. We have been through that subject. We must now be thinking of some other kind of health care legislation. The most critical element is the method of financing.

That point brings me to the only reason I have taken the floor. I am most regrettably compelled to vote against the Saltonstall substitute. I appreciate the many fine arguments made in support of the amendment. Some I have had the privilege of acknowledging myself. I shall be compelled to vote against the amendment for the fundamental reason that I am convinced by the lapse of time that the people who will be paying the bill under the social security tax really want to pay it. That is a fundamental point which I think my colleagues must understand as to my thinking.

I am intellectually convinced with the sixth sense of a politician—I have no proof, no Gallup poll—that people want to pay the tax. They want the dignity and substantiality which payment of the tax would bring for them in the future.

Under those circumstances I think we cannot help but say, "All right; if that is it, then let it be pay as you go."

No matter how we slice the general revenue approach it would take a considerable amount out of the Federal Treasury, whether the plan might be the plan of the Senator from Massachusetts [Mr. SALTONSTALL], which has a minimum price tag of roughly $500 million, or my plan of 1960, which had a minimum price tag of roughly $600 million or $650 million. Those amounts would come out of the general Federal Treasury.

I am convinced that citizens want to pay the tax. I think we ought to let them pay it, especially as the plan would be protected by the options and other provisions which would prevent the plan from becoming a bureaucratic monstrosity.

Finally I say to my dear friends and colleagues that I am convinced that no other measure would pass. There is not a chance that one could pass.

We hear remarks about there not being any chance of the measure becoming law because of the action of the other body. We can worry about that point if we can get the measure through the Senate. We know that if we did not have a social security plan, we would not have the support of the administration. We would not have the support of the powerful voting bloc on the other side of the aisle.

In August of 1960 it was demonstrated that we could not do without that support. We would then have nothing. That is the point at which every Senator, in his own heart and conscience, must make his decision. We can either vote for the best thing we want to vote for and then walk away from the situation and say, "I have done the best I can and that is as far as I can go," or we can bow our heads slightly, which is what I am doing in order to get what I think is the best chance for a law. Representing 17 million people in the State of New York, I believe in good conscience that it is my duty to modify somewhat my views, which I hold sincerely and deeply, to seek a law to provide medical care for people over the age of 65.

Whatever may be the decision of other Senators, which I respect and honor, it is not enough for me to say, "I voted for the best plan I could."

I am sorry if it cannot be done that way. It cannot be done. That is not the prescription for me. In my opinion, the aged need medical care under some system, and the proposed measure is the only way I can see that squares with my conscience to secure the passage of a law on the subject.

Finally, I point out that the proposal is in a pretty good Republican tradition. As I recall, none other than Senator Taft himself came to the same conclusion with respect to Federal aid to education after going through much the same process I have gone through in the past couple of years.

Though Senator Taft has been hailed as "Mr. Republican" with the belief that such a title represents a conservative point of view, I hail him as Senator Taft who had enough courage and wisdom to change his views when it was necessary to achieve a great national objective, which is what I have to do in the present case.

I honor my colleagues, and appreciate greatly the time yielded to me by the Senator from Massachusetts.

Mr. SALTONSTALL. Mr. President, I yield myself 2 minutes in order to summarize.

My substitute amendment for the Anderson amendment would provide a voluntary program rather than one based upon the compulsory social security financing. It would involve Federal-State matching funds and State administration. It would offer benefits to meet more specific needs than what the Anderson substitute provides for an aged participant. It would require some participation on the part of the individual participating in the program.

One point that appeals to me especially is that the plan would provide for appropriations, and would not be based upon social security. Therefore, the Congress could exercise more control over it, since Congress would have the measure before it each year to determine what it should do and how it should carry on. That is highly essential.

Essentially, our substitute amendment would provide greater benefits than the Kerr-Mills plan, which is already law. I believe it would modify the Kerr-Mills bill in helpful ways. I hope that the amendment may be substituted.

Mr. President, I am prepared to yield back the remainder of my time if the Senator from New Mexico is likewise prepared to yield back the remainder of his time.

Mr. ANDERSON. Mr. President, if a quorum call can be arranged, I will yield back the remainder of my time.

Mr. SALTONSTALL. Mr. President, I yield back the remainder of my time.

Mr. ANDERSON. I yield back the remainder of my time.

The PRESIDING OFFICER. All time is yielded back.

Mr. MANSFIELD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The question is on agreeing to the amendments of the Senator from Massachusetts [Mr. SALTONSTALL] in the nature of a substitute for the amendments of the Senator from New Mexico [Mr. ANDERSON]. The yeas and nays have been ordered, and the clerk will call the roll.

The legislative clerk called the roll.

Mr. HUMPHREY. I announce that the Senator from New Mexico [Mr. CHAVEZ], the Senator from Idaho [Mr. CHURCH], the Senator from Mississippi [Mr. EASTLAND], the Senator from Arizona [Mr. HAYDEN], the Senator from Ohio [Mr. LAUSCHE], the Senator from Washington [Mr. MAGNUSON], the Senator from Arkansas [Mr. MCCLELLAN], the Senator from Florida [Mr. SMATHERS], the Senator from Ohio [Mr. YOUNG], and the Senator from Alabama [Mr. SPARKMAN] are absent on official business.

I further announce that the Senator from Arkansas [Mr. FULBRIGHT] is necessarily absent.

I further announce that, if present and voting, the Senator from New Mexico [Mr. CHAVEZ], the Senator from Idaho [Mr. CHURCH], the Senator from Washington [Mr. MAGNUSON], and the Senator from Ohio [Mr. YOUNG] would each vote "nay."

Mr. KUCHEL. I announce that the Senator from Utah [Mr. BENNETT] and the Senator from Kansas [Mr. PEARSON] are necessarily absent.

The Senator from Texas [Mr. TOWER] is absent on official business.

The Senator from South Dakota [Mr. BOTTUM] is detained on official business, and his pair has been previously announced.

If present and voting, the Senator from Utah [Mr. BENNETT] would vote "yea."

Mr. KEATING (after having voted in the negative). On this vote I have a pair with the distinguished Senator from South Dakota [Mr. BOTTUM]. If he were present and voting, he would vote "yea." If I were at liberty to vote, I would vote "nay." Therefore I withhold my vote.

The result was announced—yeas 34, nays 50, as follows:

[No. 118 Leg.]

YEAS—34

Aiken	Ervin	Murphy
Allott	Fong	Prouty
Beall	Goldwater	Robertson
Boggs	Hickenlooper	Saltonstall
Bush	Hill	Scott
Butler	Hruska	Smith, Maine
Capehart	Jordan	Thurmond
Carlson	Kerr	Wiley
Cotton	Long, La.	Williams, Del.
Curtis	Miller	Young, N. Dak.
Dirksen	Morton	
Dworshak	Mundt	

NAYS—50

Anderson	Hart	Monroney
Bartlett	Hartke	Morse
Bible	Hickey	Moss
Burdick	Holland	Muskie
Byrd, Va.	Humphrey	Neuberger
Byrd, W. Va.	Jackson	Pastore
Cannon	Javits	Pell
Carroll	Johnston	Proxmire
Case	Kefauver	Randolph
Clark	Kuchel	Russell
Cooper	Long, Mo.	Smith, Mass.
Dodd	Long, Hawaii	Stennis
Douglas	Mansfield	Symington
Ellender	McCarthy	Talmadge
Engle	McGee	Williams, N.J.
Gore	McNamara	Yarborough
Gruening	Metcalf	

NOT VOTING—16

Bennett	Hayden	Smathers
Bottum	Keating	Sparkman
Chavez	Lausche	Tower
Church	Magnuson	Young, Ohio
Eastland	McClellan	
Fulbright	Pearson	

So the amendments of Mr. SALTONSTALL and other Senators, in the nature of a substitute for the Anderson amendments, were rejected.

Mr. MANSFIELD. Mr. President, I move that the Senate reconsider the vote by which the amendments were rejected.

Mr. ANDERSON. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. BUSH. Mr. President, will the Senator from Montana yield, so that I may offer my amendment?

Mr. MANSFIELD. I yield.

Mr. BUSH. Mr. President, I offer my amendment identified as "7-9-62—O," and ask that it be stated.

The legislative clerk read as follows:

On page 1, line 4, of the bill strike out "Public Welfare Amendments of 1962" and insert in lieu thereof "Public Welfare and Health Insurance Amendments of 1962".

On page 100, line 16, of the bill strike out "II" and insert in lieu thereof "III".

On page 100, line 18, of the bill strike out "201" and insert in lieu thereof "301".

On page 100, line 23, of the bill strike out "202" and insert in lieu thereof "302".

On page 100, between lines 15 and 16, of the bill insert the following:

"TITLE II—HEALTH INSURANCE PROTECTION SUPPLEMENT

"Short title

"SEC. 201. This title may be cited as the 'Health Insurance Protection Supplement Act of 1962'.

"Findings and declaration of purpose

"SEC. 202. (a) The Congress hereby finds and declares that (1) the heavy costs of health care in some cases threaten the financial security of aged individuals who are beneficiaries of the insurance system established by title II of the Social Security Act, (2) while an increasing percentage of such individuals can and do qualify and pay for voluntary health care insurance, others cannot afford much insurance, (3) many of such individuals are, accordingly, forced to apply for private or public aid, thereby aggravating the financial difficulties of private and public welfare agencies and the burdens on the general revenues, (4) voluntary health care insurance in its many forms has exhibited an ever-increasing ability to meet the health care needs of those elderly individuals who can afford to pay the premiums therefor, (5) both voluntary health care insurance and the voluntary system of providing health care in the United States should be encouraged and not crippled, (6) Federal and State revenues from income and premium taxes on carriers of such insurance and on the providers of health care should be supported and not diminished, and (7) it is in the interest of the general welfare that financial burdens resulting from health care services required by elderly individuals who are beneficiaries of the insurance system established by title II of the Social Security Act be met by channeling any Federal funds through voluntary mechanisms, leaving to State and local programs (such as the medical assistance for the aged programs established pursuant to title I of the Social Security Act) the responsibility of providing otherwise unmet needs for health care services on the part of individuals not covered by such insurance system.

"(b) Therefore it is the purpose of this title to provide to elderly recipients of benefits under title II of the Social Security Act an additional cash benefit of up to $9 per month for the sole purpose of reimbursing them for expenses incurred by them in paying the premium costs of such voluntary health care insurance as they may desire to subscribe to; to preserve State regulation of insurance as provided by the so-called McCarran Act (Public Law 15, Seventy-ninth Congress, approved March 9, 1945) by properly leaving to the States the control of health care insurance contracts the payment of the premiums of which are reimbursable under the provisions of this title; and to encourage the continued phenomenal development of the unique United States system of voluntary health care and health insurance.

"AMENDMENTS TO THE SOCIAL SECURITY ACT

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

"'TITLE XVII—HEALTH INSURANCE PROTECTION SUPPLEMENT

"'Definitions

"'SEC. 1701. For purposes of this title—

"'Health Insurance Protection

"'(a) The term "health insurance protection" means an enforceable contract (1) which is with a carrier (as defined in subsection (c)) under which the carrier agrees to provide, pay for, or reimburse the cost of, health care services, and (11) which is guaranteed renewable or noncancelable and under the terms of which the premium rates cannot be changed with respect to any individual unless such rates are uniformly changed with respect to all other individuals in the same class or category as such individual;

"'HEALTH CARE EXPENSE

"'(b) The term "health care expense" means part or all of the cost of any of the items listed in section 6(b) of title I; and

"'CARRIER

"'(c) The term "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization—

"'(1) which is subject to the jurisdiction of the official or agency established by State law for the purpose of regulating and supervising carriers of insurance which offer policies of health care insurance operating within the State, reviewing and approving the form and content of such policies, and examining and approving the reasonableness of the benefits provided thereunder in relation to the amount of the premium charges therefor; and

"'(2) which is lawfully engaged in providing, paying for, or reimbursing the cost of, health care services under individual or group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization.

"'Entitlement to benefits

"'SEC. 1702. (a) Every individual who—

"'(1) has attained the age of sixty-five;

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

"'(3) has selected a carrier which has obligated itself to provide health insurance protection to such individual which is guaranteed renewable or noncancellable and under the terms of which the premium rates cannot be changed with respect to any individual unless such rates are uniformly changed with respect to all other individuals in the same class or category as such individual, for a period not less than twelve months in duration, shall be entitled to a health insurance protection supplement for each month for which he is entitled to such benefits under section 202, beginning with the first month with respect to which he meets the conditions specified in paragraphs (1), (2), and (3).

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

"'(1) a carrier shall be deemed to have obligated itself despite the existence of a contractual power in the carrier to terminate such obligation for fraud, overinsurance, nonpayment of premium, or other reason permitted by the insurance laws of the State wherein such individual resides; and

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

"'Health insurance protection supplement

"'SEC. 1703. (a) The health insurance protection supplement shall be a monthly sum equal to one-twelfth of the annual cost of health insurance protection in force for or on behalf of an eligible individual, but in no event shall such sum exceed nine dollars per month.

"'(b) The health insurance protection supplement shall be paid monthly by the Secretary to or on behalf of such eligible individual upon certification not less often than once each year of evidence satisfactory to the Secretary that a carrier has obligated itself (as provided in section 1703(a)(3)) with respect to such individual. Certification by a carrier so obligated shall be satisfactory evidence to the Secretary.

"'(c) Upon receipt of an assignment by an eligible individual of his health insurance protection supplement to a carrier, the Secretary shall pay such supplement to such carrier.

"'Overpayment

"'SEC. 1704. In the event health insurance protection for an eligible individual is terminated during a period for which health insurance protection supplement has been paid, the recipient of the supplement shall refund to the Secretary an amount equal to the amount of the premium for such protection which is attributable to that portion of such period which follows the date such protection was terminated. In default of such refund and in the discretion of the Secretary, the provisions of section 204 (relating to overpayments and underpayments) shall apply.

"'Application of certain provisions of title II

"'SEC. 1705. The provisions of sections 206, 208, and 216(j), and of subsections (a), (d), (e), (f), (h), and (i) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

"'Payment of health insurance protection supplement

"'SEC. 1706. (a) Payments of health insurance protection supplement provided under this title shall be made by the Secretary, prior to audit or settlement by the General Accounting Office, from the Federal Old-Age and Survivors Insurance Trust Fund.

"'(b) Notwithstanding any provision to the contrary contained in subsection (a) or (b) of section 201, there is hereby authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund (in the manner provided in subsection (a) of section 201) an amount equal to 100 per centum of the taxes received and covered into the Treasury by reason of the increase in tax rates provided by section 201 of the Health Insurance Protection Supplement Act of 1962.'

"Technical amendments

"Suspension in Case of Aliens

"SEC. 204. (a) Subsection (t) of section 202 of such Act is amended by adding at the end thereof the following new paragraph:

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

"Persons Convicted of Subversive Activities

"(b) So much of subsection (u)(1) of such section as follows subparagraph (B) thereof is amended by (1) inserting '(1)' after 'whether', and (2) by inserting 'and whether such individual is entitled to payment of a health insurance supplement under title XVII,'.

"AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1954

"Changes in tax schedules

"Self-Employment Income Tax

"SEC. 205. (a) Section 1401 of the Internal Revenue Code of 1954 (relating to the rate of tax on self-employment income) is amended to read as follows:

"'SEC. 1401. RATE OF TAX.

"'In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

"'(1) In the case of any taxable year beginning after December 31, 1961, and before January 1, 1963, the tax shall be equal to 4.7 percent of the amount of the self-employment income for such taxable year;

"'(2) In the case of any taxable year beginning after December 31, 1962, and before January 1, 1966, the tax shall be equal to 5.8 percent of the amount of the self-employment income for such taxable year;

"'(3) In the case of any taxable year beginning after December 31, 1965, and before January 1, 1968, the tax shall be equal to 6.6 percent of the amount of the self-employment income for such taxable year;

"'(4) In the case of any taxable year beginning after December 31, 1967, the tax shall be equal to 7.3 percent of the amount of the self-employment income for such taxable year.'

"Tax on Employees

"(b) Section 3101 of such Code (relating to rate of tax on employees under the Federal Insurance Contributions Act) is amended to read as follows:

"'SEC. 3101. RATE OF TAX.

"'In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121 (a)) received by him with respect to employment (as defined in section 3121(b))—

"'(1) with respect to wages received during the calendar year 1962, the rate shall be 3⅛ percent;

"'(2) with respect to wages received during the calendar years 1963 to 1965, both inclusive, the rate shall be 3⅞ percent;

"'(3) with respect to wages received during the calendar years 1966 to 1967, both inclusive, the rate shall be 4⅜ percent; and

"'(4) with respect to wages received after December 31, 1967, the rate shall be 4⅞ percent.'

"Tax on Employers

"(c) Section 3111 of such Code (relating to rate of tax on employers under the Federal Insurance Contributions Act) is amended to read as follows:

"'SEC. 3111. RATE OF TAX.

"'In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121 (a)) paid by him with respect to employment (as defined in section 3121(b))—

"'(1) with respect to wages paid during the calendar year 1962, the rate shall be 3⅛ percent;

"'(2) with respect to wages paid during the calendar years 1963 to 1965, both inclusive, the rate shall be 3⅞ percent;

"'(3) with respect to wages paid during the calendar years 1966 to 1967, both inclusive, the rate shall be 4⅜ percent; and

"'(4) with respect to wages paid after December 31, 1967, the rate shall be 4⅞ percent.'

"Effective Dates

"(d) The amendment made by subsection (a) shall apply with respect to taxable years beginning after December 31, 1962. The amendments made by subsections (b) and (c) shall apply with respect to remuneration paid after December 31, 1962.

"Railroad retirement amendments

"Health Insurance Protection Supplement Under the Railroad Retirement Act

"SEC. 206. (a) The Railroad Retirement Act of 1937 is amended by adding after section 20 of such Act the following new section:

"'Health insurance protection supplement

"'SEC. 21. (a) For the purposes of this section, and subject to the conditions hereinafter provided, the Board shall have the same authority to determine the rights of individuals described in subsection (b) of this section to have payments made on their behalf for health insurance protection supplement within the meaning of title XVII of the Social Security Act as the Secretary of Health, Education, and Welfare has under such title XVII with respect to individuals to whom such title applies. The rights of individuals described in subsection (b) of this section to have payment made on their behalf for health insurance protection supplement shall be the same as those of individuals to whom title XVII of the Social Security Act applies and this section shall be administered by the Board as if the provisions of such title XVII were applicable, references to the Secretary of Health, Education, and Welfare were to the Board, references to the Federal Old-Age and Survivors Insurance Trust Fund were to the Railroad Retirement Account, and references to the United States or a State included Canada or a subdivision thereof.

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

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

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

shall be entitled to have payment made for health insurance protection supplement referred to in subsection (a), and in accordance with the provisions of such subsection. The payments for health insurance protection supplement herein provided for shall be made from the Railroad Retirement Account (in accordance with, and subject to, the conditions applicable under section 10 (b) in making payment of other benefits) to or on his behalf to the individual entitled thereto, or, upon assignment by any such person, to the carrier providing such health insurance protection.

"'(c) No individual shall be entitled to have payment made for health insurance protection under both this section and title XVII of the Social Security Act. In any case in which an individual would, but for the preceding sentence, be entitled to have payment made for health insurance protection under both this section and title XVII of the Social Security Act, payment for such protection shall be made in accordance with procedures established jointly by the Secretary of Health, Education, and Welfare, and the Board for the purpose of minimizing duplication of requests for payment of such protection under both this section and title XVII of the Social Security Act, and preventing any duplication of such payment.

"'(d) A request for payment for health insurance protection supplement filed under this section shall be deemed to be a request for payment for such supplement filed as of the same time under title XVII of the Social Security Act, and a request for payment for health insurance protection filed under such title shall be deemed to be a request for payment for such supplement filed as of the same time under this section.

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

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

"(b) Section 1(q) of such Act is amended by striking out '1960' and inserting in lieu thereof '1962'.

"Amendments to Railroad Retirement Tax Act

"Tax on Employees

"SEC. 207. (a) Section 3201 of the Railroad Retirement Tax Act is amended by striking out ': *Provided*' and inserting in lieu thereof the following: '. With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3101 of the Federal Insurance Contributions Act are increased with respect to wages by section 205(b) of the Health Insurance Protection Supplement Act of 1962, the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3101 are so increased with respect to wages: *Provided*'.

"Tax on Employee Representatives

"(b) Section 3211 of the Railroad Retirement Tax Act is amended by striking ': *Provided*' and inserting in lieu thereof the following: '. With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3101 of the Federal Insurance Contributions Act are increased with respect to wages by section 205(c) of the Health Insurance Protection Supplement Act of 1962, the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by twice the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3101 are so increased with respect to wages: *Provided*'.

"Tax on Employers

"(c) Section 3221(a) of the Railroad Retirement Tax Act is amended by striking out '$400; except that if', and inserting in lieu thereof the following: '$400. With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3111 of the Federal Insurance Contributions Act are increased with respect to wages by section 205(c) of the Health Insurance Protection Supplement Act of 1962, the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3111 are so increased with respect to wages. If'.

"Amend the tables of contents of the bill so as to strike out the matter describing the contents of title II of the bill and inserting in lieu thereof the following:

"'TITLE II—HEALTH INSURANCE PROTECTION SUPPLEMENT

"'Sec. 201. Short title.
"'Sec. 202. Findings and declaration of purpose.
"'Sec. 203. Amendments to the Social Security Act adding a new title XVII to such Act to provide for a health insurance protection supplement.
"'Sec. 1701. Definitions.
"'(a) Health insurance protection.
"'(b) Health care expense.
"'(c) Carrier.
"'Sec. 1702. Entitlement to benefits.
"'Sec. 1703. Health insurance protection supplement.
"'Sec. 1704. Overpayment.
"'Sec. 1705. Application of certain provisions of title II.
"'Sec. 1706. Payment of health insurance protection supplement.
"'Sec. 204. Technical amendments.
"'(a) Suspension in case of aliens.
"'(b) Persons convicted of subversive activities.

Mr. HRUSKA. Mr. President——

Mr. MANSFIELD. I yield to the Senator from Nebraska.

Mr. HRUSKA. I thank the Senator from Montana for yielding to me.

Mr. President, I am deeply disturbed and somewhat amazed by the position in which the Senate of the United States finds itself today. Never in my experience in this deliberative body have I found so many, who should believe in deliberate and careful solutions of the problems facing our Nation, so bent on hasty and uninformed action. Actually, it frightens me when I think of what could happen, not only here today, on this particular measure, but in terms of the precedent that it could set for future legislation.

Just what is the situation, and why am I deeply disturbed? First, revenue-raising legislation including the social security programs and amendments thereto must originate in the House of Representatives. At the present time the appropriate House committee has under active consideration proposals to provide medical care for the aged. The Senate Finance Committee in its wisdom earlier this year rejected an attempt to consider such proposals prior to action by the Ways and Means Committee. Thus, we are faced with a situation in which certain members of the body are proposing to circumvent the orderly and tested procedure of the Congress of the United States. They propose to circumvent the House Ways and Means Committee, the House of Representatives, and the Senate Finance Committee, and offer a measure which has not been considered by any regularly constituted committee of either House of Congress.

I pose this simple question: Who knows what is contained in detail in the wording of this 75-page amendment? Certainly there are many questions which I should like to ask of specialists in the medical field, the hospital field, the insurance field, and other related fields, as to the meanings of certain words and phrases as applied to this particular legislation. Have the sponsors of this amendment constituted themselves an ad hoc committee of the Senate to consider such legislation? If so, I think we should be furnished with reports of their conversations and inquiries with experts whom they certainly should have consulted in proposing this legislation. Any regular committee would have done so. Certainly, if the regular course had been followed, we would today have had both printed hearings and a carefully written report before us, to assist us in making a wise and sound decision. These elements are sadly lacking.

But let us go one step further. Let us assume that the Senate departs from its usual depth of wisdom, and acts favorably upon this amendment. Is it conceivable that the other House would act as blindly, without any further information than what we have today?

But should even this happen and should this many-headed monster become law, to what could the administrator of its many parts turn, to determine the intent of the legislative body? Neither hearings nor reports would be available, and the only expert testimony would be the utterances of uninformed Members of this body during the debate now in progress.

Abhorrent as it is to circumvent well-established procedure, there is one other element which I believe should give pause to those who would support H.R. 10606. This measure, contrary to the amendment which is being offered to it, was thoroughly discussed and reported by the Ways and Means Committee and debated by the House of Representatives; and hearings were held by the Senate Finance Committee, and the bill was reported to the Senate. A number of important changes in the basic welfare statutes are involved. To saddle such a well-considered bill with a totally ill-considered amendment could be disastrous to H.R. 10606. The technique of attempting to saddle a well-thought-out piece of legislation in the public interest with an amendment highly controversial in nature, ill-considered by the Congress, and not directly related to the principal measure, should now, and always, be avoided, if a sound legislative process is to survive.

Mr. President, I ask unanimous consent that there be printed in the RECORD at this point a well-reasoned editorial from the July 4 issue of the Lincoln, Nebr., Journal.

There being no objection, the editorial was ordered to be printed in the RECORD, as follows:

[From the Lincoln Evening Journal and Nebraska State Journal, July 4, 1962]

NO IMPROVEMENT IN MEDICAL CARE BILL

A group of U.S. Senators from both parties has wrapped a new cover around the much-disputed program for medical aid to the aged. But it still is the same merchandise with the same defects.

The new compromise version of the plan makes little change of any significance. It would give a recipient the choice of having his hospital bills paid directly from social security funds or taking social security funds to pay for his own private health insurance plan. It also would extend hospital benefits from social security to persons not covered by social security and who have not contributed to it.

Still retained in the Senate compromise are two of the most objectionable features of the original bill:

Use of the social security approach to pay for medical care.

Extension of Federal funds for medical payments to all persons over 65, regardless of need.

The idea of using social security for medical benefits is dangerous, discriminatory, and a violation of accepted Federal tax concepts.

Advocates of this avenue might, first of all, heed the advice of President Roosevelt when the social security program was established in 1935. He warned Congress against "extravagant action" and said that if the program were "too ambitious" its whole future would be endangered.

Already the social security tax is taking 3⅛ percent of most workers' paychecks up to a maximum of $4,800 a year. Even without adding medical benefits, the rate is scheduled to go to 4½ percent, about a 50-percent increase, by 1969. Medical benefits from social security not only would increase the rate by one-fourth percent but would raise to $5,200 the maximum on which it is paid. This would add $25.50 a year in social security taxes.

Surely this is passing the danger point of making the social security program "too ambitious," even for Franklin Roosevelt.

Placing medical benefits under social security would mean that young workers particularly would be paying higher and higher taxes for years to pay the medical costs of older persons. Any worker who died before reaching age 65 presumably would lose the investment he had made for his medical protection in old age.

These features are clearly discriminatory.

Inherently, the social security tax bears heaviest on the lower-income groups. Because the tax applies only on income up to $4,800 a year (or $5,200 if medical benefits are added), any earnings above these figures are not subject to social security taxation.

By adding a little sugar coating, the Senate should not try to force the Nation to swallow such a toxin as this.

PUBLIC WELFARE AMENDMENTS OF 1962

There being no objection, the Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. YOUNG of Ohio. Mr. President——

Mr. HUMPHREY. Mr. President, I yield to the Senator from Ohio 1 minute.

Mr. YOUNG of Ohio. I need more time than that.

Mr. HUMPHREY. Whatever time the Senator from Ohio may wish.

The VICE PRESIDENT. The Senator from Connecticut is recognized.

Mr. BUSH. Mr. President, I shall be glad to yield to the Senator from Ohio for an insertion.

Mr. MANSFIELD. Mr. President, the Senator from Ohio wants to make a brief statement. He withheld the statement in the morning hour. If the Senator from Connecticut will give the Senator from Ohio time, it will be appreciated.

Mr. BUSH. I shall be glad to yield the Senator from Ohio 5 minutes.

The VICE PRESIDENT. The Senator from Connecticut yields to the Senator from Ohio 5 minutes.

Mr. YOUNG of Ohio. I may need more time.

Mr. HUMPHREY. The Senator from Ohio will get more time.

IN SUPPORT OF THE ADMINISTRATION HEALTH CARE PROGRAM FOR THE ELDERLY

Mr. YOUNG of Ohio. Mr. President, on occasion, the public welfare amendments of 1962 which are being debated at this time are referred to as a compromise of the King-Anderson health care for the elderly bill.

In some respects, I assert the legislative proposal we are considering, and which I wholeheartedly support, is an improvement over the original bill now in the committee on Ways and Means of the House of Representatives. This is a most meritorious legislative proposal. It takes a step forward toward adequate hospital, medical, and surgical care insurance for elderly men and women within our social security program. By its tax provisions it continues to leave our social security system as an actuarially sound old-age and survivors and disability insurance system.

This pending proposal includes within its beneficent provisions health insurance coverage not only for those eligible for social security to be financed through social security contributions, but also for possibly 2½ million elderly men and women who do not have social security coverage. This is a most significant step forward because most of these 2 million plus elderly men and women are the very ones who need most the hospital and health protection which this pending proposal would give.

The best estimate is that at the outset the appropriation necessary will amount to $50 million a year from our general revenue funds. In this group are men and women, many of whom have been on relief and practically all of whom are in indigent circumstances, or nearly so; in other words, dependent on charity or upon the generosity of close relatives, some of whom are themselves in modest or needy circumstances. This amount will decrease rapidly, as the life expectancy of these men and women is not great. Following a comparatively few years, there will be no appropriation required.

Furthermore, all of us look forward to the time when our social security—our old-age and survivors and disability insurance sytem—will cover all employed and self-employed, and cover them adequately, so that on retirement they will receive an ample return from the premiums they have paid during their working years. The dignity of every elderly man and woman in our Nation is involved in the legislative proposal we are considering.

Something deep inside an elderly man or woman is offended if, after a lifetime of constructive work in employment or as a self-employed individual, all he or she receives is a mere handout.

Fortunately, our social security system provides that following retirement those who are covered may retire in dignity and comfort and may be assured as long as they live that the insurance payments from the social security fund will continue.

The amendments proposed by the distinguished Senator from New Mexico [Mr. ANDERSON], and those associated with him, contain provisions for a separate trust fund for the health benefits, and for use of private voluntary organizations in the task of providing hospitalization for elderly persons.

Robert J. Myers, Chief Actuary of the Social Security Administration, has given assurances that this proposal is actuarially sound. He gave the same assurances in 1959 and 1960, under the Eisenhower administration, when he occupied the same position. Financing would be accomplished by raising the earnings base from $4,800 to $5,200 per year and by an additional one-fourth of 1 percent for employees and employers and three-eighths of 1 percent for self-employed persons.

The cost of this protection to the individual would not be excessive. In terms of dollars, the employee who earns $4,800 a year would pay $12 a year more than under present law. The employee earning $5,200 or more would pay $17.68 additional a year toward health insurance.

Mr. President, the American people want and need this legislation. In my own State of Ohio there are approximately 950,000 people who are over 65 years of age. These amendments would provide coverage to over 900,000 of these people.

Reference has been made to the Kerr-Mills bill in the course of this debate. I voted against the Kerr-Mills bill, which was enacted into law during the Eisenhower administration.

Only 88,000 people in the country have benefited as a result of the enactment of the Kerr-Mills bill, and not one individual in my State of Ohio has received any assistance as a result of that law.

Regarding the proposal before us, the American Medical Association remains the lone major holdout, still fighting a desperate battle to distort and to confuse the issue with cries of "socialized medicine" and "Government control."

At first the house of delegates of the American Medical Association—now composed of 212 members, a large majority of whom are political doctors and only 40 of whom are general practitioners of medicine—objected to the original King-Anderson bill because, they claimed, it would exclude 2½ million people from coverage. At present we are considering proposed legislation which would provide coverage for these 2½ million people, yet the political doctors of the AMA still oppose it.

The VICE PRESIDENT. The time of the Senator from Ohio has expired.

Mr. YOUNG of Ohio. Mr. President, I ask for an additional 5 minutes.

The VICE PRESIDENT. The Senator asks for an additional 5 minutes.

Mr. HUMPHREY. Mr. President, I yield 5 minutes to the Senator from the time on this side.

Mr. BUSH. Mr. President, I ask unanimous consent that that be with the understanding that I do not lose my right to the floor.

Mr. YOUNG of Ohio. That is fully understood.

The VICE PRESIDENT. Without objection, it is so ordered.

Mr. YOUNG of Ohio. The political doctors of the American Medical Association opposed social security at the time it was enacted into law. In 1936 they supported the presidential candidate who proposed repeal of the Social

Security Act, and who carried only two States in the Union. If any candidate for the Presidency should now propose repeal of the social security law, he would not carry even one State of our Union.

Mr. President, although this question has been compromised by a bipartisan agreement, and the 2½ million needy elderly men and women have been included within the beneficent coverage of the bill, these political doctors now say this is just another version of the old King-Anderson bill. The AMA remains faithful to its policy of opposing anything and everything which is progressive and forward looking. By "AMA" I mean the house of delegates, which operates that group. I do not mean the rank-and-file physicians and surgeons of the country. Judging from the mail from my own State of Ohio, I feel that a majority of the physicians and surgeons are in support of the legislation which we are now considering.

May I say that there is one provision I personally do not like, but as most legislation is a matter of compromise, I shall accept it. I refer to the feature providing that the hospitalized individual must pay $10 toward his hospital bill up to the 10th day as an inpatient in a hospital. In other words, an elderly person must be prepared to pay as much as $90, and in some instances this may be a genuine hardship.

It is stated that this is on the principle of $50 or $100 deductible property damage insurance. I do not like this illustration. We are dealing with very ill elderly men and women, many in most unfortunate and needy circumstances. We are dealing with our fellow human beings, not with automobiles, or other chattels.

We do not want colossal debt to be the penalty that afflicts an average family if some loved elderly person in that family requires extended hospital care.

At the outset I favor placing this program on a complete coverage basis. However, if that cannot be had, I will go along and support the measure, as I enthusiastically do, believing that later the provision will be eliminated.

Mr. President, the fear of numerous nuisance claims is groundless. I assert that most persons are, like myself, fearful of hospitals. We do not want to go into them. We do not want to be sent there in a limousine. We all have intimate knowledge of the fact that loved ones, near and dear to us, have been taken to a hospital on one or two occasions—and then the end. So, I feel that the $90 deductible provision is unnecessary. I do not join in any views expressed that if we remove this feature there will be an excess of requests for hospitalization.

Mr. President, I am proud to be a longtime and wholehearted advocate of the social security financing principle. I voted for such a bill in 1960 because it provided a method through which people during their working years can build adequate protection against heavy medical costs in their later years. I firmly believe that the social security system is the only method through which older people can be relieved of some of the fear of rising and unpredictable health costs. It is only through our social security system that workers can provide for themselves. We must make it possible for them to do so.

Mr. HUMPHREY. Mr. President, will the Senator yield?

Mr. YOUNG of Ohio. I am happy to yield to the distinguished senior Senator from Minnesota.

Mr. HUMPHREY. I commend the Senator from Ohio on his excellent statement in support of the health care program under the terms of social security. I agree with what the Senator has said with reference to the bill. The provision for a $90 payment on the part of an individual when he goes to a hospital for first 9 days was inserted in the bill as a compromise feature. Its removal would improve the bill. I do not think that the plan would result in abuse. The Senator is correct. Nevertheless, I support the bill and have for a long time. The Senator might be interested to know that the first piece of legislation that I was privileged to cosponsor when I came to the Senate, and of which later I was the main sponsor, was a measure which would provide hospital care for persons age 65 and over under the social security system.

The VICE PRESIDENT. The time of the Senator has expired.

Mr. YOUNG of Ohio. I thank the distinguished Senator from Minnesota. What he has said fortifies me in the views I have expressed today.

Mr. BUSH. Mr. President, for the information of the Senate, I announce that I intend to ask for a yea-and-nay vote on my amendment. It will not require more than an hour for me to explain the amendment, so that if there is not too much debate on it, the whole process should not consume more than an hour and a half. I would be most cooperative in trying to hold the situation in check in case there are Senators who wish to get away early today. But I serve notice that I intend to ask for a yea-and-nay vote on the amendment.

I yield to the Senator from Illinois [Mr. DIRKSEN] such time as he may require.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. BUSH. Mr. President, I wish to modify my amendments as follows:

On page 6, line 16, strike out "for a period not less than twelve months in duration,".

On page 18, between lines 5 and 6, insert the following:

EFFECTIVE DATE OF HEALTH PROTECTION BENEFITS

Section 208 health insurance protection supplement provided under title XVII of the Social Security Act or under section 21 of the Railroad Retirement Act of 1937 shall be payable only with respect to months after June, 1963.

On page 18, after the matter describing the contents of section 207 of the bill, add the following:

Section 208. Effective date of health protection benefits.

Mr. President, I deplore the procedure and circumstances under which the Senate is considering one of the gravest social issues of our times, the problem of financing adequate health care for our senior citizens.

I deplore the procedure because it bypasses the House Committee on Ways and Means and the Senate Committee on Finance, the two committees in the respective Houses of Congress which are responsible for considering such proposed legislation.

Without the benefit of careful committee consideration and of an analytical committee report, the Senate is considering one of the most technical and intricate pieces of proposed legislation to come before Congress. This is no way for a responsible legislative body to proceed.

I deplore the circumstances because this question has been brought before the Senate not with the intention that Congress will enact at this session meaningful legislation which will provide needed help for the aged, but with the intention of creating a political issue for the fall elections. I doubt that there is any Senator who believes in his heart that if amendments dealing with health care for the aged are adopted by the Senate as a rider to the pending bill, H.R. 10606, such amendments have a ghost of a chance of being adopted in the other body.

This is too serious a problem and too important in terms of the welfare of elderly people to be made a political

football, but that, I believe, is what has been done by the deliberate choice of the leadership of the Democratic Party.

Nevertheless, and because it faces us, I believe this proposal offers us an opportunity for a discussion of the various proposals which have been made, under which the Federal Government could assist elderly people to meet the costs imposed by illness.

It seems to me that a question of need is involved, and I believe there is a need for Federal action in this field which extends beyond the Kerr-Mills legislation, which I supported and which was enacted in the last Congress. The social security system provides an acceptable method of financing such a Federal program. Let me outline the reasoning behind this conclusion.

Men who are now 65 years of age can expect to live into the seventies. Women who are now 65 years of age can expect to live into the eighties.

The financial problems of the elderly are difficult. Half of the people over 65 years of age have incomes of less than $1,000 a year. Three-fourths of them have incomes of less than $2,000 a year. Eighty-seven percent have incomes of less than $3,000. Sixty percent have total assets of less than $10,000. Forty percent have assets below $5,000.

Medical costs for the elderly are higher than for the rest of the population, and the elderly are poorly protected against them. Almost half of those who are 65 years of age and over have no prepaid health insurance. Of those who have some form of insurance, one-fifth have less than 75 percent of their hospital bills covered. These may be dull statistics, but they explain why the greatest fear of the elderly is that they will be stricken with catastrophic illness, requiring expensive medical and surgical treatment and long periods in a hospital or nursing home. It is clear that a serious social problem confronts society, one for which a solution must be found.

In my judgment, legislation in this field will not be enacted this year. However, this debate may lay the foundation for the enactment of legislation by a future Congress which will provide a sound method of meeting the serious problem of financing health care for the aged.

For this reason, I have called up my amendments in the nature of a substitute for the amendments proposed by the distinguished junior Senator from New Mexico [Mr. ANDERSON], the distinguished senior Senator from New York [Mr. JAVITS], and other Senators. My amendments provide that persons 65 years of age or over who are eligible to receive either social security or railroad retirement benefits may receive a monthly insurance supplement of up to $9 for the purchase of voluntary health insurance. The receipt of such supplementary payments would require a certification of the purchase of such insurance, and the insurance would be financed by an increase in the social security and the railroad retirement tax.

The benefits would be provided under any kind of insurance policy the insured desire to purchase, provided the policy was guaranteed renewable and noncancelable and is offered by a carrier which is under the jurisdiction of a State regulatory body.

In other words, a member of the social security system who would be eligible for the additional coverage might purchase any kind of policy he chose for health care in an open, free, and competitive market.

In several respects, the Anderson-Javits proposal is an improvement over the plan offered by the Kennedy administration—the so-called King-Anderson bill. I commend those Senators for their accomplishment in producing this compromise. However, I cannot support the Anderson-Javits proposal because it contains some of the fatal defects of the administration bill, which it replaces. Among the defects are, first, that benefits are to be provided in services instead of dollars. There are no reliable and accurate estimates of future costs. Costs have been estimated by the administration at an annual rate of $1,200 million. Competent insurance actuaries have estimated the costs to be $2,500 million. A reliable estimate made by the New York Board of Trade is that the costs might be as high as $4 billion or more. Using statistics from the National Health Survey of 1957 and 1958, the New York Board of Trade concluded that if H.R. 4022, the King-Anderson bill, had been in effect in 1960, the hospital costs would have been been $4,300 million, roughly four times the estimate of the Department of Health, Education, and Welfare; and other estimates support this conclusion.

Moreover, eligible beneficiaries would be given no freedom of choice under the pending measure. Under the revised Anderson-Javits proposal, there would be no freedom of choice. The Anderson-Javits proposal is limited essentially to hospital and nursing home care. Such care represents less than 25 percent of all medical costs which confront elderly people. My authority for this information is a statement made by Representative THOMAS CURTIS of Missouri, which appears in the CONGRESSIONAL RECORD of March 6, 1962.

My proposal avoids these defects. My proposal is a fiscally responsible pay-as-you-go plan, with benefits paid in dollars, in amounts not exceeding the funds raised by an increase in the social security tax. Each beneficiary will have complete freedom to choose the kind of health insurance protection best suited to his individual needs, from the wide range of plans now offered by the Blue Cross, the Blue Shield, the mutual insurance companies, the commercial insurance companies, or plans underwritten by employee organizations. The Federal Government would pay up to $9 a month, or $108 a year, to help meet the cost of such protection. That money would be used to buy, in the free competitive market, insurance policies available from insurance associations and insurance companies, under competent State direction.

In recent years, there has been a major breakthrough in solving the problem of providing health insurance protection for the aged. One of the more outstanding programs in this field has been provided by Connecticut 65 extended health insurance, which now protects approximately 26,000 persons aged 65 or over in my State. It makes major medical insurance available, without physical examination, to individual elderly residents of the State, and is underwritten by 32 insurance companies authorized to write insurance in the State of Connecticut.

Mr. President, at this time I wish to refer, for the RECORD, to certain options and basic benefits available under the Connecticut 65 plan. For instance, an applicant has a choice of four optional plans.

Option 1 costs $10 a month, and provides a lifetime major medical benefit of $10,000, of which not more than $5,000 may be used in a single year.

Option 2 costs $7.50 a month, and provides a lifetime benefit limit of $5,000, with a $2,500 limit in a single year.

Option 3 costs $17 a month, and provides a $10,000 major medical benefit, plus a plan of basic hospital and surgical benefits.

And option 4 costs $14.50 a month, and provides the $5,000 major medical benefit, plus a plan of basic hospital and surgical benefits.

The basic hospital and surgical benefits of options 3 and 4 are designed to complement the major medical benefits, and will be available only to those who do not have other basic benefits. The basic hospital and surgical benefits of options 3 and 4 will pay hospital room and board charges up to $12 a day, for a maximum of 31 days in each calendar year, and other hospital charges up to $125 per calendar year, and surgical charges up to the maximum under a schedule of surgical procedures, with a maximum benefit of $360 in any one year.

So, Mr. President, from my brief outline of these optional plans, it can be seen that quite a variety of insurance is available today, and also insurance policies can be bought in the open market, for the aged, without physical examination; and they do provide coverage for surgical expenses and doctors' fees.

I may say I have discussed this plan with various doctors. Of course, there have not been any hearings on this amendment; and this is one of the things about this procedure that I do not like at all. But doctors who have been violently opposed to the so-called King-Anderson approach are not opposed to this amendment, because the members of the social security system would be given cash with which to buy this insurance; and the medical profession is one which has promoted and benefited substantially by the development of insurance organizations, such as the Blue Cross, the Blue Shield, and so forth.

So I do not believe we run into any conflict here with the medical profession, although of course its members should have a chance to be heard.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD, in connection with my remarks, a description of the Connecticut 65 plan.

There being no objection, the memorandum was ordered to be printed in the RECORD, as follows:

I. SUMMARY OF THE PLAN

Connecticut 65 is the short name for Connecticut 65 extended health insurance. Its purpose is to make major medical insurance available without physical examination to individual elderly residents of the State. It is underwritten by 32 insurance companies authorized to write health insurance in the State of Connecticut. It is marketed through a voluntary unincorporated association called Associated Connecticut Health Insurance Companies, which originally consisted of 10 Connecticut-domiciled companies which were joined by 22 others domiciled elsewhere but writing health insurance in Connecticut. Coverage is provided under a policy issued to a trustee bank, and is available to Connecticut residents age 65 or over. However, a Connecticut resident who moves away can maintain his coverage if he keeps up the premium. If one spouse is eligible and elects the coverage, the other is also eligible if not less than 55 years old and not working more than 30 hours a week. Coverage is available without physical examination or health questions, but to be eligible an applicant must not have been confined in a general, special or convalescent hospital during the 31 days prior to his enrollment.

Much thought and study was given to the plan of benefits to be offered. Not only was the experience of the companies used for this purpose, but valuable suggestions were received from medical society officials and others.

The applicant has a choice of four optional plans:

Option 1 costs $10 a month and provides a lifetime major medical benefit limit of $10,000, of which no more than $5,000 may be used in a single year.

Option 2 costs $7.50 a month and provides a lifetime benefit limit of $5,000, with a $2,500 limit in a single year.

Option 3 costs $17 a month and provides the $10,000 major medical plus a plan of basic hospital and surgical benefits.

Option 4 costs $14.50 a month and provides the $5,000 major medical plus a plan of basic hospital and surgical benefits.

The basic hospital and surgical benefits of options 3 and 4 are designed to complement the major medical benefits and to be available only to those who do not have other basic benefits.

Basic benefits

The basic hospital-surgical benefits of options 3 and 4 pay: hospital room and board charges up to $12 a day for a maximum of 31 days in each calendar year; other hospital charges up to $125 per calendar year; surgical charges up to the maximum under a schedule or surgical procedures with a maximum benefit of $360 in any one year.

Major medical benefits

The major medical benefits contain a deductible which is applied on a calendar-year basis. The deductible is a variable sum consisting of $100 plus the amount of benefits provided under Connecticut 65 basic, whether the insured had Connecticut 65 basic or not.

Major medical expenses are classified into type I and type II. Type I expenses are hospital expenses; type II expenses are covered medical expenses other than hospital expenses. After the deductible, the plan pays 100 percent of all type I covered expenses up to $250, and then 80 percent of the remainder. It pays 80 percent of the type II covered expenses.

Type I expenses, under the $10,000 plan (options 1 and 3), are hospital room and board charges up to $18 per day and charges for other hospital services and supplies; or, after 5 days in a general or special hospital, room and board in a convalescent hospital up to $10 a day, for as long as 90 days in a year.

Type II expenses under the same options include surgical fees up to 1⅔ times the amount shown on the basic schedule; anesthesia fees up to 20 percent of the surgical fee allowance; charges for nursing by registered nurses in or out of the hospital up to $18 per day; doctors' calls up to $6; and the usual range of drugs, diagnostic services, and other medical services and supplies.

Under the lower $5,000 major medical plan, the specified limits on type I and type II expenses are somewhat less, but the principle is the same. For example, the limit on hospital room and board is $15 a day.

Detailed examples of how the benefits work out will be found on pages 8 to 10 of the "Answers to Your Questions" booklet in exhibit 8. A few examples will suffice. In one case, for total expenses of $1,587 for a heart attack, Connecticut 65 option 3 would have paid $1,216. In another case, for total expenses of $630 for gall-bladder removal, benefits would have been $530. In a third case, for total expenses of $2,587 for lung cancer, benefits would have been $2,022.

II. BRIEF CHRONOLOGY OF CONNECTICUT 65

One of the most extraordinary things about the Connecticut 65 plan is that the idea was not even in being 11 months before the beginning of the enrollment period on September 1, 1961. Between October 1, 1960, and September 1, 1961, the idea became crystallized; permissive legislation was requested and enacted; 32 health insurance companies were participating in a newly formed voluntary association; and an intensive promotion campaign was underway.

In September 1960 it was obvious that, while at least 3 out of every 4 of Connecticut's elderly population were covered for basic protection against health care costs, nevertheless, many were unable to obtain major medical insurance to protect them against the cost of catastrophic illness.

In the first weeks of October 1960 an ad hoc committee of representatives from five Hartford insurance companies convened, and a working committee of six began frequent sessions that still continue. It was the consensus that the Connecticut companies represented should explore thoroughly the possibility of meeting needs in the major medical area for those 65 and over. The ad hoc committee directed the "committee of six" to develop the entire program in detail and report back by the end of the year 1960.

In November and December 1960, drafts of the Connecticut 65 plan itself, the necessary legislation and the framework of a voluntary association had been completed, plus programs for all-important liaison with such as legislators, doctors, nursing homes, hospitals, agents of all lines, newspaper editors, social welfare authorities, etc. Drafting and redrafting of the basic documents continued for months.

In January 1961, the initial announcement of the plan was made and legislation was introduced in the 1961 session of the Connecticut General Assembly. Meetings were held with representatives of agents' associations.

In March, the proposal was presented to the Insurance Committee of the General Assembly in support of the permissive legislation. The Connecticut State Medical Society, the Connecticut Chamber of Commerce, the Connecticut Association of Insurance Agents, and the Connecticut Association of Life Underwriters all supported the bill at the hearing.

In April, the bill passed both houses of the general assembly. It was signed by the Governor on May 3, 1961, as Public Act 95 (exhibit 1). Also in May, 10 Connecticut companies accepted invitations to join the proposed Associated Connecticut Health Insurance Companies. Claims, policy forms, and promotion subcommittees were appointed, and an advertising agency and a direct-mail agency were retained.

In June and July 1961, the drafting and revision continued. The subscription agreement (exhibit 2) was signed by 10 Connecticut companies, which were soon joined in the next few months by 22 companies domiciled elsewhere but writing a substantial volume of health insurance in Connecticut. The policy forms and the enrollment booklet were filed with the Connecticut Insurance Department which was kept advised of developments.

The direct-mail campaign began August 18 and lasted until September 21. Education of agents through slide films and flipcharts was underway. During this period, an agreement was also executed with a trustee bank as policyholder of the Connecticut 65 plan.

III. PRESENTATION TO THE PUBLIC, AND RESULTS

Early in April 1961, a subcommittee on promotion was formed, whose first duty was to determine the budgetary needs of a campaign to market Connecticut 65.

It was determined that a budget of $190,000 was indicated, and, upon authorization of this amount by the executive committee of the association, two separate firms were employed; one, an expert specializing in newspaper, radio, and TV advertising; and another, specializing in direct-mail advertising.

The advertising program comprised a series of full-page and half-page ads in all Connecticut daily and Sunday newspapers beginning August 20, 10 days prior to the beginning of the enrollment period, and continuing through the month of September. During this same period, 337 spot announcements were made over 36 Connecticut radio stations and 33 spot announcements per week were aired over the 3 Connecticut TV outlets.

This program developed 12,805 inquiries, of which 2,034 were converted into enrollments. It also brought in 1,463 direct enrollments through enrollment coupons which were an integral part of the advertising copy. The value of this program cannot be measured only by the immediate results attributed to it, since the communication problem involved demanded a very widespread impact upon the entire Connecticut citizenry, whether part of the actual market for Connecticut 65 or not.

The direct mail program included promotions to agents, to employees and policyholders of the participating companies, and to people of influence in business, professional and civic circles. Heavy mailings were, of course, directed to two major prospect groups—those 65 and over and those 40 to 65, the latter representing the sons, daughters and others concerned in the welfare of their elders.

Agents received a comprehensive promotional kit which included enrollment forms, sales aids, instructions and reorder forms for all the materials furnished; 9,906 enrollments came in through agents.

Several of the large participating companies made mailings to their Connecticut employees and policyholders. Centers of influence mailings to doctors, lawyers, bankers, and State and municipal leaders included complete information about Connecticut 65 in booklets; 2,280 enrollments resulted from these combined activities.

A prospect mailing of 380,000 reached the primary market of those 65 and over and the secondary market of those 40 to 65.

As inquiries came in from these mailings and from the newspaper, radio and TV campaign, appropriate additional material was mailed to those inquiring, including enroll-

ment forms. In all, some 600,000 pieces were mailed, developing 30,000 inquiries which resulted in 8,201 enrollments.

Backing up this intensive promotion was a continuous publicity campaign undertaken by the Insurance Information Office of Connecticut. This campaign started with newspaper releases in January 1961, when the original bill was introduced in the legislature, and continued through the legislative hearings. This was followed by pictures of the Governor signing the enabling bill into law, and news stories on all phases of the organization and progress of the program, including the final results.

The program was the subject of frequent favorable editorial comment in the Connecticut press. This was most welcome to the participating companies. The information office also arranged for many meetings with Connecticut State Agents' Associations, at which time the plan and the marketing program were presented graphically through liberal use of visual aids. These meetings were largely responsible for the interest and enthusiasm of the agents in endorsing and promoting the plan.

No opportunity for promotion was overlooked. The toll-free telephone number for inquiries at headquarters was Enterprise 6565. The appearance of the insurance policy itself, copies of which have been widely circulated, was given professional attention, as was that of the enrollment booklet. Even the enrollment form was revised to reflect suggestions made from the marketing point of view.

As stated elsewhere, all promotional releases and devices were reviewed by qualified advisers and cleared for conformance with all regulatory requirements. The development of a sympathetic working relationship between the promotion people on the one hand, and the underwriting and legal teams on the other, was essential to the development of a successful marketing procedure. Successive enrollment periods are contemplated, the first in 1962. This, too, will be marked by advertising and direct mail promotion commencing shortly before the enrollment period opens. It is not anticipated that this enrollment period will involve the large-scale operation believed to have been necessary initially, since the momentum gained during September is being maintained by a low-key advertising program to keep Connecticut 65 before the public.

Enrollment results

The first enrollment period was restricted to 1 month—September 1961. During that period the number actually enrolled was 21,850. This was a gratifying percentage of the real market among Connecticut's elderly, as the statistics in the next section will show.

At the headquarters of the Associated Connecticut Health Insurance Cos. in Hartford, by mail and telephone during September 1961, there were 45,122 inquiries processed.

Under Connecticut 65, the insured does not have to sign the enrollment form. All promotional material emphasized this fact. As a result, almost 30 percent of the 21,850 enrollees were enrolled by sons, daughters, or others who felt morally or legally responsible for them.

Thirteen thousand seven hundred and seventy enrolled for option 1, $10,000 maximum, major medical only. Four thousand eight hundred and ninety-one enrolled for option 2, $5,000 maximum, major medical only. Thus, 85 percent did not enroll for basic benefits. This confirmed the belief of the participating companies that a great preponderance of Connecticut's elder citizens already had basic medical and hospitalization protection; 3,181 enrolled for one of the major medical options plus the Connecticut 65 basic benefits; the average age of those enrolling was almost 75 years; 14,904 of the enrollees were females.

The period of a fixed 1-month enrollment was selected and adhered to for two reasons. First, there was the obvious underwriting reason: to prevent antiselection by those who might otherwise defer enrollment until the time they knew they would be hospitalized. More important was the human foible of procrastination, with action spurred only by a categorical deadline. For example, on September 25, 5 days before the close of the enrollment on midnight of a Saturday, only 7,193 enrollments had been received. More enrollments were received during the last day of the enrollment period than during the first 3 weeks.

Almost 50 percent of the enrollment was received as the result of the activities by agents. The Connecticut Insurance Department permitted any resident Connecticut agent, licensed to write health insurance, to participate in the Connecticut 65 plan, whether or not the company with which he held a contract was a participating company in that plan. Commissions for agents ranged from $5 for the $5,000 major medical (option 2) to $10 for the larger major medical combined with basic (option 3). Thus, an agent could earn as much as $20 for a sale to a couple. Commissions are payable only at the inception of the coverage. However, it was the expressed intention of the Associated Connecticut Health Insurance Cos., if commissions on all policies not received through agents had exceeded advertising expenses, to allocate the difference among agents in proportion to their writings.

As far as marketing is concerned, our experience indicates that a short but intensive communications campaign is the proper approach, and that the promotional team should be organized early and be kept fully advised as to the development of the program. Representatives of the agency forces of the State should be brought into the picture as soon as practicable and their active support secured, not only for the purposes of seeking their endorsement of the necessary legislation, but also for communication of the program to the insuring public.

IV. STATISTICS CONCERNING CONNECTICUT'S AGED POPULATION

The companies developing the plan considered it feasible for other reasons, which included the economic standing of Connecticut's elderly population; the fact that three out of four already had some sort of basic health insurance; and the compact size of Connecticut.

Connecticut is a small State, 49th in area, any part of which can be reached in little over an hour's drive from Hartford.

Its population totals 2,535,000. Of this number, about 10 percent, or 242,615, are age 65 and over. The real market, however, for the plan was in reality far below this figure. For example, 25,000 of the elderly are confined to State and Veterans' Administration institutions. Fourteen thousand receive medical care and living payments through the old-age assistance program.

Another 55,000 are still employed (with their wives, this total swells to some 92,000), and certainly a very large percentage of this group is covered under employer-sponsored group insurance programs. Furthermore, an increasing number of group plans are continuing major medical coverage for retired employees.

In addition, Connecticut has implemented the Federal Kerr-Mills program, and effective April 15, 1962, it is expected that there will be an additional 35,000 persons whose income and asset status makes them eligible for the payment of a considerable part of their medical-care expense through tax funds. After application of a $100 deductible under the Connecticut Kerr-Mills Act (Public Act 578, 1961), the actual claimants in any 1 year are expected to number some 11,000.

Thus, after eliminating those who may not have a need for coverage of the type provided under the Connecticut 65 program, the real market was about one-half the total of age 65 and over in the State. Threfore, the number enrolling during the intial 1-month enrollment period represents 20 percent of the real market.

Connecticut is also a wealthy State. Its average social security benefits are at the highest level in the country, and the income and assets, including home ownership, of its elderly population are also well above the national average.

The drafters of Connecticut 65 felt that this program could help many persons from becoming medically indigent under the Connecticut Kerr-Mills program. This in turn would lower the tax costs of the State of Connecticut.

Consequently, there is no exclusion under the Connecticut 65 plan for expenses which otherwise would be payable under the Kerr-Mills program in the absence of this insurance. In other words, Connecticut 65 will pay so that Kerr-Mills program will not have to pay.

Mr. LAUSCHE. Mr. President, will the Senator from Connecticut yield?

The PRESIDING OFFICER (Mr. BURDICK in the chair). Does the Senator from Connecticut yield to the Senator from Ohio?

Mr. BUSH. I yield.

Mr. LAUSCHE. Would the plan proposed by the Senator from Connecticut be financed through the social security?

Mr. BUSH. Yes, it would be financed by an increase of one-fourth of 1 percent in the tax on employers and employees, and would produce an estimated $1,100 million in the first year.

Mr. LAUSCHE. Would the fund accumulated through the increased tax be mingled with the general social security fund which now exists, or would it be separate?

Mr. BUSH. This money would go into the general fund, but in a special account—the health insurance account, to be available only for use as described in the amendment.

Mr. LAUSCHE. Am I correct in understanding that the amendment proposed by the Senator from Connecticut contemplates adding to the normal payments made to a social security beneficiary the sum of $9 a month, totaling $108 a year, to be used by him to buy health insurance in private companies?

Mr. BUSH. Yes, in the open competitive market; that is correct. Of course, the figures $9 and $108 are estimates; but I think they are reliable estimates, based on the fact that this tax will produce about $1.1 billion.

Mr. LAUSCHE. If the beneficiary is paid this money, must he buy a policy of coverage?

Mr. BUSH. He cannot have the money unless he is going to buy a certified life insurance program, under State supervision, in whatever State it may be.

Mr. LAUSCHE. In other words, he cannot accept the $9 a month and just keep it?

Mr. BUSH. Yes, it cannot be used for any purpose except the purchase of health insurance, and it has to be certified; and if the individual so chooses, he could arrange for the Department itself to pay directly to the insurance company

agreed upon or specified by the individual. When he agreed that he would buy a particular health-insurance program, the premiums could be paid directly by the Government agency to the insurance company.

Mr. LAUSCHE. The Senator from Connecticut stated that the amendment allows flexibility to the beneficiary in choosing the type of policy of health insurance he will buy.

Mr. BUSH. That is correct; and in a few moments I shall show what a variety of health-insurance programs are available to persons 65 years of age or over. Quite a wide range of health-insurance policies is available from many of the great insurance organizations, in addition to Blue Cross and Blue Shield. For instance, in that connection I mention the Prudential Life Insurance Co.; I also mention the Metropolitan Life Insurance Co., the largest insurance company in the country; and there are other insurance companies, as well as mutual companies and nonprofit organizations, which are offering a great variety. I have already referred to the four options available under the Connecticut 65 plan; and there are others.

Mr. LAUSCHE. Under the Anderson bill, would the beneficiary be indemnified for his medical expenses incurred when he employed physicians?

Mr. BUSH. My understanding is that they do not touch it. Nothing in the King-Anderson bill—and I do not believe this has been changed by the merger with the Javits amendment—permits the payment of doctors' fees or surgical fees.

Mr. LAUSCHE. How would the proposal of the Senator from Connecticut handle that phase of it?

Mr. BUSH. The program of the Senator from Connecticut gives the individual money with which he may select a health insurance plan which may or may not include payments to surgeons or doctors, so that it is up to the individual whether he wants to use the money to buy that kind of program or whether he wishes to buy one which would provide money to pay only for hospital or nursing home care—which is all the Anderson measure provides for. So my proposal leaves it up to the individual to choose.

The needs of the people may be different. One person's needs may be different than another's. One person may be financially better off than another. I do not profess that every citizen who may be under social security and who has attained the age of 65 will be able to use the program suggested by me to completely cover every conceivable need that may occur, but certainly that cannot be said for the Anderson bill. As I shall show in a little while, there is evidence that the Anderson bill covers less than 25 percent of the medical costs which confront the elderly.

The substitute I speak of is much more versatile, and gives a person a chance to choose what kind of health insurance he is going to use and gives him the money for it.

One of my objections to the Anderson bill is that it does not give money; it gives service in kind. This is in contradiction to the social security system, which is a cash system. It provides for a tax which produces cash money. It is paid out in money, at $100 a month, or whatever the entitlement of a person is who gets to be 65.

My proposal follows that pattern. It is a cash system. It raises the money any pays it out in amounts that are determined as the measure suggests, so the person himself can buy what he needs in the way of health insurance, or at least helps him buy it.

The social security law does not guarantee a man clothing, shelter, and food, which is distributing social security in kind. Instead, it give a person cash to supplement whatever other resources he may have to provide the necessities of life. It has proven to be a pretty sound system. I am sure the people would not repeal it in any kind of referendum. My proposal follows that pattern.

Mr. LAUSCHE. It is the Senator's position that when the cost is fixed at $9 a month, we know what the whole structure is going to cost. Is that correct?

Mr. BUSH. That is correct. I am not "dancing in the dark" about the cost of it. I am not saying it will cost $1.2 billion and then find it may cost twice as much, which it has been estimated by actuaries in the insurance business is true of the Anderson proposal.

Mr. LAUSCHE. What does the Senator from Connecticut estimate will be the cost of his plan?

Mr. BUSH. Within the amount of $1.1 billion and $1.2 billion a year, because that is what would be produced under the tax.

Mr. LAUSCHE. And the benefits being paid in dollars, we know what the cost will be. Is that correct?

Mr. BUSH. Yes. We know how many eligible members there will be. I estimate there will be about 12 million persons eligible under the social security system who would be eligible for these benefits. We divide that number into $1.2 billion and arrive at the cost of approximately $100 a year.

Mr. LAUSCHE. The Senator says that the King-Anderson bill provides services in kind, and therefore the cost of it cannot be estimated to any degree of reasonable accuracy.

Mr. BUSH. I think that is one of the gravest criticisms that can be made of it. I think it is a very dangerous bill from that angle. There is no limitation in cost.

Mr. LAUSCHE. Will the Senator repeat the testimony on the estimated cost of the King-Anderson bill?

Mr. BUSH. I said it was estimated by the Department of Health, Education, and Welfare that it would cost $1,200 million a year. I said insurance actuaries of great experience in the insurance industry have estimated it would cost twice that amount, or $2½ billion.

I also said that actuaries in the employ of the New York Board of Trade have estimated that, had the bill been in effect in 1960, it would have cost $4,300 million. They say other estimates support that conclusion. So it can be seen what a drain such a law could possibly be upon the social security system. It could bankrupt it.

That cannot be done under my amendment, because no more could be spent than was taken in by the tax, and if it was necessary to increase the spendable money, then the tax would have to be increased. But it would be done affirmatively, and would not sneak up behind us, the way I am afraid will happen under the King-Anderson bill.

Mr. LAUSCHE. How does the Senator answer the argument that is made that there may be beneficiaries who will not be accepted as insurable risks by private companies?

Mr. BUSH. I shall answer that question in some detail.

Mr. LAUSCHE. I will not press the question at this time, then.

Mr. BUSH. I shall go into it. Several plans are already in operation. For instance, under the senior citizen hospital surgical group plan, they make no medical examination and there is no health requirement for the group protection. That plan is in existence now. I hold another such plan in my mind.

I shall go into it in some detail, if the Senator will permit me to do so.

Mr. LAUSCHE. Very well.

If I may now direct the Senator's attention to the final draft of the Anderson bill, which has some provisions allowing the beneficiary to become covered in a private insurance company, as distinguished from payments of services in kind, my recollection is that that amendment provides he shall have the right to be insured in a private company only if he had, previous to his retirement, been the holder of a policy. Is the Senator familiar with that phase of it?

Mr. BUSH. My impression is that the Senator is correct in that.

Mr. LAUSCHE. Perhaps I should ask that question of some of the proponents of the measure.

Mr. BUSH. I think they can answer it with more certainty, but I believe the Senator is correct.

Mr. LAUSCHE. But, to summarize, it is the Senator's position that complete freedom will be granted the individual to obtain hospital care, nurses, and doctors, and that the beneficiary will not be tied to regulations and laws of the Federal Government. The money will be given to him, and he will have, out of it, money for coverage against medical expenses and hospital expenses and whatever other insurance he wishes to buy for the amount received.

Mr. BUSH. The Senator is correct. This proposal is simply an extension of an existing system. There are thousands of health care insurance plans in effect now for people under 65. There are thousands of health care insurance plans in effect for people 65 and over. All we are doing is giving to these large numbers of senior citizens, 55 percent of whom, as I said, have incomes of $1,000 or less, the benefits of this program. What we would do is give them premium money up to $9 a month so they can buy some of these health insurance plans already on the market. It does not have any more effect on the doctors than the

existing situation has, and such plans are available in the free market.

Mr. LAUSCHE. Every retired person of the age of 65 would be eligible to receive a policy of health insurance if he was covered by social security. Is that correct?

Mr. BUSH. That is correct. The railroad retirement system would be blanketed in, also.

Mr. LAUSCHE. How would the Senator take care of those persons not under social security?

Mr. BUSH. I have not attempted to go that far. The social security plan itself does not take care of those persons. I have tried to keep my amendments in tune with the social security system as it is today.

Mr. LAUSCHE. The Kerr-Mills law would take care of them.

Mr. BUSH. The Kerr-Mills law is extant and is available to those who demonstrate need, as determined by each State to suit itself. There is, of course, that backstop in effect now.

I would say that a large number of the people the Senator probably has in mind would find the Kerr-Mills assistance available.

Mr. LAUSCHE. I thank the Senator.

Mr. KEATING. Mr. President, will the Senator yield?

Mr. BUSH. I am glad to yield.

Mr. KEATING. In order to clear the record, the revised Anderson amendments also would take care of those not under social security.

Mr. LAUSCHE. Would the Senator please repeat that statement?

Mr. KEATING. The revised Anderson amendments would take care of those persons not under social security.

Mr. LAUSCHE. But not out of the social security taxes; instead, out of the general funds of the taxpayers; is that correct?

Mr. KEATING. That is correct.

Mr. BUSH. Mr. President, I have welcomed the questions of my good friend from Ohio, which have helped me to develop the subject materially.

I wish to turn now to an illustration of some of the health insurance plans which are available, as set forth in the Health Insurance Institute's brochure.

For instance, there are what are called the senior citizen hospital-surgical group and group approach plans, which have a selected yearly premium range from $78 to $108 for people 65 years of age and over. The mass enrollment technique is involved. Applicants are eligible irrespective of their past medical histories and without medical examinations. The selected yearly premium range, which I mentioned, is from $78 to $108, for all persons 65 years of age and over, at a universal premium charge.

This plan provides, as I say, no medical examination, no health requirement, and group protection. It provides for daily room and board. It provides $10 a day for a duration of 31 days. It has an allowance for extras, including 50 percent of the charges up to $125 maximum. It has a maximum surgical schedule of $200. The entrance age is up to "65 plus." There are extra benefits, such as outpatient emergency accident service.

That is only one approach to the problem. There are also the senior citizen lifetime guaranteed renewable hospital-surgical expense plans, with selected yearly premiums ranging from $86.60 to $244.75. This is a senior citizens' lifetime guaranteed renewable hospital-surgical expense plan with variable allowances for daily room and board, variable protections from 21 days up to 60 days, miscellaneous extras from $50 to $100. The maximum surgical schedule varies from $150 to $300. That plan is available.

Rather than go into any great detail in regard to the various plans, I ask unanimous consent that the plans and tables marked in the bulletin I hold in my hand, from page 5 to the bottom of page 14, may be printed in the RECORD at this point in my remarks.

There being no objection; the tables were ordered to be printed in the RECORD, as follows:

I. SENIOR CITIZEN HOSPITAL-SURGICAL GROUP AND GROUP APPROACH PLANS

Selected yearly premium range: $78–$108, 65 and over.

These plans, providing hospital and surgical expense benefits to those 65 and over, are offered by insurance companies under a mass enrollment technique. Enrollment can be either made during specified time periods on a statewide basis or all-year-round by personal application on reaching age 65.

Offering hospital room-and-board benefits up to $10 a day, these plans pay benefits for as long as 31–140 days during hospital confinement. Additional benefits are paid to help meet other extra hospital expenses such as drugs, laboratory fees, surgical charges, and even the costs of care in nursing homes.

Applicants are eligible irrespective of their past medical histories and without medical examinations. Some plans, however, require the newly insured person with a preexisting health condition to wait 6 months before benefits are available for that particular condition.

Protection of these plans cannot be terminated for any individual policyholder—only for State residents as a group. Similarly, premium charges can only be adjusted for an entire group—not on an individual policyholder basis.

An association group plan, sponsored by the American Association of Retired Persons, is available to persons 65 and over after first joining the association for a membership fee of $2. This plan provides benefits for hospital, surgical, and hospital out-patient treatment. It also has optional benefits covering doctor visits, nursing home care, and extended hospitalization periods.

The selected yearly premium range noted above for the plans listed is for all persons 65 and over, at a universal premium charge.

TABLE I.—*Senior citizen hospital-surgical group and group approach plans: No medical examination, no health requirement, group protection*

Name of plan	Daily room and board	Duration of stay (days)	Miscellaneous extras	Maximum surgical schedule	Entrance age up to—	Extra benefits	Remarks
American Association of Retired Persons, 711 14th St. NW., Washington, D.C.: Group hospital-surgical plan.[1]	$10	31	50 percent of charges to $125 maximum.	$200	65 plus	(1) Outpatient emergency accident.	Optional benefits: 50 doctor calls each year; hospital, home, office, nursing home above $25 deductible; post-operative nursing home; 29 days additional hospital room and board at $7.50 a day. 12 months' waiting period on conditions hospitalized in 12 months preceding membership of plan.
Continental Casualty Co., 310 South Michigan Ave., Chicago, Ill.: 65-plus plan.[2]	$10	31	$100	200	do		6 months' waiting period on preexisting conditions. In addition to general enrollments, plan also open to persons applying within 30 days before or after 65th birthday.
Fireman's Fund Insurance Group, 3333 California St., San Francisco, Calif: Fund 64.[3]	$10	31	$100	200	do		6 months' waiting period only on conditions with medical history.
The Ministers Life & Casualty Union 3100 West Lake St., Minneapolis, Minn.: Senior health plan.	To $10 [4]	140 (reduced to 70 days at age 70).	To $160 by assignment.	150	60 plus	(1) Outpatient emergency accident, (2) home nursing, (3) poliomyelitis.	6 months' waiting period on preexisting conditions. Open on enrollment to ministers, their wives or widows. (Program cannot be terminated or premium changed unless done for all policyholders.)

Footnotes at end of table.

TABLE I.—*Senior citizen hospital-surgical group and group approach plans: No medical examination, no health requirement, group protection*—Continued

Name of plan	Daily room and board	Duration of stay (days)	Miscellaneous extras	Maximum surgical schedule	Entrance age up to—	Extra benefits	Remarks
Mutual of Omaha, 33d and Farnam Sts., Omaha, Nebr: Senior security plan.[4]	$10	60	Above a $100 deductible 80 percent of charges to maximum of $1,000.	$225	65 plus	(1) Nursing or convalescent home $5 a day up to 55 days following 5 days' hospitalization.	6 months' waiting period on preexisting conditions.
National Retired Teachers Association, 711 14th St. NW., Washington, D.C., in-hospital plan:							
Plan A	To $15	31 plus $10 daily room and board next 90 days.	50 percent of charges to $120 maximum.	200	No age limit	(1) Outpatient hospital service, (2) postoperative nursing home, (3) in hospital medical.	Optional benefit: 50 doctor visits; home, office, and nursing home.
Plan B	$10	31 plus $7.50 daily room and board next 29 days.	do	200	do	(1) Outpatient treatment, (2) postoperative nursing home.	12 months' waiting period on conditions hospitalized in 12 months preceding membership of plan. Program open during enrollment to retired teachers.
New York State Retired Teachers Association, Leonard Davis & Co., Inc. (consultants to NYSRTA) 18 Dove St., Albany, N.Y.: Group hospital-surgical-medical health plan:							
Plan A	$12	31 plus $10 daily room and board next 90 days.	$120 plus 50 percent of next $180.	200	do	(1) Outpatient treatment; (2) in-hospital medical; (3) postoperative nursing home care.	12-month waiting period on prehospital conditions. Programs open during enrollment to New York State retired teachers.
Plan B	$12	31	$120	200	do	(1) In-hospital medical; (2) outpatient treatment; (3) postoperative nursing home care.	
Plan C	$12	31 plus $10 daily room and board next 90 days.	$120 plus 50 percent of next $180.	200	do	(1) In-hospital medical; (2) 50 doctor calls each calendar year—home, office, nursing home; (3) outpatient treatment; (4) postoperative nursing home care.	

[1] See AARP out-of-hospital major medical plan, table IV, below.
[2] See Continental Casualty Co's. major hospital $5,000 reserve plan, table IV, below.
[3] See Fireman's Fund Insurance Group's plus $10,000 plan, table IV, below.
[4] Maximum $1,200 for hospital room and board, miscellaneous and nursing care in any one year; over age 70, $900 maximum.
[5] See Mutual of Omaha's $50-a-week special security plan, table III, below.
[6] See National Retired Teachers Association's out-of-hospital major medical plan, table IV, below.

II. SENIOR CITIZEN LIFETIME GUARANTEED RENEWABLE HOSPITAL-SURGICAL EXPENSE PLANS

Selected yearly premium range: $86.60–$244.75, male 65.

Americans, past 60, who desire hospital and/or surgical expense protection on a guaranteed renewable individual or family basis can choose from a multitude of insurance companies' policies.

These policies generally offer hospital room-and-board benefits from $5 to $25 a day with a wide selection of additional benefits for extra hospital expenses. Surgical allowances under these policies can range up to $500.

As with other guaranteed renewable lifetime policies, the insured person only can terminate the policy and the insurance company can only adjust premiums by policyholder class.

Benefits are paid for periods from 31–365 days. Entrance ages for applicants are 61 and over.

The selected yearly premium range noted above for the policies listed was calculated for a man of 65 at maximum policy benefits.

TABLE II.—*Senior citizen lifetime guaranteed renewable hospital-surgical expense plans*

Company	Daily room and board	Duration of stay (days)	Miscellaneous extras	Maximum surgical schedule	Entrance age up to—	Extra benefits
Aetna Life Insurance Co., 151 Farmington Ave., Hartford, Conn.	$5 $7.50 $10	21 30 60	$50 $75 $100 Optional $25–$50–$100 deductible.	$150 $225 $300	80+	(1) Outpatient surgery.
American National Insurance Co., Moody at Market Sts., Galveston, Tex.	$5 $5 to $25	365	$425, by assignment	$300	75+	(1) Outpatient hospital; (2) medical—hospital, home, office; (3) nursing benefit.
Atlantic Life Insurance Co., 609 East Grace St., Richmond Va.	$5 to $18	90	1st day, $20 to $72; 7 days plus, $50 to $180.	$200	75	(1) Emergency accident, (2) poliomyelitis.
Bankers Life Co., 711 High St., Des Moines, Iowa.	$5 to $25	50	$50 to $250	$250 to $450	75	(1) Poliomyelitis.
Business Men's Assurance Co. of America, 215 Pershing Rd., Kansas City, Mo.	$7 to $24	45	80 percent of charges up to maximum $100.	$200	80	(1) Emergency accident.
The Colonial Life Insurance Co. of America, 111 Prospect St., East Orange, N.J.	$5 to $20	60	$50 to $200. Optional $25–$50–$100 deductible.	$400	75	(1) Outpatient surgery, (2) outpatient service, (3) emergency accident, (4) in-hospital medical.
Columbian Mutual Life Insurance Co., 305 Main St., Binghamton, N.Y.	$5 to $25	30	$75 to $375	$250	80	(1) Emergency accident.
Country Life Insurance Co., Post Office Box 575, Bloomington, Ill.	$5 to $20	120	$50 [1] to $200.[1] Optional $50–$100 deductible.	$200 to $300	75	(1) Outpatient hospital emergency accident, (2) in-hospital medical.
Empire State Mutual Life Insurance Co., 315 North Main St., Jamestown, N.Y.	$5 to $15	50	$30 to $90	$200	80	(1) Registered nurse in home, (2) Home-office-hospital medical, (3) out-patient.
Farmers and Traders Life Insurance Co., 960 James St., Syracuse, N.Y.	$5 to $20	45	$50 to $200	To $200	79	(1) In-hospital medical, (2) Hospital outpatient service.

Footnotes at end of table.

TABLE II.—*Senior citizen lifetime guaranteed renewable hospital-surgical expense plans*—Continued

Company	Daily room and board	Duration of stay (days)	Miscellaneous extras	Maximum surgical schedule	Entrance age up to—	Extra benefits
General American Life Insurance Co., 1501 Locust St., St. Louis, Mo.	$5 to $20	120	$100 to $200. Optional $50 to $100 deductible.	$200 to $300	75	(1) In-hospital medical.
Girardian Insurance Co., 100 Exchange Park North, Dallas, Tex.	$10 to $15	100	$30 to $100	$300	80	(1) Ambulance service, (2) emergency accident, (3) nursing expense up to 10 days.
Great American Reserve Insurance Co., 2020 Live Oak, Dallas, Tex.	$8 to $25	31	$250 [2]	$360 to $420	80	
The Guardian Life Insurance Co. of America, Park Ave. South at 17th St., New York, N.Y.	$10 $15 $20	[3] 50	$100 $150 $200 Mandatory $50 deductible.	$150 $225 $300	60+	(1) Guaranteed lifetime premium.
Illinois Mutual Life & Casualty Co., 411 Liberty St., Peoria, Ill.	$6 to $15	40	$100. Optional benefit: Accidental death and dismemberment.	$200 to $400	74	
Inter-Ocean Insurance Co., 2600 Victory Parkway, Cincinnati, Ohio.	$5 to $15	60	$100 to $300	$200 to $400	80+	(1) In-hospital medical.
John Hancock Mutual Life Insurance Co., 200 Berkeley St., Boston, Mass.	$8 to $15	50	$64 to $120. Mandatory $25 deductible.	$250	75	
Life Insurance Co. of Georgia, 573 West Peachtree St. NE., Atlanta, Ga.	$6 to $10	31	1st day, $30 to $50; 5 days plus, $60 to $100. Optional $15 deductible.	$150 to $250	80	(1) Poliomyelitis.
The Lincoln National Life Insurance Co., 1301–27 South Harrison St., Fort Wayne, Ind.	$5 to $20 $25 [4]	120	$60 to $240 $625,[4] $1,250 [4]	$200 to $400	71+	(1) Emergency accident.
Lumbermen's Mutual Casualty Co., 4750 Sheridan Rd., Chicago, Ill.	$8 to $10	60	$80 to $100. Mandatory $25 deductible	$200 or $300	75	(1) Emergency hospital accident.
Metropolitan Life Insurance Co., 1 Madison Ave., New York, N.Y.	$7.50 to $20	42	$60 to $160	$250 to $500	80	(1) Poliomyelitis.
Monarch Life Insurance Co., 1250 State St., Springfield, Mass.	$5 to $30	180	$100 to $750. Optional $25–$50 deductible. Optional benefit: Supplementary accident.	$300 to $600	61+	
The Mutual Life Insurance Co., o 1New York, 1740 Broadway at 55th St., New York, N.Y.	$8 to $15	45	$80 to $150. Optional $25–$50 deductible.	$250	80	(1) Poliomyelitis.
Nationwide Mutual Insurance Co., 246 North High St., Columbus, Ohio.	$10	30	100 percent of 1st $100; 80 percent of next $250.	$200	65+	(1) In-hospital medical, (2) home nursing, (3) out-patient expense, (4) nursing home.
New York Life Insurance Co., 51 Madison Ave., New York, N.Y.	$5 to $15	60	$50 to $150. Mandatory $25 deductible.	$250	75	(1) Additional hospital allowance fo major surgery, (2) poliomyelitis.
North American Life & Casualty Co., 1750 Hennepin Ave., Minneapolis, Minn.	To $20 [8]	40	To $200. Optional benefits: Supplementary accident; death and dismemberment; in-office-home-hospital medical.	$250	70	
The Ohio State Life Insurance Co., 366 East Broad St., Columbus, Ohio.	$5 to $20	120	$50 to $200 $125 [5] to $500 [5] Optional benefits: In-hospital medical; accident expense treatmeut.	$200 to $300	75	
Pacific Mutual Life Insurance Co., 523 West 6th St., Los Angeles, Calif.	$10 to $20	45	$100 to $200. Optional $30–$40–$50 deductible.	$300 to $500	80	
The Prudential Insurance Co. of America, Prudential Plaza, Newark, N.J.	$8 to $16	35	$60 to $120. Optional $50 deductible	$250	75	(1) Poliomyelitis.
Reserve Life Insurance Co., 403 South Akard St., Dallas, Tex.	$8,[6] $10,[6] $12 [6]	[7] 180	Customary charges for operating room; dressings, splints, casts; respiratory equipment plus additional allowances for other specified services. Optional benefit: $5,000 specified disease supplement.	$300	75+	(1) In-hospital private duty nurse for accident, (2) first-aid treatment.
Medical surgical	$200 surgical; yearly aggregate $300 medical in hospital, home, office with additional allowances for treatments; nurse benefit; accident.				75+	
State Mutual Life Assurance Co., of America, 440 Lincoln St., Worcester, Mass.	$5 to $20	90	$50 to $200. Optional $50 deductible	$200 to $400	85	(1) In-hospital medical, (2) emergency accident.
Teachers Protective Mutual Life Insurance Co., 116–118 North Prince St., Lancaster, Pa.	$5 to $20 $5 to $15	120 120	$100 to $250 $100 to $250. Optional $25–$50–$100 deductions.	$100 to $400 $100 to $200	69 85	(1) Outpatient hospital, (2) private nurse in home.
The Travelers Insurance Co., 700 Main St., Hartford, Conn.	do	50	3 days, $25 to $75; 8 days plus, $50 to $150.	$200 to $300	75+	(1) Emergency accident.
Union Mutual Life Insurance Co., 400 Congress St., Portland, Maine.	$5 to $25	31	$25 to $125 or $50 to $250. Optional $50 deductible. Optional benefit: In-hospital medical; diagnostic expense.	$200, $300, and $400.	70	
Washington National Insurance Co., 1650 Chicago Ave., Evanston, Ill.	$8 to $12	31	$80 to $120. Optional $25–$50–$100 deductible.	$200 to $300	61+	Do.
Wisconsin National Life Insurance Co., 220 Washington Ave., Oshkosh, Wis.	$10 to $25	35	1st day; $45 to $112.50, plus $10 each day thereafter for remainder of benefit period; 7 days plus $140 to $350.	$400 [8] to $500 [8]	75	
Woodmen Accident & Life Co., Woodmen Accident & Life Bldg., 1526 K St., Lincoln, Nebr.	$5 to $25	100	$100 to $200. Optional $25–$50–$100 deductible. Optional benefit: In-hospital medical.	$150 to $450	70+	
World Insurance Co., 203 South 18th St., Omaha, Nebr.	$5 to $20	31	$50 to $200	$150 to $300	75	(1) Ambulance, (2) outpatient accident.

[1] With $50 deductible, $125 to $500; with $100 deductible, $250 to $1,000.
[2] Mandatory $25 deductible.
[3] In 12 consecutive months.
[4] With optional $50–$100 deductible.
[5] With optional $50 deductible.
[6] Other plans available—$6 daily room and board, 180 days, $250 surgical; $4 daily room and board, 60 days, $200 surgical.
[7] 30 additional days each year policy in force to maximum 365 days.
[8] Surgical schedule determined by daily room and board.

III. Weekly or Daily Benefit Senior Citizen Hospital Expense Plans—Group Approach and Guaranteed Renewable for Life

Selected yearly premium range: $54 to $168.50, male 65.

These policies pay a stated dollar allowance, ranging from $25 to $210, for a maximum number of weeks while the insured person is under hospital care. Benefits provided are designed to meet the added expenses of the policyholder's hospitalization.

Under a group approach plan, persons 65 and over can make application for this protection during specified enrollment periods. The plan is issued regardless of the applicant's present health condition and without medical examination.

Premiums can be modified only for the entire State group and protection cannot be terminated for an individual policyholder—only for the group as a whole. This particular group-type plan is issued as a supplement to a basic "Senior Security" health insurance plan. (See section I.)

Under guaranteed renewable policies which provide benefits for lifetime, the insured person has the sole right of policy termination. The insurance company can adjust premiums only on a policyholder class basis.

The selected yearly premium range noted above for the plans listed was calculated for a man 65 years of age at maximum weekly plan benefits.

Table III.—*Weekly or daily benefit, senior citizen hospital expense plans—Group approach and guaranteed renewable for life*

Company	Maximum benefit	Duration	Entrance age up to—
American Casualty Co. of Reading, 412 Washington St., Reading, Pa.	$25 to $175	26 weeks hospitalization each accident or illness; duration of stay after 65, 13 weeks hospitalization each accident or illness.	59
Girardian Insurance Co., 100 Exchange Park North, Dallas, Tex.:			
Under 60	$50 to $150	Up to 50 weeks [1]	60
Over 60	$50 to $100	do	75
Insurance Co. of North America, 1600 Arch St., Philadelphia, Pa.	$70, $105, $125, $140, $210, with $300 surgical	8 weeks' hospitalization each accident or illness; same plan for under 65.	75
Mutual of Omaha, 33d and Farnam Sts., Omaha, Nebr.:			
Over 65	$25 or $50 a week to $150 a week	Up to 13 weeks' hospitalization each accident or illness.	74
Under 65	$25 or $50 a week	Up to 50 weeks' hospitalization each accident or illness; 4 weeks after 65.	59
Mutual of Omaha, 33d and Farnam Sts., Omaha, Nebr.: Group approach, issued in conjunction with senior security plan (see sec. 1) regardless of medical history and without medical examination to all persons 65 and over.	$50 a week	Up to 50 weeks' hospitalization	65+
Provident Life & Accident Insurance Co., Fountain Sq., Chattanooga, Tenn.: Over 65.	$5 a day, $7 a day, $10 a day, with optional $200 surgical.	365 days' hospitalization each accident or illness; same plan for under 65.	75
World Insurance Co., 203 South 18th St., Omaha, Nebr.	$100 a month [2] to $400 a month [2]	12 months; same plan for under 65.	80

[1] After policy is in force for 1 year, 10 additional weeks will be added for each of the next 5 years making a total of 50 additional weeks.
[2] This plan pays monthly benefit.

IV, Senior Citizen Catastrophic Expense Plans

Selected yearly premium range: $55 to $211.75, male 65.

Under these policies, persons 65 and over can choose benefits toward the expenses of prolonged hospital and/or medical care. Each of these plans has a deductible feature which the insured person must satisfy before policy benefits commence. Some have a sharing of expenses (coinsurance) by the policyholder above the specified deductible.

All the plans listed have a lifetime guarantee. Requirements for enrollment vary according to whether a group or individual insurance technique is used. Dependent upon the particular plan, there may or may not be a health requirement for application.

Benefits under these plans for hospital and/or medical catastrophic expenses can reach a maximum of $7,500 to $10,000.

A recent innovation in Connecticut by insurance companies has made available to all residents 65 and over a statewide plan offering protection against catastrophic medical expenses and basic hospital charges.

The selected yearly premium range noted above for the plans listed was calculated for a man 65 years of age with full plan benefits.

Table IV.—*Senior citizen catastrophic expense plans*

Name of plan	Maximum benefit	Deductible	Coinsurance	Entrance age up to—	Renewability	Remarks
Senior citizen major hospital plans: Continental Casualty Co., 310 South Michigan Ave., Chicago, Ill.	$5,000	$500	No coinsurance	[1] 65+	Group approach (see sec. I).	Plan covers hospital charges for room and board to limit of $25 a day together with hospital miscellaneous services.
Fireman's Fund Insurance Group, 3333 California St., San Francisco, Calif.	$10,000	$200	20 percent	[2] 65+	do	6 month's waiting period only on conditions with medical history—Plan covers hospital charges for room and board together with hospital miscellaneous services.
Metropolitan Life Insurance Co., 1 Madison Ave., New York, N.Y.	$5,000, with $15 a day hospital room for 180 days with $250 surgical schedule.	$50 [3]	20 percent [3]	65+	Guaranteed renewable for life.	Extra benefits—medical and private nurse in hospital; nursing home.
	$10,000, with $25 a day hospital room for 240 days with $500 surgical schedule.	$50 [3]	do.[3]	65+	do	
Mutual of Omaha, 33d and Farnam Sts., Omaha, Nebr.	$5,000 with $25 a day hospital room.	$250, $500	20 percent	65+	do	Extra benefit—In hospital private duty nursing.
Senior citizen major medical expense plans: American Association of Retired Persons, 711 14th St. NW., Washington, D.C.	$10,000 [4] (lifetime); $2,500 [4] (yearly).	$100 in calendar year for out-of-hospital expenses.	20 percent [4]	65+	Group contract noncancellable for individual.	6 months' waiting period only on conditions with medical history within 6 months prior to effective date of contract.
Connecticut State plan: Associated Connecticut Health Insurance Companies.	$10,000 [5] (lifetime); $5,000 [5] (yearly).	$100 in calendar year with basic hospital plan.	20 percent [6]	[7] 65+	Lifetime unless terminated for all residents of State.	Basic hospital plan available if desired.
Mutual of Omaha, 33d and Farnum Sts., Omaha, Nebr.	$5,000, $7,500, $10,000	$500,[8] $750,[8] $1,000	25 percent	75+	Lifetime guarantee regardless of change in health.	

Footnotes at end of table.

TABLE IV.—*Senior citizen catastrophic expense plans*—Continued

Name of plan	Maximum benefit	Deductible	Coinsurance	Entrance age up to—	Renewability	Remarks
National Retired Teachers Association, 711 14th St. NW., Washington, D.C.	$10,000 [9] (lifetime); $2,500 [9] (yearly).	$100 in calendar year for out-of-hospital expenses.	20 percent [6]	([10])	Group contract noncancellable for individual.	6 months' waiting period only on conditions with medical history within 6 months prior to effective date of contract—Open on enrollment only to retired teachers.
Washington National Insurance Co., 1630 Chicago Ave., Evanston, Ill.:						
Plan A	$1,000 [11] to $6,000 [11]	$50, $100, $250,[12] $500,[12] $750.[12]	Internal limits on hospital room and board; convalescent home; surgery; physician and private nursing services; 20 percent coinsurance on miscellaneous hospital services; ambulance; X-rays; laboratory tests; drugs; medical supplies and rental of medical equipment; physician and private nursing services.	69	Guaranteed renewable for life.	
Plan B	$1,000 [11] to $2,500 [11]	$100, $250,[12] $500,[12] $750.[12]	do	70	do	Optional benefit: Guarantee right to increase coverage in future without evidence of insurability.

[1] Plan available only to people 65 and over regardless of medical history and without medical examination during enrollment periods.
[2] Available only to members of the fund/65 plan.
[3] Deductible and coinsurance apply to charges for miscellaneous hospital services, medical and private duty nursing; plan pays 80 percent of such charges and 100 percent of other services up to the aggregate maximum benefit each accident or illness.
[4] With internal limits, plan pays 80 percent of specified medical expenses in hospital, home, or nursing home to annual maximum on out-of-hospital expenses.
[5] $5,000 lifetime plan also available.
[6] Plan pays 100 percent of the first $250 for hospital charges including miscellaneous services and room and board to $18 a day and 80 percent thereafter; 80 percent of surgical fees according to $600 schedule; 80 percent of physicians' fees up to $6 a day; 80 percent of private nurse up to $18 a day—all expenses not to exceed the $5,000 yearly maximum.
[7] Open only to residents of the State of Connecticut 65 years of age or older, Sept. 1, 1961.
[8] Choice of deductibles available with all maximum benefits.
[9] With internal limits, plan pays 80 percent of specified medical expenses out of hospital or in nursing home up to annual maximum.
[10] No age limit.
[11] These plans are designed on a unit value schedule with units ranging from $2 to $6 (plan A); $2 to $5 (plan B)—Maximum benefits listed are in dollar amounts of the minimum and maximum number of unit values available under the plans.
[12] Mandatory deductibles for family income over $30,000; with other hospital-surgical coverage—$500 and $750 deductible.

ANSWERS TO OBJECTIONS RAISED BY THE SENATOR FROM OREGON [MR. MORSE] TO THE BUSH AMENDMENTS

Mr. BUSH. Mr. President, a few days ago my distinguished friend the senior Senator from Oregon raised some objections to my plan, and made a speech on the floor, which I read in the RECORD. I wish now to deal with the criticisms the Senator made of my amendments. The first objection the Senator had was:

> Any program that offers a fixed cash * * * indemnity rather than specified medical services cannot meet the special problem of the aged.

My reply is that this is an indictment of the existing social security system, which provides benefits in cash only, leaving complete freedom to the individual to spend the money he receives for food, shelter, clothing, and so forth. If this objection is valid, then the existing system should be changed so that the Federal Government would provide all the necessities of life—house the individual in a Federal dormitory, feed him in a communal dining room, buy his clothing, and so forth—instead of giving him cash to spend as he chooses.

The second objection raised by the Senator from Oregon was, referring to my amendments:

> Its sole guarantee of benefits is to the highly profitable and loosely regulated insurance industry * * * the total annual cost would be some $1,300 million. During 1960, commercial insurance companies returned only 53 cents in benefits for every dollar they collected for individual health policies. On this basis, assuming that all the beneficiaries elected commercial policies, only $689 million of the $1,300 million would be spent on health services. The other $600 million would go for insurance company profits and overhead.

My reply is that these objections are invalid for two reasons: First, they are based on the erroneous assumption that the amendments would provide reimbursement only for individual health policies issued by commercial insurance companies. The amendments, in fact, would provide reimbursement for health protection provided by Blue Cross, Blue Shield, mutual insurance companies, employee organizations as well as commercial companies. Second, the allegation that commercial companies "returned only 53 cents in benefits for every dollar collected" has no application to Blue Cross, which, incidentally, has 55 million health insurance contracts outstanding. It has no application to Blue Cross, Blue Shield, and similar nonprofit organizations, nor to mutuals nor to employee organizations. So far as commercial companies are concerned, the record shows 90 percent paid out in benefits on group policies. It is anticipated most elderly persons would select group protection plans.

I fear, Mr. President, that the Senator from Oregon has been attacking the insurance industry rather than my plan, because every single one of his criticisms I think has a valid and logical answer.

The third objection the Senator made was this:

> There is no stipulation that the insurance companies must offer plans at group rates. In fact, the bill seems to be predicated on the purchase of individual policies.

My answer is that this objection is based upon a misunderstanding of the intent of the amendments. The amendments define a "carrier" as a "voluntary association, corporation, partnership or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health care services under individual or group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization"—page 5, line 18, through line 3 on page 6.

A policy to be eligible for reimbursement payment must be issued by a "carrier which has obligated itself to provide health insurance protection—to an individual beneficiary—which is guaranteed renewable or noncancelable and under the terms of which the premium rates cannot be changed with respect to any individual unless such rates are uniformly changed with respect to all other individuals in the same class or category as such individual." This obviously clearly contemplates group policies.

The fourth objection by the Senator from Oregon is as follows:

> Many of these people when they reach 65 will be so ill or such obviously poor risks that no insurance man in his right mind would sell them a policy. The Senator from Connecticut does not even offer to refund the money that such older people—unable to get coverage because they are ill or other-

wise poor commercial risks—will have contributed over the years.

To that I reply as follows:

There are now an increasing number of health protection plans available to elderly people without physical examination or limitations because of previous health history. I refer Senators to "Connecticut 65" and other plans put in RECORD. I have previously mentioned them. So far as people now 65 or nearing 65 are concerned, they will have contributed nothing to the financing in any event, so the discussion of refunds is meaningless. So far as younger people are concerned, an increasing number of health protection plans provide for continued coverage after 65; additionally, it is reasonable to assume the number of plans offered to 65 and over without examination will continue to increase.

The Senator from Oregon [Mr. MORSE] listed a total of eight "specific" objections to the Bush amendments, many of them repetitious of points already discussed. I will review them in the order in which he listed them:

First objection:

The payment for the insurance company—$9 monthly—is unrealistic in relation to the costs of health insurance today. It is inflationary in that it would inflate the going rate for health insurance today. It offers no protection to the beneficiary against inflation; the $9 payment of today may be virtually worthless 10 or 20 years from now.

Answer: This objection is really in two parts. The allegation that the $9 monthly payments are "unrealistic" is without merit. Much health care protection can be obtained within the limits of $9 monthly, or $108 per annum. The Connecticut 65 plan offers four options, at least one of which is well within the $9 limit. It is true that the maximum protection under Connecticut 65 costs $17 per month, but it is also true that this plan offers a wide variety of protection, including payment of surgeons' fees, doctors' bills, drugs, and so forth, which are not available under the Anderson-Javits proposal.

It must be emphasized again that Anderson-Javits is limited primarily to hospital-nursing home care. If other benefits were to be provided, such as payment of doctors' bills, the cost of drugs, and so forth, the payments in taxes under this proposal would also be "unrealistic," and would have to be increased.

As to the argument that the Bush amendments are "inflationary" this overlooks the intense competition which exists in the health insurance field among nonprofit organizations such as Blue Cross-Blue Shield, mutual insurance companies, commercial companies, and plans offered by employee organizations. With the broader market which would exist if the Bush amendments were adopted, it can safely be assumed that this competition would be intensified rather than diminished, and would drive rates down rather than up.

Additionally, the allegation that a $9 payment may be "worthless" 10 or 20 years from now is specious. It applies equally to the existing social security system. If living costs rise, it may be assumed that existing social security benefits will be periodically adjusted by the Congress. If health care costs rise, payments under the Bush amendments would also be periodically adjusted. This would require increases in the social security taxes, but this result would also follow if the Anderson-Javits approach were to be adopted.

The "inflation" argument assumes that continued inflation is inevitable. This would be true only if inflationary policies are condoned by the Congress.

Second objection:

Providing a dollar subsidy, instead of medical services, has two serious faults: It is inequitable in any national program:

(a) Nine dollars would purchase a policy providing a greater amount of care in one section of the country than it would in another.

(b) All aged persons eligible for the subsidy * * * would not have available to them the same policies with the same benefits offered by the same companies.

Answer: As to (a), this criticism applies equally to existing social security benefits. Living costs vary widely in different sections of the country, generally speaking being higher in the North than in the South.

As to (b), many companies are licensed to issue insurance in all the States and the District of Columbia. Additionally, one of the virtues of the Bush proposal is that it permits an individual to make a selection among a wide variety of health care plans and choose the one best suited to his needs.

Third objection:

Absolutely no control is offered by the Bush bill over policy provisions excluding or restricting coverage for specified medical conditions or illnesses.

Answer: As previously noted, there are an increasing number of plans available to the elderly without physical examination or limitation because of previous health history.

Fourth objection:

In the bill, there is absolutely no guarantee that a beneficiary of a trust fund established for his benefit by the U.S. Government will receive fair value in return for the dollars paid for insurance.

Answer: Intense competition among providers of health insurance is the best assurance that value will be received for an individual's premium dollars. To be eligible to participate, a carrier must be under State supervision which should be adequate to prevent the issuance of fraudulent policies. Additionally, it may be assumed that HEW, although without regulatory powers under the terms of the amendments, would offer guidance to and information to elderly persons concerning the type of policies available.

Fifth objection:

It is said by Senator BUSH that the Federal Government will receive back, in the form of taxes, part of the subsidies paid. It is not a proper function of the Federal taxing power to expend large amounts of tax money, in order to receive a small amount in return. The amount of profits retained by insurance companies would undoubtedly exceed any taxes paid to the Federal Government.

Answer: This was a minor argument in support of the amendments. It has no application to the large amounts of health insurance issued by nonprofit organizations such as Blue Cross-Blue Shield, mutual companies, and employee organizations. Insofar as commercial companies are concerned, the Federal Government would receive in revenues a substantial percentage of any profits earned.

Sixth objection:

The social security beneficiary who is able to get a policy will have his money administered, divided up, and parceled out by a company which does not represent him at all, or only does so nominally, and whose principal obligation is to its stockholders.

Answer: This objection again is based upon the misconception that the amendments relate only to health insurance provided by commercial companies. It has no application to the nonprofit mutual organizations which loom so large in this field. Both the nonprofit organizations and the commercial companies have a good record in looking after the interests of their policyholders.

Seventh objection:

Section 1601(a) of the bill refers to "renewable or noncancellable" policies as the only type acceptable for subsidy. On the other hand, section 1602 says that an otherwise eligible beneficiary is entitled to subsidy if he gets a policy which obligates the insurance company to provide protection "for a period not less than 12 months in duration." These two provisions appear quite contrary.

Answer: This objection is the only one which has real validity. The inclusion of the language referring to a policy of not less than 12 months' duration was a drafting error, in the bill, and has been corrected in the modified amendments in the nature of a substitute which are now before the Senate.

I thank the Senator for bringing this defect in the bill to my attention, but the incident illustrates the dangerous pitfalls in attempting to write such technical legislation on the floor of the Senate. It reinforces the argument that all amendments dealing with financing health care for the aged should be referred to the Finance Committee for careful study and correction of such technical defects as may exist before floor action.

Eighth objection:

Almost every commercial hospital and surgical-medical contract excludes coverage for care provided in State and local facilities.

Answer: This objection applies equally to the Anderson-Javits proposal which excludes coverage for care provided in mental institutions, tuberculosis sanitariums, and so forth.

If a person is already being cared for in State or local hospital facilities, he is not in need of duplicating protection.

The voluntary health insurance and prepayment plans are truly dynamic in character. Nowhere is their ability to adapt to changing circumstances and needs of society made more clear than in coverage for older people.

Predictions have been made that as many as 75 percent of the people over 65 may be covered by voluntary plans by 1969.

Such predictions are based on the assumption that there will be no more legislation in this field. With adoption of my proposal, it is logical that the current rapid progress would be accentuated further. Virtually all who want and need coverage would have it almost immediately.

It is valid to assume that its adoption would expand the benefits of health care for older people more rapidly than could possibly be done by any plan requiring creation of new and cumbersome machinery for direct Federal administration of a medical care program.

As I have said, one of the features of the King-Anderson proposal and its successor that disturbs me is that it would result in the creation of a giant, groping, new bureaucracy to distribute health care, not in money, but in kind. It would be designed so that the Federal Government representatives would be directing people to do this or that. They would have no freedom of choice, no freedom of selection. I very much fear that the administrative costs of setting up the proposed great and unnecessary bureaucracy would become a very heavy burden to the social security system.

That is one of the very grave objections to the King-Anderson approach. Certainly it is one of the reasons why my enthusiasm for it is under very great control.

Not all older people have the same needs. Nor are services available in the same way or extent to all people. Patterns of care vary from community to community and from State to State.

With a voluntary system, the individual may choose from a wide variety of plans. He may elect to exclude certain types of services and to include others. These elections, freely arrived at on an individual basis, are possible now. They would be strengthened and enhanced through my amendments. Such elections would not be possible under any federally operated service plan.

After all, older people do not need to have some one in Washington decide what kind of protection they should have. This they can do themselves. This, I believe, is what they want to do.

The problem which confronts many of them is financial.

I have been a member of the Senate Committee on Needs for Aged People. I have attended hearings. The point that stands out in the hearings is the fact that some aged people are short of cash. It is money that they need. It is that essential need with which my proposal is concerned. My plan would provide money without destroying the freedom of the people to exercise their right of election.

As I have already noted, Mr. President, the cost of the amendments to H.R. 10606 proposed by the Senator from New Mexico [Mr. ANDERSON] and the Senator from New York [Mr. JAVITS] cannot be accurately calculated.

Estimates of the early year costs for the King-Anderson bill, as I said earlier, have run as high as $4 billion. The Anderson-Javits amendments would obviously cost even more. The truth is, costs cannot be calculated for a service-type program.

Adoption of these proposals would involve a commitment of taxes in an amount which neither Congress nor the public can calculate. My proposal, in contrast, is capable of maximum cost estimates which will permit exact appraisal of the burden which the individual must bear.

Through cash benefits, as in my proposal, the taxes can be accurately estimated. The program thus created would be responsive to continuing exercise of fiscal responsibility by the Congress.

Should it seem prudent, at some later date because of changed circumstances, to alter the health insurance benefits payments under my proposal, such changes could be made by Congress just as benefit payments under the existing social security system have been made.

They would always be made, however, with the taxpayer—both young and old—in mind.

Older people do not want to be made wards of the state, for medical care or for anything else.

They do want equitable treatment.

They want recognition that they are the first and most serious victims of inflation. In health insurance, as in other matters, they feel they are entitled to some action by their Government which will help them to meet the rising costs with which they are confronted.

This is what my proposal would provide.

It does not claim to pay for all of the costs of medical care or for all of the costs of any health insurance plan an individual might choose. It does provide a payment which will give the older person a chance for health insurance comparable to that of other citizens.

It provides a cash payment which will meet the cost of basic services. It puts the older person on a footing in buying health insurance comparable to what he would have while working. This is what the older person wants—an equitable chance to stand on his own two feet.

This my amendment would do without jeopardizing the whole social security system, without disregard of fiscal responsibility, without interfering with the American system of medical care, and without destroying any part of the individual's freedom to evaluate his own needs and elect his own method of providing for them.

Mr. President, in conclusion, I might say that the big question now is whether we will attempt a new adventure of distributing health care in kind at the Federal Government level, or whether we will stick to the original purposes of the social security system, which was to raise cash through a special social security tax and to distribute the cash in accordance with the payments made by the members of the system.

My plan is in concert and in tune with the social security system. It is a fiscally sound plan. My plan is a noninflationary plan, and a plan which will not materially, if at all, increase the size of the Federal bureaucracy, which would certainly be vastly increased by the adoption of the King-Anderson plan or even by the modification of it which is before the Senate at the present time.

That concludes my remarks. I will reserve the balance of my time.

Mr. CHURCH. Mr. President, I suggest the absence of a quorum. I ask that the time be equally divided.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. MANSFIELD. Mr. President, I suggest the absence of a quorum, and I ask unanimous consent that the time for the quorum be charged to the opposition to the Bush amendment.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MANSFIELD. Mr. President, on the pending question, I ask for the yeas and nays.

The yeas and nays were ordered.

The PRESIDING OFFICER. Is all time yielded back?

Mr. BUSH. Mr. President, I yield back the remainder of my time.

Mr. MANSFIELD. I yield back the remainder of my time

The PRESIDING OFFICER. All time has been yielded back. The question is on agreeing to the amendments in the nature of a substitute offered by the Senator from Connecticut. The yeas and nays have been ordered, and the clerk will call the roll.

The Chief Clerk called the roll.

Mr. HUMPHREY. I announce that the Senator from Connecticut [Mr. DODD], the Senator from Mississippi [Mr. EASTLAND], the Senator from Louisiana [Mr. ELLENDER], the Senator from California [Mr. ENGLE], the Senator from Michigan [Mr. HART], the Senator from South Carolina [Mr. JOHNSTON], the Senator from Oklahoma [Mr. KERR], the Senator from Washington [Mr. MAGNUSON], the Senator from Maine [Mr. MUSKIE], and the Senator from Massachusetts [Mr. SMITH] are absent on official business.

I further announce that the Senator from Arkansas [Mr. FULBRIGHT], and the Senator from Missouri [Mr. LONG] are necessarily absent.

I further announce that, if present and voting, the Senator from Connecticut [Mr. DODD], the Senator from Louisiana [Mr. ELLENDER], the Senator from Mississippi [Mr. EASTLAND], the Senator from California [Mr. ENGLE], the Senator from Michigan [Mr. HART], the Senator from South Carolina [Mr. JOHNSTON], the Senator from Oklahoma [Mr. KERR], the Senator from Washington [Mr. MAGNUSON], the Senator from Maine [Mr. MUSKIE], the Senator from Massachusetts [Mr. SMITH], and the Senator from Missouri [Mr. LONG] would each vote "nay."

Mr. KUCHEL. I announce that the Senator from Vermont [Mr. AIKEN], the Senators from Maryland [Mr. BUTLER and Mr. BEALL], the Senator from Utah [Mr. BENNETT], the Senator from Kentucky [Mr. COOPER], the Senator from New York [Mr. JAVITS], and the Senator from Kansas [Mr. PEARSON] are necessarily absent.

The Senator from Nebraska [Mr. HRUSKA] is absent on official business.

If present and voting, the Senator from Maryland [Mr. BEALL], the Senator from Utah [Mr. BENNETT], the Senator from Kentucky [Mr. COOPER], the Senator from Nebraska [Mr. HRUSKA], the Senator from New York [Mr. JAVITS], and the Senator from Kansas [Mr. PEARSON] would each vote "nay."

The result was announced—yeas 5, nays 75, as follows:

[No. 119 Leg.]

YEAS—5

Bush	Lausche	Saltonstall
Chavez	Prouty	

NAYS—75

Allott	Gruening	Moss
Anderson	Hartke	Mundt
Bartlett	Hayden	Murphy
Bible	Hickenlooper	Neuberger
Boggs	Hickey	Pastore
Bottum	Hill	Pell
Burdick	Holland	Proxmire
Byrd, Va.	Humphrey	Randolph
Byrd, W. Va.	Jackson	Robertson
Cannon	Jordan	Russell
Capehart	Keating	Scott
Carlson	Kefauver	Smathers
Carroll	Kuchel	Smith, Maine
Case	Long, Hawaii	Sparkman
Church	Long, La.	Stennis
Clark	Mansfield	Symington
Cotton	McCarthy	Talmadge
Curtis	McClellan	Thurmond
Dirksen	McGee	Tower
Douglas	McNamara	Wiley
Dworshak	Metcalf	Williams, N.J.
Ervin	Miller	Williams, Del.
Fong	Monroney	Yarborough
Goldwater	Morse	Young, N. Dak.
Gore	Morton	Young, Ohio

NOT VOTING—20

Aiken	Ellender	Kerr
Beall	Engle	Long, Mo.
Bennett	Fulbright	Magnuson
Butler	Hart	Muskie
Cooper	Hruska	Pearson
Dodd	Javits	Smith, Mass.
Eastland	Johnston	

So the amendments were rejected.

Mr. HUMPHREY. Mr. President, I move to reconsider the vote by which the amendment was rejected.

Mr. ANDERSON. Mr. President, I move to lay that motion on the table.

The PRESIDING OFFICER (Mr. METCALF in the chair). The question is on agreeing to the motion of the Senator from New Mexico to lay on the table the motion of the Senator from Minnesota.

The motion to lay on the table was agreed to.

ORDER OF BUSINESS

Mr. DIRKSEN. Mr. President——

The PRESIDING OFFICER. Does the Senator yield himself time on the bill?

Mr. DIRKSEN. I yield myself 1 minute.

I should like to inquire of the distinguished majority leader, and also the distinguished acting majority leader, with respect to what plans there are for the remainder of the day. I understand the distinguished Senator from Minnesota [Mr. MCCARTHY] has an amendment, as does the distinguished Senator from Colorado. I do not know whether other Senators have amendments to offer.

Mr. MORSE. Mr. President, I have a very important one.

Mr. DIRKSEN. That is quite all right. I was trying only to determine what the work volume would be for the rest of the day and whether there were likely to be any yea-and-nay votes.

Mr. MORSE. I want a yea-and-nay vote.

Mr. HUMPHREY. Mr. President, I believe my colleague [Mr. MCCARTHY] indicated he would be willing to have a voice vote on his amendment.

Mr. MCCARTHY. I would like to have the amendment adopted. I do not care whether there is a rollcall.

Mr. KEATING. Mr. President, if the Senator will yield, I am sure the Senator from Minnesota will agree the amendment is important.

Mr. HUMPHREY. I hope it will be adopted overwhelmingly.

Mr. MORSE. Mr. President, I would like to have a yea-and-nay vote, because I think my amendment has a better chance to pass on a rollcall.

Mr. HUMPHREY. The Senator from Oregon will, as always, be accommodated, either willingly or unwillingly, and in this case willingly.

I believe the amendment of my colleague from Minnesota will be voted on by voice vote. In the meantime, I wish to talk to the Senator from Oregon. [Laughter.]

Mr. DIRKSEN. Mr. President, it would appear that there might be a yea-and-nay vote this afternoon. I made the inquiry in view of the fact that it was agreed the Senate would not be in session tomorrow, and certain Members of the Senate want to catch planes and trains.

Mr. MCCARTHY. I do not necessarily ask for a yea-or-nay vote, but if there should be a showdown, I would want to be sure that a voice vote indicated how Members of the Senate actually felt about the amendment.

Mr. President, on behalf of myself and Senators HUMPHREY, HART, DOUGLAS, JAVITS, KEATING, and SCOTT, I call up my amendments identified as 6-29-62—C, and ask for their immediate consideration.

The PRESIDING OFFICER. The amendments offered by the Senator from Minnesota for himself and other Senators will be stated.

The CHIEF CLERK. It is proposed on page 72, between lines 14 and 15, insert the following:

FEDERAL PAYMENTS FOR FOSTER CARE IN CHILD-CARE INSTITUTIONS

SEC. 135. (a) Clause (3) of paragraph (a) of section 408 of the Social Security Act is amended by inserting "or child-care institution" after "foster family home".

(b) Paragraph (b) of such section is amended by striking out "of this section in the foster family home of any individual" and inserting in lieu thereof the following: "of this section—

"(1) in the foster family home of any individual, whether the payment therefor is made to such individual or to a public or nonprofit private child placement or child-care agency, or

"(2) in a child-care institution, whether the payment therefor is made to such institution or to a public or nonprofit private child-placement or child-care agency, but subject to limitations prescribed by the Secretary with a view to including as "aid to families with dependent children" in the case of such foster care in such institutions only those items which are included in such term in the case of foster care in the foster family home of an individual".

(c) Clauses (1) and (2) of paragraph (f) of such section are each amended by inserting "or child-care institution" after "foster family home".

(d) The last sentence of such section is amended by inserting before the period at the end thereof the following: "; and the term 'child-care institution' means a nonprofit private child-care institution which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing."

On page 72, line 17, strike out "135" and insert in lieu thereof "136".

On page 101, line 5, strike out "and 152" and insert in lieu thereof "135, and 152".

Amend the table of contents of the bill, in the part of such table which describes the contents of part C of title I of the bill, by striking out "Sec. 135" and inserting in lieu thereof "Sec. 136", and by inserting after the matter describing the contents of section 134 of the bill the following:

"Sec. 135. Federal payments for foster care in child-care institutions."

The PRESIDING OFFICER. How much time does the Senator from Minnesota yield to himself?

Mr. MCCARTHY. I yield myself 5 minutes.

This amendment restores to the bill a provision which was proposed by the administration, accepted by the Ways and Means Committee of the House, and approved by the House when it passed H.R. 10606.

A number of witnesses testified to this provision before the Senate Committee on Finance. Insofar as I can recall the record, no witness opposed the inclusion of this language in the bill, although the provision was eliminated by the committee.

This provision relates to the contribution of the Federal Government for the care of certain foster children, that is, those who, under the direction of the court, are taken from their own homes and assigned either to foster family homes or to private child-care institutions. Under existing law, the Federal Government contributes to the support of children who are removed by court order from unsuitable ADC homes and are placed in foster family homes. It is proposed this year that aid be extended to these children even though they are placed in foster institutional homes.

My amendment would simply concur and support the action taken by the House and recommended by the administration.

In April only 1,226 children were being assisted under the temporary program relating to foster children. One of the reasons for including child-care institutions in the program is that it is most difficult for welfare agencies to find foster family homes for the children who have to be removed from their own families because the home is unsuitable. Oftentimes the children may suffer from a psychological disturbance as a result of the conditions which require their removal from their own homes. Whatever the reasons may be, it has been found that it is difficult to find private foster homes to which they can be assigned.

Oftentimes such children require special psychiatric and special medical care. These services are not available in the private foster family homes whereas child-care institutions are likely to have the necessary experience and facilities.

For this reason, the administration recommended that the provision be extended to cover placement of children in private nonprofit child-care institutions as well as in private foster family homes.

All such action must be taken under the direction of a court. There is no welfare agency decision, but instead a decision supported and directed by a court.

The Children's Bureau has estimated that about 1 percent of the aid for dependent children involves children who are in unsuitable homes, so the estimated number who might be added by this amendment is an additional 30,000 children. The number should not be that high, since, according to testimony in the hearings, many children who should be removed are being left in unsuitable ADC homes because the States and local communities cannot afford to place them in child-care institutions and thus lose the ADC payments. This indicates that we are already appropriating funds for the care of the same children, but that they are being cared for under the most undesirable of conditions.

It seems to me that the language recommended by the administration should be restored. It was recommended by the Ways and Means Committee and adopted by the House of Representatives. It should be restored by the Senate this afternoon.

I urge the Senate to agree to these amendments, sponsored by my colleague from Minnesota [Mr. HUMPHREY], the Senator from Michigan [Mr. HART], the Senator from Illinois [Mr. DOUGLAS], the Senators from New York [Mr. JAVITS and Mr. KEATING], and the Senator from Pennsylvania [Mr. SCOTT]. A number of other Senators have indicated their support but did not add their names as cosponsors within the time allotted under the rule.

Mr. PASTORE. Mr. President, will the Senator yield?

Mr. McCARTHY. I yield to the Senator from Rhode Island.

Mr. PASTORE. I ask unanimous consent that the name of the Senator from Rhode Island may be added as a cosponsor to the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MORSE. Mr. President, I wonder if the Senator from Minnesota will accept as a cosponsor the senior Senator from Oregon.

Mr. McCARTHY. I am glad to have the Senator as a cosponsor.

Mr. YOUNG of Ohio. Mr. President, will the Senator from Minnesota yield to me?

Mr. McCARTHY. I yield to the Senator from Ohio.

Mr. YOUNG of Ohio. Would the Senator be willing to permit the name of the junior Senator from Ohio to appear as a cosponsor?

Mr. McCARTHY. I shall be more than pleased to do so.

Mr. YOUNG of Ohio. I ask that that be done.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LONG of Louisiana. Mr. President, will the Senator permit me to join as a cosponsor?

Mr. McCARTHY. I am glad to do so.

Mr. LONG of Hawaii. Mr. President, I ask the Senator to permit me also to be a cosponsor of the amendment.

Mr. McCARTHY. I am pleased to have the Senator as a cosponsor.

Mr. KEATING. Mr. President, will the Senator yield?

Mr. McCARTHY. I yield to the Senator from New York.

Mr. KEATING. I compliment the Senator for the leadership he has shown. I am happy to be a cosponsor.

Mr. President, I fully believe the aid to dependent children program should contain the mechanism to provide for the care of children who are removed by a court order from unsuitable homes. These unfortunate children, once removed, must clearly be given aid and attention so that they can eventually be placed in a suitable home. Under the original bill, specifically section 135, this help could be offered in two alternate ways, depending on both the needs of the child and the circumstances. They could either be sent directly to foster homes, or, where this is not possible or immediately desirable, to child-care institutions. Unfortunately, the provision allowing for the placement in a child-care institution was deleted from the House-passed bill in committee. This deletion forces the State welfare agencies into the position of either finding a foster home immediately, which is often extremely difficult, or, in some serious cases, leaving the child in an unsuitable home.

Certainly, no one would want to hinder the improvement of this valuable program by such an omission. We offer the amendment to H.R. 10606 whereby a State welfare agency would have the option of sending these neglected children to child-care institutions. This amendment is crucial to the effectiveness of this program of aid to dependent children. It is in this spirit that we have offered it.

The aid to dependent children program and the so-called TADC program are concerned with those children who are in need or who are removed from their homes because their homes are deemed unsuitable. The term "unsuitable" means a home situation in which the child is being abused, neglected, exploited, or permitted to live in demoralizing conditions by his parents or guardians. Deciding that any home is unsuitable is obviously a matter of utmost importance to the child involved. Ie presents a real problem for welfare officials who must gather sufficient evidence to take the issue to a court, and who then must provide for this suddenly helpless and totally dependent child.

Naturally the desirable course of action is to place the child in a foster home as quickly as possible. Agencies which provide for such placement services are conducted under both public and voluntary auspices. Finding a foster home is an extremely difficult and time-consuming procedure, and there are many factors involved. There is often an intermediate period of counseling, treatment, or readjustment which is of great importance to the child. The child often needs a place to stay during an interim period because finding a foster home is often difficult.

Placement services are performed for the child by both public and voluntary agencies within the States. Often more than one agency is serving the same child at the same time in different capacities; or first one agency will contribute to the care of a child and then another. As can be seen from the table below, while there are more children served in foster family homes by public agencies, there are more served in child-care institutions through voluntary agencies.

Mr. President, I ask unanimous consent to include a table on this subject at this point in the RECORD.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

Children in foster family care and in institutions for dependent and neglected children, by auspices of agency, United States, selected years 1933–61 [1]

Year	Total			Children in foster family care			Children in institutions		
	Total	Public	Voluntary	Total	Public	Voluntary	Total	Public	Voluntary
1933	[2] 249,000	[2] 72,000	[2] 177,000	[2] 105,000	[2] 49,000	[2] 56,000	144,000	23,000	121,000
1950	([3])	([3])	([3])	([3])	([3])	([3])	95,000	18,000	77,000
1952	([3])	([3])	([3])	127,900	91,800	36,100	([3])	([3])	([3])
1958	229,500	117,300	112,200	143,500	106,400	37,100	86,000	10,900	75,100
1960	[4] 240,000	[4] 129,000	[4] 111,000	185,900	117,800	41,100	[4] 81,100	[4] 11,200	[4] 69,900
1961	[4] 244,500	[4] 133,300	[4] 111,200	164,200	122,300	41,900	[4] 80,300	[4] 11,000	[4] 69,300

[1] National estimates prepared by the Children's Bureau. Excludes children in maternity homes for unmarried mothers, residential treatment centers for emotionally disturbed children, training schools for delinquent children, institutions for mentally or physically handicapped children and other institutions.
[2] Includes children in adoptive homes.
[3] Not available.
[4] Excludes temporary shelters.

Mr. KEATING. Mr. President, the 1933 figure above is interesting. It shows that in that year voluntary agencies provided over half of all the foster care administered. Now, public agencies provide almost four-fifths of all foster family care. As far as children under institutional care are concerned, however, the voluntary agencies have maintained a greater percentage than public agencies for the last 20 years.

Another significant tabulation is the total number of children provided with welfare services. In 1961, while a total of approximately 245,000 children were aided, the breakdown was almost 50–50 in relation to public and voluntary agencies. I fully believe that the temporary child-welfare program for the children of unemployed workers passed last year would be incomplete if it did not take both the public and private sectors into consideration.

Private agencies, which provide an equally important and valuable function in the area of child welfare, should not be denied financial assistance merely because they are private. Such discrimination does not make sense, especially where the interested parties are homeless children.

Public institutions alone cannot handle this program adequately. Each child has different problems which must be coped with. It does not matter to the child what type of agency is helping him. It should not matter to us. I do not by any means object to exercising care in the administration of these Federal funds, but there is something out of balance when the sheer fastidiousness of administration thwarts the effectiveness of a program.

This amendment represents simple fairness and will greatly improve this bill. It deserves our full support.

Mr. McCARTHY. Mr. President, I yield back the remainder of my time.

Mr. HUMPHREY. Mr. President, I yield back my remaining time.

The PRESIDING OFFICER. All time has been yielded back.

The question is on agreeing to the amendments offered by the Senator from Minnesota [Mr. McCARTHY], for himself and other Senators.

The amendments were agreed to.

Mr. McCARTHY. Mr. President, I move to reconsider the vote by which the amendments were agreed to.

Mr. HUMPHREY. Mr. President, I move to lay that motion on the table.

The PRESIDING OFFICER. The question is on agreeing to the motion to lay on the table the motion to reconsider.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The bill is open to further amendment.

Mr. HUMPHREY. Mr. President, I ask unanimous consent that the time necessary for the call of the roll when I suggest the absence of a quorum not be charged to either side.

The PRESIDING OFFICER (Mr. HICKEY in the chair). Is there objection to the request of the Senator from Minnesota? The Chair hears none, and it is so ordered.

Mr. HUMPHREY. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The Chief Clerk proceded to call the roll.

Mr. HUMPHREY. Mr. President, I ask unanimous consent that further proceedings under the quorum call may be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HUMPHREY. Mr. President, I yield 20 minutes to the Senator from Utah [Mr. Moss] from the time on the bill.

The PRESIDING OFFICER. The Senator from Utah is recognized for 20 minutes.

Mr. MOSS. Mr. President, I wish to make my speech without interruption, and then I shall be happy to yield if there are questions.

Mr. President, it has been said that one way to measure a civilization is by the degree to which it is concerned with the welfare of its oldest and weakest members. The dimensions and intensity of the debate now underway in this body—and the resonance of its echo throughout the country—shows very clearly that we are a mature people, a civilized people, seeking earnestly to ameliorate our weaknesses and elevate our standards in the care of our aged.

I am gratified that neither here in this body nor out in the country are there many people who are callous enough to say that we need no improvements in our programs of medical care for the elderly or no widening of their scope. To my immense satisfaction, most of those who have debated this issue have recognized that our present laws and authorities fall far short of doing the job our national welfare requires, and have agreed that status quo is not enough. We have not, therefore, had to discuss here at length the question of need, but have been able to direct our attention to the question of method—of how best to help our people meet the high cost of ill health in old age and to do it in a sensible and characteristic American way.

There are, as Senators know, three methods which may be employed to establish a sound, long-range program of health protection for the elderly—private health insurance, public assistance financing, and financing through the Social Security mechanism. It is our job here and now to sift and carefully evaluate each one of them.

Most of us, I am sure, would like to put as much reliance as possible on private health insurance. We know that the industry has been making heroic efforts to meet the health needs of our aged. But despite these efforts, it has been pretty well demonstrated by now that private health insurance cannot—by itself—cover the catastrophic and chronic illnesses of the aged at premiums the retired can afford to pay. Many policies for the aged provide only the most limited of coverage. Because of poor health, some of our elderly cannot qualify at all for insurance, or can only secure coverage that excludes or limits preexisting conditions—precisely those which create the greatest expenses. At the present time only about half of our people over 65 have private insurance coverage, and even the most optimistic predictions do not promise that even in 10 or 15 years private policies which are both broad and reasonable can be provided by private insurance for any substantial portion of those over 65. Both the Blue Cross association and the American Hospital Association have stated that some form of government assistance is necessary to provide adequate health insurance for the elderly.

Public assistance financing, the second method, has, of course, been with us in varying degrees of effectiveness for some time. It has two main facets. The first is the type of program almost all States have to provide some measure of medical care for people on relief, and the second is the innovation resulting from the passage of the Kerr-Mills act 2 years ago which made matching funds available to the States for the establishment of a new category of assistance to assist older persons who were not on relief; who had sufficient resources to meet their ordinary living expenses but who could not cope with the high costs of medical care. Unfortunately, due to the fact that, in the main, the State's portion of the cost of medical assistance for the aged programs must be financed from general revenues, only one-half of the States have been able to put medical assistance to the aged—or MAA—programs into operation since Kerr-Mills became effective in October, 1960. The States, hard-pressed for funds and with strong competing demands for the funds that are available, apparently simply cannot afford either to establish medical assistance for the aged programs or to establish comprehensive programs.

Efforts have been made to mask this simple fiscal fact of life by offering a distorted figure of the number of States with Kerr-Mills programs. This is achieved by combining the total number of States that made some changes in their programs for people on relief with the total number of States that established new medical assistance for the aged programs. Thus we hear 36 States, 38 States, and 46 States as the total of those having established Kerr-Mills programs.

The plain fact is that only 25 States have established programs of medical assistance for the aged—and these, in many cases, are inadequate programs.

I do not make that statement critical of the States, because of the very great fiscal problems that confront our States.

Mr. President, I ask unanimous consent to have printed at this point in my remarks an article entitled "Struggling States—Many Report Deficits Despite Higher Taxes, Recovery in Economy," published in the Wall Street Journal on July 6, 1962. The article discusses the fiscal problems confronting the States and their inability to meet all the demands upon their revenue.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

STRUGGLING STATES—MANY REPORT DEFICITS DESPITE HIGHER TAXES, RECOVERY IN ECONOMY—EDUCATION, WELFARE EXPENSES RISE SHARPLY; SOME WEIGH NEW ROUND OF TAX BOOSTS—MORE LOOK TO FEDERAL AID

(By John F. Lawrence)

The fiscal health of the Nation's State governments, which has declined steadily in recent years, is failing to respond even to the dual tonic of new taxes and economic recovery.

In California, despite a 7 percent rise in revenues, income fell at least $8 million short of covering spending in the fiscal year that ended last Saturday, whittling to less than $30 million a surplus that totaled four times that just two years ago.

In Mississippi, tax collections ran 4 percent ahead of estimates, but the State spent some $20 million more than it took in during the 2-year budget period that ended June 30. Appropriations for the coming 2 years will gobble up $17 million in new taxes and still exceed anticipated revenues by $10 million.

These are by no means isolated examples of what's happening to State finances. In a Wall Street Journal survey of 21 of the most populous States, just over half reported that spending outran revenues in fiscal periods ended June 30. Although tax collections rose more than expected in seven States surveyed, only two of these expect to report an excess of income over outgo for the year. Many States are digging into surplus funds normally intended as a buffer against slump years. Others are slipping deeper into the red.

MORE PRESSURE FOR FEDERAL AID

This erosion of State finances, particularly in a year of strong revenue gains, is expanding pressure for new State taxes and increased Federal aid to States. State spending has more than doubled in the last decade, according to Federal statistics. Population growth has helped push up expenditures for education by 10 percent a year since 1959, while gains in over-all State revenues have averaged less than 9 percent. Increased chronic unemployment and new assistance programs have contributed to a rapid climb programs have contributed to a rapid climb in welfare expenses.

To meet these costs, at least four States—Illinois, Minnesota, New Jersey, and Virginia—have established new study commissions to plan a broad overhaul of the tax laws and an increase in revenues. Many,

too, are trying new enforcement tactics to squeeze added funds out of present levies. But nearly all State officials foresee a growing reliance on Federal funds to meet the higher costs. Uncle Sam poured $6.4 billion into State programs in fiscal 1961, more than 22 percent of general State revenues. That's up from $2.6 billion, or less than 18 percent of State revenues in 1953.

This year's darkening financial picture contrasts sharply with the fiscal rebound most States experienced during the last economic recovery. State revenues totaled $27.4 billion in the year ended June 30, 1960, topping expenditures by $200 million. In the following year, however, spending rose 6.9 percent while the recession held revenues to a 4.9-percent rise, leaving a $400 million deficit. It's almost certain final tabulations for the latest fiscal year will show spending again exceeded revenues by a substantial margin.

To be sure, the current high level of business activity has helped a few States improve their fiscal standing. Maryland's tax collections ran $6 million ahead of estimates in the year just ended. With expenditures about on target, the gain boosted the State's reserve fund to about $18 million from $12 million a year ago. A new sales tax and a stronger economy are helping Texas wipe out a $60 million deficit during the current biennium, which has another year to run.

But for most States, the trend is decidedly in the other direction, largely reflecting skyrocketing costs.

PUBLIC AID TROUBLES

"Revenues are keeping up with expectations, but the public aid people have run into trouble," says Ted Leth, superintendent of budgets for Illinois. The legislature, due to convene next January, faces a demand for $100 million to tide the welfare agencies through to the end of the biennium next June. "Unless there are new taxes, that'll all be deficit," says Mr. Leth. The State had hoped instead to wipe out a $35 million deficit from the last biennium.

Other States are suffering from overoptimistic revenue forecasts as well as higher costs. Indiana counted on getting $214 million from its gross income tax, which provides 80 percent of its general fund, in the fiscal year just ended, up from $192 million in fiscal 1960–61. "We don't know why, but revenues are falling about $11 million short," says a top financial officer of the State. The State already had expected spending to run about $15 million above current revenues, cutting into a $49 million surplus. The revenue lag will slim the surplus to less than $25 million.

Michigan has suffered both ways. "Welfare expenses and aid to local school districts both exceeded the appropriations and our recovery didn't materialize soon enough to lift revenues as much as we hoped," says Clarence W. Lock, Michigan's revenue commissioner. Result: Instead of a revenue balance last year, the State added $20 million more to its $71 million deficit.

SOME STATES CUT BACK

Even more surprising for a recovery year, some States have been forced to make last-minute cutbacks in spending. Ohio collected about $608 million in general fund revenues, 5 percent more than a year before, but spending was headed for $630 million, a rise of 6 percent, until the State began economizing. "We've held off on some $7 million of capital improvements and deferred some equipment purchases," says James Maloon, finance director. Spending thus totaled $618 million, leaving a $10 million deficit.

Pennsylvania planned to wind up $9 million in the black in the year ended June 30 and use the surplus to help meet increased costs in the current fiscal year. But the State came into June $10 million behind schedule and had to scramble to catch up. It stepped up its bill collecting, held off on some spending programs—including such things as buying autos—and managed to get a $4.7 million windfall from a favorable decision in a large corporate tax case.

Only higher taxes have headed off worsening budgetary situations. Pennsylvania's climb out of the red is the result of an increase to 4 percent from 3 percent in the State sales tax and other tax changes 3 years ago. Wisconsin averted a $60 million deficit in the biennium ending next year when the legislature just before Christmas added a new sales tax.

Two-thirds of the 47 State legislatures that met in 1959 raised taxes and half, including some that raised rates in 1959, did so in 1961. Only 21 legislatures meet in even years and Mississippi and Michigan passed the only major 1962 tax bills. The former boosted cigarette and corporate franchise taxes. Michigan last month passed a series of new taxes expected to net $77 million annually, including higher cigarette, beer, and corporate franchise levies and a 4-percent tax on liquor.

Despite this flurry of tax activity, pressures already are mounting for another round of increases. Wisconsin's revenues, based on present taxes, are expected to rise 5 percent in the next biennium starting July 1, 1963, while "a survey of all departments points to a 20-percent overall increase in costs," says John A. Gronouski, commissioner of taxation. "That figure may be shaved some, but there's no question in my mind there's going to be a gap between revenues and expenses. The issue in the current gubernatorial race isn't whether to raise taxes but how."

"We're getting pressure for more aid to local school districts and for higher faculty salaries at State colleges, but we're not going to have any money from present taxes to put into any new programs," says Roy M. Bell, California's assistant director of finance.

"The cost of everything is going up, except for stocks," quips C. H. Morrisett, Virginia's tax commissioner. The State's general fund budget for the 2 years that began July 1 is $573 million, 15 percent above that of the biennium just ended.

Among the biggest factors in the State's spending rise is increased aid to local areas for schools, welfare, and other programs. New York State's local assistance expenses amounted to $1,265 million in the latest fiscal year, up 12 percent from fiscal 1960–61. They're expected to climb another 8 percent in the current year.

The biggest part of local aid goes to education. Kansas early this year increased its annual contributions to local districts to $20 a pupil from $15. This program is a key factor pushing the State's general fund budget for the current year some $9 million over revenue estimates, eating into a $27 million cash reserve. As recently as 1954 State contributions ran only $6 a pupil.

INDIANA ENROLLMENTS RISE

"We've been getting a 30,000 increase a year in enrollment in public schools and we figure each 30 students adds $30,000 a year in costs, including new classrooms, teachers salaries and other expenses," says an Indiana finance official. "Primarily because of school costs, expenditures are rising more rapidly than revenues and this undoubtedly is going to mean new taxes," he adds. Indiana's fiscal 1962–63 budget contemplates using nearly all of the remaining $25 million surplus.

State governments in some cases are feeling voter pressure to ease the burden of school costs on local property taxes. In Ohio the State now is paying roughly a third of the public school costs, down from 43 percent 10 years ago, with the property taxes paid directly to local governments making up the difference. "There's considerable feeling that we should at least halt the growth in the share carried by the property tax," says Mr. Maloon, finance director.

Compounding the educational cost problem is a bulge in the rate of increase in enrollment at State colleges and universities, where the expenses rest even more heavily on the State government. In California, elementary and secondary school enrollment is expected to reach 5 million by 1970, up a third from the current level, while enrollment in State colleges and universities, now totaling 130,000 is expected to double.

Ohio's problem is heightened by the fact that not one new university building has been built in the last 2 years, reflecting a shortage of funds. This has created a backlog of demand. The lack of facilities, plus above-average tuition charges have caused the State in the last decade to fall to 27th from 17th among the States in the percentage of high school graduates going to college, according to Mr. Maloon.

Welfare spending is another key area of rising costs. Illinois spent roughly $280 million on welfare in the previous biennium and hoped to get by with the same spending in the current 2-year period winding up next year. But instead, spending is running almost one-third above the last biennium. "The Chicago stockyards closedowns threw many unskilled people out of work, lengthening relief roles," explains Mr. Leth.

Recognizing their budget problems will grow increasingly severe in the years ahead, more States are forming commissions to study ways of revising revenue laws to get increased taxes without unduly burdening any one taxpayer group. Many older State bodies also are giving increased consideration to broad tax changes. In Illinois, a recently appointed revenue committee is expected to make recommendations for new tax legislation when the State's lawmakers convene in January.

Growing spending pressures are overcoming some traditional opposition to new taxes. The State senate in Michigan came the closest in its history to passing an income tax this year. In Ohio, "most of the big pressure groups that have opposed increases in the past, now are resigned to some new taxes, though they're naturally all trying to put the monkey on someone else's back," says James Hunter, Ohio's research director for taxation.

U.S. GRANTS TO PENNSYLVANIA UP

Whatever the outcome of the moves for new tax legislation, it's clear the States expect to lean more heavily on Federal assistance. "Despite some altruistic comments to the contrary, I don't think the States, hard pressed as they are for money, are going to turn down Federal aid as new programs are made available," maintains David Baldwin, Pennsylvania's budget secretary. Federal grants to the Quaker State for public assistance alone have totaled $119 million in the last 12 months, up from $94 million the previous year and $87 million in 1959–60.

Many States are trying to ease the financial pinch somewhat through new enforcement methods. Rhode Island faced a $1 million deficit in its budget for the year just ended but made up the difference by boosting the audit staff to 35 people from 20 and raising starting salaries to $6,000 from $4,000 to attract better talent.

"We've taken in $54 in extra taxes for each hour of work per man and the added cost is only $3 an hour," explains John H. Norberg, assistant tax administrator. Since the program started last August, the State has run 1,000 audits of tax returns from retailers and other businessmen, compared with 80 in all of fiscal 1961. "At least 75 percent of the audits have produced additional revenue," says Mr. Norberg.

New York currently is training a squad of new field examiners, at least 10 of whom are likely to be sent out of the State to check whether corporations headquartered elsewhere but doing business in New York are paying the taxes they should. "If this proves productive, we'll expand the program," says Joseph H. Murphy, commissioner of taxation and finance.

Cooperation between Federal and State tax collectors is increasing. At least 17 States now use income as reported to the Federal Government as the basis for assessing personal or corporate income taxes, 5 more than in 1957. A dozen States have made agreements, most within the past five years, to exchange audit information with the Federal Government.

Mr. MOSS. Mr. President the third method is the one under active consideration here today—use of the social security mechanism to provide that people during their working years build up insurance to pay for the major part of their hospital expenses when they retire. The social security mechanism has been chosen because we know it works, and works well. Through it, over 90 percent of our people now have old-age insurance, and already it has given millions a measure of security and independence. The overwhelming number of votes in favor of expanding this system, or increasing its benefits, each time the issue comes before the House and the Senate, are strong testimony of congressional confidence in this program. The amendment before us recognizes the reliance our people have on social security, and their belief in it, by establishing a separate trust fund for medical benefits so the present well-operating system of old-age benefits cannot possibly be disturbed or endangered.

It is apparent, however, that none of this triumvirate—private health insurance, public assistance financing, or social security financing—can by itself assure our elderly of all the health coverage they need. But a combination of the three could. With the insurance built up through social security payments through the years covering a major part of the biggest item of health costs—that is hospital bills—we would have good reason, I believe, to expect that private insurance could be provided at reasonable rates to cover a substantial portion of the other health costs of the vast majority of our elderly. Kerr-Mills would be available to fill in the gaps for the needy aged.

The missing element in this combination at present, is, of course, social security financing of part of the hospital costs, and I am most hopeful that before Congress adjourns this element will be added.

I am frankly disturbed, however, that some of my colleagues see in Kerr-Mills a full solution to a great national problem, and have suggested that we merely sit back and let the States "make haste slowly" in putting the Kerr-Mills medical assistance to the aged program into operation. I am frankly disturbed by the fact that they feel Kerr-Mills could become a going concern, nationwide, in all of its aspects, all would be well, and our job would be done.

The Kerr-Mills Act, laudable as its objectives are, is philanthropy. We have always been a philanthropic people. We have always tried to see that our people who are old and ill and do not have money have been given the care they need. County commissioners in counties out across the country have been struggling with this problem for years. We have county hospitals and charity wards and other State and county public institutions to help out. Our doctors have given generously of themselves and their time treating indigent patients without cost. Federal matching funds made available to some States through the Kerr-Mills medical assistance to the aged program have helped somewhat. But, as I have pointed out, not enough.

But—and this is what disturbs me—the people who support only Kerr-Mills support only philanthropic care. They ignore the needs of our millions of elderly who have no wish to receive care at the taxpayers' expense, but who are nevertheless staggered by the drain on their savings—and on the pay checks and savings of their children—when they have an extended hospital stay. These people do not seek philanthropy. In fact many of them would rather suffer silently, and even to die, rather than bend their knees for charity to pay their medical bills. To offer these people only Kerr-Mills—medical assistance to the aged—to ask that they submit to a means test before they can be given any help—is to show a thorough lack of understanding of American character, of the determination of many elder Americans to continue to take care of themselves in their old age as they have in the past, even if it means to go without medical care. To offer Kerr-Mills only is to be insensitive to the American spirit, to the American glory in independence.

I am also concerned by the lack of understanding of those who say that because of inauguration of Kerr-Mills in some of the States has not increased greatly the number of recipients, there are really not very many of our senior citizens who need help with their medical bills. In my State of Utah, for example, where payments were commenced on September 1, 1961, total payments through April totaled only $336,642, of which the Federal share was $214,565. In April of this year payments were made to only 508 of Utah's over-65 population, which represents less than 1 percent of the aged in the State.

In the first place, Utah has a law under which relatives are required to contribute to the costs of medical care. We also have a lien law, which gives the State a preferred claim against any property owned by these old folks. The above may account for in part the small number of people utilizing the program.

But I believe there are some other aspects of Utah thinking, and of Utah moral and ethical standards, which bear on the situation. Utah people have a particular pride in being self-reliant and independent. It is our heritage—a heritage handed down from our pioneer ancestors, and a heritage of which we are immensely proud. The doctrine of self-reliance is taught constantly by the Latter-day Saints Church, and reiterated by the other religious organizations represented in the State, as it is, I am sure, by these religious faiths in all parts of the country. But because of our heritage and our strong belief in self-reliance, I am confident that the people of Utah would resort to every other possible means of assistance before turning to charity.

Utah is also a particularly close knit family State. We have large families—in fact I believe they are among the largest in the country—and many of the members of the family remain in Utah instead of moving out to other States. Or if they do go elsewhere during their working years, many of them return to Utah in retirement to be with their families. Large families can, and with magnificent generosity do when it is at all possible, contribute to the care of their senior members when such help is needed.

But in Utah, as in every other State, the rising cost of living has cut deeply into the value of retirement incomes, and the rising cost of medical services has made it more and more necessary for children and other members of the family to help senior members with their medical bills. And, as in every other State, the slender resources of the vast majority of our senior citizens—and those of their children, who have heavy responsibilities of their own—are under great strain. Many of them have written to tell me so. I am confident that there are many people in Utah—a State of resolute and self-reliant people—who would far prefer a system under which they would contribute during their working years to a fund for the higher-than-average medical costs of their retirement years than a system which would offer them care only as a charity patient.

The use of the social security machinery for this purpose is sound and practical, because it does not give a person something for nothing, but provides him with a way of insuring himself against dependency for hospitalization when he becomes ill in his old age. In that it takes steps to prevent dependency before it occurs, it is thoroughly in keeping with the American tradition, so highly held in my State, of self-reliance.

Mr. President, the amendment before us today would establish a program of medical assistance which is in keeping with the American tradition and consistent with the dignity, independence, and integrity to which each citizen is entitled. It is a sound, sane, and conservative program in that it purports only to pay a good part of the hospital and related costs of our elderly, roughly 25 percent of their medical expenses. It would do so on a self-financing basis through social security rather than being a drain on all taxpayers.

It would have no bearing on the doctor-patient relationship, except to make it more pleasant for the patient who would be relieved of part of his worries

about the cost of his illness, and for the doctor, who would be more likely to be paid for his services because the patient would not have to stretch his money over both doctor and hospital.

There are those who insist the program would be a step toward socialized medicine. There is absolutely no basis for this charge. The program is, instead, a bulwark against socialism. If we can give our elderly enough relief with medical bills through this program, there will be little pressure for nationalization.

Students of this subject point out that countries which have turned to socialized medicine have never had strong systems of private health insurance. In contrast, we have in the United States a private health insurance system that is strong, very strong and quite adequate, except with respect to coverage of older persons.

I think it also important to note that the British do not believe that their type of program is an inevitable consequence of the kind of program we are now proposing. On the contrary. According to the U.S. News & World Report for March 26, 1962, some British officials wish they could start all over again with the kind of program proposed here. I quote:

Some top officials here say that, if Britain were starting today from scratch to tackle the problem of medical care, she would not attempt outright nationalization.

"If we had a chance to do it again," one high-ranking official says, "I think that we would favor some form of compulsory medical insurance, supplemented by tax funds together with subsidies to hospitals to keep down costs. We would also act to limit the cost of drugs. In short, the state would insure that everyone had access to medical care at a reasonable cost, but without nationalizing the entire system and putting all doctors on the Government payroll."

This official adds that President Kennedy's proposal to provide medical care for the aged through the U.S. social security system is the first step toward the kind of system that Britain probably would introduce now if there could be a fresh start.

Despite such evidence to the contrary, there are those who still claim that, with enactment of hospital benefits financed through social security, the United States will be headed down the British path of nationalized or socialized medicine.

Mr. President, we must relieve our elderly people, at least in part, from the harrowing worry of the cost of illness which hangs over them. This fear is no specter dreamed up to push for action on the measure before us. It is real, it is there. Anyone who reads the income statistics of our elderly with an open mind and an open heart—anyone who listens to our senior citizens themselves with thought and compassion, must know the fear is there—must realize something must be done about it.

How can anyone who has ever paid any hospital bills himself doubt that a retired couple with an income of less than $2,500 and less than $500 in liquid assets, would be struck a staggering blow by a serious illness which ran up hospital bills into the hundreds, even the thousands? Yet half of all our aged couples have less than $2,500 in annual income.

How can anyone who has ever paid a hospital bill himself doubt that a person with an income of less than $1,000 a year, and probably not even $500 in money he could draw, could and probably would be completely wiped out by a long hospital stay.

We should not force our elderly, after a lifetime of independence, to turn to public assistance or private charity, or to take from their children what they know their children need desperately for themselves and for the new generation coming on.

We should set up now a program which will assure them that the greatest part of those dreaded medical costs—the costs of a hospital stay—will be paid for as a right, and not a charity, through our social security system, from funds they will contribute themselves while they are strong and healthy and working.

I am convinced that we will do this—I am convinced that we are a civilized nation, and that we will demonstrate this again by not only showing the measure of our concern for the oldest and weakest of our members, but by doing something which will help them to help themselves.

As my good friend, Senator LONG, of Hawaii, has said, if ever there was a proposal based on sound American thinking, this is it.

It is based not on European practice, not on the ideas of Bismarck, or Marx, or Lenin, but on the reasoning of that most conservative of great Americans, the godfather of the Republican Party, Alexander Hamilton.

Does that surprise you? Let me explain. Back in 1798, Hamilton, always alert to protect the taxpayer, had a problem. It involved young America's sailors. Leaving home on their ships healthy and hearty, they returned many months later with many of their members ill with scurvy, racked with strange diseases or suffering from injuries.

Inevitably they wound up in the big ports of our young Nation dependent for medical care on the local taxpayers—on local relief—on a Kerr-Mills sort of setup. To Hamilton—a businessman if there ever was one—this made no sense whatsoever. Moreover, it set a dangerous precedent for other groups in the population.

So Hamilton—not Karl Marx—Alexander Hamilton said "Why should we not charge these sailors a very small part of their wages when they are healthy and employed to pay for their own care when they are sick and injured?" It made sense to our 100 percent American forebears. The Congress enacted it into law in 1798 thus providing a system of self-financing care for merchant seamen and, at the same time, originating our U.S. Public Health Service.

It was the safe, sane, conservative, intelligent, businesslike approach in 1798.

It remains, today, in 1962, the same safe, sane, conservative American answer to a great American problem.

Mr. President, I urge that the amendments of the Senator from New Mexico be adopted.

Mr. CARROLL. Mr. President, I call up my amendment identified as "7-6-62—A."

The PRESIDING OFFICER. The amendment will be stated.

The LEGISLATIVE CLERK. On page 4, between lines 8 and 9, insert the following:

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

Mr. CARROLL. Mr. President, the Department of Health, Education, and Welfare has no objection to the amendment and has so notified the junior Senator from New Mexico [Mr. ANDERSON], the principal sponsor of the bill providing health care insurance benefits for the aged.

My amendment merely makes clear that in enacting a health care benefits program, it would not be the intention of the Congress to deprive any person of any benefits to which he is entitled under a State medical program or, may I add, under the pending legislation.

STATE MEDICAL PLAN IN COLORADO HAS SUPERIOR FEATURES

In Colorado we have one of the best medical care for the aged programs in the country, for our elderly citizens who are on the old-age pension rolls. It provides certain benefits that are not available under the Anderson-Javits bill.

The aged people in Colorado who are now receiving State medical assistance want to be assured that we in the Congress will not enact a law that will give them some coverage while at the same time restrict their use of the more comprehensive coverage of medical care under the Colorado program.

I urge the adoption of my amendment as a means of reassuring those now receiving State medical assistance that they can continue to use benefits of State plans as assistance supplementary to a Federal health insurance program.

The situation in Colorado, very briefly, is that in round figures we have about 50,000 old-age pensioners in the Colorado old-age system. Like all systems, ours is based on need. Of those 50,000 pensioners about 41 percent are people who also draw a pension from social security.

In other words, if a social security annuitant in Colorado, who draws $75 a month, has no other income, and demonstrates a need for assistance, he can come under the State pension program and draw a State pension of $35. The maximum State pension is $110. If he comes under the Colorado pension program, he is then permitted to participate in the pension's medical care program, even though he is a social security annuitant.

I point out, however, that under the program presented by the junior Senator from New Mexico, not only the social security annuitants, but all of our pen-

sioners would be eligible for hospital and certain nursing home and other benefits.

In addition to an excellent pension system, one of the finest in the Nation, Colorado offers its aged people a medical care program, which provides comprehensive assistance under a constitutional limitation of $10 million a year.

The sole purpose of my amendment, so far as Colorado is concerned, is to provide that when a pensioner avails himself of the benefits of the Federal plan, the State must protect the pensioner's rights under the Colorado program by paying the first $90 hospital charge required under the Federal program.

In short, how can the aged poor people, who are on fixed State pensions and in need, pay the $90 deductible if they do not have the money? The principal purpose of my amendment is to make absolutely clear that the Congress expects that in the State of Colorado the $90 deductible hospital charge will be paid for old-age pensioners out of the Colorado Medical Care Fund.

However, I must emphasize that not only will it provide for the aged of Colorado, it will provide similar protection for pensioners in 45 States as well. So the amendment will have a widespread effect.

In effect my amendment assures that Colorado old-age pensioners will receive more assistance than they now receive under the State plan alone.

As the Federal plan begins to work and the pensioners use its benefits, I have assurance that the Colorado plan will be expanded. Certain suspended medical services will be restored and new services added. I am hopeful that when the Anderson-Javits program goes into effect the Colorado medical care plan will begin to provide dental, drugs, and prosthetic device payments.

STATES RIGHTS PRESERVED

My amendment is framed as a firm declaration of policy of the Congress. It applies only to the Federal health benefits insurance program for the aged. It does not impinge on the right of a State to modify and reshape its own medical assistance program. But it does say that Congress does not intend that anyone lose the advantages of a State program simply because he becomes eligible for the Federal health benefits insurance program.

FORTY-FIVE STATES AND POSSESSIONS AFFECTED BY CARROLL AMENDMENT

Forty-three States, the Virgin Islands, and the District of Columbia now make medical care in some degree available to the aged who are on old-age assistance. In the year 1960 they made vendor payments of $295 million for medical care and money payments of $149 million; a total of $444 million.

Twenty-three percent of all assistance to the aged in 45 States and possessions was in the form of medical care.

In 1960 there were 2,358,272 aged Americans who were eligible to receive State medical asistance in one form or another in an average month.

The types of State medical assistance vary widely from State to State, but in almost each case there are some medical care benefits not available in the bill before us.

For example, 42 States and possessions provide payments to doctors.

The Anderson-Javits bill does not cover doctor bills. It is basically a hospital, nursing home bill, designed to help the aged in meeting the enormous expense involved in increased costs of hospital, nursing home and health care, relieving the burden of serious and catastrophic illness.

The aged in these 42 States want to be assured that they will continue to receive doctor care under their State plans if they elect to use the hospital, nursing home and health care provided under the bill before us.

Thirty-six States provide dental care; 40 provide prescribed drugs outside the hospital. Neither of these benefits are available under the bill we have before us.

Again, the aged in the States where these benefits are available want assurance they will not lose these benefits.

At this point, Mr. President, I ask unanimous consent that there be printed in the RECORD a list of States now providing medical assistance to the aged in forms of either doctor services, dental services, or drugs, or a combination of the three.

There being no objection, the list was ordered to be printed in the RECORD, as follows:

States providing some type of medical assistance to the aged (as of Oct. 1, 1961)

State	Physician services	Dental services	Prescribed drugs
Arkansas	X	X	X
California	X	X	X
Colorado	X	(1)	X
Connecticut	X	X	X
Delaware	X	X	X
District of Columbia	X	X	X
Florida	(1)	X	X
Hawaii	X	X	X
Idaho	X	(1)	(1)
Illinois	X	X	X
Indiana	X	X	X
Iowa	X	X	X
Kansas	X	X	X
Kentucky	X	X	X
Louisiana	X	(1)	X
Maryland	X	X	X
Massachusetts	X	X	X
Michigan	X	X	X
Minnesota	X	X	X
Missouri	X	X	X
Montana	X	(1)	(1)
Nebraska	X	X	X
Nevada	X	X	X
New Hampshire	X	X	X
New Jersey	X	X	X
New Mexico	X	X	X
New York	X	X	X
North Dakota	X	X	X
Ohio	X	X	X
Oklahoma	X	(1)	(1)
Oregon	X	X	X
Pennsylvania	X	X	X
Puerto Rico	(1)	(1)	X
Rhode Island	X	X	X
South Carolina	(1)	(1)	X
South Dakota	X	X	X
Texas	X	X	X
Utah	X	X	X
Vermont	X	(1)	(1)
Virgin Islands	X	X	X
Virginia	X	X	X
Washington	X	X	X
West Virginia	X	X	X
Wisconsin	X	X	X
Wyoming	X	(1)	(1)

[1] No program.

Source: Bureau of Family Services, Social Security Administration (in "The Health Care of the Aged," Health, Education, and Welfare, 1962).

Mr. CARROLL. Mr. President, from the foregoing chart Senators can determine the effect of my amendment on their States.

COLORADO'S MEDICAL CARE PLAN

The Colorado State program of medical care for its senior citizens on old-age pension is one of the finest in the country.

Colorado pioneered in the use of Blue Cross and Blue Shield as its agent in administering the hospital and doctors fee program. The relationship with Blue Cross and Blue Shield has worked out to the complete satisfaction of pensioners, doctors, and hospital administrators.

In 1961 Colorado spent $10 million on medical care to the aged.

Much of this was paid for services not available under the Anderson-Javits bill.

For example, $2,053,568.84 was paid to Colorado doctors in 1961; 34,197 doctor bills were paid for in hospital services, averaging $59.52 per bill for surgical and $41.97 for medical services; 128,089 home and office calls by doctors were paid for; $372,284.27 was paid for 138,110 drug prescriptions for nursing-home patients; $24,097.62 was paid for ambulance transportation service.

Under my amendment the Congress declares as a matter of policy that it expects these services to continue to be available to the aged pensioners.

Another problem confronting Colorado pensioners which would be cured by my amendment involves hospital care.

Under the Anderson-Javits bill the patient is required to pay $10 a day for the first 9 days of hospital care, and $20 for each diagnostic study by outpatient hospital diagnostic services.

In Colorado in 1961 the average hospital stay by pensioners was 9.9 days. There were about 18,000 hospital admissions.

My amendment assures Colorado pensioners that the first 9 days of hospital care, or the $90 deductible hospital charge, will be provided by the Colorado State medical program and the balance of the stay by the new Anderson-Javits program within its limitations. In other words, the Colorado program should supplement the Federal program, filling in the gaps.

FEDERAL BENEFITS NOT CONSIDERED INCOME

Another problem is raised when a Federal health insurance program is considered in connection with State pension and medical care programs. My amendment also meets this problem.

The beneficiaries of State plans are concerned lest by taking advantage of the Federal program as a resource they suffer a disadvantage in having the State consider Federal health care benefits as income counted against their State pension.

My amendment establishes as a matter of congressional policy that this disadvantage to State pensioners not occur.

My amendment assures the State old-age pensioner that he may use Anderson-Javits benefits and still continue to draw his regular monthly pension without penalty.

The director of the welfare department of the State of Colorado, Mr. Guy

Justis, informs me that he would expect every eligible Colorado pensioner to avail himself of the Anderson-Javits benefits as a resource.

However, I am assured that even though this is a resource it will be considered only as a medical aid resource and nothing more. It will not be considered as income which would dilute the monthly pension.

My amendment emphasizes that the Congress, as a matter of policy, declares that no pensioner shall be disadvantaged as a result of enactment of the Anderson-Javits bill. Hence the pensioners' monthly pension is protected and safeguarded.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE DOES NOT OBJECT

I have discussed this proposal with officials of the Department of Health, Education, and Welfare, who say it is not, and never has been, their intention to reduce benefits to any person eligible for benefits under a State pension plan. I replied that that might very well be; but I did not know who the next Secretary of Health, Education, and Welfare would be or what his interpretation of the act would be. Therefore, I desired to protect my Colorado old-age pensioners by spelling out, as far as I could, that the policy and intent of Congress would be not to reduce any benefits to a pensioner receiving assistance under a State plan. This is the entire purpose of my amendment.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD the text of a letter dated July 6, 1962, from Hon. Wilbur J. Cohen, Assistant Secretary of Health, Education, and Welfare, to the distinguished junior Senator from New Mexico [Mr. ANDERSON]. The original letter is in the possession of the Senator from New Mexico.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE,
July 6, 1962.

Hon. CLINTON P. ANDERSON,
U.S. Senate,
Washington, D.C.

DEAR CLINT: This is in reference to an amendment to your health insurance amendment to H.R. 10606 proposed by Senator CARROLL on July 5. The purpose of the amendment is to reassure recipients of old-age assistance and other persons receiving public assistance that the enactment of your health insurance amendment would not be detrimental to them. As a practical matter, we do not believe that this would occur and accordingly from the standpoint of the operation of the programs are not convinced that an amendment is necessary.

However, since there apparently is widespread concern, at least in Colorado, among the old-age pensioners, we sympathize with Senator CARROLL's desire to provide as much reassurance as possible without restricting the right of States to modify and reshape their assistance programs.

We would accordingly have no objection to its inclusion in your amendment with a few minor drafting changes reflected in the enclosed draft which, we understand, are acceptable to Senator CARROLL.

Sincerely,

WILBUR J. COHEN,
Assistant Secretary.

Mr. CARROLL. Mr. President, I believe this is a very necessary amendment. It has been under consideration for several days. I have discussed the proposal with the people of my State, especially pensioners, and they have expressed deep apprehension about this health insurance benefits bill. I think the amendment will strengthen the proposal offered by the junior Senator from New Mexico, who has shown brilliant leadership in this field. The amendment will strengthen the position of pensioners not only in Colorado, but throughout the Nation, as well.

Mr. ANDERSON. Mr. President, will the Senator from Colorado yield?

Mr. CARROLL. I yield.

Mr. ANDERSON. I have had this proposal studied carefully by officials of the Social Security Administration and all other persons who might be concerned with the administration of any part of the bill, should it become law. They have all assured me that there is no objection to the amendment of the junior Senator from Colorado. I hope it will be adopted by the Senate.

Mr. CARROLL. I thank the Senator from New Mexico.

Mr. President, my amendment affects 2,358,272 aged pensioners in 45 States and possessions, assuring them of the use of their State medical care plans as supplementary programs to the Anderson-Javits program, and assuring them that in no way will they be disadvantaged by a reduction in their monthly pensions and present benefits.

Mr. President, I move the adoption of my amendment.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Colorado [Mr. CARROLL].

The amendment was agreed to.

amendment of voting against the motion to table. Those who favor laying the amendment on the table have been saying in the corridors and in conferences in regard to the amendment that unless it is tabled, great damage will be done to a number of our vital public-assistance programs.

Mr. President, I am emphatically opposed to laying the amendment on the table. That would be an unwise, illogical, and wholly irrelevant procedure at this time. The subject of health care for the elderly has been before the Congress for years. We must decide about it on its merits, not on the basis of some extraneous parliamentary procedure.

Mr. President, let me also say that I heartily support the joint resolution, which the distinguished Senator from New Mexico [Mr. ANDERSON] has introduced, to grant a 60-day extension of the Public Welfare Act. This is the principal answer to the charge that the strategy in connection with our health-care amendment would deprive public-assistance recipients of the care they need. If those who so strenuously urge that the Anderson amendment be tabled are really so much concerned about the public-assistance recipients, such Senators should support the joint resolution to provide a 60-day extension so that we can intelligently and carefully debate the health-care issue.

Perhaps no other domestic issue has stirred up so much interest and excitement throughout the Nation. How can we, as conscientious legislators, say that all we want to do is table this amendment? That would not decide anything. In effect, it would amount to our saying, "We do not want to take a position; we just want to get the thing out of the way for a while."

The question arises, what are we actually talking about when people refer to those on relief who are being hurt by our prolonged consideration of the bipartisan health-care amendment to the Public Welfare Amendments Act.

I have checked with the Commissioner of the Social Security Administration, and I have some facts which ought to be on the record. The only public-welfare programs that are affected by this delay are programs that were temporarily enacted when we last amended the Public Welfare Act. Primarily, what is involved is the temporary aid to dependent children program for the children of unemployed parents. It was enacted 1 year in 1961, and now has lapsed. The bill before us would extend this program. There are, therefore, a considerable number of children, whose parents are unemployed, for whom no Federal money has been available since July 1.

The relevant question is, Are these children going without? In my own State of New York, the State has continued to make payments under general assistance for these children, on the basis that the State will be reimbursed later by the Federal Government. There is very little doubt in my mind that the State will be reimbursed. I am glad that New York State has taken care of these people in the interim, and I am happy to report that other States are doing the same.

Unfortunately, there are three States which have not made arrangements to continue this program until new legislation is enacted. These States are Illinois, Connecticut, and Oregon. In these three States, children are being hurt.

I favor a temporary 60-day extension right now. I recognize that in Illinois, Connecticut, and Oregon some children are temporarily being hurt by our delay. I am concerned about these children; but I caution the Senate against generalizing too carelessly, so as to make it appear that this delay is curtailing existent and continuous public welfare programs for which the authority is already existent, and which can be extended on the basis of the resolution which we passed to take care of the new fiscal year.

In the three States involved, the problem is not one of intentions or motivation. It generally involves a rigidity of State law, which does not allow for the temporary transfer of funds from one public welfare program to another. In cases where the legislature is not in session or cannot act swiftly on such matters, we are creating a real problem.

All in all, 13 States have programs to provide aid to the dependent children of unemployed parents. Four States—Massachusetts, New York, Pennsylvania, and Utah—have taken specific action to extend temporarily these programs. Three States, as I have said, are "out in the cold." The remaining six States have programs which, as of the present moment, have not been impaired, according to the best knowledge of the experts at the Department of Health, Education, and Welfare. One of these six States is Oklahoma; and this situation ought to be of interest to the senior Senator from that fine State.

Mr. President, several other temporary features in the public welfare law are affected by this delay. The $1 a month increase made last year in the aid to the aged program is similarly affected. Again, many States are making this additional payment, because they are convinced that the Congress will act, and, therefore, that funds to reimburse them will be available at some future date.

Thus, Mr. President, the need for positive action is apparent. Seventeen to eighteen million people in the Nation and over 1½ million people over the age of 65 in New York State alone are awaiting our decision. All of us realize, perhaps even more sharply after reading the thousands of moving pleas from our constituents, that something has to be done. Let us do it. Let us not, by tabling, say that we are not going to do anything about this critical problem.

Mr. ANDERSON. Mr. President, I ask unanimous consent that, following the completion of the speech by the Senator from Colorado [Mr. ALLOTT], the Senator from Kansas [Mr. CARLSON] be recognized for 20 minutes, without the time being counted against either side.

The PRESIDING OFFICER. Without objection, it is so ordered.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. ANDERSON. Mr. President, there seems to be no amendment pending now to the amendment which I have offered on behalf of myself and a number of other Senators.

I ask unanimous consent that at this time the Senator from New York [Mr. KEATING], the Senator from Colorado [Mr. ALLOTT], and the junior Senator from New Mexico, may be recognized for such time as they may require, without having the time they use charged to the time available to either side in connection with the time allotment.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. KEATING. Mr. President, I wish to say a few words about the key vote on health care for the aged which will be taken on Tuesday. I refer to the vote which will be taken on the motion to lay on the table the revised Anderson amendments, of which I am a cosponsor.

There has been considerable loose talk about depriving children and persons on public assistance by voting for this

Mr. ALLOTT. Mr. President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator will state it.

Mr. ALLOTT. As I understand the parliamentary situation, it is not necessary to have an amendment pending in order to speak at this time.

The PRESIDING OFFICER. The Senator is correct.

Mr. ALLOTT. What we are offered by the Anderson-Javits amendment is this: Basically, we still have the King-Anderson bill, with a few modifications. Benefits would consist of payments to medical facilities for services rendered to eligible individuals for the following kinds of services:

First. Inpatient hospital care: 90 days per benefit period subject to a deductible of $10 per day for the first 9 days but not less than $20 plus

Second. Skilled nursing home care in homes affiliated with a hospital after transfer from a hospital: 120 days per benefit period plus 2 extra days of nursing home care for each unused day of hospital care total nursing home care for each benefit period not to exceed 180 days, plus.

Third. Home health services: 240 visits per calendar year plus.

Fourth. Outpatient diagnostic patient services subject to a $20 deductible for each 30-day period.

Those eligible still include all persons 65 or over eligible to receive social security or railroad retirement benefits an estimated 15 million persons with the addition of some 2.5 million more persons not so eligible under social security or the railroad retirement act but who will be 65 before 1967 or reach age 65 before 1973 if they meet a special insured status requirement of a certain number of quarters of coverage prior to that date.

The program would be financed in three ways: First, the amount of annual wages and earnings subject to social security payroll taxes would be increased from $4,800 to $5,200; second, social security and railroad retirement payroll taxes would be increased by 0.50 percent of taxable earnings. The increase equals 0.25 percent on employers, 0.25 percent on employees, and 0.375 percent on the self-employed.

These changes would be effective in 1963 for wage base, and in 1964 for tax increase. Benefits for those not eligible for social security or railroad retirement benefits would be financed from general revenues. Administration would still be under the Federal social security system, with the States and accrediting bodies used in determining eligibility of providers to participate. The providers could use agents to represent them before the Government on their participation in the program and on the reimbursement provisions. The new provisions of which much is made, and which I will discuss later, are: First, to allow the Secretary of HEW in his discretion, to designate an agent, such as Blue Cross, chosen by the provider of services, to handle the administrative details in the provider's dealings with the Government; and, second, to allow the patient or beneficiary the privilege of having the benefits to which he is entitled under the bill paid to the provider—the hospital—by his own private health insurance organization such as Blue Cross; such organization would then be reimbursed by the Government.

Also, a separate trust fund for health insurance would be established.

WHAT IS OFFERED AND DEFICIENCIES

Ultimately, any appraisal of merits and demerits in such widely different approaches to Government aid as Kerr-Mills Act and the Javits-Anderson bill requires that the fundamental, philosophic differences be examined carefully. These are basically three in number. Each must be studied from the viewpoint of both the immediate effect and the long-range implications. Broadly speaking, these three fundamental differences under the Javits-Anderson bill are as follows:

First. All of the beneficiaries, whether they be under social security or not, would receive aid regardless of need;

Second. Care would be limited to (a) a specific number of days in the hospital and nursing homes; (b) physician diagnostic services provided through hospital clinic; and (c) services of the home health agencies, which must be a nonprofit corporation or a public agency.

Excluded would be (a) drugs, except those provided in one of the above-cited institutions; (b) private physician services in or out of the institution; and (c) nursing or other professional services except those provided through one of the above cited institutions.

Third. Administration of the program, for all practical purposes, would be by the Federal Government in Washington.

It is in these three areas of conflict that the fundamental issues regarding Government's role in medical care for older people are to be found.

ANDERSON-JAVITS SUBSTITUTES GOVERNMENT CARE FOR PRIVATE INITIATIVE

In direct contrast with the Kerr-Mills Act, the Anderson-Javits approach would provide limited help to everyone over 65 covered by social security, plus approximately 2,500,000 persons not covered by social security, whether such persons in either instance need or want help or not.

The amendment which has just been adopted relating to the State of Colorado, which is a very unusual and peculiar situation, will aid this situation somewhat. Even millionaires would be recipients of aid. The disregard of the need factor by the Anderson-Javits bill is important in its immediate effects. Most obvious is the unnecessary cost to the taxpayer providing services for those who are able and willing to accept personal responsibility for meeting their own needs. Equally important is the virtually complete destruction of a substantial portion of the voluntary health insurance effort which is rapidly responding to the needs of older people.

Immediate effects, however, are insignificant when compared with the possibilities of the future. Historically, there has been a tendency for age requirements to be lowered once a program of this type gets underway. While social security benefits are not technically a matter of legal right for those who have paid their social security taxes, they are generally so regarded by the individuals paying such taxes. It is quite reasonable to assume that this belief in their right might reinforce efforts for age requirements, eventually completely destroying the private enterprise system of medical care now enjoyed by the American people. That such a possibility is real, is underscored by the fact that many of the prime movers for King-Anderson, and now Anderson-Javits, have long advocated total, compulsory Federal health care for the whole population.

In the United States as elsewhere, Government very definitely operates on precedent. Once the precedent is established under the Anderson-Javits, or a similar bill, that medical care should be provided to individuals without regard for need, no matter how few the number or how limited the benefits, it will be a simple matter to extend such assistance to increasingly large numbers, conceivably to all of the people. The dangers of such an extension are especially real under the social security tax method of financing such assistance. Since working people will be paying the bill, it is almost inevitable that many of them will want to share in the benefits. Former Congressman Forand, author of a previously rejected bill similar to the King-Anderson bill, has said:

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

I have in my hand two charts which show the fantastic growth of funds for the public assistance programs under the Social Security Administration and the funds for the National Institutes of Health since 1956. I believe that once the Anderson-Javits program was enacted, we could expect an even more rapid growth in the size of that program than we have experienced with the National Institutes of Health and the public welfare programs under HEW.

Mr. President, because I think the growth of the Department of Health, Education, and Welfare, and also the growth of the National Institutes of Health, under a similar program for health, provide a reasonable guidepost for what we may expect in this area, I ask unanimous consent that the two charts, identified as chart 1 and chart 2, which I have in my hand, be made a part of the RECORD at this point.

There being no objection, the charts were ordered to be printed in the RECORD, as follows:

CHART 1.—*Budget estimates and appropriations to the Social Security Administration, 1956 through 1963, estimate*

	1956	1957	1958	1959	1960	1961	1962	1963
Limitation on salaries and expenses, Bureau of Old-Age and Survivors Insurance (trust fund):								
Budget estimate	$93,229,000	$122,211,000	$145,085,000	$173,532,000	$191,600,000	$237,660,000	$280,625,000	$285,400,000
Appropriation	91,229,000	121,500,000	144,085,000	171,221,000	191,600,000	232,200,000	267,570,000	
Reimbursement for military service credits:								
Budget estimate								78,600,000
Appropriation								
Grants to States for public assistance:								
Budget estimate	1,457,000,000	1,592,000,000	1,850,000,000	1,974,800,000	2,043,500,000	2,190,000,000	2,586,200,000	2,688,300,000
Appropriation	1,447,000,000	1,575,000,000	1,770,000,000	1,957,960,000	2,037,500,000	2,177,000,000	[1] 2,401,200,000	
Grants for training public welfare personnel:								
Budget estimate			2,500,000		1,000,000		3,500,000	3,500,000
Appropriation								
Assistance for repatriated U.S. nationals:								
Budget estimate							939,000	875,000
Appropriation							764,000	
Salaries and expenses, Bureau of Family Services:								
Budget estimate	1,690,000	1,748,000	2,295,500	2,226,500	2,345,000	3,113,000	3,742,000	4,096,000
Appropriation	1,636,250	1,748,000	1,979,500	2,166,500	2,345,000	2,726,900	3,442,000	
Grants to States for maternal and child welfare:								
Budget estimate	30,000,000	35,288,700	41,500,000	43,000,000	43,500,000	48,500,000	64,750,000	76,750,000
Appropriation	34,156,600	39,361,000	41,500,000	45,000,000	46,500,000	51,833,000	60,100,000	
Salaries and expenses, Children's Bureau:								
Budget estimate	1,896,500	1,922,000	2,197,124	2,185,000	2,300,000	2,507,000	2,668,000	2,853,000
Appropriation	1,740,000	1,822,000	2,043,124	2,172,000	2,300,000	2,493,500	2,668,000	
Cooperative research in social security:								
Budget estimate			2,080,000		700,000	700,000	1,500,000	1,900,000
Appropriation						350,000	700,000	
International social security meeting:								
Budget estimate								100,000
Appropriation								
Special foreign currency program:								
Budget estimate						25,650	2,213,000	1,800,000
Appropriation							1,607,000	
Salaries and expenses, Office of the Commissioner:								
Appropriation:								
Budget estimate	191,400	212,000	315,000	342,000	337,000	412,000	590,000	711,000
Appropriation	184,400	212,000	300,000	342,000	337,000	372,800	590,000	
Transfer from old-age and survivors insurance trust fund:								
Budget estimate	149,600	160,000	244,000	268,500	276,000	300,000	322,000	418,000
Appropriation	138,600	160,000	240,000	268,500	276,000	296,000	322,000	

[1] Excludes 1962 supplemental contained in H.J. Res. 745 of $80,000,000.

CHART 2.—*History of appropriations, National Institutes of Health*

Fiscal year	Budget estimate	House allowance	Senate allowance	Senate increase over—		Appropriation	Appropriation increase over—	
				Estimate	House		Estimate	House
1956	$90,314,800	$89,773,000	$113,416,800	$23,102,000	$23,643,800	$98,458,000	$8,143,200	$8,685,000
1957	126,525,000	135,525,000	183,007,000	56,482,000	47,482,000	183,007,000	56,482,000	47,482,000
1958	190,183,000	190,183,000	226,783,000	36,600,000	36,600,000	211,183,000	21,000,000	21,000,000
1959	211,183,000	219,383,000	320,577,000	109,394,000	101,194,000	294,383,000	83,200,000	75,000,000
1960	294,279,000	344,279,000	480,604,000	186,325,000	136,325,000	400,000,000	105,721,000	55,721,000
1961	400,000,000	455,000,000	664,000,000	264,000,000	209,000,000	560,000,000	160,000,000	105,000,000
1962	583,000,000	641,000,000	835,670,000	252,670,000	194,670,000	738,335,000	155,335,000	97,335,000
Total	1,895,484,800	2,075,143,000	2,824,057,800	928,573,000	748,914,800	2,485,366,000	589,881,200	410,223,000

Mr. ALLOTT. Mr. President, the proponents of the Anderson-Javits social security approach claim that this plan is not the "opening wedge" for a total, compulsory Federal health care system—that if the plan works poorly, surely it would not be expanded; and that if there is no real need for expansion it would not be expanded. Further, it is said that if it works well, why should it not be expanded? My comment on this is as follows:

In other countries, once the principle of government medical care has been accepted for part of the population, it has ultimately spread to all.

Many advocates of the social security approach have long supported total compulsory "health insurance."

Whether it works poorly or well has had little influence on the spread of state medicine. Human beings are usually unwilling to pay for services given someone else as a right for long without insisting that the right be extended also to them. This is the built-in expander of any government medical program not based on need.

Americans, in part as a result of the voluntary medical care system, may be more sophisticated regarding care than people in other countries. However, they too, would be subject to the same human motives which have tended to make state medicine universal once the principle has been accepted for any group.

Whether expansion of the program is planned was apparently supplied during the hearings on the King-Anderson bill before the House Ways and Means Committee during the summer of 1961. The witness was Walter Reuther, president of the United Auto Workers of America, a person not unknown to have an attentive ear at the White House these days. Said Reuther:

Obviously it is a matter of commonsense that those who share my point of view that the present proposal (the King-Anderson bill) is not adequate in certain areas would want to continue their efforts to get amendments in the future to make it more adequate. Nothing is static. Nothing is fixed. Therefore, if we could get the principle established we want established, we want to build on that principle, just as we built on the (original) social securtiy principle.

This statement is similar to that of former Representative Forand, and similar, I am sure, to the thinking of a great many people. It forms the basis, together with the illustrative charts I have put into the RECORD, for conclusive proof in my mind that this is the opening wedge of the program, and that it will grow in size and be extended, and that the Government bureaucracy required to handle it will grow and grow in the same proportion.

It should also be noted that much more is at stake in the social security approach than medical care.

If the dollars now provided by the social security system are replaced with medical services—because someone in Government has decided that that is what older people need—it is illogical to stop there.

Why should not the noncash principle be extended to food, clothing, shelter, and other necessities?

Some of the people advocating the social security approach would like to greatly expand public housing for older persons. In both the executive and legislative branches there is considerable discussion of what constitutes "proper housing" for older people. It implies that Government should decide what housing is needed whether it really meets the desires of older people or not.

These bureaucracy builders are strangely disinclined to provide equivalent amounts of cash which people could spend as they, themselves, choose.

Government involvement in activities which should be left to individual initiative, private enterprise, and voluntary action is dangerous to the Nation's future. For, while socialization of part of medical care has been followed by total socialized medicine, even more serious is the historical fact that socialized medicine has been but a beginning of nationalization of other fields.

Nor is public approval proof that a plan is good. This is particularly true in medical care.

Many people in England, for example, seem to like their "socialized medicine." Possibly this springs from the low level of medical care they had before, a good portion of which was socialized in 1911. Perhaps they fail to recognize that they, as individuals, ultimately are paying for the scheme through indirect taxes as well as payroll deductions. They may enjoy the luxury of a "free" housecall for the common cold. Apparently the opportunity to "put the doctor in his place" by having him superficially at one's beck and call appeals to many.

This is not medical "care"; it is medical "attention." The difference is great.

Failure of the United Kingdom to build badly needed hospital beds has been a major factor in deterioration of care for its truly sick people. Over the first 13 years of their total socialized medicine program, only one new hospital was built. During the same period, the United States, exclusive of Federal hospitals, had a net increase in new hospital beds of 334,000.

It is further said that being a contributory program the social security approach would place no load on the Federal budget, but that it would, in fact, help balance it.

The significant thing to keep in mind in meeting the costs of Government activities is whether such costs are to be met through taxes, inflation, or through other methods, all of which confiscate part of the individual's assets or earnings.

I suggest, Mr. President, although the employer under social security contributes an equal amount to that which the employee contributes, this comes from the net earnings of the corporation. It is a fact ordinarily overlooked that to such an extent this eliminates from the net earnings of the corporation a portion which might otherwise be shared with the employee.

The social security system and other self-financing programs such as the highway trust fund do not appear in what is usually referred to as the Federal budget, but this is purely an administrative device.

Special taxes, such as those under social security, are actually no different from other taxes; except, possibly, as to the method of levy. Expenditures under such special programs are equally no different in their effects on the economy.

Obviously, if costs are high, they not only reduce the freedom of individuals to spend their money, but also impair the ability of States and communities to gain public acceptance of taxes needed to pay for their programs.

COST FACTORS AND ESTIMATES INVOLVED IN ANDERSON-JAVITS AMENDMENT

I would like to take a moment to discuss the cost factors and estimates involved in the Anderson-Javits amendment. We have seen from a review that the benefit structure and eligibles for OASI benefits under the Anderson-Javits proposal are not essentially different from those contained in H.R. 4222 and S. 909. Therefore, as respects the OASI eligibles and those eligible under the Railroad Retirement Act, cost figures and estimates remain approximately the same as calculated for the original King-Anderson bill. In hearings on H.R. 4222, held before the House Ways and Means Committee during 1961, there appeared significant differences in cost estimates by the Department of Health, Education, and Welfare, and witnesses for the insurance industry. These differences are shown by the partial quote from testimony presented on behalf of the American Life Convention, the Life Insurance Association of America and Health Insurance Association of America by H. Lewis Reitz, president of the latter:

> Insurance company actuaries have developed estimates that benefits provided under H.R. 4222 would cost $2.2 billion in 1963, as compared with the administration's estimate of $1 billion. In 1964, with the nursing home provision available for the entire year, the total cost would rise to $2.5 billion. The administration's estimate is again $1 billion. By 1983, the annual cost of H.R. 4222 would be $5.4 billion, while the administration has estimated that by 1990 the cost will reach only $2.5 billion. The level premium cost of H.R. 4222 as defined by the social security administration are 1.73 percent on a $5,000 taxable earnings base, while the administration's estimate is only 0.66 percent.

The administration's statistics were established by Robert J. Myers, Chief Actuary of the Social Security Administration, on the basis of National Health Survey reports which include the experience of the aging population of the country. The insurance company base is much more selective. Its tables are based on the actual claim experience under Blue Cross-Blue Shield plans. It estimates hospital costs in 1963 at $37 per diem, while the administration figure is $32. It includes railroad retirees. H.R. 4222 does not. Mr. President, while there is a question of choosing which figures we wish to believe, I am inclined to go the insurance industry estimates which are, as I said, based upon the actual claim experience of insurance companies, as well as Blue Cross and Blue Shield plans. Long experience would indicate that this substantial, actual data is far more reliable in predicting cost than is unverified data obtained from household interviews of limited sample of the aged population as was used in development of the HEW estimate.

Following is a breakdown of these overall figures to a calculation of what a worker entering the labor force next year would pay with and without both medical tax:

Year	Without medical care tax	With medical care tax
1963	$174	$201.50
1964	174	201.50
1965	174	201.50
1966	198	227.50
1967	198	227.50
1968	222	253.50
1969-2007	8,658	9,886.50
Total	9,798	11,199.50

With respect to the cost of providing benefits to non-OASI eligibles, I believe proponents of this amendment to assume a cost of $250 million to provide coverage to 2.5 million aged people. They indicate that the net cost of covering such aged persons would be only $50 million and that the Government would derive a savings of some $200 million via lesser payments under public assistance and veterans programs. I believe these estimates to be totally unrealistic for the following reasons: I belive the estimates are understated because: First, they understate the number of aged persons not eligible for either OASI or railroad retirement benefits; second, they understate the cost of providing health benefits to each person eligible under the provision of the amendment; third, they overstate the savings which the Government would realize under this new public assistance and veterans programs.

With respect to the number of aging who would be eligible, I believe the proponents of this amendment derive their figures as follows: As of January 1964, there will be 17.9 million aged persons. Of this number, they say, a quarter of a million, while not eligible for either social security or railroad retirement would be covered under the Federal civil service governmental health insurance plans. Subtracting this quarter of a million, they incorrectly arrive at 17.5 million. They then indicate that about 15 millions aged persons are eligible for either social security or railroad retirement, leaving a remainder of 2.5 million aged persons who could require health care benefits to be financed from the general revenue. According to the Social Security Administration of the Department of Health, Education, and Welfare, there will be 17.9 million persons at age 65 or over on January 1, 1964. Excluding the quarter of a million Federal civil servants—even this figure

may be high—leaves a remainder of 17⅔ million—17.65 million, not 17.5 million. According to the same governmental sources, there will be 14.4 million aging persons eligible for OASI and an additional quarter of a million of railroad retirement benefits not already included under OASI. By subtraction there remains 3 million aged persons not covered by either OASI or railroad retirement or having benefits by reason of being Federal civil servants who could qualify for health care benefits from the general revenue, as opposed to the proponents' estimate or 2.5 million.

Proponents also estimate that the cost of caring for each non-OASI eligible would be $100. The insurance industry's detailed actuarial cost estimates included in their testimony before the House Ways and Means Committee last year in hearings on the King bill indicate the cost per OASI eligible should be approximately $141 in 1964. The non-OASI aged population is, according to Government estimates, a significantly higher age group than is the OASI population. This being the case, the cost per person among non-OASI aged should be even higher than $141. Apart from this, and using the base cost of $141 per person with an allowance of 10 percent for the cost of administering these benefits, the cost in 1964 for providing health benefits to the non-OASI eligible population should approximate $465 million as compared with the amednment proponents esitmate of $250 million.

Also, I am unable to substantiate the proponents estimate that this aspect of the program would result in a savings of $200 million. It is a reasonable to assume that such an estimate is unduly optimistic. According to the Social Security Administration, public assistance expenditures for general hospital care for the aged in 1960 totaled $100 million. Such expenditures were for aged persons under old age assistance, of which about one-third are also covered under OASI. If it is assumed that OASI and non-OASI public assistance recipients use hospital care at about the same amount, then $67 million was expended by both Federal and State Governments to provide general hospital care in 1960 to the non-OASI aged. The Federal Government's share of this $67 million approximates $45 million or two-thirds. In 1960, the Veterans' Administration spent $165 million for general hospital care for the aged. It should be noted that the very large majority of veterans are covered under OASI. The savings to be derived via this program for the non-OASI aged is therefore questionable. Apart from all this, and accepting the $200 million savings which is, as I have indicated, very likely too high, I estimate the net cost to the Federal Government for providing health benefits to the non-OASI population to be $265 million in 1964. There is a likelihood that this figure could well be in excess of one-third of a billion.

At any rate, we have the situation where heavier taxes toward financing this proposed health insurance proposal plan would be directly imposed only upon contributors to the social security and railroad retirement systems. Those persons not covered by either system would pay no direct contribution, although nearly all of them would be eligible for a full range of medical insurance benefits. The cost of this program for these persons would be financed through appropriations from a general fund of the Treasury. We therefore have such a situation where persons contributing toward social security or railroad retirement would be paying more than their fair share for the health insurance plan. They would pay once through increased taxes under social security or the railroad retirement. They would pay again through general income taxes.

Also, in view of the underestimation of the cost of the envisaged program by the Department of Health, Education, and Welfare, and consequently the underestimation of required revenue to finance the program, the conclusion is inescapable that the proposed increase in the social security tax will only be a first installment increase. More hikes must occur.

ANDERSON-JAVITS DOES NOT MEET OLDER PEOPLES NEEDS

The second fundamental difference the Kerr-Mills Act and the Anderson-Javits approach makes, is that the latter would provide limited services which might, or might not meet the pressing medical and financial assistance needs of the patient. I have already listed specified benefits under the Javits-Anderson bill.

Many supporters of the King-Anderson bill and the Anderson-Javits amendment have an exaggerated idea of what the measure would provide. For this reason, it is most important to spell out some of the services it does not provide.

It does not provide for drugs outside the hospital or nursing home. Among those appearing at hearings by the Senate Special Committee on Aging to voice concern about medical costs, a high percentage were more concerned about the cost of drugs than any other item. Admittedly, the cost of some of these life-saving drugs, which often spell the difference between almost normal living and acute illness or death, is great when they must be taken daily month in and month out. Often, they represent the product of advances in medical care which keep the patient out of an institution.

When the cost of drugs seriously impairs the ability of older people to meet their needs, the Kerr-Mills Act—fully implemented—would provide the help. Anderson-Javits would do nothing. It would do nothing, that is, unless the individual were taken from his home and placed in a hospital or nursing home unnecessarily.

This criticism of Anderson-Javits is reinforced by the fact that the most common illnesses among our elderly citizens are chronic and acute, best cared for in the home and not an institution, medical or surgical. The major ingredients in their care are the physician's skill and drugs or appliances, not for long institutionalization.

Anderson-Javits would not provide for physician's services in the home or nursing home at all. It would not provide medical or surgical services by a physician in the hospital, except in the field of pathology, radiology, psychiatry and anesthesiology or certain types of services rendered in the hospital by an intern or resident in training under approved teaching program.

The physician is the key to the quality of medical services and ultimately the health of the patient. How the family physician, the surgeon and other physicians can be excluded from a medical care program which claims to be adequate is inconceivable. Yet this is what Anderson-Javits does. The only physicians eligible to provide services under the bill are those who are captives of the hospital and who, in effect, work as its employees in the field of pathology, radiology, psychiatry and anesthesiology, or as interns and residents. If it is the aim of Anderson-Javits to replace the physician with the hospital corporation as the person to whom a sick person turns, its provision represents a long step toward such objectives. It is questionable whether this is the wish of the people, including those who, though misunderstanding, now support the administration bill.

ANDERSON-JAVITS CONCENTRATES POWER IN CENTRAL GOVERNMENT

The third major difference between the present law and the Anderson-Javits approach revolves around the question of whether the administration should be by State and community, as under the Kerr-Mills Act, or by the Federal Government. Congress has long acted on the precedent of grants and aid to States as the proper governmental technique in providing services to individual citizens who need them. This principle is inherent in the present law as set forth in the Kerr-Mills Act. Adoption of Anderson-Javits would be in direct violation of this precedent with most serious implications for the Nation's whole governmental system.

Much more is at stake here than a simple matter of administrative techniques. The whole doctrine of separation of governmental powers, as worked out by the Founding Fathers and reaffirmed by succeeding generations, is at issue.

Adoption of the Anderson-Javits approach would be more than a "foot in the door" for socialized medicine; it would be a long step toward the creation of a new and all-powerful Federal bureaucracy in Washington with a corollary destruction of significant authority and responsibility by State and local government.

In the field of health, itself, the present participation by the Federal Government is limited. If the principles in the Anderson-Javits bill are accepted, they could equally apply to public health measures. If the States are deemed incompetent in provision of medical care to individuals in need, why shouldn't they be deemed incompetent to conduct administration of public health activities? The latter much more clearly affect the total population. They far more certainly cross State lines in their several implications. Are State and

local health departments to be replaced by a Federal health juggernaut?

This question is not confined solely to health or medical care. In its large implications, it must be viewed in the total context of possible changes in America's Government. There seems to be a substantial group of people who want to destroy the traditional division of powers, replacing them with centralized concentration of control far removed from the people.

The Kennedy administration has given encouragement to this point of view. Two recent examples should suffice: First, the unsuccessful recommendation that Congress surrender to the executive its control over taxes; and second, the unsuccessful effort to increase Federal involvement in local and State affairs through the proposed creation of a Department of Urban Affairs and Housing, which would have responsibility for certain types of activities in all communities of more than 2,500 population—using definition of "urban population" used by U.S. Bureau of the Census.

The differences between the Kerr-Mills law and the Anderson-Javits approach regarding further extension of Federal control are obvious.

One claim made on behalf of Federal administration, as under the Anderson-Javits amendment, which does appeal to some people, is that it provides all covered persons with eligibility for the same benefits. Some disadvantages of such uniformity, of course, have been cited by me heretofore.

It should be noted further, however, that eligibility for services is not the same as receipt of services. In many areas of the Nation, especially rural communities, only part of the services provided for by the Javits-Anderson approach are available.

Provision of "on paper" outpatient hospital clinic services means nothing if they are not nearby. They are normally available only in teaching hospitals.

Corporate "home health services" such as described in the Javits-Anderson bill exist in few cities and are virtually impossible in small communities. In contrast, the Kerr-Mills Act has flexibility to give those in need the benefits of any services available in any community.

This difference between the Kerr-Mills Act and the Anderson-Javits should be an especially important consideration to people in rural areas as they try to evaluate the two kinds of approaches.

Nonetheless it should be admitted that, while ultimately the States will probably all fully implement the Kerr-Mills Act, such action never immediately follows passage of a grant-in-aid program by the Congress. Some States have not implemented the law. Improbably, but conceivably, some State such as Alaska with its average age of 26 and only 2.4 percent of its people over 65, may never pass it. Others may prefer to pay the bill themselves without Federal aid while still meeting the need.

Basically, however, the issue here is the question of haste versus quality and equity. Undergirding it is the question of whether we shall continue to express confidence in the division of powers between the States and the Federal Government.

Much ado has been made over the provisions now added in the Anderson-Javits amendment, not present in the original King-Anderson bill, which would first, allow the Secretary of Health, Education, and Welfare in his discretion, to designate an agent, such as Blue Cross, chosen by the provider of services, to handle the administrative details in the provider's dealings with the Government; and second, allow the patient or beneficiary the privilege of having the benefits to which he is entitled under the bill paid to the provider—the hospital—by his own private health insurance organization such as Blue Cross; such organization would then be reimbursed by the Government.

The only result of these provisions is this: The Secretary of Health, Education, and Welfare, in the first instance, while authorized to enter into agreements with these organizations to handle certain administrative details and act as intermediaries between the providers and the Government, is under no compulsion to do so. Such a relationship, even if made, is of course under the strict guidance and control of the Secretary and the Department as it inevitably must be when solely Federal funds are being dispensed.

Incidentally, I have in my hand a release from the American Hospital Association—Blue Cross—which indicates they are not interested in participating in this way as mere fiscal agents for a Government benefit program. The mere using of Blue Cross or any other organization, as intermediary, either for the provider or for the patient beneficiary, confers no increased benefits upon either. Benefits paid and received would be the same as they would be if the patient or hospital were dealing directly with the Government.

I ask unanimous consent that the release, dated July 9, 1962, be included in the RECORD at this point in my remarks.

The PRESIDING OFFICER (Mr. JAVITS in the chair). Is there objection?

There being no objection, the release was ordered to be printed in the RECORD, as follows:

NEWS RELEASE BY AMERICAN HOSPITAL ASSOCIATION, JULY 9, 1962

CHICAGO, July 8.—The American Hospital Association today objected to the program for financing health care of the aged proposed in the Senate as amendments to a public welfare bill.

Frank S. Groner, chairman of the association's house of delegates and administrator of the Baptist Hospital, Memphis, Tenn., issued a critical statement at the association's headquarters here.

Mr. Groner, immediate past president of the AHA, said, "The association's house of delegates at a special meeting last January voted its opposition to the program for the health care of the aged in the King-Anderson bill (H.R. 4222). The amendments proposed by Senator ANDERSON do not remove what the association believes are fundamental defects of the King-Anderson bill: (1) administration of the program by the Social Security Administration; (2) lack of any test of financial need of the recipients, and (3) underfinancing.

"We recognize that Government assistance is necessary to enable many retired persons to obtain needed health care. We believe that such assistance should go to the individual to aid him or her in purchasing prepayment through the voluntary system. The Senate amendments permit the administration of the program by the Social Security Administration. We believe it does not belong there. The provision in the Senate amendments for purchase of coverage through Blue Cross or private insurance would make them mere fiscal agents for the Government benefit program.

"Secondly, we believe that the individual aged person should receive governmental financial assistance on a decreasing scale related to income. We believe that a dignified test of income can be devised so that the Government provides assistance to individuals in relationship to their need for such assistance. The King-Anderson bill and the Senate amendments provide no such test.

"Thirdly, as we told the House Ways and Means Committee in our testimony on the King-Anderson bill, the program is underfinanced with all the dangers inherent in such underfinancing.

The changes that the Senate amendments would make in the King-Anderson bill do not therefore, in our opinion, overcome its fundamental defects."

Mr. ALLOTT. Mr. President, note the case of the patient electing his "option" to have his private health insurance organization act as his intermediary. The term "premiums" or "payment of premiums" are not used in this connection. Rather than receiving premium payments for the individuals it insures, the carrier would be reimbursed for the amounts it pays to the providers of service for the authorized benefits. The carrier in effect, would merely be a middleman fiscal agent. The provision is silent with respect to any adjustment in premium payments by the individual for the services which would be financed by the Government. Wherein, then, lies the "option"? We still have a program bestowed upon all, regardless of need, and financed in the largest part by the middle and low income groups of the country.

(At this point Mrs. NEUBERGER took the chair as Presiding Officer.)

Mr. ALLOTT. I believe that just a word about the Department which would be asked to administer this multimillion-dollar program is also in order. For, whatever else can be said for the various programs, I think we all want to be sure of the best administration possible of whatever plan is adopted, to insure maximum benefits from the taxpayers' dollar. We have had certain practices brought to our attention during the past year that, with everything else being equal, would make me dubious about saddling the Social Security Administration with this new, huge program.

My good friend, and able colleague, the Senator from West Virginia [Mr. BYRD] has, since becoming chairman of the District of Columbia Appropriations Subcommittee, been conducting extensive investigations into the welfare programs within the District of Columbia. I have been following the results with great interest as has the full Appropriations Committee. The final result of

the investigation of the 5-percent sample of the aid to dependent children program disclosed that 66 percent of the cases were ineligible. The Appropriations Committee, in commenting on Senator BYRD's findings, in its report on the fiscal year 1963 HEW appropriations bill, stated as follows:

This, in the committee's opinion constitutes a shocking waste of Federal and local funds. The committee has previously been advised by the Federal agency that ineligibility in the caseloads throughout the country is estimated to be less than 2 percent. If the situation found to exist in the District is common to other large cities, it is estimated that the waste of public funds would run into the hundreds of millions of dollars. The committee will expect the Department to make an all-out effort to carefully review eligibility under the ADC program throughout the country. This review should include local, State, and Federal personnel organized into a concerted effort to eliminate any abuses of the program. A full report of the Department's findings will be expected when the Department appears before the committee next year.

It is incumbent upon the committee to insist upon a thorough check in view of the seeming complacency exhibited by Federal, State, and local community officials, particularly in light of the results disclosed through the special investigation in the Nation's Capital.

I shall personally be looking forward with interest to the requested report, should it reflect anywhere near the waste of public and local funds that would be the case with a national projection of the facts turned up by Senator BYRD's investigation. I, for one, could not help but approach, with great apprehension, the turning over to the Social Security Administration the great, new responsibilities it would have under the Anderson-Javits amendment until they put their present house in order.

Again, within the Department of Health, Education, and Welfare, I believe the public has been shocked by the revelations of mismanagement and loose management of the grants research program of the National Institutes of Health, which have been brought out by the Intergovernmental Relations Subcommittee of the House Committee on Government Operations, chaired by Representative L. H. FOUNTAIN, of North Carolina. On April 28, 1962, the Committee on Government Operations issued a comprehensive report on the health research and training grants programs administered by the National Institutes of Health. The report was based on more than 2 years of study by the staff of the committee's Intergovernmental Relations Subcommittee and identified areas of weaknesses in the management of these programs and made recommendations for corrective action. Public hearings were held by the Intergovernmental Relations Subcommittee on August 1 and 2, 1961, in which the Surgeon General of the Public Health Service and the Director and other officials of NIH discussed the committee's recommendations and NIH's plan for implementing them.

The subcommittee held public hearings again on March 28, 29 and 30, 1962, to review the progress made by NIH in strengthening the management of this grant program.

The following is the summary of findings from the first report issued by the House Committee on Government Operations on April 28, 1961:

SUMMARY OF EARLIER FINDINGS

The committee found that NIH is not adequately organized to administer the grant programs with maximum effectiveness. In particular, NIH has failed to provide for a meaningful review of the financial requirements of research projects as part of the technical review process. Further, NIH does not maintain sufficient direct and continuous contact with grantees for the purpose of determining appropriate levels of continuation support in relation to project accomplishments and needs.

At present NIH makes commitments for the future support of projects in specified amounts for periods as long as 8 or more years. Ordinarily, there is no further review of project requirements during this period, and the amount of the grant is paid automatically each year upon request. The grantee, on the other hand, may request supplemental amounts to meet unforeseen project expenses. This arrangement, obviously, is not conducive to the most prudent use of grant funds.

The present management policies and procedures are especially unsatisfactory in connection with research grants to commercial firms and for the support of meetings of scientific organizations.

The committee noted areas where existing grant arrangements are not designed to obtain full advantage from the available or potential research resources of educational institutions. These areas have been identified and recommendations offered for bringing such institutions more actively into the national health research effort.

The committee believes that economies and greater efficiency can be achieved through the development of more uniform policies and procedures in connection with the many special purpose training programs supported by NIH.

The committee gave close attention to the problem of appropriate Federal payment for the indirect or overhead costs associated with grant-supported research. The committee recommended an equitable indirect cost arrangement for the use of all Government agencies that support research in educational institutions.

Following this report, in general, the National Institutes of Health concurred with the committee's findings and recommendations made. Both by correspondence and in the hearings held in August of 1961 officials of NIH and the Public Health Service expressed substantial agreement with all but one of the recommendations and indicated their intention to take corrective action.

Hearings, as I said, were held by the subcommittee again on March 28, 29, and 30, 1962, to obtain further information on the progress of NIH in implementing the committee's recommendations. These hearings were concerned principally with the administration of research grants. The committee was informed, at that time, that certain actions had been taken in response to several of its recommendations. However, it became evident, in the course of the hearings, that NIH had done relatively little to improve the overall management of its grant program, since the committee report of 1961.

The committee, in March, expressed its particular concern by the continued absence of sound procedures for determining the initial and continuing financial need of grantees. In the House Government Operations Committee report, issued on June 30, 1962, the committee expressed its dissatisfaction with the slow progress which NIH had made to strengthen the grant programs for health research. They stated that while NIH had acted in several areas in response to the committee's recommendations, relatively little effort had been made to improve the overall management of these important grant programs. In particular, the committee pointed out that it had found no significant improvement in the inadequate fiscal review of project requirements on which it reported last year.

The committee observed that the adequacy of NIH policies and procedures for insuring the appropriate research funds was tested earlier this year by means of a detailed audit of the grants awarded to Public Service Research, Inc., a company which had received substantial NIH support. The audit report disclosed that the company misused and profited from grant funds and, in general, used a very broad discretion which NIH allows grantees in expending research money for its own advantage. The audit also disclosed poor coordination between NIH and the Public Health Service, of which NIH is a part. NIH continued to pay Public Service Research, Inc., the 15-percent indirect cost allowance on grants after the Public Health Service had established an indirect cost rate of 6.66 percent to the company in connection with their research contract.

Following completion of the contract, the Public Health Service permitted the company to retain Government-owned equipment for use in connection with an NIH grant, but made no effort to ascertain that the equipment was necessary to the NIH project. Shortly thereafter, NIH awarded a new grant to the company, which included funds for the purpose of equipment similar to that which the company had already had in its possession from the completed Public Health Service contract.

The committee observed further that the suggestion had been made that the findings of this audit are not applicable to most NIH grants, since the grantee in this instance is a company operating for profit, while most NIH grants are made to nonprofit institutions. The committee stated this reasoning misses the essential point that under its present inadequate administrative arrangement, NIH does not know whether or not grant funds are expended prudently and for the intended purposes, and consequently NIH cannot provide reasonable assurance that the misuse of grants is not widespread.

The committee went on to say that it appears that Congress had been overzealous in appropriating money for health research. They said the conclusion is inescapable from a study of NIH's loose administrative practices that the pressures for spending increasingly

larger appropriations has kept NIH from giving adequate attention to basic management problems. The committee stated it expected NIH to give high priority at this time to attacking the task of correcting its management deficiencies and strengthening its capacity for the effective and efficient operation of these vital health programs.

Madam President, I have before me one of the most amazing publications it has been my lot to come across during the number of years in which I have served in this body. It is the "Research Grants Index for Fiscal Year 1961," U.S. Public Health Service, listing the 13,500 projects presently underway in the research grants program of the National Institutes of Health. I emphasize that in my observations of, and possible criticism of administration over these various programs within the Department of Health, Education, and Welfare, it is certainly not my intention to import or infer any degree of partisanship. Many of these loose practices have been developing for years over the past two or three administrations. I believe that Representative FOUNTAIN's committee, and Senator BYRD, through his investigation, have and are doing the country a distinct service. I applaud them. To me, it is a logical extension of this concern that when we come to a juncture such as we are at today of the weighing of another multi-million dollar program which will be administered by the Department of Health, Education, and Welfare, that we cannot do other than pause for a moment and say, "Where are we going? Should we not put the house we have in reasonable order, before we consider further additions?"

When we are asked to give the Department of Health, Education, and Welfare these great additional responsibilities, I believe in light of the revelation spoken of above, reluctance has substance. Oh, but you say, Kerr-Mills is also under the Social Security Administration and you support it. My answer is to say, of course I am and I believe Kerr-Mills has the potential for meeting our health problems of our elderly, if given a fair trial. And, I further say, let's give it that chance. But you can also be sure that if instance and evidence is presented of mismanagement and loose administration of this program, I shall be among the first, on the floor of this body, to criticize the same and ask for remedial legislation.

Lest we lose the point that I am attempting to make, these instances of need for serious overhaul of programs within the Department of Health, Education, and Welfare are not, and would not, in and of themselves, be sufficient reason to oppose the social security approach to our problem of health of our aging, everything else being equal. But, I point them out as being just "one more nail in the coffin" of what I consider to be the completely wrong approach for the answer to and the financing of the problem which all of us certainly are endeavoring to solve.

BYPASSING OF COMMITTEE CONSIDERATION

Madam President, I should also like to turn this body's attention briefly to the undue haste with which we are considering the proposals under the Anderson-Javits amendment. We have not even had the benefit of a single hearing on this far-reaching piece of legislation. S. 909 was introduced early last year, but no hearings have been held on it. The Anderson-Javits and other amendments, of course, were introduced but a few days ago. Hearings likewise have not been held on these amendments. Even were I for this program 100 percent, I would still be constrained to vote against this amendment at this time, in view of the lack of hearings and orderly procedure and sufficient time to give the full consideration necessary for intelligent consideration of this broad new program. It is inconceivable to me that in this body we could, in good conscience, take such hasty action as we are apt to take here in light of the long-lasting ramifications of action in this field such as requested.

MAIL CONTENT

Whenever a controversial piece of legislation, such as the King-Anderson approach, or as it is now amended, comes before us our offices are invariably flooded with mail pro and con. I think it is a correct generalization to say that we, as Members of Congress, are often inundated with "pressure mail" of the sort instigated and pressed by a single organization or organizations. Often this mail takes the form of mimeographed letters or postcards. All, of course, with the same message, but merely with different signatures. This expression on the part of our constituency is, of course, important and we are glad to have it. However, occasionally, we find an issue which initiates a spontaneous outpouring of the feeling of those we serve without any person or persons prodding such an expression. I believe that many in this Chamber will agree with me that the so-called medicare issue is one of these occasions. My mail from Colorado is, and has been since the first of the year, running approximately 90 percent against the administration program and 10 percent in support of it. While these statistics are noteworthy in themselves, it is even more interesting to me to read my mail and to see that almost all of the letters I am receiving seem to bear that unmistakable stamp of personal and deep-seated feeling and sincerity concerning this issue.

Madam President, I ask unanimous consent to have printed at this point in the RECORD a number of what I consider to be representative letters of the 90 percent or more of which I have received in opposition to the social security approach to the problem of medical care for the aged.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

DENVER, COLO.,
June 25, 1962.

Hon. GORDON ALLOTT,
U.S. Senate, Washington, D.C.

DEAR SENATOR ALLOTT: As a constituent of yours I wish to express my opposition to the King-Anderson medicare bill.

I am retired, but feel that this is not necessary and do not want to see this bill passed.

Thank you for your cooperation.

Sincerely,

DOLLIE E. DAVIS.

FORT COLLINS, COLO.,
June 22, 1962.

Senator GORDON ALLOTT,
U.S. Senate, Washington, D.C.

DEAR SENATOR ALLOTT: May I present my views on the King-Anderson bill?

As a tax-paying citizen I oppose this bill because it would increase taxes for the young wage earners out of proportion to the benefits received. It is not an insurance program into which they are paying, but a tax which they must pay for the benefit of someone else, and many of those eligible to receive help do not need it at all.

As the daughter of a prospective recipient of this aid I am opposed to this bill, for my own mother has proved that it is not necessary. She is past 70 years of age and has been living for several years primarily on her social security checks with practically no help from any of her children. She maintains her own private health and hospital insurance, and has never been deprived of adequate medical care because of lack of funds. She visits her own doctor when she is ill—not because she is entitled to care. All of her children respect her more because of this; but we know that, given opportunity to be sick without cost, she would soon enjoy much poor health. I'm sure there are many older people of this temperament.

As a registered nurse (I am registered in Nebraska, not Colorado), I hope that this bill will never inhale its first breath as law, because, although I am not know active in nursing. I know from past experience that time spent on paper work—recordkeeping, and the like—is time spent away from the patient. There is no possible way to carry out such a program without increasing the nonnursing duties of qualified nurses or adding personnel to handle the extra tasks—thereby increasing the cost, of course.

As a doctor's wife I am extremely concerned about this bill, for I know that anything that creates resentment in the mind of a doctor decreases his efficiency as a medical practitioner. I'm sure you are aware of the fact that the medical segment of our population does resent this bill as an infringement upon their rights as members of our free enterprise system, and perhaps even more because of its inevitable infringement upon the near-sacred doctor-patient relationship. I will certainly appreciate your consideration of these statements and I will greatly appreciate anything that you may do to keep our Government from adopting King-Anderson bill as law.

Very sincerely,

Mrs. JOHN H. (BETTY) FLOYD.

JUNE 18, 1962.

Hon. GORDON L. ALLOTT,
U.S. Senate, Senate Office Building, Washington, D.C.

DEAR SENATOR ALLOTT: Please count me in with the persons who are most definitely and strongly opposed to the King-Anderson bill.

Personally I have to make a living for myself and two minor children and every penny counts. Federal and State taxes certainly are high enough as they are, and I do not see any reason why I should take another cut with increased social security taxes without any benefit for myself or anybody else except for the Government and the additional Federal employees who will have to handle matters.

Generally the bill in my and many other people's opinion, would mean another step to complete dependence on Washington, D.C., cutting down our personal freedom which is supposed to be guaranteed by our Constitution. We are proud of this freedom, looking at nations run by dictators, and want to keep it this way.

Sincerely,

Mrs. CORRINE BYKERK.

COLORADO SPRINGS, COLO.,
June 18, 1962.

DEAR SENATOR ALLOTT: I am writing in protest to the King-Anderson bill. I am in a position where I know that I will have to give financial aid to my parents in case of their illness, but I would much rather do this and know what it will cost me than to have medicare attached to social security.

I am sure you are familiar with the social security schedule for the future, and this bill would just add to this growth, as I cannot remember when the Government made a projected estimate of a project's cost that wasn't far below the final expense. I do not want my children paying taxes to keep up this creeping socialism that has been the trend in my lifetime.

The Kerr-Mills bill is as close as I want the Government to get into medicare, as it is based on need, and this is the way it should be. I do not want to be forced to pay for medical care which I do not want.

The Government is in competition with private business too much as it is and this is just another step in that direction.

I am 36, and I have talked to very few people in my age group who are for this bill.

I am asking that you please vote "no" on this bill, or any medicare which is not based on need and is attached to social security.

Yours truly,

WILLIAM H. FRAY.

DENVER, COLO.,
June 19, 1962.

Hon. GORDON ALLOTT,
U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR ALLOTT: As a senior citizen, one who had not retired and who is not collecting social security payments, one who is still paying such tax, but who could collect all the wonderful benefits promised us "oldsters," I wish to explain to you why I think it is not a good way to solve the problems of the older people by voting into law H.R. 4222, the King-Anderson bill.

I definitely feel that the proposed amount of tax added to the present social security tax cannot possibly take care of the older people who will immediately be in need of hospital care, once H.R. 4222 is passed. I feel that a much greater percent of our salary will have to be added to our present social security tax, after the first year of experimentation.

Old people have been led to believe that this is an insurance against sickness, as well as hospitalization, which it is not; they will be very bitter when they come to the realization that it does not pay doctor bills, does not pay for drugs, unless one is hospitalized, does not pay the first $90 hospital bill (and that may be pretty hard for a really poor person to raise—and they are supposedly the ones the bill is supposed to help). What a jolt to a poor, old, sick, deluded person. The bill speaks of nurses to visit the homes—where are all the nurses? It will be impossible to get enough visiting nurses, and so a poor old sick person will be on the "waiting list"—another disillusioned soul.

Why not let the law we now have take care of our older people? It is working well, and instead of being a colossal Federal giant (ready to gobble up the hard working, tax-paying younger people) it is a sane law, helps those who really need help, thus is not so expensive to operate, and not such a burden on the young people, who will be paying enormous bills which will be incurred if H.R. 4222 should be passed.

I ask that you think of the effect the passing of the King-Anderson bill will have on future generations, how will the terrific payments be paid if, by any chance, there should be a depression and payrolls should shrink appreciably. So many, many things to think about—let's not be in such a hurry—there is plenty of time to work things out so that all will be benefited, and at not such a high price. Youth is always in a hurry—impatient; age says "let us think things through before acting." Let's think things through and use what we have until a better plan can be worked out, which is not the King-Anderson bill.

Respectfully,

GRACE ISBEL.

DENVER, COLO.,
June 21, 1962.

Representative MILLS,
Chairman, House Ways and Means Committee, House of Representatives, Washington, D.C.

DEAR SIR: When you are considering proposing any sort of medical care program for the elderly, will you please ponder my plight and my reactions to such a program?

I am 73 years old, permanently bedridden from a progressive central nervous system disease. I have a brother 71 who has been crippled the major portion of his life. My husband was incapacitated and partially bedridden for the major portion of his life after retirement, because of a cerebral hemorrhage.

Now we have always been of the average income group; my husband was a stereotyper for the Denver Post; we have raised a daughter, purchased two homes. Now, in our declining years we have a limited income, a total for both my brother and myself of $1,500 from the rent of apartments in the home in which we reside, plus our social-security payments of $40 for my brother and $60 for myself as a widow. (Approximately these figures. Annually, roughly $2,700 for all expenses.)

The point I wish to make is this: We do not wish any medical care program tied to a social security program. If we, with this type of major illness and with our limited income, can, through a reasonable program of thrift and saving, plus a willingness to exclude frills from our lives because we can't really afford them, then anyone can do the same; can afford to pay the fees for the Blue Cross program, so can other oldsters. I have no objection to people being given assistance when, through absolutely no fault of their own, they have some catastrophe and require outside assistance. But to tax this and future generations to pay the expenses of thousands of people who, despite good financial times of the past 20 years, have failed to provide for themselves, is unthinkable.

It is highly possible, of course, that with these extremely wealthy people, the $12 or $14 extra a year deducted from the paychecks of the currently employed would mean so little that they ignore it; $14 buys my grandson seven pairs of sneakers each year, or my granddaughter two pairs of school shoes. Why should this younger generation and their children be saddled with the responsibility of care for people who have never seen fit to take care of themselves? Let the local units assume the responsibility for any special programs and keep this away from social security. After all, hardly anyone could have any more medical expenses than we do (medicine alone runs nearly $40 a month), and if we feel we can manage adequately without it, surely others can, too. It's merely a matter of doing for yourself first.

Certainly those of you who have the future of this country in your hands should take a long look. If you keep the Government out of our affairs, control spending, and exercise some caution, then we would probably be left enough money to afford our own welfare program on an individual level. As a former Democratic committeewoman for Denver precinct, I am absolutely against this, and I am going to change my registration if this trend in the Democratic Party toward such irresponsibility continues.

EMILY JOHNSON.

FORT COLLINS, COLO.,
June 17, 1962.

DEAR SENATOR: I want to express my feelings against the King-Anderson bill.

I believe this is only a step away from socialized medicine, and does not really take care of the problems for all the people who may need help.

I am a registered nurse and know the need of a great many people. I feel this should be handled by the States and counties. It is closer to the ones who should be more responsible for their families.

Sincerely,

PHYLLIS WOLFE.

P.S.—I am mailing a copy to Senator JOHN CARROLL.

COLORADO ACADEMY OF
GENERAL PRACTICE,
Sterling, Colo., June 5, 1962.

Hon. GORDON ALLOTT,
U.S. Senator,
Washington, D.C.

DEAR SENATOR ALLOTT: On behalf of the Colorado Academy of General Practice, which numbers 339 members, I want to congratulate you on the fine representation you have provided for our State in the deliberative bodies of our National Assemblies. We believe in your good sense of fair play and unbiased judgment, even when we have disagreed with you.

Today, I would like to bring you some of our thoughts on the current King-Anderson bill. I am sure that by this time you have reviewed all of the theatrical pros and cons of this measure. Perhaps we can give you facts on some actual case histories in our files to show you factually how third-party interference does not bring the best medical care to our aged population.

This is the case of a 70-year-old lady afflicted with an inoperable brain tumor. This tragically ill lady had deteriorated to such a state that the only means of mercifully treating her was by a small feeding tube passed through her mouth into her stomach. This lady was in a hospital and the attending physician felt that high protein, high caloric liquids passed through this tube were the minimal necessities of care for her. When she was transferred to a nursing home, the attending physician ordered this type of feeding continued for her. However, the nurses from the nursing home called to inform him that they could not use this type of feeding for her because the high caloric, high protein liquid used to feed her through the small tube was not approved by the State welfare department. Her attending physician immediately sought to have this food approved for her use. After many calls to the welfare department people, and after explaining her care in detail to them, his request to have this food furnished for her was denied.

Let us bring to your attention some of the economic wastes found in the decisions of a board which takes the prescription of medicines out of the attending physicians hands. Frequently we use a vitamin-hormone supplement for the elderly patient. They usually eat poorly and need additional vitamins, and this hormone helps prevent the wasting of their bony structure. The only preparation of this kind "approved" by the welfare board is a three-a-day expensive capsule. The same results can be accomplished by a one-a-day capsule at approximately half the cost, and obviously one-third the dosage.

All communities in the United States are attempting to prevent over-utilization of the

available hospital space. Our methods to accomplish the best utilization of bed space is to discharge patients as soon as they are able to leave the hospital. Once again we can show you how third party interference in the traditional doctor-patient care not only causes overutilization of hospital beds, but also takes control of the patient out of the hands of the doctor

In this State when it is time to discharge an elderly patient, who is on welfare, from the hospital into a nursing home, the family usually calls the welfare department to complete the arrangements. Time after time the family is told by the welfare worker that the person is entitled to 30 days of hospitalization and there is no hurry to get her into a nursing home. Obviously the doctor has lost his patient control, money has been unnecessarily spent on hospitalization, and a hospital bed has been occupied longer than necessary.

These are just a few of the actual case histories which could be related to show how bureaus are a step toward poor medical care. And, I might remind you these are facts from a State which is supposed to have one of the better old age welfare plans. The thing that we American Academy of General Practice members, and the thing that we know you feel is most important is good, compassionate medical care for our senior citizens.

We would like to reiterate that we feel such legislation as the King-Anderson bill has the same and probably more inherent weaknesses which lead to third party interference in the care of patients than does a limited State plan such as we have in Colorado. Would you like to read these case histories as those of your parents or grandparents? We invite your thoughtful consideration of these facts and depend upon your considered judgment.

Very sincerely yours,

KENNETH H. BEEBE,
Executive Secretary.

DENVER, COLO.,
July 3, 1962.

Hon. GORDON ALLOTT,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR ALLOTT: I am asking that you do not support President Kennedy's so-called medicare bill or King-Anderson bill. It seems the only thing it can do is work a hardship on us who are already on social security. After all it seems to us if there is funds to cover those who have never paid anything into social security at any time, those funds should be given to the ones who are drawing social security at present. Many are like us. My husband paid in to it ever since it began and now when his health is broken and he can't work at anything even though his age is 68 we have to get along on $119 which is his social security. I would like to see any of the ones who dream up these fantastic ideas get along on what they call social security. We are both in poor health and our drug bill each month is a staggering amount, a cut in all drug prices would help everyone. I hope you will give this your best thoughts by not supporting it. America does not need socialized medicine, it has not worked elsewhere either.

Yours truly,

Mrs. A. W. BLAKE.

GREELEY, COLO.,
June 29, 1962.

DEAR SENATORS GORDON ALLOTT AND JOHN CARROLL, AND HON. PETER DOMINICK: Mr. Bistline and I are against the King-Anderson bill. We would like to be independent of a set organization governing medical and welfare plans.

Because of health my husband retired last October from his Union Pacific railroad crossing watchman's work on York Street in Denver. He is 71 and I am 56 so he gets $108.80 for 19 years of railroad service and $47 social security. We decided last fall that we should stay with the Employees Hospital Association. The two above incomes come once a month. As a pensioner Mr. Bistline pays $30 a quarter to the hospital association and $10 a year for union dues.

The pensioners' treatment benefits are allowed if and when treatment be given by doctors who are on the staff of that association; and association doctors in the association hospitals. The bills for care by doctors who are not on the staff of this association will not be honored.

There are times Mr. Bistline would like to select his own doctor in Greeley. The nearest association hospital is in Denver. Who wants to go to Denver away from home and relatives when we have a good one in Greeley? It would cost me to run the car to Denver if he was a patient there. I could use the railroad pass and take all day for one visit in the afternoon. There would be street bus and taxi fares to consider in Denver.

We are thinking seriously of dropping the above plan and stay with the Colorado Blue Cross-Blue Shield series 9, standard A plan so we can have the freedom of selecting our own doctor and hospital. The plan is covering both of us and we have carried it for some time.

Yours truly,

MABEL BISTLINE.
ANDREW J. BISTLINE.

MONTE VISTA, COLO.,
June 16, 1962.

Senator GORDON ALLOTT,
Washington, D.C.

DEAR SIR: I am writing to ask you to use your influence against the King-Anderson medical bill. I am under social security and in case of sickness might get help under such a bill but I am very much opposed to it. I have three sons who are paying social security tax and one who is in business and would have to pay the higher tax for himself and also his share for the men working for him. And there are many more like them; younger people raising their families, and it is unfair for them to have to pay the higher tax and especially as many people (as I understand it) who do not need the help would profit by it. And, too, many who are not under social security and really need the help would not be included. So I ask again will you please oppose this bill.

Yours truly,

Mrs. LOUIS BOCKHASES

DENVER, COLO.,
July 6, 1962.

Hon. GORDON ALLOTT,
Senate Office Building,
Washington, D.C.:

Anderson-Javits amendment to H.R. 10606 is unacceptable. Colorado would have less than 300 beds for our pensioners in nursing homes under this amendment.

Representative LELA S. GILBERT.

DENVER, COLO.,
June 29, 1962.

Hon. GORDON ALLOTT,
Senate Office Building,
Washington, D.C.:

Revised version King-Anderson still unacceptable, strongly urge your opposition.

H. VIRGIL DAVIS,
Democratic Committeeman.

DENVER, COLO.,
July 7, 1962.

Hon. GORDON ALLOTT,
U.S. Senate,
Washington, D.C.:

Anderson-Javits amendment to H.R. 10606 unsatisfactory because of effect on private enterprise and Colorado pension plan.

Representative BERT A. GALLEGOS.

DENVER, COLO., *July 6, 1962.*

Senator GORDON ALLOTT,
Washington, D.C.:

Anderson-Javits amendment to H.R. 10606 absolutely deplorable. Definition for nursing home a farce. Would cover only 17 of the 165 licensed homes in Colorado and represent only 270 of 5,874 beds. Requirement for hospital affiliation or common control and Government contract serious infringement on free enterprise system, hamper Colorado's pension program and is no critera for excellence.

Board of Directors, Colorado Nursing Home Association: H. Virgil Davis, President, Denver; Helen R. Douthit, Denver; Edith Wilson, Canon City; Howard Drayer, Lakewood; Vesta Bowden, Aurora; Gomer O'Dell, Lamar; Doris Schwarz, Delta; Donald King, Boulder; Ingebord Tim, Grand Junction.

GLENWOOD SPRINGS, COLO.,
July 3, 1962.

Hon. GORDON ALLOTT,
Senator from Colorado, Senate Office Building, Washington, D.C.

DEAR SENATOR: We are opposed to the King-Anderson medical bill, and urge you to vote against it.

We are over 65 years of age, and would benefit if this bill became a law; but we can see no reason why younger people should be taxed to pay our hospital expense, when we are able to pay our own.

Yours very truly,

GEORGE A. MCKINLEY.
OLGA M. MCKINLEY.

Mr. ALLOTT. Madam President, what is most reassuring to me is the large number of our aged population within my State who indicate they recognize the real meaning and end result behind the administration's proposal and thus realizing the same oppose them. This is doubly reassuring when we consider the lengths to which the present administration has gone to ballyhoo, publicize, and give the full Madison Avenue treatment to their program. I, for one, believe that the response to these pressure tactics, both in my State and throughout the Nation, is a testimonial to the wisdom and understanding of the individual voter in our country on an issue truly important to the welfare of the entire nation.

Madam President, I wish to comment particularly on one of the messages which I have just placed in the RECORD. It is from Denver, Colo., is addressed to me, and reads as follows:

Anderson-Javits amendment to H.R. 10606 is unacceptable. Colorado would have less than 300 beds for our pensioners in nursing homes under this amendment.

Representative LELA S. GILBERT.

I have called special attention to this telegram because Mrs. Gilbert is an able legislator in our State and also because she is not a member of my party. She would be shocked if she were accused of

being a member of my party. Mrs. Gilbert is an outstanding member of the Democratic Party in my State, and I think her interest in the whole field of social welfare is sufficient to give great weight to what she has said.

In addition, I have already called attention, a few days ago, to a poll conducted by radio station KOSI, in Denver. KOSI took the President's challenge and ran a series of statements pro and con in order to stimulate public interest. The listeners were then invited to call the station and register an opinion on the proposal.

Madam President, I ask unanimous consent to have printed at this point in the RECORD a letter addressed to me under date of June 8, 1962, by Mr. W. L. Armstrong, managing director of KOSI, giving the details of how the poll was taken and what was done with the results.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

DENVER, COLO., *June 8, 1962.*

Hon. GORDON ALLOTT,
Senate Office Building,
Washington, D.C.

DEAR SENATOR ALLOTT: As you know, KOSI has been extremely interested in the King-Anderson bill, which is now pending before Congress. We have felt that the public has not been very well advised as to the merits and drawbacks of this proposal, and, in an effort to stimulate public enthusiasm for the close scrutiny of the bill, we have set out to broadcast a series of statements, both pro and con, regarding the legislation, and asked our listeners to call us at KOSI public opinion poll headquarters where we set up a battery of telephone operators to receive calls from listeners expressing themselves either for or against the legislation.

It occurred to me that you will be interested in the results of the poll. During 4 days our operators (pledged to keep the tally honestly and acurately and supervised by station personnel) answered 6,397 phone calls and reported the following:

	Calls	*Percent*
For	881	13.7
Against	5,516	86.3
Total	6,397	100.0

We, of course, maintain an absolutely impartial position on the bill and attempted to present both sides of the case in the various statements which were broadcast by speakers favoring and opposing the legislation. While we do not think that this public opinion sample is necessarily scientific nor projectable to the State of Colorado as a whole, we do believe that it has some meaning. Certainly the mere fact that so many people took the trouble to express themselves on the issue indicates the importance of it to the public.

We hope this information will be of interest and useful to you.

Respectfully submitted.

W. L. ARMSTRONG,
Managing Director, KOSI.

Mr. ALLOTT. Madam President, out of a total of 6,397 replies to this impartial program, 86.3 percent responded against the so-called medicare approach.

SUMMARY

In this rather long and somewhat detailed discussion, I have endeavored to cover as many aspects as possible of the very urgent and complex problem facing us today. It is certainly not a new problem, but one that has long, and in many forms, been before us.

The legislation before us today is not a new concept in the field of medical care for the aged. Actually, this is just the latest in a long series of legislative proposals which have been advanced over the years to establish, in one form or another, a system of compulsory health insurance at the Federal level.

During the late 1930's and the early 1940's, a series of bills sponsored by Senators Murray and Wagner, and Congressman Dingell received considerable attention. These bills would have set up a national, compulsory health insurance system, financed by taxes on salaries and wages, under which benefits would be provided for persons of all ages. These original proposals and their resultant progeny died in congressional committees in 1943.

Slightly altered, they were next introduced in 1945 under the guiding hand of President Truman. Again the measures were killed, and in 1947 were killed again.

In 1947, Representative Aime Forand introduced his bill which too would add medical benefits to the Social Security Act for anyone eligible for social security. The bill was, admittedly, the forerunner of the bill, an amendment to which we are discussing today, which was first introduced by the then Senator John F. Kennedy.

Then, in 1960, the Kerr-Mills Act, which cares for our aged with medical problems today, became effective. This action was taken only about 20 months ago; yet, even now, its critics are saying it is totally inadequate. Such astuteness and farsightedness is highly commendable and certainly to be envied. I would hope that just such astuteness and analytical prowess could also be focused on the measures now being proposed, and that no longer will it be implied that simply by enacting medical care legislation financed through social security, all the physical ills and financial problems of a suffering humanity can be cured. However, I seriously doubt that such a miracle of clairvoyance will be unfolded before us in connection with the legislation we are considering here.

At any rate, compulsory health insurance programs have a long history of rejection, going back to the 76th Congress. Virtually each succeeding Congress since 1939 has studied and considered such legislation and, obviously heavily influenced by that same public opinion, has rejected such an approach.

On the other hand, Madam President, only seldom in history have the Halls of Congress resounded with such unanimity on any major legislative measure, as was afforded the Kerr-Mills Act in 1960.

In the House of Representatives, Kerr-Mills was passed by a rollcall vote of 381 to 23. Later in that same session, and sponsored by the distinguished Senator from Oklahoma [Mr. KERR], the Senate passed an amended version of H.R. 12580 by a yea-and-nay vote of 91 to 2. The House later, by a rollcall vote of 369 to 17, agreed to a conference report which incorporated virtually all the Senate changes. I might interpolate that a little of this same spirit of cooperation could be used right now in connection with certain appropriation matters. But, back to the matter at hand, after accepting the conference report, the House returned Kerr-Mills back to the Senate, which approved it by a yea-and-nay vote of 74 to 11.

Thus, a program by which medical care for the aged could be provided on the sound basis of need was adopted.

But—and again I must repeat—it is now only 20 months later; and without even giving all our States an opportunity to adopt Kerr-Mills, a plan is now proposed that would ultimately scrap the approach of Kerr-Mills to this problem, retire it into antiquity, and replace it with legislation that could lead the economy of this Nation further down a road leading ultimately to a welfare state.

Because of this the flashing yellow light of "caution" is no longer a proper warning signal for our economic path. We must replace it with the alarming steady glow of the red "stop" signal. Because with every such advance onto the fringes of the welfare state, the individual's ability to take care of his own problems diminishes, and his incentive to go to the government increases. Protagonists of legislation that would further encroach on individual initiative, consciously or not, are moving us toward a system which would inevitably lead us into an era where there will be a public sector to our economy and that is all.

In the light of the past history of legislation calling for any such a compulsory health insurance program as we are discussing today, and the very vehement opposition that has been expressed by so many to such legislation—to me, it seems somewhat presumptious for us to even be here discussing such a measure. My mail, from Colorado has been running over 9 to 1 against any such compulsory program. And, while Colorado is certainly not among the most heavily populated areas of this Nation, by reason of our geography and economy, we do offer a good "cross-section" of the people of this Nation. This mail is enlightening in two respects. First, it is not mail that has been created by any so-called "pressure group." As my colleagues here know, it is extremely easy to detect this type of mail. Second, by far the greater portion of this mail reflects a distinct and surprisingly well-thought-out opinion opposing the financing of any such program through social security.

As a matter of fact, a very large portion of the letters I have received express very clearly and succinctly that the writer is opposed to this legislation primarily because of the proposal to be so financed.

Still another factor with reference to this mail bears mentioning here. It is well known that the volume of our mail picked up rather considerably immediately following the television show emanating from Madison Square Garden in which the President participated. Mail from my constituents in opposition to any social security financed program of compulsory health insurance did increase rather sharply. It cannot be said that

the American Medical Association show which followed almost immediately had any great influence on this mail, because the American Medical Association show was carried in Colorado on a 12-day delay basis. It was not shown in Colorado until 5 p.m., mountain standard time, on June 2.

As a matter of fact, during that 12-day lapse between the shows, my mail in opposition to the administration's medical care proposals reached perhaps its highest peak.

So I simply cannot subscribe to any theory that the interest in Colorado and the opposition mail from Colorado were generated by any side-show tactics.

In the State of Colorado, during mid-1961 a public opinion survey was conducted by Research Services Inc. for the Colorado State Medical Society. This opinion survey was conducted statewide, over a period of several weeks. No marked line of political partisanship was reflected in the public opinion. Eighty percent of the Coloradoans contacted favored some form of medical care for people 65 or over. But the same ones voted 2 to 1 against any compulsory program which would include all aged persons, regardless of need. In effect, the survey showed that the people of Colorado favored a medical plan for the aged, provided that "those who can will shoulder their own load". As the statistics on my mail will indicate, this feeling has evidently increased, rather than diminished in the following months.

Let me refer again, for just a moment, to the Kerr-Mills Act. By far the most prevalent argument we have heard against the Kerr-Mills Act have been based on scornful references to a "paupers oath". The "means test" required by the Kerr-Mills Act is referred to as an "undignified" invasion of privacy. Two or three generations ago, persons with even a reasonable income made concerted objection to an "invasion" of their privacy, in voicing their objections to an income tax, with its resultant forms. Is it any more unreasonable or an invasion of privacy for people who deserve, and should receive, help for medical care, to make a statement of their resources, than for others to file an income tax form? I think not.

The "means test" is not deserving of such censure. Most States, which have accepted the Kerr-Mills Act approach to the medical-care problem, permit all relief recipients to obtain and retain a helpful amount of property, Any action to recover any funds paid out must be delayed until such time as the recipient is deceased.

Mr. Kennedy, himself, has admitted that under the present proposals to provide medical care, even a millionaire could receive Government-paid medical care, provided he was 65 or over. Mr. Kennedy once commented that he was sure that a millionaire would not mind paying the small social security tax, in order to avail himself of this privilege. Perhaps the millionaire would not mind paying the small tax, Mr. President; but there are many of us of much more modest means who do object to paying such a tax in order that the millionaire may have the privilege of paying the tax and receiving the benefit when no need exists.

Yes, Madam President, my constituents in Colorado have made it quite clear to me that they want no part of any compulsory plan for health insurance without regard for need. I would be derelict in the fulfillment of my duty to my people and to my State if I did not listen, and listen carefully and well; and I cannot believe that the people of Colorado are alone in their almost unanimous opposition to social security financed medical-care legislation. For this reason, it is difficult for me to understand how this legislative body can even consider such a proposal as the one we have before us today, unless, we, too, are now willing to subscribe to the theory that this Government knows best what our people "need," and, unless we are no longer interested in what they "want."

The ultimate and universally desired solution to this problem can be achieved only when each segment of our economy and government lays aside deep-seated prejudices and works side by side, unselfishly and unstintingly, toward a solution of the problem of providing, not just adequate, but the best medical care for our aged, when and where they are unable to provide it for themselves.

Businss and labor must certainly be aware that their retirement regulations are archaic and antiquated by today's medical standards. They must also recognize that their personnel recruiting standards are no longer realistic. Developments over the past 20 years in the field of medical arts have slowed down the aging process and have added years to the life expectancy and working efficiency of mankind. Yet neither business nor labor has changed to any great extent its retirement programs, to make them coincide with these great strides in medical science. Workers are still being retired when they reach 60 or 65, simply because they have reached that age, without giving any consideration to their efficiency or their continued skills. Qualified workers of 40 years of age or more still have difficulty in obtaining employment.

Madam President, the Government must be prepared to provide the necessary funds, under a fiscally sound approach, to assure our aged people that they will have available, when needed, the best possible medical care that can be obtained.

Until such time as these segments of economy and government arrive at a point where this solution is possible, I sincerely believe that the Kerr-Mills Act is the best vehicle by which our aged can be assured that we care and that we want to see that they have available every possible financial aid to cover their medical needs.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. CARLSON. Madam President, the Senate Finance Committee, after extended hearings, reported to the Senate the Public Welfare Amendments of 1962 (H.R. 10606) which is now before the Senate for consideration.

This bill, as reported by the Senate Finance Committee, if approved by the Senate and accepted by the House of Representatives, would greatly extend and improve the public assistance and child welfare service programs of the Social Security Act.

The Senate Finance Committee heard much testimony in behalf of this legislation from the Secretary of Health, Education, and Welfare, representatives of State boards of social welfare, and private groups and individuals. In my opinion, it is one of the most forward-looking steps taken in our social security program since its inception.

Many of the amendments adopted and approved in this bill are the result of experience in dealing with our social security problems.

Now sudden consideration by the U.S. Senate of a compromise program on hospital care for the aged threatens to short-circuit the usual committee procedures of the Senate and endanger enactment of H.R. 10606.

I think it is the consensus of opinion of everyone who has worked on this problem and is familiar with the legislative procedures, that the pending Anderson amendment will not be enacted into law in this Congress. I would regret to see an amendment added to H.R. 10606 that would endanger enactment of the bill this year.

Personally, I feel that our aged need medical care and regret that we in the Senate are confronted with a bill that has not had public hearings and thorough study by the Senate Finance Committee.

As a matter of fact, the Anderson amendment as pending before the Senate, is a combination of several proposals for medical care for the aged and is not the original King-Anderson bill.

The new measure adds four features to the administration-endorsed King-Anderson bill.

One would blanket in an estimated 2½ million persons not covered by social security. No contribution is asked from those who would receive this windfall and the new benefits would be paid to the wealthy as well as the needy.

Another change would permit a highly desirable option under which benefits could be used to pay premiums on private health insurance. This would not, however, change the compulsory nature of the tax.

The bill also would embody other changes which might or might not safeguard the present trust fund and give State or private agencies a role in administration.

This proposal would be costly in many respects. It seems to me that this is not the time to advocate a substantial addition to the social security payroll tax, when our Nation is in an economic recession and organized labor, as well as business is calling for a Federal tax cut.

Madam President, one of the favorite topics of conversation today is the prospect of a reduction in personal and corporate income taxes. As I stated, some leaders of business and labor favor this course. And what is even more surprising, a number of Government officials do likewise. Fearless of the political consequences, these gentlemen argue that tax cuts would pump a much-needed supply of plasma into our ailing national economy.

The American taxpayer can hardly believe his ears, but as a man who already contributes a third of his income to the tax collectors at all levels of government, the idea is most appealing.

Tax increases are not new to him. In fact, every time he turns around it seems that some duly constituted authority is asking him to dig a little deeper and a tax cut is more than he had dared hope for.

Not that the taxpayer is completely deluded. He realizes that no tax cut has yet developed. He is aware that this may only be a mirage shimmering in the heat of an election year, but it is the most appealing mirage in town.

Personally, Madam President, I happen to think the taxpayer is long overdue for a break, and I would like to see him get one. But a peculiar thing is happening; the very people who talk tax cuts in one breath propose tax increases in the next.

While the pending Anderson amendment is so written that no one could draw any benefits before January 1, 1964, the higher taxes to pay for the program would start January 1, 1963.

Under the proposal, persons 65 or older would receive hospital and home health services beginning January 1, 1964, and nursing-home benefits the following July 1.

The bill would make the social security tax apply to the first $5,200 a year a person earns instead of the first $4,800. The tax base would be increased next year. In 1964 an extra one-fourth of 1 percent would be tacked to the regular social security tax scale to finance the health benefits. With periodic rate boosts already booked by Congress to support the main social security pension program, the total payroll tax for ordinary workers, after January 1, 1968, would be 4⅞ percent on the first $5,200 earned each year.

Now, that is a maximum of $253.50 a year, of which $31.50 would go for the health program as now envisioned. Personally, I feel that the cost will go higher.

For self-employed, the total social security levy would climb to 7⅞₀ percent in 1968. That is a maximum of $379.60 a year, including $48.40 for medicare.

In addition, money would be taken out of the General Treasury to extend health care to people past 65 who cannot qualify for social security benefits under present rules. It is estimated that the net cost of this, as proposed in the amendment, would be $50 million for the first year, 1964.

Extending benefits to these 2½ million persons is one of the main features of the compromise bill.

As I read the bill, persons reaching 65 before 1967 automatically would be deemed eligible for social security health benefits, even though they could not get monthly checks. A person becoming 65 in 1967 could draw health benefits if he worked on jobs covered by social security for at least six quarters, about 18 months. This requirement would increase by 9 months each year, so that by 1972 the same yardstick would apply to everybody.

The amendment states that only nursing homes affiliated with hospitals could take part in the program. This, in my opinion, is a serious flaw in the amendment, in that large rural sections of this Nation would receive no benefits from this amendment, because few nursing homes in rural areas have hospital connections. In other words, this is a "city bill."

It is my purpose to discuss more fully and thoroughly the proposed increases in social security taxes.

The Members of this body well know social security taxes are already scheduled to reach 9¼ percent by 1968, regardless of whether or not the pending amendment becomes law, but these presently scheduled increases apply to a taxable base of $4,800—not $5,200.

One and a half percent of the scheduled increases have yet to come into effect, but will do so at the intervals prescribed under the present law. Under the present proposal, that 1½ percent would also be levied on a $5,200 taxable base.

So this is really a double tax, for it not only increases the percentage taken from payroll, but it increases the amount of income subject to the tax.

This is not an unimportant point, Mr. President.

Suppose we take a worker earning $6,000 a year today. He pays $150 a year in social security taxes, and his employer pays an equal amount. By 1968, the scheduled increases will bring the amount of his tax to $222. Once more, his employer will match that amount.

Add the one-quarter of 1 percent for employer and employee called for under the pending amendment, and the addition seems minor; but increase the wage base from $4,800 to $5,200, and apply the full tax required to pay for both old-age benefits and health care, and we wind up with both employer and employee paying $253.50 by 1968.

In terms of the self-employed, today they pay $225.60 on $4,800, and would pay $331.20 by 1968 under the present law. Add the increase the amendment proposes, and raise the tax base to $5,200 and the self-employed person will pay $379.60.

Thus, the effect of passing the pending amendment would be to increase by 69 percent the amount paid by employers and employees in the next 6 years—and by 68 percent the amount paid by the self-employed.

I submit, Madam President, that a tax increase of this magnitude should not be considered in offhand fashion. It should have thorough and full committee consideration before being presented to the Senate.

We have had no hearings on this far-reaching measure—we appear to have disregarded the right of the House to initiate tax legislation—and we seem to be totally disinterested in the fact that similar legislation is now being considered by the Ways and Means Committee after extensive hearings.

This is neither proper procedure nor wise procedure. It little serves the deliberative function of this body.

We are urged to make haste when no person aged 65 or more would receive a single benefit under the Anderson amendment until 1964, when it would take effect.

We are urged to accept—without question—the contention of the amendment's supporters that the need of this age group is so pressing that everyone must have a program because some may need it.

We are asked to approve a heavy tax increase on the working people of the Nation in order to provide health benefits for all the aged, regardless of the fact that more than half are insured—many are covered under existing welfare programs—more than 4 million are still employed and Kerr-Mills exists to help those who need it.

We are required to speed our decision on a measure that would radically alter the very basis of social security itself, the concept that beneficiaries should be paid in cash, not in services—which has always been basic in the social security system—that they may use their benefits as they see fit, not that an all-wise Federal Government will give the taxpayer no option but to take or leave the health services he is compelled to pay for.

I shall do no more than note, in passing, the highly arguable wisdom of a measure that would predictably entangle the hospitals and nursing homes in red-tape, overcrowd them, and lower the world's highest quality of health care.

I shall, however, mention that adoption of the pending amendment would be inflationary, and that no tax is justified which is unnecessarily levied to pay for an unnecessary program. Instead, I should like to ask how long this tax increase would suffice.

There can be only one answer to this. It is easier to start an avalanche than it is to stop one. Programs of this sort can be quickly and easily made law, but once such action is taken, the process is difficult—if not impossible—to reverse. Let me cite the history of the Social Security Act itself since its passage.

The act became law in 1935, and the tax originally called for was 1 percent of wages on a base of $3,000 a year.

In 1939, the act was amended to provide benefits for dependents and survivors under a modified benefit formula, and in January 1940, the first monthly OASI benefits were paid.

The maximum primary benefit was $40 a month.

Under the law, the tax was scheduled to increase to 2 percent in 1944, 2½ percent in 1946, and 3 percent in 1949. But in the war year of 1942, the OASI contribution rates were frozen at 1 percent through 1949.

The rate was increased to 1½ percent for employees and employers as of January 1, 1950. But on August 28 of that year, the act was amended to extend coverage to some additional 10 million people, to liberalize conditions for eligibility, to improve the retirement test, to provide wage credits of $160 a month for military service from September 1940 through July 1947, to increase benefits substantially, to raise the wage base to $3,600 to provide a new contribution schedule, and to eliminate the 1944 provision authorizing appropriations to the trust fund from the General Treasury.

I mention this to stress the importance of the changes that take place even with a program which we expected to be rather stable when we first approved it.

The following year the OASI tax rate was 1½ percent for employees and employers and 2¼ percent for the self-employed on a wage base of $3,600. This worked out to $54 yearly for employees and employers and $81 for the self-employed. The maximum primary benefit was now up to $80 a month.

On July 18, 1952, the Social Security Act was amended to increase benefits, extend the period of wage credits for military service through December 31, 1953, and liberalize the retirement test. The primary benefit maximum was increased to $85 a month.

As of January 1, 1954, the tax rate rose to a flat 2 percent for employees and employers alike, and 3 percent for the self-employed. Employees and employers each paid a maximum of $72 a year, and the self-employed paid $108.

The act was amended in 1954 to cover farmers—certain professionals—farm and domestic employees—State and local government workers—ministers and the members of religious orders. The taxable wage base was raised to $4,200. In addition, the amendments raised the ultimate contribution rates, increased benefits, liberalized the retirement test still further, permitted a drop-out of four or five of the lowest earnings in computing benefits, and authorized the disability freeze program. The maximum primary benefit was increased to $108.50 a month.

At this point, Madam President, each social security beneficiary was receiving an average of $30 in benefits for every 50 cents he had paid in taxes, which meant that $29.50 was being contributed by younger workers to every person drawing a $30 benefit—surely a substantial subsidy from the younger generation.

On October 1, 1956, the act was, however, amended again. This time benefits were provided for the permanently and totally disabled between the ages of 50 to 64. The retirement age for women was lowered to 62, with reduced benefits—self-employed professional people—other than physicians—were covered—and a disability insurance trust fund was established from taxes collected on one-fourth of 1 percent of the taxable wage base of $4,200 for employees and employers, and three-eights of 1 percent for the self-employed.

Miscellaneous amendments were made to the act in 1957, and the first monthly benefits under the disability program were paid in that year.

Then, on October 28, 1958, social security benefits were again increased, dependents of disabled workers became eligible for benefits, the taxable wage base was raised to $4,800—and the work clause was increased to $100 a month. The "floor of protection" had been raised by now to $127 a month.

In 1959, the OASDI tax rate was 2½ percent for employees and employers, and 3¾ percent for the self-employed. The employees and employers were now paying $120 each year, with self-employed paying $170.

But the tax rate was increased to 3 percent as of January 1, 1960, for employees and employers—and to 4½ percent for the self-employed. Employees and employers each paid $144, the self-employed paid $216.

On September 13, 1960, the age limitation for disability benefits was removed, the work clause was liberalized, and coverage requirements were reduced from two of four quarters elapsing since 1950, to one of three quarters elapsing since 1950.

On June 30, 1961, men were made eligible for reduced benefits at age 62; coverage requirements were reduced from one of three quarters elapsing since 1950, to one of four quarters elapsing from that time; widows', widowers', and parents' benefits were increased, and the tax rate was again raised.

As of January 1, 1962, the tax rate for employees and employers was 3⅛ percent with the tax rate for the self-employed set at $4\frac{7}{10}$ percent. Thus, employees and employers pay $150 each per year, and the self-employed pay $225.60.

Let us now climb aboard the medicare escalator and see where it takes us.

Under existing law, the tax rate will be increased as of January 1, 1963, to 3⅝ percent for employees and employers, and $5\frac{4}{10}$ percent for the self-employed. On top of this scheduled increase would come the proposed raise in the taxable wage base from $4,800 to $5,200. Translated into taxes, employees and employers would pay $188.50 instead of the scheduled $174, and the self-employed would pay $280.80 instead of the scheduled $259.20.

The following year, under the Anderson amendment, the tax rate for employees and employers would go to 3⅞ percent and to $5\frac{8}{10}$ percent for the self-employed. Under these rates, the employees and employers would be paying $201.50 and the self-employed would be paying $301.60.

In 1966, the tax rate for employees and employers would go to 4⅜ percent, and to $6\frac{6}{10}$ percent for the self-employed. And by 1968, employees and employers would be paying 4⅞ percent each, with the self-employed paying $7\frac{3}{10}$ percent.

Thus, in 1968 and thereafter, the employee and employer would be paying $253.50 each, and the self-employed would be paying $379.60—if—and there is a big if here—the cost of the pro-

posed benefits could be met by the proposed increase in taxes.

It might be wise to qualify that even further, Mr. President, and add a second "if." We must also include the proviso that social security benefits are not further liberalized in the meantime.

Now a pattern emerges from this examination of our past experience with the Social Security Act. I cannot see how any Senator can overlook it. We have deferred scheduled tax increases, we have extended coverage to new groups, we have increased benefits for both retired and non-retired groups, and we have done so all too often without imposing new tax increases to cover their cost.

We have done this by passing on a mounting debt to the younger worker, until we are now at the point where estimates by competent actuaries of the accrued liabilities resulting from the social security program range from $289 billion to more than $600 billion.

We are raising the money to pay current benefits through current taxes, but I ask Senators if there is not a limit to the size of the tax burden that future generations will be willing to bear? Or, for that matter, will be able to bear?

I am far from persuaded that the tax increases called for by the Anderson amendment will be sufficient to pay for the benefits promised.

Moreover, I am far from convinced that a heath care program of the type proposed would remain limited to its present scope. I have variously heard it estimated that the benefits provided under this amendment would take care of an estimated 40 percent or less of an older person's health care expenses.

I suggest that this fact alone would guarantee an expansion of the program. More liberal benefits, broader coverage, easier eligibility requirements—where do they lead? Just as surely as night follows day, the pressures would mount to expand this plan until it ultimately became a full-fledged program of compulsory national health insurance covering every man, woman and child in the Nation at a staggering cost.

Is this a farfetched conclusion? I think not, Mr. President. We have been warned, time and again, by the proponents of social security medicine. They have been remarkably candid in calling measures of this sort "a foot in the door," a beginning, a mechanism for bringing about socialized medical care for Americans.

The Department of Health, Education, and Welfare, which has lobbied for this sort of bill not only before Congress, but before the public, now employs some 75,000 people—an increase of more than 10,000 in the past year and 4 months, by the way.

This constitutes a tidy little bureaucracy, Mr. President.

Let us suppose that the proponents of social security medicine are successful in their effort to bring about a system of compulsory national health insurance for the United States. Can you imagine what the bureaucracy will become?

One out of every hundred citizens of Great Britain is now employed by the Ministry of Health. If that same ratio applied in this country, HEW would be required to hire one and three-quarter million more employees.

I have served long enough on the Finance Committee to know how much we do not know about the sort of legislation proposed in the amendment.

The amendment departs radically from the Forand bill—the McNamara bill—the Anderson-Kennedy amendment—the King-Anderson bill now being considered by the Ways and Means Committee, and any other proposed legislation invoking the social security program as a financing mechanism.

It is significant, however, that the only committees that ever have held hearings on this species of measure have voted overwhelmingly against releasing those measures to the floor. Specifically, I am referring to the Senate Finance Committee, which held hearings on the Forand bill, and the Ways and Means Committee, which held hearings on the Forand bill and the King-Anderson bill as well.

I feel the actions of both committees were sound. And I suspect that the sponsors of the amendment are bypassing the Finance Committee, and overriding the prerogatives of the House, because they recognize that the closer the scrutiny this measure receives, the less likely it is to win Senate or House approval.

Madam President, I for one will vote against the amendment as unnecessary, hastily contrived, incalculably expensive, and certain to grow in the years ahead until it saddles this Nation with a full-fledge system of compulsory national health insurance for every American.

Mr. ANDERSON. Madam President, on Tuesday, the senior Senator of Utah [Mr. BENNETT] spoke at some length in regard to his objections to the Anderson amendment to H.R. 10606. I take this opportunity to reply to some of the points he made.

MEDICAL ASSISTANCE A COMPLEMENTARY PROGRAM

First, I wish to correct the impression of the Senator from Utah, that we who favor the social security approach to health care for the aged suggest that medical assistance for the aged should be abandoned. I know of no supporter of health insurance through social security who takes this approach. As I and others have said many times, we propose health insurance through social security as a basic program supplemented by private insurance for all who can afford private insurance. But for those in special hardship circumstances and with special needs, medical assistance for the aged would fill the gap. The record should show that in 1960 I voted for it in the Finance Committee and was glad the Senate approved it.

We envisage the same role for medical assistance for the aged in the medical field that old-age assistance fills in connection with the cash retirement benefits under the old-age and survivors insurance program. In the case of old-age assistance, provision was made for two programs simultaneously—old-age assistance and old-age insurance. One was not a substitute for the other—they were complementary.

In the case of the disabled, there are programs of aid to the permaneitly and totally disabled and the program of disability insurance under social security. But the enactment of disability insurance under social security did not force any abandonment of the disability assistance program—they are complementary and are designed to work together, not against each other.

The role we envisage for the medical assistance for the aged program would be to help those whose own resources, plus social insurance, are insufficient for all their medical needs. The States could add benefits covering physicians' services, the amount deductible for hospitalization, drug benefits, and dental services, and could add all these benefits with much less strain on their finances because the primary load is carried through social insurance.

The Senator points out, on page 12189 of the RECORD, how Congress has remained firm against health care to the aged through social security, and he has on the top of the third column on that page a most interesting observation. Said he:

> The Senate Finance Committee also conducted hearings on the Forand bill and voted to hold the measure in committee.

I do not recall any hearing on the Forand bill. I do not want to involve members of the staff of the Senate Committee on Finance, but there are those on the committee staff who do not recall hearings on the Forand bill. I wish the Senator would tell us when the hearings were called; who called them; who conducted them, and when the vote was taken.

After he gets through doing that, I wish he would explain another portion, which I read from his speech. After stating that the Senate Finance Committee had voted to hold the Forand bill in committee, the Senator from Utah says:

> Despite this, an attempt was made—as the Senators remember—to amend the Kerr-Mills proposal by tacking on the Forand bill. This effort, sponsored by Senator ANDERSON, of New Mexico, and the then Senator but now President of the United States, John F. Kennedy, was defeated also:

Categorically I deny that. I ask him to tell me when and in what fashion the junior Senator from New Mexico offered to amend the Kerr-Mills proposal by tacking on the Forand bill. We proposed an amendment to the social security bill, but we did not seek to strike out any section of what is now called the Kerr-Mills legislation. If the Senator from Utah has evidence to the contrary, I shall be happy to have him present it. In order to assist him, I may advise him that he will find some reference to this subject on page 16941 of the permanent CONGRESSIONAL RECORD. He will see that I offered an amendment, and he can read the amendment. It was not tacked on to the Kerr-Mills legislation, and it was not the Forand bill. It will be very simple for the Senator to ascertain the facts. I commend to him a little study of the RECORD, in case

his memory is no longer accurate on the subject.

The Senator's ability to confuse the issue follows the motto of my home State of New Mexico, "It grows as it goes."

The next paragraph reads:

However, Madam President, aside from the Senate Finance hearings on the Forand bill * * *.

Here we have a second learning of the Senate hearing which, in my opinion, never took place and which members of the staff of the Finance Committee assure me never took place. I recognize that people attending the hearings have mentioned the Forand bill, the Murray-Dingell-Wagner bill, and all sorts of legislation, but I believe the hearings were called to consider other items and were not in any sense hearings on the Forand bill. However, a considerable portion of these hearings were devoted to the question of health insurance for the aged under social security.

Madam President, I have obtained a copy of the hearings held by the committee. They relate to H.R. 12580 to extend and improve coverage under the Federal old-age, survivors, and disability insurance system, and the like. In the table of contents references are made to the McNamara amendment, the Williams of New Jersey amendment, the Javits amendment, the Byrd of West Virginia amendment, the Keating amendment, the Morse amendment, the Schoeppel amendment, the Humphrey amendment, the Hartke amendment, and the Anderson amendment; but nowhere do I find any reference to the Forand bill.

A little further along, the Senator from Utah says:

Recognizing the need to proceed in an orderly fashion, the committee earlier this year voted 10 to 7—not on the merits of the bill, but on the procedure involved—to delay consideration of the King-Anderson bill until the House had had the opportunity of taking action.

I have examined the records kept by the Committee on Finance and I find no such action. As a matter of fact, the Finance Committee, by order of its chairman, Mr. BYRD, on January 31, 1962, issued a press release, of which I have a copy, and it listed two votes. The first is described by the committee clerk in this fashion:

Motion by Senator ANDERSON that hearings be held on his bill S. 909 (incorporating the President's recommendations) not later than April 1, 1962, regardless of whether the House of Representatives had acted on the identical bill now pending in the House Committee on Ways and Means.

That was the motion on which the vote was 10 to 7. It was not a vote to delay action until the House had an opportunity of taking action. It was a vote on a motion to take action to start hearings not later than April 1 regardless of whether the House had or had not taken action. The Senator from Utah was there and he knows that is the real fact.

The second motion, which finally prevailed, was that prompt hearings would be held on the bill as soon as the House of Representatives passed and sent to the Senate, for further action, a medical-care-for-the-aged bill. That was merely a pious declaration, because that would happen in 999 out of 1,000 bills of this importance. It would not do what the Senator from Utah suggests—namely, pledge itself to hold hearings on this proposal when it was constitutionally proper for it to take such action; and the records of the committee so reveal.

I should also like to remind the Senator from Utah that the Committee on Finance had some discussion on very similar legislation in 1960. In fact, in its report on the Social Security Amendments of 1960, the committee had this to say about the problem of health costs among the aged:

The major issue presented to the committee this year has been the increasing cost of adequate medical care for older people. The evidence presented to the committee indicated that these costs derive, to a large extent, from the fact that impressive improvements have been made in medicines and medical technology, which assist in better diagnosis and treatment, and from improved hospital and other facilities and their wider availability to the public. The knowledge that these costs are unpredictable, and sometimes very heavy, especially for our older men and women living on reduced retirement incomes, has been a matter of grave concern to this committee.

The information provided in 1960 on the need for such a program and on other elements of the proposal I am now advancing is clearly sufficient for informed action at this moment. Furthermore, our extended discussion on the floor serves to cover many of the elements of study that are new since 1960. Finally, we should not forget the hearings and studies of the Senate Special Committee on Aging, which have pointed up the deficiencies of the medical-assistance-of-the-aged program and have disclosed other facts which clearly show the need for the enactment of our amendment.

Mr. JAVITS. Madam President, at this point will the Senator from New Mexico yield to me?

Mr. ANDERSON. I am happy to yield to the Senator from New York.

Mr. JAVITS. Yesterday, I submitted a statement, as part of my remarks, headed "Summary of Consideration Given to the Problem of Health Costs of the Aged"; and I had available at that time a large table and a number of volumes, all of which will be available on Monday. So, as the Senator from New Mexico has said, extensive consideration, in the greatest detail, has been given to this matter. Indeed, it probably has been more carefully analyzed and discussed, both in and outside of Congress, than has any other domestic issue in recent times, with the possible exception of the trade issue; and inasmuch as it is a matter which is very close to the hearts of so many persons, I believe it fair to say that the people probably have paid more attention to the debates on this issue than they have to the debates on any other issue, ever since this matter began to be discussed, and at least since 1959, when we had the first activity in this field by the then Secretary of the Department of Health, Education, and Welfare, Mr. Flemming. The discussion at that time was directly connected with the type of plan we are debating now.

So I think the Senator's statement that this matter has received a very great amount of consideration is entirely correct.

As a matter of fact, so much consideration has been given to it that probably none of us would be able to take the time which would be required to analyze all the hearings on it, including those on the special problems of the aged, to which the Senator from New Mexico has referred.

Mr. ANDERSON. I thank the Senator from New York.

Let me say that a while ago someone wrote me a letter stating, "I wish you would do something on this bill. There have been so many discussions of it on the radio and elsewhere that we would like to have you get on something else, for a change"—from which I conclude that the public is not altogether in the dark about this subject.

But, Madam President, I can say that there is at least one historic precedent for bringing up this matter in the way the Senator from New York and I have done. In 1950, a very far reaching amendment to the social security bill H.R. 6000, was introduced by Senator Knowland, of California, on the floor of the Senate, and was passed. The provision restricted the authority of the Secretary of Labor to withhold grants to States for administration of unemployment insurance in certain questions of compliance with the Federal Unemployment Tax Act and title III of the Social Security Act. No hearings on this subject had been held in the Senate or the House committees. The subject matter of H.R. 6000 was restricted to old-age and survivors insurance. Public assistance, and maternal and child health and welfare provisions. No hearings on any unemployment compensation title had been held in either the House committee or the Senate committee.

If Senators wish to learn more about that case, I suggest that they examine the CONGRESSIONAL RECORD for June 20, 1950, at pages 8886 and 8887.

That amendment, offered by Senator Knowland, was passed by the Senate; and I have been interested to note that a number of very distinguished Senators voted for it. Among them were the chairman of the Finance Committee, the Senator from Virginia, Mr. Byrd, who voted for it even though no hearings were held on it in the committee; and I note that other Senators who voted for it were the Senator from Idaho, Mr. Dworshak, the Senator from Mississippi, Mr. Eastland; the Senator from Arkansas, Mr. Fulbright; the Senator from Iowa, Mr. Hickenlooper; the then Senator from Texas, Mr. Johnson; the then Senator from California, Mr. Knowland; the Senator from Arkansas, Mr. McClellan; the Senator from Virginia, Mr. Robertson; the Senator from Georgia, Mr. Russell; the Senator from Massachusetts, Mr. Saltonstall; the Senator from Mississippi, Mr. Stennis; the late Senator Taft, the Senator from Wisconsin, Mr. Wiley; and the Senator from Delaware, Mr. Williams.

All of them voted for that amendment in 1950. So even if there had not been any hearings at all on the measure now

before us, there would still be a very good historic precedent to the effect that a very important subject which worries and concerns the public can be brought up and can be voted upon and can be passed by the Senate.

THE PEOPLE FAVOR HEALTH INSURANCE UNDER SOCIAL SECURITY

The Senator from Utah [Mr. BENNETT] was also concerned about whether the sentiment of the American people is truly behind health insurance through social security. He mentions mail that has been received. It is a little dangerous to use counts of mail in measuring sentiment, because organized groups can send, or can arrange to have sent, tremendous amounts. Fifty thousand physicians can use their stenographic help to send mail over their own signatures and their wives' signatures, in numbers approaching the millions, without great cost. I may also mention other aids which have been offered in connection with mailing letters against the proposal; and I ask unanimous consent to have printed in the RECORD at this point a clipping from the Amarillo, Tex., Globe-Times of May 22.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Amarillo (Tex.) Globe-Times, May 22, 1962]

C. OF C. OFFERS MEDICARE HELP

Citizens wishing to express themselves to Members of Congress on the King-Anderson medicare plan have been invited to seek the assistance of the Congressional Action Committee of the Amarillo Chamber of Commerce.

Chamber President Bob Mills pointed out Monday that the service is available to anyone.

"If you wish help in composing and sending telegrams or letters, just call the chamber telephone number and our people there will fill you in on what to do," Mills said. "They will even send your telegrams and letters for you as you dictate them."

The chamber's board recently voted a resolution opposing the bill which embodies the administration's medicare plan.

"Let Washington know how you feel on medicare," said Mills. "This is the key issue in Congress at the moment."

Mr. ANDERSON. The Chamber of Commerce of Amarillo offered to send telegrams and letters as they were dictated, if they opposed health insurance. Nevertheless, I do not believe that the mail shows any change in true sentiment; and in regard to the mail received by the President and the Secretary of Health, Education, and Welfare, let me state that although there has been some talk about an alleged change of heart among Americans, and although it has been said that most of the correspondence being received here in Washington is in opposition to a social security program of health insurance for the elderly, I believe that there is some danger in placing too much importance on counts of letters, because they do not necessarily represent the views of the American people.

Nevertheless, I am pleased to report that the letters received by officials in the administration have been running 2 and 1 in favor of the social security health insurance measure. Since January 1, the Department of Health, Education, and Welfare has handled 30,500 pieces of mail—which had been referred to it by the White House or was addressed to Department officials—in which the writers took a position on the social security health insurance measure. Of these letters, 20,500 were in favor of the social security proposal and 10,000 were opposed to it.

Since the May 20 Madison Square Garden rally and the AMA television statement of the 21st, the volume of correspondence received by the Department has increased greatly. Since that time the ratio between letters favoring the proposal, and those opposing the proposal has remained about the same as it was in the previous part of the year. Of the total letters received since the rally, about 16,000 favored and about 8,500 opposed the social security measure—again a 2-to-1 ratio in favor of the social security legislation.

I understand from some of my colleagues that shortly after the Madison Square Garden rally and the AMA television presentation, there was an increase in the number of letters from people who opposed the proposal. At the time, some Senators were wondering whether this suggested that the health insurance proposal was losing the support of the American people. I checked with the Department of Health, Education, and Welfare about this, and found that shortly after the Madison Square Garden rally and the AMA statement, there was some increased letterwriting on the part of those who oppose the health measure, but that the efforts of the opponents were very quickly buried under an avalanche of letters from those who favor the measure, and that the 2-to-1 ratio was quickly restored. I have concluded from all this that the people who write letters in favor of the measure are a little slower in getting around to putting their thoughts down on paper and posting their letters than are those who oppose the measure. This is not surprising, since, I understand, a much higher proportion of the letters against the measure have been typed on office stationary than was the case with letters which favored the measure.

I may say that just the other day a group came to my office with a petition containing 500,000 signatures. They had previously distributed similar petitions bearing more than 2 million names. I think those 2½ million persons seriously want this proposal, and I believe they clearly indicated that fact.

Although the aged do not write letters easily, they do find other ways like these petitions to make known their feelings about our amendment.

The Senator from Utah [Mr. BENNETT] also referred to the results of 52 congressional polls. It did not occur to him to mention that the great majority of those were conducted in conservative Republican districts; and I do not believe that such districts represent the entire United States at this time.

Furthermore, almost none of the polls showed how the people questioned were selected, nor were the questions asked in the polls designed in a way to obtain unbiased responses. Sometimes the questions stated the outright lie that the social security system was failing and then asked about an addition to the system. Finally, the mailed inquiries often resulted in a very low rate of response; and the normal procedure in a valid statistical investigation requires a sampling of the nonrespondent, to determine whether their views were different from the views of those who did answer. In not a single case was this statistical requirement fulfilled.

The Senator from Utah also reviewed the findings of the Gallup poll. The original Gallup poll on health insurance, conducted in June 1961 asked a question that truly could be used to deduce sentiment for or against the proposal for a social security measure. At that time 67 percent were in favor and 26 percent were opposed. More recently, however, the question has been changed; and the question asked now is for a preference as between the President's proposal and a voluntary plan discussed in Washington. The only so-called voluntary plans discussed before this chamber are those which would make use of Blue Cross and similar organizations as part of a health-care measure for the aged.

The Senator from Utah may not realize that my amendment makes provision for the use of such voluntary organizations as part of its makeup.

Although the number who supported social security was greater than the number of those who supported the vaguely described choice of a Blue Cross plan, we have provided both these elements in our present plan, so that both alternatives are included; and those who favor either might well be considered as favoring the amendment now before us. In that case, 89 percent of the people polled might be said to favor the proposal.

I ask unanimous consent to insert in the RECORD at this point a more detailed statement.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

The results of three Gallup polls that deal with the public's attitude toward financing the health care of the aged have been published since June 1961. In the first poll, respondents were asked if they would favor or oppose a social security tax increase to pay for "old-age medical insurance." The results showed 67 percent favored this kind of measure and 26 percent were opposed.

In April and again in June of this year the public's attitude on the subject was surveyed again, but the question was posed in an altogether different manner. The respondents were told that two different "plans" were being discussed in Washington for meeting hospital costs for older persons and then they were asked to express a preference between the two. "One plan," it was stated, "would let each individual decide whether to join Blue Cross or buy some form of voluntary health insurance. The other plan would cover persons on social security and would be paid by increasing the social security tax deducted from paychecks." It is impossible for anyone to determine what this first "voluntary plan" means. (Of course, right now aged people can join Blue Cross or buy private insurance, but few can afford the high cost of adequate insurance.) But since it was described as a "plan," it

suggests that something new will be offered, and since there is no mention of financing, many respondents no doubt jumped to the conclusion that some miraculous health insurance plan had been developed that the elderly could afford without help from Government or increased taxes.

Under some recent proposals (made by Blue Cross and others), general Federal funds would be used to subsidize the cost of private health insurance policies for aged people. If proposals of this kind were that was meant by "plan," it should have been stated clearly so that respondents would understand that the choice was between two different methods of Federal financing. The results of the Gallup poll then might have been meaningful.

Considering the two alternatives, it is indeed remarkable that such a high proportion voted for social security. In the April and June surveys, 55 and 48 percent, respectively, voted for the social security plan as opposed to 34 and 41 percent, respectively, for the "voluntary plan." But since the first alternative was so vague, the results of the two surveys cannot be said to indicate any trend. Only the survey made in June 1961 has any real meaning in suport of or against social security.

It is a separate matter whether the social security program should work with Blue Cross and private insurance. It is of interest to note that the proposal by Senator ANDERSON would provide an option of carrying private insurance, with the cost of such insurance financed through the social security system and provides for use of Blue Cross in administering the program. It would appear that such a proposal would have the support of many of the persons who voted either for letting people join private insurance or expressed a preference for social security health insurance.

MAURICE STANS ARTICLE

Mr. ANDERSON. Senator BENNETT also put into the RECORD Tuesday an article by Maurice Stans. He may not have recalled at that time that I pointed out the various errors in Mr. Stans' statement in the CONGRESSIONAL RECORD of February 8. I would like just briefly at this time to mention two points in connection with the Stans statement.

First, Mr. Stans says medical assistance for the aged was the Flemming-President Eisenhower proposal. Senator SALTONSTALL would apparently disagree with this because his proposed substitute to my amendment is in fact the very Flemming proposal that Maurice Stans says was already enacted.

Another element of Mr. Stans' article that deserves comment is his reference to 3 million persons going unprotected. As all of us here must know by now, my amendment has modified S. 909 to provide protection for all the aged not now insured under social security or railroad retirement.

Senator BENNETT says the King-Anderson bill provides a means test or labels persons over 65 as indigent. I presume he is also referring to the amendment now under discussion. In his statement, Senator BENNETT decries the fact that persons of wealth, as well as persons who are poor, are covered under the amendment. In other words, benefits under my proposal can be received with pride because it makes no distinction between the rich and the poor. No mark of failure is involved in social security. Senator BENNETT appears not to have understood this.

In the course of debate on our proposed amendment the distinguished Senator from Colorado [Mr. ALLOTT] stated that our older people who need health care are getting it. I wish that it were possible to share realistically the distinguished Senator's sanguine view of the circumstances of the aged. But there are some hard, bitter facts that we cannot pass over.

Most of the aged do get health care when there is a critical need for it. Often this means exhaustion of savings of a lifetime, sale of home, terrible sacrifices by sons and daughters, and resort to public charity. The primary purpose of providing health insurance under social security, of course, is to give the aged some assurance that they will not suffer financial catastrophe as a result of the costs of needed health care. But, in addition, the proposed health insurance plan will mean that many older people who are not getting the care they need will be able to get it. The truth is, lack of ability to pay does stand in the way of obtaining necessary health care. Survey after survey has shown large numbers of aged people who need health care, but could not afford it and as a result went without necessary treatment. The scandals of our nursing homes should have alerted everyone to the facts. Even a casual examination of the abundant data on health care utilization as related to income should convince even the most obdurate of the sad situation of our older people.

I ask unanimous consent to insert in the RECORD at this point a statement which provides ample evidence that many aged people do not get the health care they need.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

The purpose of our proposed amendment is not to provide care but to give the aged some assurance that they will not suffer financial catastrophe as a result of the costs of needed health care.

But lack of ability to pay does stand in the way of care. The Texas Research League (which is so opposed to Federal programs it does not support Kerr-Mills) found that 3.5 percent of the Texas public assistance caseload—8,718 cases—had medical needs that were not being met under existing programs. This does not include an additional 12,733 cases of unmet medical need, which were excluded for various reasons, for example, because no local specialist was available and the patient was too ill to be moved. This study was included in the report of Ways and Means Committee hearings on H.R. 4222 (July–August 1961), beginning on page 855.

The background studies prepared by State Committees for the White House Conference on Aging show unmet medical need. For example, the report from the State of Alabama indicated that 21 percent of the aged persons polled in house-to-house interviews stated that lack of money prevented them from seeing a doctor in 1959. In a survey conducted in Tucson, Ariz., more than 17 percent of the aged persons contacted reported that they were unable to have the type of medical care they should have had because of lack of funds. Of course, these figures represent the opinions of aged people who are not competent to diagnose their own conditions accurately or to make professional judgments as to whether the care they received was adequate. The point is that these people believed they had need for health care, and this need was not fulfilled because of lack of funds.

There is considerable evidence to indicate that whether an individual will avail himself of health services is closely related to his income. The higher an individual's income the more he is likely to obtain health services when he needs them. This is illustrated by a Health Information Foundation study which showed that during a 12-month period (1957–1958) mean gross expenditures per individual for personal health services ranged from a low of $75 for those whose family income was under $2,000 to a high of $119 for individuals in the $7,500 and over income group.[1]

Low income also is related to health insurance coverage. The National Health Survey revealed that about 33 percent of the people in families with annual incomes under $2,000, had hospital insurance as contrasted with 84 percent of individuals in families with incomes of $7,000 or more. Only 46 percent of the aged have any hospital insurance—a reflection not only of the fact that they generally have low incomes but also of their status as a poor-risk group. Persons who have hospital insurance tend to utilize hospital services more than those without such insurance. This is particularly true of persons aged 65 or over. During the 12 months prior to being interviewed, 13.7 percent of the aged with hospital insurance had been in a hospital one or more times as compared with 8.2 percent of those without hospital insurance. Moreover, according to a study by the Health Information Foundation, families with health insurance spend considerably more for health services than those without insurance—and this is true not only with regard to the services covered by their insurance but also with regard to other health services.[2]

One of the factors bearing on the question of whether individuals get the health care they need is the extent to which they delay seeking personal health care when they need it. Twenty-one percent of the public's regular doctors who were interviewed in a survey by the Health Information Foundation felt that their patients waited too long before seeing a doctor.[3] The great majority (94 percent) of the doctors felt that insurance affects the patient's attitudes or behavior. Of these doctors, 68 percent said the patient is more willing to undergo hospitalization, surgery or treatment, or is more willing to have it done earlier if he has insurance. Nineteen percent said the patient comes to the doctor sooner or more readily.[4] The study concludes that "the public's regular doctors * * * indicate that possessing insurance affects their patients' willingness to accept surgery, diagnostic procedures and the like, and that in this sense possessing insurance affects the amount of medical care that people are likely to get. These doctors are inclined to believe that possessing insurance results in better health."[5] In other surveys people were asked whether they delayed seeking medical care when they were not feeling well and if so, why. A significant number of people replied that they put off needed health care for financial reasons.

Nevertheless, there is even considerable doubt that many of the people with insurance get care which may be medically in-

[1] "Family Expenditure Patterns for Personal Health Services," HIF Research Series No. 14, p. 8.

[2] Ibid., pp. 9–10.

[3] "An Examination of the Concept of Preventive Medicine," HIF Research Series No. 12, p. 18.

[4] "Public Attitudes Toward Health Insurance," HIF Research Series No. 5, pp. 6–7.

[5] Ibid., p. 18.

dicated. For example, in a report of a study of hospital and medical economics conducted by the University of Michigan, it was noted that "from a medical standpoint, 'understay' is more serious than 'overstay' since it indicates the patient did not receive the minimum level of care needed for his diagnosis, as determined by the professional panels." That report shows that for 18 diagnoses studied, 6.8 percent of the discharged patients left too early, and where the patient footed the entire hospital bill himself understay (16.7 percent) was far more common than overstay (6.3 percent). Underuse of diagnostic and treatment facilities within a hospital was also found to be common. "More than one patient out of four (29.4 percent) failed to receive procedures required by their diagnosis, according to the criteria set by the professional panels."

Data from the National Health Survey indicate that the number of times a person with chronic limitation of activity sees a doctor during the year is related to income. The following table relates the number of physician visits per person per year for persons 65 years and older with major limitation of activity to the individual's family income:

Family income:	*Physician visits*
Total	14.3
Under $2,000	12.9
$2,000 to $3,999	14.9
$4,000 to $6,999	15.0
$7,000	21.6
Unknown	11.4

Care provided to indigents in nursing homes is often of questionable quality. About two out of five nursing home beds are in facilities with fire or health hazards so that the beds are classified as "nonacceptable" under Hill-Burton legislation. Many patients in nursing homes do not have their own doctors and many nursing homes do not have regular attending physicians. In some instances patients are apparently not even seen by a doctor for a year or longer at a time.

The report on a detailed study of nursing homes in Florida by a Citizens Medical Committee on Health appointed by former Governor Collins had this to say in its concluding observations:

"From these data it is evident that the nursing homes in Florida are predominantly custodial institutions, giving in the main minimum care to those with physical and mental disabilities of the aged and to those who are without home, family, or relatives who would or could provide the care needed. Accepting the opinion commonly expressed that it requires at least $150 per month to provide reasonable care in an acceptable environment, then more than one-half of the patients cannot be provided suitable care for economic reasons. This appears to be the dominant problem in the improvement of nursing home facilities and care."

of the distinguished acting majority leader, the Senator from Minnesota [Mr. HUMPHREY]: When we contrived the unanimous-consent agreement limiting the time available for debate on the bill which is the unfinished business of the Senate, there was no agreement about division of the time immediately prior to the taking of the vote on the motion to lay on the table. Under the unanimous-consent agreement, the vote on the motion to lay on the table will come, as agreed upon, tomorrow. I would assume that tomorrow perhaps an hour would be devoted to the morning hour; and that would leave 2 hours before the vote on the motion to lay on the table.

Since there was no agreement in regard to that time, I suggest to the acting majority leader that he proffer a further unanimous-consent agreement to the Chair; namely, that the 2 hours prior to 3 o'clock tomorrow be divided equally between the opponents and the proponents.

Mr. HUMPHREY. Mr. President, I have discussed this matter in a preliminary way with the Senator from New Mexico [Mr. ANDERSON], the principal sponsor of the amendments; and it appears to me that the suggestion which has been made is equitable. Therefore, I should like to propose the following unanimous-consent agreement: That beginning at 1 o'clock tomorrow, the time between 1 p.m. and 3 p.m. be divided equally, to be controlled by the majority leader and the minority leader, or whatever Senators they may designate, in connection with the Anderson amendments and the motion to lay those amendments on the table.

Mr. DIRKSEN. Mr. President, before the question is put, let me respectfully suggest to the distinguished acting majority leader that included in the request there be a provision that there be no intervening motion or amendment. If an amendment were offered at that time, obviously under the existing unanimous-consent agreement it would take 30 minutes for each side, and would preempt that much time from the time available on the main business which then would be before the Senate.

Mr. HUMPHREY. Mr. President, I feel that that suggestion is meritorious. Therefore, I amend the unanimous-consent request, so as to provide, in addition, that no other motion or amendment shall intervene during the period between 1 and 3 p.m. tomorrow, until the Senate has disposed of the motion to lay the Anderson amendments on the table.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.

PUBLIC WELFARE AMENDMENTS OF 1962—ADDITIONAL UNANIMOUS-CONSENT AGREEMENT

Mr. DIRKSEN. Mr. President, I wish to direct an observation to the attention

Mr. HUMPHREY. Mr. President, I shall ask unanimous consent that the Senator from New York [Mr. KEATING] and other Senators, when amendments other than the Anderson amendments are not pending, may speak without the time being charged to either the proponents or opponents of the Anderson amendments. We followed such a procedure on Friday last.

Mr. President, I ask unanimous consent that Senators who wish to speak on matters not related to the pending amendments be permitted to do so without the time being charged either to the bill or to the opponents or proponents of the amendments.

The PRESIDING OFFICER (Mr. BURDICK in the chair). Is there objection to the request of the Senator from Minnesota? The Chair hears none, and it is so ordered.

PUBLIC WELFARE AMENDMENTS OF 1962

Mr. HUMPHREY. Mr. President, I ask the Presiding Officer to lay before the Senate the unfinished business.

Without objection, the Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

The PRESIDING OFFICER. The question is on agreeing to the Anderson amendments.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. PELL. Mr. President, I rise today to express my very great satisfaction with the amendments recently submitted by the Senator from New Mexico [Mr. ANDERSON] to his bill, S. 909. I am proud to have been a cosponsor of the original S. 909, as well as of the amendments recently submitted by the distinguished Senator from New Mexico.

The amendments strengthen and improve the original bill. First, and most important, virtually everyone over 65 is now covered. Specifically, protection is afforded for the 2½ million older people who are not under social security and, hence, were not covered by the original Anderson bill. Now included are uninsured persons on old-age assistance and other public-welfare programs, widows whose husbands died before becoming insured, and persons who are without health-insurance protection under other public programs.

Second, the amendments tend to decentralize the role of the Federal Government in a national health-assistance program. The Secretary of Health, Education, and Welfare is to be given specific statutory authority to delegate some of the more sensitive administrative functions to nonprofit organizations experienced in the providing of health services. Those who have criticized this legislation as an opening wedge of Government intervention in hospital affairs will be comforted by an arrangement which permits private, voluntary organizations to act as intermediaries between the hospitals and the Government. The amendments also provide that the Federal Government would use State agencies to judge whether hospitals which are not accredited by the Joint Commission on the Accreditation of Hospitals are qualified to participate in the program.

Third, the amendments provide an option to beneficiaries to continue private health insurance protection and to encourage private health insurance supplementation.

The Anderson bill, as amended, has the support, I am pleased to say, of many Senators on both sides of the aisle. It represents an excellent demonstration of the positive results of a democratic system in operation. Numerous conferences have been held in response to criticisms and opposition from a variety of sources. We Democrats owe a considerable debt to our Republican colleagues for their responsible efforts to broaden the original version of the bill. The present bill as it now stands deserves the support of the Senate. It is my very strong hope that it will be passed in the near future.

Mr. KUCHEL. Mr. President, I ask unanimous consent that, under the same understanding, I may now yield to the distinguished senior Senator from Georgia [Mr. RUSSELL].

The PRESIDING OFFICER. Without objection, it is so ordered; and the Senator from Georgia is recognized.

Mr. RUSSELL. Mr. President, the pending proposal—the so-called Anderson-Javits amendments—is undoubtedly among the most controversial Congress will consider at this time. The adherents of both sides of this question are almost fanatical in their support; and every Senator knows, from his mail and other communications, of the very deep general interest in this question.

Mr. President, there is no doubt in my mind that a majority of the American people are willing to support some adequate plan that will prevent our senior citizens past 65 from suffering for want of hospital care. It has always seemed to me that a proposal that would finance itself by imposing a tax to defer its cost was a conservative approach. I am strongly disposed to vote for a well-considered, carefully planned, and carefully thought out program in this area.

However, Mr. President, we are called upon to vote on a measure that has not been subjected to the tests ordinarily given legislation, and which has not followed the usual legislative process. This is a new and highly involved question, and it involves the expenditure of large sums of money.

If committee hearings are important in any case, they are certainly demanded in this instance before we enact such a highly complicated measure. There has been no opportunity for those on either side of the question to speak and present their views to the proper committees of Congress. The only estimates of the costs of the plan and its method of operation are those which have been given us by the authors of the bill.

The original so-called King-Anderson proposal has been completely rewritten, not by a committee representing all shades of opinion, but by a small group of Senators who represent the strongest proponents of the medicare idea.

Mr. President, I have consistently insisted that it is most unwise and improper for the Senate to consider and enact legislation of general interest which has not followed the required ordinary procedures. I have repeated on this floor in debate, time and again, that only an extreme national emergency can justify junking our committee system in the consideration and enactment of legislation. The only place where an American citizen has the right of petition is before a congressional committee.

The last of the several editions of this bill that we have had presented by its authors may be as desirable and as effective as the authors insist. But it is brought before us without providing the opponents with an opportunity to be heard and without the benefit of the professional and actuarial testimony and data that would enable the Senate to know just what it is doing in voting such a comprehensive and far-reaching piece of legislation.

As I see it, the vote on this proposal involves the integrity of our parliamentary procedures. I cannot conceive of a more dangerous precedent than to start taking up bills of this magnitude without a written record of hearings and without a committee's having given the subject thorough study, in order to be able to advise the Senate and help us arrive at a proper decision. Such a precedent would plunge the Senate into tumult and confusion, and, if followed, would change the whole character of our legislative processes. We should not sacrifice our whole procedure upon an altar of expediency.

I wish to reiterate, Mr. President, that regardless of the subject matter involved, I always have in the past—and I shall continue to do so in the future—strongly oppose abandoning orderly procedure and evading and bypassing committee consideration, particularly on legislation as far reaching as that embraced in the amendments which are before us.

I do not know of any other bill which has inspired such great differences of opinion; and if we were to pass this bill solely on the testimony of its authors, however, high may be our opinion of them and their ability, I fear that we would have ample cause to regret it in the future.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

HEALTH CARE FOR THE AGED

Mr. KUCHEL. Mr. President, stripped of its verbiage, the issue in the pending debate is clear: Should the Congress bring to the elderly people of America any protection by way of insurance against the catastrophic costs of hospitalization?

I answer that question in the affirmative. I hope the Senate will. I believe the American people do.

Legislation on the general subject of health care insurance for Americans over the age of 65 has been pending in both Houses of Congress for many years. In the last session of Congress, what popularly became known as the King-Anderson bill, sponsored by Representative KING of California, and our able colleague from New Mexico [Mr. ANDERSON], became the most prominently known piece of legislation in this field.

Some of us on this side of the aisle objected to the King-Anderson proposal. We did it in a constructive fashion. We did not object to it with bitterness or with the desire to sweep what we believe is an American problem under the rug. We objected to it because we believed there were serious defects in the way that proposal was written. I emphasize, we did not desire to turn our backs on the problem, the very real and pressing problem confronting the people of the Nation.

We developed our thinking. We met together. We studied the testimony. We talked to experts. We sat down with the Senator from New Mexico [Mr. ANDERSON] and discussed what we believed ought to be amended into his proposal. The distinguished Senator from New Mexico studied our proposals, carefully and at length. And then he agreed almost entirely with our proposals, and today what can be properly termed as the "Anderson-Javits bill" is before the Senate for action. My name is on that bill as a cosponsor. I hope the Senate

will approve this constructive and vastly improved legislation, which I believe represents honest progress for our people.

Mr. President, there are two groups of Americans who have no worries regarding the mounting costs of hospitalization. One is the very small but fortunate group of senior citizens who have enough funds to pay for hospital bills, however costly they may be, when serious illness strikes them. The other group is unfortunate. It consists of those with marginal or submarginal incomes or with no income at all. When they become ill, they are cared for entirely at public expense. There is another group, by far the largest—those over 65 who are retired and who live modestly on what they have been able to save during their productive years, or on what they receive from social security or other forms of retirement. It is this group with whom we are concerned today. It is the members of this group who fall in the middle income bracket, who, as old age approaches, have a constant and growing worry as to what may happen if a member of the family were to be faced with serious illness requiring any lengthy hospitalization.

A SERIOUS PROBLEM REQUIRING A REALISTIC SOLUTION

Those over 65 form an ever-increasing proportion of our total population. In 1900 only 4 percent, or 3.1 million Americans, were over 65. This has now risen to almost 10 percent, or 17.5 million people. The miracles wrought by modern medical science and public health have resulted in an increasing life span. At the same time, within our industrial society, there is an increasing tendency to retire workers at a fixed and ever-younger age. We know that women tend to outlive men and, thus, among our senior citizen group there are many widows with few, if any, financial resources. At the end of this decade there will be 20 million people over 65, and by 1980 the figure will have reached 25 million.

We have an opportunity now to come to grips with the health care problem which confronts our senior citizens based on the evidence that is already in. We must formulate a workable and dignified program now which will meet their minimum health needs in the future.

What are these needs? The incidence of medical costs for our senior citizens is extremely high. In 1960, the combined public and private medical care expenditures for all Americans totaled almost $25 billion. About $5 billion of this amount was expended on those over 65 years of age. Think of it—one-fifth of the medical care costs for a group which is composed of less than one-tenth of our total population. Only half of our senior citizens have any protection against hospital costs, and often this protection is of little assistance when the time comes for them to utilize it. Based on statistics available for the period 1958 through 1960, in a majority of hospital stays of the aged, health insurance paid no part of the bill, and for the remainder it was often less than one-half of the bill. Many who need medical insurance most—such as the chronically ill, the poor health risk, the unemployed, and the low income retiree—are least likely to have hospital insurance.

Private and public retirement income all too often do not permit a sufficient cushion to meet the high costs which result from hospitalization. The current average monthly payment to a retired worker under the old-age and survivors insurance program is only $76. This certainly would not go far if serious illness should occur. This certainly is inadequate, when one considers that the total annual median medical cost, based on a 1957 survey among couples who were social security beneficiaries but who were not hospitalized, amounted to $150. Among couples when one or both were hospitalized, the annual median medical costs were nearly five times as high, or $700 per year. And hospital costs have continued to rise rapidly since 1957. With today's prices, the comparable median would now be between $800 and $900.

Hospital room rates are going up much faster than other medical care prices. In the decade ending in 1960, hospital room rates more than doubled—rising from $15.26 per day in 1950 to $32.23 in 1960. If we scrutinize the Index of Medical Care Prices, a component of the Consumer Price Index, which has been compiled by the Bureau of Labor Statistics of the U.S. Department of Labor, this rise in medical care costs becomes especially vivid. For example, in 1940, all medical care was at 72.7 on the price index using 1947 to 1949 prices as 100. By the end of 1961, all medical care had risen to 162.6. Physicians' fees, dentists' fees, and the cost of prescriptions and drugs rose less than this. But the hospital daily service charge—which includes the charge to full-pay adult inpatients for room and board, routine nursing care, and minor medical and surgical supplies—rose from 50.4 in 1940 to 248.4 by the end of 1961. The index on the cost of hospitalization insurance which began in 1951 reflects this great increase in the cost of hospitalization. In 1951, the hospitalization insurance index was at 85.6. By the end of 1961, it had reached 190.6. I think it is evident from these basic facts that something must be done, and must be done soon, to help the typical American citizen who is over 65 meet the ominous hazard of illness and hospitalization.

A BIPARTISAN AND IMPROVED BILL

A year ago, the so-called King-Anderson bill was introduced. Its purpose was to provide some hospital insurance to those over 65 years who were members of the social security system. Some of us in the Senate objected to some of its provisions. We pointed out that the problems attendant upon serious illness were not confined to those under social security. We simply said that any hospital insurance legislation should provide benefits to all people who are over 65 years, whether they are under social security or not.

We had other objections and constructive alternatives. I think that it is in the best traditions of the U.S. Senate that we, all of us who are coauthors of the pending amendments, were able to come into complete agreement on our divergent views. We jointly, Republicans and Democrats, offer this constructive proposal to the Senate.

We sought to find realistic answers for a realistic problem. We synthesized and brought together the best that was offered in various Democratic and Republican proposals before the Senate. I believe that we have come forth with a comprehensive measure which is truly in the public interest. I pay particular tribute to my warm friend and Republican colleague from New York [Mr. JAVITS] and to my warm friend and Democratic colleague from New Mexico [Mr. ANDERSON].

Our joint bipartisan proposal now before the Senate fully meets the first of my two major objections to the original administration bill. We now cover not merely those who are eligible to receive social security benefits, but also all those who are over 65. I believe this is essential. I have long felt that it was completely unreasonable to discriminate against 2½ million citizens who, for one reason or another, had never been covered under either the social security or the Railroad Retirement Acts. These citizens are now to be blanketed into the program. Their benefits will be paid from general revenues appropriated by the Congress.

All those who reach 65 before the beginning of 1967 will also be eligible. After that, there will be a transition period during which those who desire to have these benefits will have the opportunity to secure the needed quarters of social security coverage in order to qualify. It is expected that within two decades over 95 percent of the labor force will have social security coverage. In my own State of California we now have approximately 1,514,000 senior citizens. Two hundred and forty-nine thousand of this group have neither social security nor railroad retirement coverage. However, under our amendment, they will at last be included in the program.

With the blanket coverage of all those who are retired and who no longer have the opportunity to acquire the needed credits, I have concluded that the social security approach provides the truly conservative and fiscally responsible way to finance these essential benefits. It meets the requirements of dignity and self-sufficiency since the individual pays during the period in which he is able to work and earn his living. It is a businesslike way to finance the program since the needed funds are raised on an insurance basis to pay for the benefits to be available in one's retirement years.

A notable leader in American industry, Mr. Edgar F. Kaiser, testified in favor of the social security approach before the House Committee on Ways and Means. Mr. Kaiser, a distinguished Californian, knows firsthand as president of the Kaiser Foundation Health Plan, and has repeatedly stated publicly, that hospital insurance under social security is neither socialism nor government-administered medicine. I agree. It is the

very antithesis of it. It is insurance which will foster nongovernmental hospitalization. Said Mr. Kaiser:

> The logical outgrowth of social security financing, as contrasted with appropriations from general revenues and administration through social welfare agencies, will be to keep a greater and increasing proportion of retired persons in the mainstream of medical and hospital care, with services provided in private and voluntary hospitals. This will reduce reliance on county hospitals and other governmental institutions.

Such comments from an eminent businessman like Mr. Kaiser make a lot of commonsense to me.

Another improvement in this current proposal and one which many of us have long advocated is the establishment of a separate Federal health insurance trust fund. This separate trust fund will assure the preservation of the financial soundness of the social security medical system. Thus, the health care program will have to stand alone, on its own merits, and the benefits granted will have to bear a strict relationship to the income received as a result of the increase in the social security tax of one-fourth of 1 percent each for employees and employers and by three-eights of 1 percent for the self-employed. This tax would be effective on January 1, 1964. It would apply to a wage and salary tax base of $5,200 per year or lower. The financing of this program by the social security system and the use of the separate trust fund assure that moneys raised for hospitalization insurance will be used for this purpose alone. This is a much sounder method of operation than annually appropriating the needed funds from the general revenue of the Government where whim and the tactics of particular pressure groups could mean either feast or famine for the program.

A PRIVATE OPTION AND STATE–PRIVATE PARTICIPATION

Another major objection which many of us had to the original administration proposal was that no opportunity was provided for an individual to continue his needed health care program in one policy and thus keep his established relationships with a private health insurance plan, if his experience had been a satisfactory one. A few industries, labor organizations, and public groups have negotiated health insurance programs which continue on into one's retirement.

Some of us have worked diligently for the option provided in our original agreement and to improve upon it. This option permits the Federal health insurance beneficiaries to elect to have their benefits paid by a private insurance company. They must make their choice within 3 months after they become eligible for the program. The private company would be reimbursed by the Federal health insurance trust fund for benefit payments made under the Federal categories of hospitalization as well as for their administrative costs up to one and a half times the administrative costs in the public program.

When we coauthored the Anderson-Javits amendment, it was understood that the private option provision would be the basis for further discussions. In the intervening days we have sought to perfect this private option.

Some of us have suggested the possibility of developing an alternative package of hospitalization benefit insurance available from private insurance companies which would give a freedom of choice to the beneficiary. Thus, an individual would have the choice, upon retirement, of continuing with his private plan which would contain an equivalent to the basic provision which is 90 days' hospitalization and $90 deductible. He could choose, as an alternative 45 days' hospitalization with no deductible. Such a choice would be available only if an individual had held a nonprofit private health insurance plan—such as a group plan, a prepayment group practice plan, or commercial nongroup plan, generally known as a mass enrollment plan, where the carrier's acquisition costs are comparable to the acquisition costs under most commercial group plans—for at least 1 year prior to retirement.

Commercial nongroup plans, regardless of whether or not the acquisition costs were comparable with those under group plans, could qualify to offer only the 90-day hospital benefit if the carrier met one of the following three tests: First, did business in 50 States and wrote 1 percent or more of the Nation's individual health insurance business; second, was determined by the Secretary to be national in scope; or, third, did 5 percent or more of the individual health insurance business within a State. This type of plan would have to be held for at least 2 years prior to reaching the age of 65.

In order to qualify, these plans need contain only the hospitalization provision during the 1- or 2-year qualifying period. However, once the individual reaches 65 and desires to continue with his private policy, that plan would have to provide also all the auxiliary benefits of the pending legislation. These benefits include skilled nursing facilities, home health, and outpatient hospital diagnostic services. Any charges made against these benefits would be reimbursable from the Federal health insurance trust fund. Thus, the elderly citizen has the right to choose different plans to meet his hospitalization needs.

I have thought it essential that individual choice be provided. It is. I have thought it essential that private enterprise participate in this program. It does. The result of our freedom-of-choice amendment will be the encouragement of a new and enlightened era in the provision of health care for the aged. The establishment of a competitive yardstick between the operations of the Social Security Administration and the various private health insurance carriers will, I am sure, prove to be a useful guide in evaluating the effectiveness with which each group operates both in terms of benefits conferred and in terms of administering those benefits.

With approximately 40 percent of the senior citizen's basic health needs met through the hospitalization and nursing home provisions, private health insurance carriers will have a greater opportunity to concentrate on the provision of supplemental benefits. Indeed, our proposal gives private health insurance an additional incentive to compete. Our senior citizens will have the opportunity to secure more comprehensive coverage at a reduced cost, since the basic burden and risk is being borne by the social security system.

I have also thought that the States and those who are experienced in the health care field should have a responsible role in implementing this new program. An appropriate provision is in our bill. Each State can participate in determining the eligibility of its health care facilites. In addition, the State can through its public health department provide consultation services to the providers of hospital care under this program. States would be able to supplement the authorized benefits if they desire. Moreover, under the Anderson-Javits amendment, the Secretary of Health, Education, and Welfare may delegate some of his administrative functions to Blue Cross or similar group-plan insurance organizations are experienced in dealing with hospitals and other providers of health services. A group of hospitals or other providers of health services may, under our legislation, also designate a private organization of their own choice to receive bills for services and pay them. Thus, hospitals which have established relationships with private health care organizations will be able to continue them under the government program. The result should be more efficiency in the administration of this program.

THE BENEFITS

So much for the improvements which have been made in the approach and the methods of operation. Now, what benefits are granted under the bill?

Our Federal health insurance program would provide for inpatient hospital services for up to 90 days during a single period of illness. The patient would be required to pay $10 per day for up to 9 days during each benefit period, with the minimum payment set at $20.

Payment would be made for up to 180 days of skilled nursing home services for patients who transfer to a hospital-affiliated nursing home from a hospital. The intent is not to underwrite terminal care but to reduce the cost of hospitalization by providing a half-way point between the hospital and the home. Home health services for up to 240 visits could be paid for during a calendar year. These home health services would be furnished by, or through, public or nonprofit agencies under a plan prescribed by a physician. These services would include nursing care, physical, occupational, and speech therapy, medical supplies—other than drugs, appliances for temporary use, and certain part-time or intermittent homemaker services.

In addition, payments would be made for outpatient hospital diagnostic services of the kind customarily furnished by or through a hospital to its outpatients. Payments for outpatient hospital

diagnostic services furnished an individual during any 30-day period would be subject to a $20 deductible.

I recall some of the comments my able friend the Senator from New Mexico [Mr. ANDERSON] made the other day, in speaking of our proposal:

The benefits follow the Blue Cross approach by concentrating on coverage against the most burdensome health costs that older people face—that is, the cost of hospitalization. But the amendment improves on the usual Blue Cross-type benefit package somewhat by providing, in addition to payment for more hospital service than the usual Blue Cross plan for the aged, payments for certain skilled nursing facility, visiting nurse, and hospital outpatient dianostic services. These supplemental benefit features were included so that physicians would be free to recommend less-expensive substitutes for hospital care without increasing their patient's health costs.

The Blue Cross approach that the amendment follows has been proved to be a highly successful form of protection against health costs. It not only meets the most burdensome health costs people face, but it is designed to fit in with the other kinds of health insurance people ordinarily want. The Blue Cross-type benefit plan I am proposing would provide only basic protection to which the elderly will want to add by buying health insurance against surgical costs, physicians' fees, and other health costs.

Blue Cross has been proved satisfactory in every respect except one. An essential part of the traditional Blue Cross approach is that it be sold to everyone in the community for the same premium. In effect, what this has meant is that Blue Cross provides coverage to the elderly at a premium that isn't large enough to cover their high hospital costs. In recent years, Blue Cross has been paying out $375 million in benefits a year for the elderly while collecting only $200 million from them—and the deficit has to be made up by the younger subscribers. Blue Cross has as much as said that it can't do business on this basis any longer and that—in order to compete with the commercial insurers—it will have to double or triple the premiums for the aged. Blue Cross also recognizes that the aged can't pay the high premiums that are necessary and that Government help is needed.

In essence, then, what I am proposing is a Blue Cross-type benefit plan for the elderly that is financed through social security in such a way that the full cost of their coverage will be met. Finally, and this is also very important, by following the Blue Cross approach, the proposed program can benefit from Blue Cross experience and can follow practices which are already well established and accepted by hospitals.

This concept we developed. It is sound. It is American. The comments of the Senator demonstrate the great and growing hazard facing those over 65, and the increasing difficulties they face in insuring themselves against the prodigious costs of illness requiring hospitalization.

FACT VERSUS FICTION

I have been interested in reading the charges and countercharges which have been raised concerning this amendment. The bogyman of Federal encroachment on the doctor-patient relationship and on control of our hosiptals has been frequently voiced. Our proposal cannot possibly interfere with the doctor-patient relationship. And we do not intend that it should. No doctor's services are paid for by our bill unless those services, such as pathology, radiology, physical medicine, and anesthesiology, are rendered by physicians in the employ of, or working under, an arrangement with the hospital as an incidental part of the hospital care. Then these services are paid for only because the doctor and the hospital have agreed of their own free will to provide such incidental services in this manner.

Mr. President, I read into the RECORD at this point section 1701(a) at page 4, as follows:

SEC. 1701. (a) Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any hospital, skilled nursing facility, or home health agency; or to exercise any supervision or control over the administration or operation of any such hospital, facility, or agency.

I do not believe in government control of medicine. I do not believe in government interference with the doctor-patient relationship. The individual will continue to have free choice as to his doctor. The bill would in no sense interfere with his right. With his doctor he will choose his own hospital, if in his doctor's judgment, hospitalization is required.

Another improvement in the current proposal which I believe should once and for all sweep away this charge of Federal encroachment is the provision that all hospitals which are accredited by the Joint Commission on the Accreditation of Hospitals—composed of members of the American Medical Association and the American Hospital Association—will be automatically included. I understand that approximately 85 percent of the hospital beds in America meet these standards. For the remainder, in order to enable some of these hospitals to participate, the Secretary of Health, Education, and Welfare will have authority to set certain standards which do not exceed those that have been agreed to by the two professional groups which make up the joint commission. If the Secretary were not permitted to set such standards, there undoubtedly would be some areas of this country where no hospital facilities would be eligible. Thus, it is the private medical and hospital professions which will set the maximum standards and not the Secretary. If a hospital has a grievance, it would be well advised to discuss it with the American Medical Association and American Hospital Association joint commission.

I have been interested in some of the comments which have been made on the bill by a few members of the medical profession in my State. I have received many telegrams and letters, some from members of the medical profession wholeheartedly in favor of our amendments, and some from doctors just as vigorously opposed. Under our American way of life, an American citizen has a right to express himself to those who represent him through the elective process in a parliamentary body. I recognize the right of any citizen in or out of the medical profession to register his views with his representative in the Senate and in the House of Representatives, no matter in what fashion he represents those views.

I have received threats from some people, telling me that if I tried to help fashion a piece of legislation to bring to elderly Americans some semblance of assistance with respect to hospitalization insurance, the days of my public service would be at an end.

I respect the right of an American citizen to register his views, indeed, to make that kind of threat. But I have the right as a Senator, indeed, I have a duty, standing on this floor, to reject threats, and to do that which I believe I ought to do for my country and for my State.

I had a great predecessor in the Senate from California, Hiram W. Johnson. The Presiding Officer (Mr. BURDICK in the chair), will remember him, and the Presiding Officer's late father served with him. Some people tried to push Hiram Johnson around in his day but no one succeeded. There was a great Senator. Once, when someone tried to push him around he came to the floor of the Senate and said, "Mr. President, I would rather be a dog and bay at the moon than to come crawling in the U.S. Senate on my stomach when someone threatens me to do his bidding." That is a very good philosophy to follow for any Senator who tries as best he can to represent the public interest.

I have no doubt that every Member of the Senate, Republican and Democrat, he who supports the bill and he who opposes it, as he sees the light, is endeavoring to represent the best interests of the country. That is why we have debate. Divergencies of views are good. Out of a discussion of them, out of argument, can come the truth and the way to progress. What do we seek to follow, Mr. President? It is the public interest. That is what we serve. And threats of reprisal ought not to dissolve us from that bounden American duty.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD the text of a telegram to me from 42 members of the medical profession in California.

There being no objection, the telegram was ordered to be printed in the RECORD, as follows:

CHICAGO, ILL., *June 26, 1962.*

HON. THOMAS H. KUCHEL,
Senate Office Building,
Washington, D.C.

The undersigned, Malcolm C. Todd, M.D., member of the 42-man delegation to the American Medical Association and a national director of the American Medical Political Action Committee, has been authorized to convey this message of 18,000 California doctors, their friends and political allies to you. Since I could not talk to you by long distance this morning, I told your Mr. Ewing House that we are unalterably opposed to any compromise in our opposition to the King-Anderson bill now in the House Ways and Means Committee. We strongly urge that you not to be a party to pulling Democratic chestnuts from the political fire by assisting Senator ANDERSON in his abortive attempt to initiate similar legislation in the Senate. You know that this move is simply to pay a campaign debt to labor and to attempt to embar-

rass Republican Members. On the principles that you are taking over prerogatives of the lower House and that ANDERSON'S proposal has not had sufficient Senate study it is our strong plea that you oppose this Democratic political chicanery on such an important matter as the care of the senior citizens of our country. We wish to point out that Kerr-Mills law is being implemented in California and physicians are supporting it. We are on record in favor of any necessary changes for Kerr-Mills to be absolutely certain that those who need care will get—underline "get"—care. Our American Medical Political Action Committee is developing tremendous strength in medical and allied circles. Sunday night 1,000 doctors heard Senator TOWER at a $25-per-plate dinner. We plan to do everything within the power of an aroused profession to preserve sound American principles and that includes the protection of patients to select their own physicians without governmental interference in providing the best care in the world. The following delegates assembled here in Chicago join me in this statement which will also be distributed to our many friends and our patients:

O. W. Wheeler, CMA's president, Riverside; Warren L. Bostick, immediate past president of California Medical Association; Donald A. Charnock, past president, CMA, Los Angeles; Burt L. Davis, president of general practitioners of California, Palo Alto; James C. Doyle, Beverly Hills; James E. Feidmayer, Exeter; Leopold H. Fraser, Richmond; Henry Gibbons, 3d, San Francisco; Eugene F. Hoffman, AMA's television committee, Los Angeles; Charles B. Hudson, Oakland; Arthur A. Kirchner, AMA's liaison committee with nurses, Los Angeles; J. Lafe Ludwig, AMA's legislative chairman, Los Angeles; Arlo A. Morrison, president of National Blue Shield Plans, Ventura; J. Norman O'Neill, Los Angeles; J. B. Price, Santa Ana; John M. Rumsey, San Diego; Ralph C. Teall, CMA's speakers bureau, Sacramento; Dwight L. Wilbur, San Francisco; Jay J. Crane, Los Angeles; Joseph H. Failing, San Marino; Harry R. Walker, Oakland; Rutherford T. Johnstone, Los Angeles; E. Vincent Askey, AMA past president, Los Angeles; John W. Cline, AMA past president, San Francisco; Dwight H. Murray, AMA past president, Napa, Walter H. Brignoli, St. Helena; Dudley M. Cobb, Los Angeles; Robert Combs, San Francisco; Francis J. Cox, San Francisco; Edward H. Crane, Jr., Los Angeles; Donald C. Doods, Oakland; Leon P. Fox, San Jose; Charles E. Grayson, Sacramento; Carl M. Hadley, San Bernardino; Donald D. Lum, Alameda; William F. Quinn, Los Angeles; Hartzell H. Ray, San Mateo; Wilbur G. Rogers, Glendale; Samuel R. Sherman, president elect of CMA, San Francisco; J. E. Vaughn, California American Medical Political Action Committee director, Bakersfield; Francis E. West, CMA past president, San Diego; and to this list we believe we can, with deepest respect and the fondest of memories, add the name of our dear departed Glenn Curtis.

Mr. KUCHEL. Mr. President, I wish to comment on the telegram. It came to me from 42 members of the medical profession of California, meeting in national convention in Chicago. They said, in part:

We are unalterably opposed to any compromise in our opposition to the King-Anderson bill now in House Ways and Means Committee. We strongly urge that you not be a party to pulling Democratic chestnuts from the political fire by assisting Senator ANDERSON in his abortive attempt to initiate similar legislation in the Senate You know that this move is simply to pay a campaign debt to labor and to attempt to embarrass Republican members. On the principles that you are taking over prerogatives of the Lower House and that ANDERSON'S proposal has not had sufficient Senate study it is our strong plea that you oppose this Democratic political chicanery on such an important matter as the care of the senior citizens of our country. We wish to point out that Kerr-Mills law is being implemented in California and physicians are supporting it. We are on record in favor of any necessary changes for Kerr-Mills to be absolutely certain that those who need care will get—underline get—care. Our AMPAC is developing tremendous strength in medical and allied circles. Sunday night 1,000 doctors heard Senator TOWER at $25 per plate dinner. We plan to do everything within the power of an aroused profession to preserve sound American principles and that includes the protection of patient's to select their own physicians without governmental interference in providing the best care in the world.

I can agree with part of their telegram, I want patients in America to be permitted to select their own physicians, without any governmental interference, in providing the best health care in the world; and, Mr. President, this bill will help promote that design. It does not interfere with it. But for the rest of the telegram, Mr. President, let me say that a U.S. Senator has a responsibility to decide for himself where the public interest lies. And, having decided, I reject the position these gentlemen take.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD an article entitled "Doctors Pressuring Senator KUCHEL," written by David Perlman, and published in the San Francisco Chronicle of June 28, 1962.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

DOCTORS PRESSURING SENATOR KUCHEL

(By David Perlman)

CHICAGO.—California physicians turned their political guns on Senator THOMAS KUCHEL yesterday in an effort to prod the Los Angeles Republican away from support of old-age health care through social security.

The Californians warned the Senator that he faces "the power of an aroused profession" if he alienates organized medicine by agreeing to any compromise on the King-Anderson bill.

But the Senator quickly shrugged off the California threat; his office told the Chronicle that KUCHEL will insist on joining a bipartisan effort to amend the health care measure and push its passage through the Senate early next week.

WORRIES

The 42-man delegation of California physicians to the American Medical Association's annual meeting here is deeply worried about KUCHEL's politics these days.

KUCHEL is part of a liberal Republican group that opposes King-Anderson but favors a social security mechanism for financing health services to the aged. Because the King-Anderson bill now seems firmly bottled up in the House Ways and Means Committee, the Kennedy administration is seeking to push a vote on it by the Senate, where passage would be easier.

But KUCHEL and his liberal GOP group have set a price for their support: They want the measure amended to provide Federal funds for the nearly 4 million old people who are not covered by social security, and to offer recipients a choice between Government-financed care or cash benefits to pay for private health insurance.

ACCEPTABLE

Senator CLINTON P. ANDERSON, Democrat, of New Mexico, and Senator JACOB JAVITS, Republican, of New York, have just agreed that a compromise such as sponsored by KUCHEL, might be acceptable to Senate Democrats.

The measure—possibly brought to the Senate floor as an amendment to a pending welfare bill already passed by the House—is expected to come up by Monday.

The California delegates here are incensed by KUCHEL's position. They, like all organized medicine, are convinced that any health care program financed by social security is inevitably a foot in the door leading to Government control of medicine, and is a piece of welfare-statism foisted off on the public by a coalition of liberal Democrats and big labor.

"We urge you not to be a party to pulling Democratic chestnuts from the political fire," the California physicians told Senator KUCHEL in a telegram. "This move is simply to pay a campaign debt to labor."

CHICANERY

The Californians warned KUCHEL he would be participating in "Democratic political chicanery" if he supported the compromise Senate plan, and told him he faces "the power of an aroused profession determined to preserve sound American principles—and that includes the protection of the right of patients to select their own physicians without Government interference."

Among the 42 signers of the political warning to KUCHEL were three former presidents of the AMA: Dr. E. Vincent Askey of Los Angeles, Dr. John W. Cline of San Francisco, and Dr. Dwight H. Murray of Napa.

Other San Franciscans who joined the move included Dr. Samuel R. Sherman, president-elect of the California Medical Association; Dr. Robert Combs, Dr. Francis J. Cox, and Dr. Henry Gibbons III.

Mr. KUCHEL. Mr. President, I ask unanimous consent to have printed at this point in the RECORD an editorial entitled "Forty-two Doctors Wire Their Senator," published in the San Francisco Chronicle of June 29, 1962. The editorial comments on the article to which I have just referred.

There being no objection, the editorial was ordered to be printed in the RECORD, as follows:

FORTY-TWO DOCTORS WIRE THEIR SENATOR

The 42 California physicians who sent a telegram warning Senator THOMAS H. KUCHEL not to risk their displeasure by working for a compromise solution of medical care for the aged have every right to do what they did.

At the same time, Senator KUCHEL needs no reminder that he has an equal right to ignore this somewhat presumptuous and fatuous warning.

We will even say that when a group invokes "the power of an aroused profession" against his proposed course of action, a U.S. Senator has the duty to invite them to go right ahead and arouse themselves.

KUCHEL, who is the Republican whip in the Senate, has been working sensibly with a few other Republicans to improve the medical care plan laid out in the King-Anderson bill. They favor the social security tax as the means for financing health services to those over 65 who are covered by social security, but they would give these recipients a choice of accepting either Government-financed care or, in lieu of that, cash benefits to pay for private health insurance.

This is aimed at the very thing the physicians say is so sacred, namely, the right of patients to select their own physicians without Government interference.

The organized medical profession, however, takes the position that any health care program financed by social security is infected with a form of socialistic leprosy against which doctors have a duty to ring their bell. Since doctors are the world's least impressive authorities on the economics of public finance, and since many of them already practice medicine in Government-controlled hospitals without serious socialistic side effects, this position strikes most laymen as simply absurd. We are glad to see that it has not frightened Senator KUCHEL.

Mr. KUCHEL. Mr. President, I frequently wonder, from the tye of argument made by those who write me in opposition to some kind of hospital insurance for the elderly, whether or not they have read our bill. In their opposition, they sometimes argue that doctors are willing to provide free medical care for all who wish it, and thus there is no need for the program. I salute the members of the medical profession across the country who have expressed such a willingness. But that is not the question in this instance. It is completely irrelevant to debate on our amendment. Our proposal does not provide for the payment of doctors' fees. The only relevant question is, Are these estimable members of the medical profession willing to pay the hospital bills for those who need hospitalization? The question was correctly answered by a distinguished Los Angeles physician having more than 40 years of practice when he testified before the Senate Special Committee on the Aging. I quote from the testimony of Dr. Daniel R. Mishell:

We as physicians can, and always will, render medical care to people at whatever modest fees they can afford to pay, but we cannot help them cope with the tremendous rise in hospital costs, a rise which is bound to continue.

Mr. President, I repeat: I vigorously object—I object without any qualification at all—to the medical profession, or any profession, becoming controlled by the Government of our country. But the proposed legislation does not control doctors. Let us recall that the medical profession—the doctors in my State and elsewhere—has endorsed the so-called Kerr-Mills Act, which today provides for the direct payment of doctors' fees. Our bill does not deal with doctors' fees.

Now I should like to recall a bit of history. The date is March 3, 1935. America was climbing out of a quagmire of economic depression. But poverty was still abroad in the land. Many people could not pay their bills. On that date, March 3, 1935, the house of delegates of the California Medical Association met and adopted a resolution. The resolution urged the enactment of legislation to create "a health insurance system mandatory as to certain population groups and voluntary as to certain other population groups." And nobody leveled a cry of "socialism" when that action was taken.

The members of the California Medical Society actively sought the passage of such legislation by the legislature of my State at that time. Senate bill 454 was introduced in the California State Senate during its 1935 session. Among 32 detailed pages, that legislation provided that "every employer pay an amount equal to 5 percent of the wages paid to his employees, other than casual employees, during any calendar month" into a fund administered by the State health insurance commission. That was the position of the medical society of my State in 1935.

I do not quarrel with the right of any individual or group to take a certain position on one occasion and another position on the next occasion. But I have recited that bit of history from the State of California to demonstrate that, from time to time, the people in the medical profession itself have been interested in health insurance legislation, with a 5 percent tax on wages.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD the text of the resolution adopted by the California Medical Association in 1935.

There being no objection, the resolution was ordered to be printed in the RECORD, as follows:

Whereas the studies of the committee of five of the California Medical Association have shown the inability of a certain percentage of our population to adequately finance the cost entailed by illness; and

Whereas because of this economic situation proper medical care is beyond the reach of this population group; and

Whereas it has been established that this problem can be alleviated by the utilization of the insurance principle; Now, therefore, be it

Resolved, That the House of Delegates of California Medical Association recommends that legislation be proposed seeking to establish a health insurance system, mandatory as to certain population groups and voluntary as to certain population groups, which shall include the following principles:

1. The patient shall have absolutely free choice of physician and hospital;

2. The medical profession shall determine the scope, extent, standards, quality, compensation paid for, and all other matters and things related to, the medical and medical auxiliary services rendered under the system;

3. There shall be no provision for cash benefits;

4. The patient shall receive adequate treatment and his physician shall receive adequate compensation;

5. The foregoing principles shall be maintained with such modifications thereof as may from time to time be recommended, or approved by the profession; and be it further

Resolved, That the California Medical Association immediately offer its full aid and cooperation to the interim committee of the Senate of the State of California charged with the study of this problem, to the end that any measure which shall be passed establishing a health insurance system at the 1935 session of the California Legislature shall contain the above principles; and be it further

Resolved, That there be formed a special committee authorized and empowered to act herein, constituted as follows: the legislative committee of the association and three members of the association to be appointed by the speaker of the house.

Mr. KUCHEL. Mr. President, in the proposal now pending, we are concerned with meeting very real health needs which statistics show increasingly arise among a growing group of our people, those over age 65, who because they have retired are the least able to pay the high cost, indeed the catastrophic cost, of hospitalization. Our proposal will not put the Federal Government into the field of medicine, although the Federal Government has been interested in and helpful to the field of medicine since the founding of our country. Yet the medical profession has been free and has prospered. We are all grateful for that fact.

It has been the established policy of the Federal Government since 1798 to provide Government medical care for our merchant seamen. In the first session of the First Congress a bill was introduced as an "act for the relief of sick and disabled seamen." Hospitals were built and physicians were employed by the Government. Each sailor was charged 20 cents a month for this service. This service grew into what is now known as the U.S. Public Health Service. This distinguished organization, which includes the National Institutes of Health, has advanced the cause of medical science and research more than any other group in America. The creation of the National Institutes of Health represents one of the great milestones of progress by Congress.

During fiscal year 1963, the Federal Government is supporting about three-fifths of the more than $1 billion which is being spent for medical research in this country. In fact, in the next year the Federal Government will spend more than $1 billion on medical and health related research and the facilities with which to conduct that research. I have received no letters from private medical researchers alleging that the Federal Government has encroached upon their freedom after they have accepted these grants.

Federal support for hospital construction alone will amount to almost $200 million in the coming year. I have received no letters from private hospital administrators, or trustees, that the Federal Government has encroached upon their freedom after they have accepted Hill-Burton funds, Federal moneys used in construction of private hospitals.

In addition, we expend over $1 billion for veterans hospitals and veterans medical care, including research and administration; $68 million will be spent on veterans hospital construction during the coming year. But in the Anderson-Javits amendment we are not talking about subsidized research, hospital construction, or health care. What we are talking about is an insurance program where one puts away in his working years funds which can be available during his retirement to meet some, not all, of his health care needs.

Mr. President, several months ago I had the opportunity to speak to the President of the United States. I told the President that I would be unable to support the King-Anderson bill as it had been originally introduced. He asked me why. I told him what flaws I believed were inherent in it. I told him what, generally, in my opinion, I would do in order to try to overcome those flaws. These were matters of principle, as I saw them. He asked me to write him a memorandum on it. I did. I ask unanimous consent that a copy of my

letter to the President of the United States, dated April 2, 1962, be printed at this point in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
April 2, 1962.

Hon. JOHN F. KENNEDY,
The White House,
Washington, D.C.

DEAR MR. PRESIDENT: In order to meet the medical care problems confronted by our senior citizens, a program will have to be devised, and soon. To be equitable, it needs to go beyond the limitations of the social security approach. While I recognize the reasonable fears of those who desire a separate trust fund rather than having benefit payments solely dependent on general funds and annual appropriations, I think the proper solution may well be a blending of both systems. For several million citizens over 65, who have never participated in the social security program, the general revenue method would seem to be the only solution. Teachers, policemen, firemen, and other public employees who have never been under social security—though many of them have wished to be—are finding their medical care problems equally great.

I respectfully suggest that the concept of freedom of choice might well extend beyond the selection of one's doctor and include, were an individual to prefer it, the purchase of a noncancellable private health insurance policy. I think that Senator JAVITS has a commendable thought on this matter. Under his proposal, an individual could take this option only if he had already been under such a private plan for at least a year before reaching the age of 65. The private carrier would receive a cash reimbursement on either a monthly or quarterly basis up to a specified amount based on the estimated annual cost of the benefits used by those not taking the private option. If the senior citizen lapsed in payment to the private carrier, he would then automatically go under the public benefit system.

There are several advantages to this option. One is that an individual could seek additional coverage not possible under the regular system in order to meet specific needs. For this he would make up the difference between the cash reimbursement and the actual cost of this benefit package. Another advantage is that the availability of this alternative would stimulate the continued growth of private health insurance and encourage experimentation by private and group health carriers to design a benefit package which would meet the medical and health needs of our senior citizens. Many workers are covered by private medical care insurance as the result of collective bargaining agreements. They might find it more convenient and practical to continue with their present private plan after retirement if this option were available. If the Secretary of Health, Education, and Welfare interposed no objections on actuarial or administrative grounds, I believe this proposal by Senator JAVITS would be beneficial.

Whatever system is finally agreed upon should be one which does not include a means test. To include this device in light of the major financing method of the system is inexcusable, as you have observed.

Some thought might be given to providing for the administration of this medical care program through State agencies. There could be some advantage here from the point of view of maintaining close contact with local conditions and providing a more rapid decision on the payment of particular benefits. More important, I think those States with the financial capacity to do so should be encouraged to build on the Federal benefit base if they so desire. State administration of this program would make this possible.

You have my cooperation in devising a constructive and forward-looking measure which I know we both hope will do the job which needs to be done and which is long overdue.

Respectfully yours,
THOMAS H. KUCHEL,
U.S. Senator.

Mr. KUCHEL. Mr. President, the recommendations made in good faith by some of us were accepted, in overwhelming degree, not alone by the Senator from New Mexico [Mr. ANDERSON], but also by the President of the United States. I do not believe we should be bullied or threatened for trying to enact legislation that is in the interest of the American people and that does represent sound progress. As Senators, we represent all of the people, not the few.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD copies of two editorials—one from the San Francisco Examiner of July 5, and one from the Washington Post of July 1.

There being no objection, the editorials were ordered to be printed in the RECORD, as follows:

[From the San Francisco (Calif.) Examiner, July 5, 1962]

MEDICARE ROAD TO REASON

The recent and excellent series by Jack Pickering, Hearst headline service medical writer, on health systems operating in six European countries, points to these conclusions:

In the immensely complicated problem of providing medical care for the aged, people of low income and other categories, no nation has produced a plan which can be considered "final" or a model for the United States to follow.

Yet there is a basic recognition of the need in one form or another of government-supported health plans. In brief the nations visited by Mr. Pickering are engaged in trying to work things out through the ageless human formula of trial, error, experience and reason.

It seems to us inevitable that we shall have to try to work things out on that formula in our country, too.

It is in this connection that we welcome the move now underway in the Senate to remove the consideration of medical care for the aged from the frozen postures of partisanship and into the area of reasonable study and debate.

To this end the bipartisan compromise supported by 5 Republicans and 18 Democrats is a distinct service.

The compromise would retain the social security financing feature of the administration's bill but would extend health insurance coverage to most older persons not eligible for social security or other Federal retirement benefits. It would modify the compulsory aspects of the administration measure by offering an option plan to those not wanting health coverage under social security, and it would permit private insurance plans to be used as administrators of the Government program.

We are not at this time coming out in support of any particular plan. The complexities and implications need a great deal of thought by all of us.

But we are, as always, in support of an approach by reason to a massive problem like this, which is what the Senate compromise attempts. Frozen postures are a disservice to everyone, including the millions of Americans directly affected.

[From the Washington Post, July 1, 1962]

MEDICAL BREAKTHROUGH

There is room for qualified rejoicing over the new bill to provide medical care for the aged introduced in the Senate on Friday by 23 sponsors. It does the bill a disservice to call it a compromise; it is an improvement on the old version. And there is something really hopeful in the fact that it has the support not only of administration leaders but of five distinguished Republican Senators as well.

The Republican support comes from THOMAS KUCHEL, the Republican whip, and Senators JAVITS, KEATING, CASE, and COOPER. Although these men are progressive Republicans, who have already accepted the principal of social security financing for the medical care program, they are also men who have been articulately critical of the administration measure. That they and the Democratic sponsors of the program were able to adjust differences and join hands in a common proposal reflects the best sort of legislative accommodation and suggests a real determination on both sides to eschew political jockeying and find a practical solution for an urgent national problem.

The changes in the bill are all commendable. It will now include persons over 65 who are not covered by social security; it would be unwise as well as unjust to leave them out of the program. It provides that accreditation of hospitals furnishing services under the program be determined by the American Hospital Association and the American Medical Association; this should insure high standards, and perhaps it will in some measure mitigate the hostility of doctors. It will allow Blue Cross or other private insurance plans to deal with the hospitals in supervising administration of the program and it will give beneficiaries an "option" to continue private health insurance protection. In addition, it will adopt Gov. Nelson Rockefeller's idea of creating a separate "health insurance trust fund" instead of lumping medical care money in with other social security accounts. We see no harm in these changes.

The Senate is to debate the medical care program this week. We hope it will be an enlightening debate which will set at rest some of the hobgoblins raised by the American Medical Association. If the Senate passes the bill, it must go to the House where hopes for its adoption are far from high. Representative WILBUR MILLS, the redoubtable chairman of the House Ways and Means Committee, is against it and so there is little hope that it will be reported out by that body. If Senatorial strategists try tacking it on to the general welfare reform bill as an amendment, it will have to go to the House Rules Committee where its chances do not seem much brighter. Nevertheless, let us rejoice that it is on its way.

Mr. KUCHEL. Mr. President, I also ask unanimous consent to have printed in the RECORD at the conclusion of these remarks, a few communications of the many thousands I have received from citizens of my State, including members of the medical profession, urging that Congress pass what some of us have now agreed upon.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. KUCHEL. Mr. President, a number of months ago I received a thoughtful letter from a constituent of mine—a retired schoolteacher who is in her

seventies. Her husband is a retired Federal employee, and is several years her senior. She told me that they are able to pay their bills fairly well, provided they watch their nickels and their dimes. They live in a small home in a suburb of Los Angeles. They live in dignity, American style. They have no social security. They get along on the income from the savings of a long lifetime. They are happy about it. They ask no favors. They are, I think, a typical elderly American family. In her letter to me she raised the following question:

When one of us goes to the hospital, as surely one of us ultimately will, and if the stay at the hospital is prolonged, as it well may be, we will pay the bills by dissipating our small estate, such as it is, in whole or in part; but we will do it even if it means mortgaging our home. But when the time comes for one of us to be a survivor, then, Senator, both of us are plagued and frightened and bewildered at whether or not the survivor can live out his or her lifespan in dignity or whether he or she will be deemed an indigent and a public charge, with no estate, no home, and no income. Please, Senator, work for some kind of legislation under which with pride and with dignity and with honor, an American citizen over age 65 who cannot afford to pay the costs of expensive hospitalization may receive some basis of insurance which will help assuage the pain to a family which so suffers.

That dear lady, whom I have never seen, wrote:

Senator, please do not turn your back on this dreadfully important problem.

Mr. President, I will not turn my back on it; I pray the Senate will not turn its back on it, either.

EXHIBIT 1

MALIBU, CALIF.,
July 1, 1962.

Senator THOMAS H. KUCHEL,
Senate Office Building,
Washington, D.C.:

As Republican and physician I urge your support of King-Anderson bill. Many physicians unwilling to express self.

Sincerely yours,

FORREST ADAMS, M.D.

SAN FRANCISCO, CALIF.

Senator THOMAS H. KUCHEL,
Washington, D.C.

DEAR SENATOR KUCHEL: This is just to let you know that I'm proud to have you for my Senator and glad that AMA doesn't have you in their pocket. Your stand on the Anderson-Javits bill sounds good to me. Don't let them pressure you. Keep up the good work. Hope you're reelected.

Sincerely,

MARIE CARLBERG.

SAN FRANCISCO, CALIF.,
September 14, 1961.

Hon. THOMAS H. KUCHEL,
Washington, D.C.

DEAR MR. KUCHEL: I wish to thank you for your letter and for your support of medical bill for persons 65 years of age and over, whether or not the individual has been covered by the social security system. Mr. Bishop and I are past 70 years and are on a railroad pension, so it stands to reason, we do not have the wherewithal to cover medical bills.

Things are pretty bad when a doctor will not leave his office for a new patient, when the emergency ambulance must remove him and leave him lay for hours before being transferred to the general hospital, where he is looked over, but nothing done about it. The man being sent home at midnight, weak and without food, the man was my husband and needs attention. I haven't mentioned myself. I probably have a misplaced vertebra. The doctors charge a mighty big fee and medicine is so high, something must be done and that soon.

I am glad there are many that are for this bill and thank you and everyone for their fine efforts to help us.

Wishing you luck and best wishes, I am,

Sincerely,

Mrs. LOUISE BISHOP.

AUBURN, CALIF., *May 22, 1962.*

Senator KUCHEL,
Congress of the United States,
Washington, D.C.

DEAR SIR: I urge you to support in every way the King-Anderson bill.

As a nation we approve the principle of prepaid pensions. Why not then give approval to prepaid medical care?

Thousands of citizens, including myself, are currently buying hospital care through Blue Shield and other organizations, apparently to the satisfaction of all parties involved. Why not arrange for people to buy hospital care through a lifetime pay-in-advance plan?

I urge you to oppose the Kerr bill, one that provides benefits only for the needy. Why should thrifty taxpayers be denied benefits? Aren't they just as deserving? Must they be penalized for maintaining solvency? Let every man prepay his hospital expenses in the manner prescribed by the King-Anderson bill, and let every man enjoy equal benefits.

I am well aware of the stand of the AMA; the doctors seem to be hysterically fighting a bogey that they themselves have created.

It is time to pass the King-Anderson bill.

Very sincerely yours,

JAMES W. PARKINSON,
A Registered Republican, Age 51, and Not on Social Security.

PALO ALTO, CALIF.,
July 10, 1962.

The Honorable THOMAS H. KUCHEL,
U.S. Senate, Washington, D.C.

DEAR SENATOR: As physicians or those responsible for training physicians, we have carefully considered the problem of financing medical care for the aged and have come to the following conclusions:

1. The retired population of this country cannot meet the cost of necessary medical care from current income;

2. A mechanism whereby these costs are prepaid during the working years must be provided;

3. Private health insurance companies cannot meet this need on a national basis without Federal subsidy;

4. The social security approach provides the most effective means of meeting this need;

5. Of the several means of administering benefits suggested thus far, either administration by the social security office or by a nonprofit health insurance plan (such as Blue Cross) would be desirable.

We respectfully call to your attention the fact that the organized campaign against the King-Anderson bill does not represent the views of many physicians. We the undersigned physicians and medical educators urge you to press for enactment this session of the King-Anderson bill or similar legislation embodying the social security principle.

Sumner J. Yaffee, M.D.; Thomas R. Walters, M.D.; Norman Kretchmer, M.D.; Robert Greenberg, M.D.; Irwin A. Schafer, M.D.; Luigi Luzzatti, M.D.; William B. Robertson, M.D., Ph. D.; Gordon Williams, M.D.; Norman J. Sissman, M.D.; David S. Hogness, Ph. D.; Paul Berg, M.D.; I. R. Lehman, Ph. D.; Elijah Adams, M.D.; Lewis Aronow, Ph. D.; Sumner M. Kalman, M.D.; George Feigen, Ph. D.; Sidney Raffel, M.D.; A. Kent Christensen, Ph. D.; Hadley Kirkman, Ph. D.; F. Thomas Algard, Ph. D.; Stanley H. Weitzman, M.D.; Anthony Iannone, M.D.; Jose C. Montero, M.D.; Joseph P. Kriss, M.D.; Herbert L. Abrams, M.D.; Leon Rosenberg, Ph. D.; Nancy Keller; Mary Ann Esser; Philip Sunshine, M.D.; Frank Morrell, M.D.; Arthur Kornberg, M.D.; Karl H. Muench, M.D.; H.V. Aposhian, Ph. D.; Tag E. Mansour, Ph. D.; John D. Gabourel, Ph. D.; Geronimo Terres, Ph. D.; Carlton Schwerdt, Ph. D.; Donald L. Stilwell, Jr., Ph. D.; Frederic L. Eldridge, M.D.; Joshua Lederberg, Ph. D.; Leonard A. Herzenberg, Ph. D.; Daniel J. Feldman, M.D.; Malcolm A. Bagshaw, M.D.; Saul Rosenberg, M.D.; Armin D. Kaiser, Ph. D.; David Glick, Ph. D.; Lelland Rather, M.D.; Kariman Wasserman, M.D.; Raymond Kivel, M.D.; Halsted Holman, M.D.; Leslie M. Zatz, M.D.

TORRANCE, CALIF., *May 23, 1962.*

DEAR SENATOR KUCHEL: After having read the various materials, watched the TV appeals of both President Kennedy and the AMA spokesman on the King-Anderson bill. I, a registered Republican and registered nurse in the State of California, urge the passage of this bill in its present form.

In this bill I see no threat of socialized medicine, no threat to the doctor-patient relationship, no unjust burden to the wage earner and no threat to the freedom and individuality of the citizen.

Sincerely,

Mrs. JEANNE WILDER,
Registered Nurse.

MILLER, SWIDE & CASEY,
ATTORNEYS AT LAW,
Whittier, Calif., May 7, 1962.

Hon. THOMAS H. KUCHEL,
Senate Office Building,
Washington, D.C.

DEAR SIR: In the general practice of law one sees a multitude of problems, and the problem of medical help for the aged is a frequent one.

I have never had much of an opinion one way or another on this problem simply because of my lethargy, I suppose, and, secondly, governmental solution has always been a last resort in my opinion, and I have secretly hoped that the medical and related professions would solve the problem themselves. I have seen too many instances of real financial hardship caused by serious medical problems in an aged family or a family with aged parents. The resultant financial and social problems caused by the illnesses are quite disruptive to these aged people and their families. Some help must be given them.

Undoubtedly, there are many costs which are prohibitive and inherent in long term medical care and they can only be handled by Government subsidies, and we have reached that stage in our development and

this is a necessary thing. I know that the present bill for the aged before Congress under social security is inadequate, but perhaps it is the best we can do at this time, and I urge you to consider voting for it, and hope that future extensions can be made from time to time.

I don't know the attitude of my partners on this matter, and this letter expresses only my personal opinion.

Very truly yours,

FRED A. SWIDE.

STOCKTON, CALIF.,
June 14, 1962.

Hon. THOMAS KUCHEL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR: I represent one of the small percentage of physicians who is not opposed to the King-Anderson bill. I have studied all the proposals carefully and realize its main deficiency (that is, not complete coverage for those over 65 who are not on social security and including those who are but do not need this assistance); however, I feel that it is still direly needed to aid the vast majority of our oldsters who cannot afford catastrophic illness costs. The Kerr-Mills bill is certainly fine, but how many realize that it is a 30-day deductible in this State, and 30 days of hospitalization can now cost $5,000. Many of my colleagues do not understand this and have only allowed themselves to believe what the AMA tells them. Therefore, I urge you, as a representative of this State, to carefully weigh all true facts before voting against the King-Anderson bill.

HAROLD L. BERKMAN, M.D.

ORANGE, CALIF.,
May 22, 1962.

Hon. THOMAS KUCHEL,
U.S. Senator, Washington, D.C.

MY DEAR SENATOR KUCHEL: I read your article in today's Times, "Kuchel Sees Passage of Medicare Plan," and find that I am in quite full agreement with you. If I had to support any one plan is presented today I would support the King-Anderson bill for the great majority of we citizens are today "paid members" of the social security having paid our annual tax into the social security fund until retired. The majority of us have no adequate protection against long-term illness or unusual surgery; neither have we any present organization through which we can bring our influence to bear to protect ourselves against excessive rates or charges for hospitalization or for excessive medical-surgery fees. I see no effort from the hospital organizations to do this job; neither do I see the AMA, as an organization doing anything—other than individual doctors, or a small group of doctors, raising their voices in protest against present excessive hospital rates or against the excessive fees of some doctors. We paid members of social security need this, or some organization, to speak for us, represent us, not only to financially help us in longtime illness, etc., but to protect us against excessive hospitalization costs.

We elder citizens have no objection, or complaints, against the Kerr-Mills bills as the Government's way of discharging its responsibility to the "needy" paupers, citizens of this country. We do say that through it, the Governments puts a premium on being a pauper. It sustains the fact that if you are a pauper, the Government rushes to your aid and provides any and all medicare service and pays the bill; the rich can afford to buy and all medicare they need. Those of us in between get only what we can pay for or spend our reserves and then declare ourselves as paupers and then come in under the Kerr-Mills bill. The ethics of such is questionable. Now 75 percent of the voters are asking the Congress to do something reasonable and appropriate to meet our need and to solve our long-term illness problems. I agree with you that the Government should make an effort to also take care of those, not under social security, either by bringing them under social security or by a separate mechanism, but treating them fairly.

The Republican chairman of Orange tells me that Orange has done the best job, ever, this year. I feel the Republicans of precinct 12 plan to vote 100 percent. I secured absentee ballots for 2 women in hospitals and also for 2 women cripples; in all I helped to secure 10 absentee ballots, and we hope that this will bring the Republican vote to 100 percent in our precinct.

Again thanking you for your efforts.

Sincerely,

JOHN H. BRADLEY.

BERKELEY, CALIF.
July 5, 1962.

Hon. THOMAS KUCHEL,
Senate Office Building,
Washington, D.C.

DEAR SENATOR KUCHEL: Allow me to urge you to support the prepayment of medical care through a social security tax.

As a practicing physician I am acutely aware of the difficulty many a person has of meeting the cost of hospitalization; especially when retired and on a limited income.

I do not believe that the officials of the American Medical Association speak for a large proportion of the doctors they supposedly represent.

Sincerely yours,

J. M. STRATTON, M.D.

LOS ANGELES, CALIF.
May 21, 1962.

DEAR SENATOR KUCHEL: I am in favor of President Kennedy's medicare program. I have just had a $2,000 hospital bill, am alone and on very small social security. It has taken all of my savings for hospital, doctor, operation $600, and medicine, etc. It was a fractured hip. I was in orthopedic hospital 39 days.

Please vote to pass this badly needed legislation.

Yours very truly,

Miss HOLDIS GELMS.

MENLO PARK, CALIF.,
May 26, 1961.

Senator THOMAS KUCHEL,
Senate Office Building,
Washington, D.C.

DEAR SENATOR KUCHEL: Now that I understand the King-Anderson bill my name may be added to the list of physicians favoring this legislation. I sincerely hope that you will vote for it.

Yours,

KARL H. MUENCH, M.D.

BERKELEY, CALIF,
June 30, 1962.

DEAR SENATOR KUCHEL: I appreciate the stand you have taken on the King-Anderson bill in spite of the AMA. We need men like you who stand by their convictions despite power groups. I hope you will continue to support the bill.

Sincerely,

JUNE RUMERY.

HOLLYWOOD, CALIF.,
May 23, 1962.

Senator THOMAS H. KUCHEL,
Washington, D.C.

MY DEAR SENATOR KUCHEL: I am familiar with and much interested in the King-Anderson bill for medicare. I have been a registered nurse for many years and have been in contact with hundreds of people, patients, most of them in the higher age groups. I have observed the anxieties of many and have also had many patients confide in me indicating their fears of hospital and medical expenses in general. I also happen to know people who cannot go into the hospital although they are in need of attention because they do not have funds or insurance.

Did you know that a part of the Los Angeles County Hospital was closed off this year and may still be for the lack of personnel?

I am sure that you are aware just as I am that more people are sick, some with very serious illnesses and cannot be cared for properly because of lack of hospital facilities. The free clinics which are few in comparison with the needs can only solve part of the problem. I for one would not want to ask for charity and still the private insurance policy which I carry would only serve me partially, although the premium that I am paying is quite large.

I strongly urge you to consider this bill from a humanitarian need rather than from any other aspect and hope you will think about it seriously.

Thanking you for your attention in this matter, I remain,

Sincerely,

ROSE G. AMELL,
Registered Nurse.

SAN RAFAEL, CALIF.,
June 28, 1962.

Hon. THOMAS KUCHEL,
U. S. Senate,
Washington, D.C.

DEAR SIR: I read in this morning's San Francisco Chronicle that California physicians are puttting pressure on you to drop support of old-age health care through social security. I hope you will withstand this effort on the part of organized medicine. There is such a need for this legislation with or without possible amendments. You are serving the best interests of your constituents if you help it to pass.

The high regard most people feel for their doctors is being harmed by AMA's violent and unreasonable cries about "socialized medicine" in this matter. It seems to be a callous attitude in the face of the need many old people have for medical care within their means.

My husband and I are in our early thirties and belong to the Kaiser Foundation health plan which we think is the ideal solution to our family needs and we will continue this. It is not self-interest which prompts this letter. I hope that you will not abandon the public need in the face of "the power of an aroused profession" which will perhaps appeal to your self-interest. We place our faith in your conscientious fulfillment of your duty to serve the American public. May your principles never waver.

Respectfully,

DIXIE MERTLE
Mrs. Robert Mertle.

AUBURN, CALIF.,
July 4, 1962.

The Honorable THOMAS H. KUCHEL,
The U.S. Senate,
Washington, D.C.

DEAR SENATOR KUCHEL: Because there has been so much pressure by the American Medical Association against a medical care plan for the aged under social security, I want you to know that not all medical families support the AMA stand.

My husband, a physician and expert (I think) on geriatrics, and I are convinced that people should be permitted to insure, and to assure their medical care during their retirement years under a plan such as the King-Anderson bill would provide. We believe that the broad base of a Federal plan is more equitable for all than the present inadequate matching-funds plan. We cannot understand the AMA's philosophy which permits its members to practice in hospitals built with Federal Hill-Burton funds, yet resists the idea of accepting fees for services

provided under a Federal program based on social security.

The aged in so-called poor States not participating in the Kerr-Mills plan need adequate medical care; also, the taxpayers in wealthy States need the protection of a broad-base plan. You know that ours is a mobile society, and large numbers of persons at retirement age move to States where the climate is kinder to them. A medical care plan based on Federal social security should permit the individual to carry his medical-care benefits with him as he moves from State to State, thus protecting a few States from having to assume an unequal burden of providing medical care to a large number of persons in their senior years.

In appraising the organized pressures against the King-Anderson bill, you may be interested to know the extremes to which the American Medical Association and one of its State medical societies went to oppose the Forand bill and the Kerr-Mills bill.

Each women's medical society auxiliary member in this area received a telephone call during the late spring 1960, from an auxiliary officer telling us to "immediately send telegrams to our two U.S. Senators, and to our Member of the House of Representatives telling you to vote against bill H.R. 4700, and all such bills." When I asked what bill H.R. 4700 was, the auxiliary officer said she didn't know. She was embarrassed to admit ignorance, and was only following orders from the California Medical Society president. You received no such message from me. This unexplained mandate from the organization, and my own conviction that the aged should be insured for their medical care under a Federal plan, resulted in my withdrawing membership from the auxiliary.

My husband and I feel that the majority of the aged persons in our country should have their medical needs provided for under a Federal plan available to them in whatever State they may live. I know that your ability and wisdom will serve the people of our Nation to their progressive and best needs when you are called upon to cast your vote.

Sincerely,

JOSEPHINE W. HIRSCH.
Mrs. Donald A. Hirsch.

REDDING, CALIF.,
June 28, 1962.

Hon. THOMAS KUCHEL,
Senate Office Building,
Washington, D.C.

DEAR SENATOR KUCHEL: I am desirous of informing you that many, repeat many, physicians are in full accord with your views of proposing a Senate bill similar to the King-Anderson bill.

Please be assured that we admire your careful and object analysis of the concept of medical care for the elder group of citizens and your courage to make up your mind and state your convictions is the mark of a mature statesman.

I sincerely regret that the AMA has seen fit to be critical of your judgment, but it reflects once again the extreme negativism of the organization.

Very truly yours,

LEE D. FULTON, M.D.

LOS ANGELES, CALIF.,
May 26, 1962.

The Honorable THOMAS KUCHEL,
U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR KUCHEL: Please, use your good influence and help pass the President's King-Anderson bill. I personally will not profit from it because I work for a board of education which does not have the social security system—but a pension plan.

As a professional nurse, who worked with doctors, hospitals and patients, I have this observation to make. I have seen both sides of the coin. The elderly wealthy have been and are properly cared for. While the self-respecting, middle-income group, in their time of illness, are suffering from the lack of medical and hospital care. From personal experience, I have known hospitals to gouge shamefully the people who are least able to pay the exorbitant hospital fees.

Please, please, in the name of decency, pass the King-Anderson bill.

Thank you.

Mrs. GERTRUDE HUMPHRIES,
Professional Nurse.

and improve the public assistance and child welfare services programs of the Social Security Act.

In the last amendment offered by the Senator from New Mexico [Mr. ANDERSON] and the Senator from New York [Mr. JAVITS] an option is given to beneficiaries either to enjoy the benefits of the Social Security Act directly, or in lieu thereof, to accept the policy of insurance equal in coverage to that contained in the general bill.

In the exercise of that option, the beneficiary must show that prior to his retirement he did carry health insurance. If he did not carry health insurance, he does not become eligible to the right to carry insurance in a private company.

My amendment contemplates the elimination of that condition, attached to the right to buy private insurance. The right to have private insurance paid for out of social security will be fully vested in the beneficiary without a showing that he was previously covered. I submit my amendment on the basis that I want the widest latitude vested not only in the medical profession, but also in the beneficiary, completely free from any implied or express control by the social security law. My amendment approves of all the provisions in the Anderson amendment as last submitted, except that it eliminates the provision that, in order to qualify for coverage under private insurance, the beneficiary must, previous to retirement, have been the holder of a policy in a private insurance company.

The PRESIDING OFFICER. The amendment will be received and printed, and will lie on the table.

Mr. THURMOND. Mr. President, the need for providing medical care for those who are unable to provide it for themselves is readily apparent. I share the concern that has been expressed as to the welfare of our elderly citizens. The recognition of this responsibility is one of the hallmarks of civilized society. I am certain that our elderly citizens realize, as should we all, that the primary responsibility for providing adequate medical care falls upon the affected individual. However, circumstances may be such that a person cannot provide for himself, regardless of his preference to do so. In this eventuality, the responsibility is spread among others in a more or less well-established pattern. Both as a matter of historic precedent and moral obligation, an individual's family assumes secondary responsibility for providing his needs. Should this solution not be available, the many charitable organizations in the community created specifically in recognition of this and similar needs should be called upon. A governmental entity must, in any and every instance, be a last resort, and the vestiges or responsibility are in ascending order from the local unit to the State government. Placing the primary obligation on a governmental unit is misplacing responsibility.

Today it seems to be passé to weigh proposals which come before Congress on the scales of the Constitution. To do so in this instance, however, reveals a lack of constitutional basis for this proposal. Our Constitution established a federal system of government, with a division of powers between the States on one hand and the Central Government on the other. The Central—or National—Government was delegated certain specific realms of authority and responsibility in the Constitution. The State governments, rather than having powers delegated to them, reserved to themselves all powers not specifically delegated to the Central Government and limited the exercise of some of the powers which they retained. Providing medical care for the aged is not numbered among the specific grants of power to the Central Government, nor is it one of the limitations put upon the States. Therefore, Mr. President, any governmental responsibility for providing medical care for the aged rests with the State or local governments and not with the Central Government in Washington. To be sure, many of the measures which have passed Congress in recent years violate this concept of the division of powers. This is not a persuasive argument in justification of a further violation in this instance. If the National Government is to provide medical care for the aged, then an appropriate amendment must be added to the Constitution to delegate such authority to the Central Government.

Many States or political subdivisions thereof, or both, have provided some program offering medical assistance for those in need. My own State of South Carolina has a program which provides medical care for those unable to provide it for themselves. The majority of the individual State programs are based on actual need, as is the case in the Kerr-Mills law. This, of course, is the prerogative of the States and I heartily commend those who have responded to the need. If the medical assistance provided under the State programs proves insufficient, then the proper recourse is to the State government and not the National Government. In each instance the funds necessary to operate the programs would come from the people, but there would be a greater percentage of return under a State program.

Mr. President, another objectionable feature of this proposed program, which we are now considering, is its compulsory nature. All persons who are currently covered under the old-age and survivors insurance program would be required to participate regardless of their need or inclination. It is estimated that upon the effective date of this program, persons of age 65 or over will number approximately 17½ million. Of this total, only 2½ or 3 million will not be covered by some form of governmentally provided medical assistance. To compensate for this, these noncovered individuals will be provided with the same health benefits as those who have over the years contributed to either the social security fund or the railroad retirement program. Thus all individuals over 65 years of age will have provided for them the same medical benefits, with no regard to either a means or needs test. This, I submit, is not the proper way to provide medical assistance for those who are truly in need. Why should a millionaire be re-

---

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. LAUSCHE. Mr. President, I send to the desk an amendment to the amendments proposed by the Senator from New Mexico [Mr. ANDERSON], as modified by the Senator from New Mexico on July 12, 1962, to the bill (H.R. 10606), to extend

quired to participate in this program and get benefits when he has no actual need of assistance?

Statistics relating to the increase in the population of citizens over 65 years of age can be used in a misleading fashion. It is true that the aged constitute slightly more than 9 percent of our population, as compared with only 4 percent at the turn of the century.

The life expectancy of a child born in 1900 was 47 years as compared with 70 years today. Much of this rise can be attributed to medical advances, both in new drugs and in expanded welfare services. However, there are several other contributing factors such as the baby booms experienced after the War Between the States and World War I, much the same as that experienced after World War II. The increase in the aged segment of our population does not necessarily assure an increase in the ranks of those truly in need of assistance. The increase in the productive and useful portion of a person's life has been in proportion to his increased longevity. Nevertheless, this proposal assumes that all individuals over age 65 are unable to provide adequate medical care for themselves. This is an assumption based neither upon fact nor logic. It completely ignores any test based upon the economic situation of the individual, the so-called means test. Likewise, there is no prescribed formula for testing the medical needs of any individual who qualifies for medical assistance under this program. This feature makes it almost inevitable that malingerers and hypochondriacs will benefit to the detriment of those truly in need of medical care.

This proposal for providing a minimum of hospital and nursing-home care is the harbinger of the attempts which will be forthcoming to socialize this segment of our society. It is inevitable that with every acceptance of so-called Federal aid, the American people yield a bit more of their local independence. The measure of self-reliance which was handed out in the original distribution of human virtues will be shrunk, as people depend more and more upon Government paternalism. Assurances have been given that this program will not lead to socialized medicine. A cursory examination of past occurrences leads me to believe otherwise. If a program which has been passed by Congress is proved to be ineffective and unsuccessful, past experiences prove that the Congress seeks the solution in the expansion of the program, rather than in its curtailment or termination.

Mr. President, some people fail to realize the implications of socialism, or programs which lean toward socialism. First of all, there is no room within the bounds of the Constitution for adopting socialist welfare programs. Furthermore, such programs are detrimental to our national well being. The assertion is frequently made that the United States is inexcusably lagging behind in social progress, and is not keeping time to the march of history abroad, because it has not adopted compulsory health insurance under Government auspices. To refute this claim, it is necessary only to examine the compulsory health programs of other nations. In most countries which have such programs, compulsory health insurance began as a part of a social security package, just as is contemplated here.

Probably the best example—at least, the most well known—is the National Health Service in Great Britain. The cost of their program has been skyrocketing from its inception. In July of last year the tax for each worker was raised so that the tax per year per person is now approximately $78. Seventy-eight dollars in England buys much more than the same amount in the United States. Yet these individual taxes constitutes only about one-fifth of the total costs of the program. Over 80 percent of the costs come from general revenues. In the first full year of its operation in 1949–50, the National Health Service cost $1.2 billion; but for the fiscal year which ended in 1961, the program cost the British taxpayers $2.2 billion.

The financial side of the picture is bad enough, but dissatisfaction stems from many other defects as well. Not only are the doctors disgruntled, but the people complain, some very bitterly, about the lack of incentive shown by the doctors. The program spawns mediocrity or worse among doctors, and punishes the ambitious ones. The practice of medicine is a highly regarded profession. Socialized medicine has reduced doctors from a professional status to no more than tradesmen. Is this what we want in the United States?

The story is much the same in the other European countries having compulsory health insurance programs. More and more these countries must limit the first benefits to discourage those who take advantage of the system. The entire scheme seems to accentuate the negative side of some individuals and spotlight his weaknesses.

The advocates of this proposal characterize it as an actuarially sound program based on the principles of insurance Anyone familiar with the social security system after which this proposal is patterned knows the error of this statement Contrary to assertions, the OASDI program itself has not yet proved its financial soundness. Both political and inflationary forces repeatedly demand further increased benefits. To avoid complete fiscal irresponsibility, additional contributions must be required to meet the increases. This program is designed to operate successfully only in an ever expanding economy. Should our economy not respond to this need for expansion for only a short period of time, the situation could become crucial.

Contrary to the principles of true insurance, under this type of financing, the working, contributing generation are paying for the benefits presently being enjoyed by those who have already become eligible. This gives rise to the element of uncertainty as to whether the contributing class will be large enough to pay the benefits earned by the recipients. Over the past 10 years the benefit payments have been increasing steadily in relation to contributions. It is impossible to estimate accurately when benefit payments will exceed contributions, but this is an ever present danger. At that time either benefits must be cut or the tax increased.

The one safeguard which OASDI has, which this medicare program lacks, is the concept of fixed sum benefits. This is an additional complication in calculating the actuarial soundness of the medicare program. Many responsible and knowledgeable individuals have testified before the Ways and Means Committe as to the total cost of medicare. As a result, the taxable base was increased from $5,000, as it was when originally introduced, to $5,200. In view of the inflationary trend caused by deficit spending, it is apparent that the actual expenditures will far exceed what has been estimated. All these factors combined, make this an actuarially unsound proposal as it is presently constituted.

It seems apparent, Mr. President, that the proponents of this measure lightly regard the time-honored procedures of Congress. This measure, while providing for a substantial expenditure of funds, is fundamentally in the nature of a revenue raising measure. Article I, section 7, clause 1 of the Constitution says:

> All bills for raising revenue shall originate in the House of Representatives.

The King-Anderson bill, which was introduced early in the first session of the 87th Congress, is still in the Ways and Means Committee of that body. That is the proper committee, under the rules established by the House of Representatives, to first consider revenue raising measures. Extensive hearings have been held by that committee, and all the aspects of the proposed legislation have been considered. Neither the committee nor the House as a whole has acted on this measure. After having all the facts fully aired and with due regard to the problems involved, the members of the Ways and Means Committee show an understandable reluctance to approve this method as the solution to the problem. Their reluctance to act, in the face of mounting pressure, serves to illustrate the wisdom of the procedural system provided by the Constitution. There has been no evidence of need shown which is great enough to justify this total disregard for proper procedures.

This entire matter has focused a great deal of attention upon this body. The Senate Finance Committee has held no hearings, or otherwise considered this vast new program, which involves untold billions of dollars. The Finance Committee should be allowed to hold hearings on this proposal so that there can be a better understanding of the program before the Senate considers it. Unwarranted and hasty action, without proper committee consideration, can only detract from the stature of the Senate as the highest legislative body in the world. Furthermore, consideration of this measure by the Senate, prior to its approval by the Ways and Means Committee or

the House of Representatives, gives the appearance of preempting the jurisdiction of that body. The public thus gains the impression that the Senate is forcing the House of Representatives to consider a measure upon which they have been reluctant to act. This is an action unworthy of the Senate, and therefore, there can be no justification for the adoption of the pending proposal.

It is my sincere hope that the Anderson-Javits amendment will be killed.

Mr. ENGLE. Mr. President, the problem of establishing a satisfactory means of financing the health care costs of our older people has been discussed widely in this country for years and the discussion has been growing as rapidly as the problem.

The problem is also a challenge. And we as a Nation are worthy to maintain our role of leadership of the free world only so long as we are willing to accept and deal with such challenges. We cannot turn away from the situation of many of our senior citizens who are faced with crushing medical bills, nor can we shut our eyes to this problem—as some seem to suggest—and hope that it will somehow vanish. Many of us in this body have had firsthand experience with the high costs of medical care—all of us, I am sure, have had many letters from older people recounting their experiences when faced with high health costs. Nothing I have read or heard, in or out of this Chamber, could convince me that the problem that older people have in meeting these costs is going to vanish. If we as a Nation continue to make only half-hearted attempts at a solution, the situation will continue to grow more serious month by month. As President Kennedy said in his state of the Union message, last January, "No piece of unfinished business is more important or more urgent than the enactment under the social security system of health insurance for the aged."

No one can fail to be deeply concerned over the disastrous effects of the big health bills which our older citizens are only too often forced to bear. As a group, the aged can neither pay the costs of their illnesses nor are they able to pay the premiums that would be required for adequate protection under private insurance. And the evidence shows that inability to meet the high cost of medical care is not confined to just the older citizens who are very poor. Even those who are financially independent are haunted by the fear that a serious illness can wipe out a lifetime accumulation of savings, threaten the ownership of a home, place heavy financial burdens on their children, or finally, after a lifetime of independence, force them to resort to public or private charity.

I am convinced that the Federal Government must act without further delay to help our older people meet their health care costs. I am equally convinced that this help must be provided in a way that maintains the individual dignity of older people as well as their security. It is for these reasons that I have pledged my support for the proposed program of health insurance for the aged under social security.

The plan proposed by our distinguished colleague from New Mexico [Mr. ANDERSON], contemplates that the financing of basic health insurance protection for the aged through social security would be the keystone of a threefold structure of protection for the aged in meeting the cost of health care. First, basic health insurance protection would be afforded almost all older people through social security; second, the existence of a program of basic protection would encourage the development of additional protection through individual savings, private insurance, and employer benefit plans; and third, good medical assistance would become practicable in all States to help the relatively small group who would still need help with health costs not covered under the proposal.

It has frankly been very surprising to me that so much heat has been generated from a proposal that is so eminently conservative. The proposal would use a mechanism that has been a part of the daily lives of the American people for over a quarter of a century. There are few Government programs that have been so widely accepted and that have proved to be so effective, as has our social security system.

Since I was first elected to the Congress back in 1943, I have seen our old-age, survivors, and disability insurance program grow from a relatively limited one that covered only wage and salary workers in commerce and industry to a broadly based system that now covers more than 9 out of every 10 working Americans and their families. Over the years the benefit amounts have been considerably increased, and benefits for disabled workers and their families have been added. And the financing of the system has remained and will remain sound. Its financing has been watched over with scrupulous care by both the Congress and the executive branch. It has been studied by outside experts who make public reports that the system is sound.

The financing is built in and is planned into the indefinite future; the only fiscally responsible method. While the benefits provided are not large, social security has become the Nation's basic program for preventing dependency when the family income is cut off by the retirement, disablement, or death of the worker—a soundly developed program which now enables the great majority of the people of our country to face the future with confidence. But this protection cannot be complete unless a person who has reached retirement age can be assured of protection against the great remaining risk of devastating hospital and medical bills. This great remaining fear is a very real one to millions of our older people.

I have heard and read, as have all of us, hundreds of statistics about the number of aged, the number who go to hospitals each year, how long they stay and literally hundreds of other cold facts and figures surrounding this proposal. Such information has been available to this body and to all who are interested in this subject and they clearly show the need for this proposal. But I wonder if perhaps in our consideration of all these figures we may not tend to forget that we are dealing with individuals—millions of them to be sure—who have their own problems, their own worries for the future.

To demonstrate that we are dealing with real people and not just cold figures, let me read a few passages from letters that older people have written on this subject. One woman writes:

My husband is 82 and I am 70. During the past several months I was hospitalized for 3 weeks and am still under the doctor's care. We own our home and my husband and I receive from social security and other pensions $271 per month which would take care of us pretty well if it had not been for hospital and doctor bills.

We have just about depleted our savings, but do not want to call on our children for help or go on welfare. We gave our four children college educations, but feel that it would be better for them to help through paying a little more social security rather than pay our hospital and doctor bills.

A man writes about the experiences of his parents:

Father retired over 2 years ago. He is now on social security and would live comfortably except for some misfortune which turned up. When he retired he automatically lost his good hospital and surgical coverage with a reputable company. To overcome this my parents took out a policy with a supposedly reputable concern and were high-pressured into paying a lot of money for this policy. Eight months ago mother took sick and expenses amounted to over $1,200. The insurance carrier claimed that this coverage was not included in the policy and simply refunded the premiums on the part covering mother and in plain English kicked her out of the policy. A few months later my father took sick with an ulcer condition and the policy paid about the quota which the schedule called for. Now yesterday we received a notice that nothing further would be paid for this type of sickness and that it would be eliminated from the policy. There isn't much left now, is there?

Of course, young people are very much interested in this proposal, too. A young man writes:

I am 29 years old. But I am more than willing to advocate a program of medical care for the aged. The following story, probably but one of thousands, will help to explain my feeling. "Because of a $119 unpaid bill, a physician refused a hemorrhaging old man as his patient. Unable to work for over 10 years due to complications of an incurable cancer, this man spent months of his time in hospitals. Twice he traveled to Mayos. But there was no cure. His savings from a lifetime as a machinist are exhausted. An "uncancelable" hospitalization policy from a prominent Nebraska firm was long ago withdrawn; in bed, and without acquaintance with legal resources, no protest was made. Because he has clung to his last security of any kind—title to his small house—he is not entitled to county medical aid. So he suffers, eating aspirins to ward off pain—awaiting death.

In the greatest, most advanced civilization of history, he has no medical care. It is both ironic and tragic. What greater incongruity could be conceived?

That is why I favor a social security medical plan for the aged, and that is why I am willing to help pay for it throughout my working lifetime.

I could, of course, go on with many more examples like these. But I think

I have made my point. When we hear about 17 or 18 million people who would get health benefits under this proposal let us not forget that these millions of people are watching what we do here. They are watching to see how we will meet a problem which is immediate and of immense concern to millions of people, old and young alike.

The PRESIDING OFFICER (Mr. HICKEY in the chair). The question is on agreeing to the amendment.

Mr. MANSFIELD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. PASTORE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. KERR. Mr. President, I rise to speak in opposition to the pending amendment. If I knew exactly how to identify it, I would do so. Since I cannot do so exactly, I shall identify the proposal now before the Senate as the Anderson-Javits amendment. I would be more particular if I knew how to be. But since the sponsors of the amendment themselves have said a number of times on the floor of the Senate that they do not yet know in what form it will be when the motion to table the amendment is made tomorrow, Senators can understand why I cannot address myself to it more pointedly or with a better designation of what it would or would not do. However, there are certain things about which I do know and I shall address myself to those items.

First, it is not a medicare bill. Whatever else may be said about the Anderson-Javits amendments, they would not provide medical care to anyone.

In fact, it does not provide anything until 1964 except an increase in taxes.

What I fail to understand is the great urgency which the sponsors of the legislation feel, and the great necessity for taking it up on the floor of the Senate without its having been cleared by the Ways and Means Committee of the House or the Committee on Finance of the Senate, when the benefits to be provided by it, if enacted, would be available to no one until 1964.

As I contemplate the fact of what it does not provide, I wish to say that no one in the Senate has been more eloquent or more pointed in his criticism of legislation of this kind than the distinguished senior Senator from New York [Mr. JAVITS] himself.

The Senator from New York appeared before the Committee on Finance in June 1960, and he placed in the RECORD a report of the seminar which he had conducted at the College of Physicians & Surgeons in New York City on March 12, 1960. In that statement he said:

> This seminar, Mr. Chairman, was a galaxy of the leading experts on geriatrics in our part of the country and from other parts of the country, and the consensus was that the most important single kind of service which could be given to those over 65 was physician's service.

I wonder where the author of that statement is today, as he advocates legislation which does not do that which he, himself, in 1960 said constituted the most important single kind of service which could be given to those over 65; namely, physicians' services.

He said that "it was a great mistake to make them go to a hospital in order to get the benefits of the health plan, for two reasons: First, you would overtax facilities; and second, it was not good for the older people themselves. There had to be a great concentration upon physician's care, and that" he said, "is what our plans seeks to do."

That was his plan in 1960.

He went on to say:

> Now, to conclude, Mr. Chairman, the social security approach to medical care for the aged presents the serious problem, as we see it, of providing mainly benefits and hospitalization and surgery rather than of adequate physician's care despite the fact, as I said, that as people grow older they need more care from the doctor.

There is this further difference between what the amendment advocated by the Senator from New York in 1960, would have done and what would be provided by the amendment he advocates today. There is no surgeons' care provided for under the amendment now before the Senate. On August 20, 1960, in the CONGRESSIONAL RECORD at page 15715, the Senator from New York said:

> The amendment which I have just now had printed is the only one before us which places the emphasis where it belongs; namely, on preventive care. I wish to emphasize that point; and I repeat that this is the only one which places the emphasis on medical care, which is where the emphasis belongs.

Yet today he is one of the champions on the floor of a plan which does not provide that which he himself so eloquently stated and oft repeated in 1960 as the most important service, the most important necessity for an adequate program for the aged.

In the debate on the floor of the Senate, as shown on page 15789 of the CONGRESSIONAL RECORD, I find a colloquy between the distinguished Senator from Pennsylvania [Mr. CLARK] and the Senator from New York [Mr. JAVITS], as follows:

> Mr. CLARK. I understand my friend's devotion and loyalty to the President of the United States, and I respect him for it, but I wonder if the Senator from New York, who is a realist in these matters, does not agree that the most practical way to provide health protection for older people is by the use of the contributory machinery of the social security system for insurance covering hospital bills and other health aids. Is not that the practical way to do it?
>
> Mr. JAVITS. I wish to state, in fairness to my colleagues in the Senate, the fundamental rationale which has animated me in the matter. I feel there is a very real and very important sociological question involved in extending the social security system to include medical care. I do not make these remarks in terms of "getting the camel's nose under the tent," but I make them very seriously. No matter what we may do now with respect to the Anderson amendment, with its very limited benefits schedule and very strict conditions about age—for example, age 68—this represents an important departure in national policy.

I wish to say in that regard that what the Anderson-Javits amendment today would provide is less than the Anderson amendment of 1960 would have provided; yet it costs more money than the argument presented by the advocates of the Anderson amendment in 1960 indicated that that amendment would cost.

The Senator from New York went on to say:

> We are opening up the social security system to a new concept, to a new purpose of health care, which I think puts us essentially in a national health scheme. It is bound to go further.

He said the other day, "We now provide what will be in this amendment when we have finally agreed upon what this language shall contain and"—I remind Senators that although the bill has been pending for some days, and although there is a unanimous-consent agreement to vote on a motion to table tomorrow at 3 o'clock, the sponsors do not yet know what the language in it will be come tomorrow afternoon at 3 o'clock.

There has not been a statement by the sponsors of the amendment that "This is it," that this is the form on which we will vote tomorrow whether to table it or not.

When I asked the Senator from New York the other day about the provisions in the amendment as now written being extended and expanded, he said, "This much now, and better things to follow."

How, I ask the sponsors of the amendment, are better things to follow? By what provision? To include what items? And at what cost?

The Senator from New York, in 1960, said:

Perhaps it will be extended to cover all social security recipients, whatever may be their ages.

That is the danger the Senator from New York saw in this amendment in 1960. Get the nose of the camel under the tent now, and later better things will follow. He said perhaps the proposal would be extended to all social security recipients, whatever may be their ages.

Then the Senator from New York said:

We are starting a system, a form of organization, a type of approach to medical care needs, which I think will take firm root as a new departure in American life.

These were statements made in 1960 in answer to a question by the Senator from Pennsylvania. The Senator from New York then said:

I think the social security approach will take us out of the mainstream of American life.

Mr. President, I wonder what there is about this scheme today—what is the magic ingredient—whereby that which would have taken us out of the mainstream of American life in 1960 is indispensable in 1962. I will tell Senators what I think the basis is. It is a political accommodation. The distinguished Senator from New York [Mr. JAVITS]—and I have a great affection and a great respect for him—said on the floor of the Senate the other day, "I have seen the light."

There must be a tremendous candlepower in the light that will attract so widely divergent opinions and objectives as those of the Senator from New York and the Senator from New Mexico [Mr. ANDERSON]. Would that I had the power to identify that light. What a power it would be; and—who knows—maybe once in a while for good.

This is what I thought of. I thought of the popular song; and if this were not such a serious matter and such a dignified environment—I hope the Senator from Michigan [Mr. MCNAMARA] will not leave the Chamber because I am not going to sing the song; I am only going to quote it [laughter]; although if I had musical talent, I would sing it, because I think it applies so dramatically to this situation:

I never cared much for moonlit skies;
I never winked back at fireflies;
But now that the stars are in your eyes
I'm beginning to see the light.

I never went in for afterglow
Or candlelight on the mistletoe
But now when you turn the lamp down low
I'm beginning to see the light.

Mr. President, can you not imagine the environment in which the Senator from New Mexico and the Senator from New York saw the light? Was that not a mystic moment in the political careers of those two great statesmen, when each had been at such variance and at such odds, and between whose positions there had been an insurmountable gulf such as would have dwarfed the gulf of burning fire between Dives, when he lifted up his eyes, being tormented, and looked out yonder and saw Lazarus in Abraham's bosom? What a chasm was eliminated when these two men began to see the light.

I used to ramble through the park
Shadowboxing in the dark
Then you came and caused the spark
That's a four-alarm fire now.

I never made love by lantern shine
I never saw rainbows in my wine
But now that your lips are burning mine
I'm beginning to see the light.

Mr. SALTONSTALL. Mr. President, will the Senator from Oklahoma yield for a question?

Mr. KERR. This is a very appropriate moment. I yield.

Mr. SALTONSTALL. I thank the Senator, because I have seen the light while listening to him.

The Senator from Oklahoma has been talking about getting this program into social security. If it goes into social security, is it the opinion of the Senator that it will ever get out; that it can ever be put back on a voluntary basis?

Mr. KERR. The Senator from Massachusetts has touched an important point, a significant point. We can win this battle every year for 20 years; but once it is lost, we will have lost the war. Not only is it true that if this system is ever fastened on to the American people through the social security tax approach will it never be released, nor will they ever be freed from it; it will grow, it will expand, it will increase. As the Senator from New York said on the floor of the Senate in 1960, as I read his statement a little while ago, the system will start here and go there. It will expand and, as the Senator from New York said the other day in answer to the Senator from Oklahoma, there will be better things to follow.

Mr. SALTONSTALL. Mr. President, will the Senator yield for another question?

Mr. KERR. I yield.

Mr. SALTONSTALL. Is it not true that if this system were put under social security, in a very few years—I think by 1970—the tax would rise to more than 9¼ percent?

Mr. KERR. It would go far beyond that. The distinguished former Secretary of Health, Education, and Welfare, Mr. Ribicoff, on May 26, 1961, was asked how far this tax would go. He said then:

I would certainly be reluctant, personally, to come in and make recommendations that will take as much above 10 percent eventually under existing law.

In 1968 and thereafter, the tax will be 9¼ percent on a maximum of $4,800. Under the proposed amendment, it will be 9¾ percent on a maximum of $5,200.

Mr. SALTONSTALL. That is, by 1970?

Mr. KERR. By 1968. But even that will not even begin to provide the money to pay for the provisions of the Anderson-Javits amendment.

Mr. SALTONSTALL. Mr. President, will the Senator from Oklahoma further yield?

Mr. KERR. I yield.

Mr. SALTONSTALL. If I correctly read the chart in the rear of the Chamber, the young worker will not begin to receive full benefits in any event, will he?

Mr. KERR. According to the statement on the chart and on the basis of figures supplied by statisticians in the Department of Health, Education, and Welfare, the youngest worker paying a social security tax in 1964 will not, when he retires at age 65, have the benefit of a health care fund that will be actuarially sound to pay his benefits without the continuing contributions of younger generations of workers.

Mr. SALTONSTALL. Mr. President, will the Senator from Oklahoma yield?

The PRESIDING OFFICER (Mr. Pell in the chair). Does the Senator from Oklahoma yield to the Senator from Massachusetts?

Mr. KERR. I yield.

Mr. SALTONSTALL. If it is placed on an appropriation basis—as I advocated the other day—and on a voluntary basis, then, every year, Congress will have the responsibility of determining whether enough money is available to pay the expenses, and to make the proper appropriations, or Congress can change the act so that the program will not get out of hand. Is that correct?

Mr. KERR. The Senator is entirely correct. If it is left up to a program, the specifications of which are written by the Congress and with the required appropriations made by the Congress, Congress will, every year, examine the program and will determine the extent to which the needs are being met and will determine the amount of money required in order to meet them; and thus Congress will have complete control.

But under this amendment, the program will go beyond the power of the Congress to control; and I challenge any Member of the Senate to read the grants of authority contained in this amendment to the Secretary of Health, Education, and Welfare, which he would be able to exercise without congressional review, and not wake up in the night in a cold sweat and with a recurring fear as he contemplates the monstrous program of control which this amendment vests in the Secretary of Health, Education, and Welfare for this money, this operation, and this program on a basis that Congress will have no further control except by means of remedial legislation.

Mr. SALTONSTALL. Mr. President, will the Senator from Oklahoma yield again to me?

Mr. KERR. I yield.

Mr. SALTONSTALL. If there is remedial legislation, it must be introduced and passed by both Houses and signed by the President, before it can become law; and in that way Congress can change the program. But if there is to be an annual appropriation, Congress can, in connection with making the appropriation each year, decide how much money will go into this form of governmental service; and if Congress does not approve what is being done, Congress can change it by reducing the appropriation.

Mr. KERR. Yes, in that way Congress has absolute and continuing annual review and control; the Senator

from Massachusetts is eminently correct.

Mr. SALTONSTALL. Mr. President, will the Senator from Oklahoma yield further?

Mr. KERR. I yield.

Mr. SALTONSTALL. If the social security system were applied, all we would be able to do—and I know this as one who has served for a number of years on the Appropriations Committee—would be to receive a report from the governmental agency concerned with what was going on; but Congress would have no power to make a change. Congress would only have the power or the right to receive that report. Is that correct?

Mr. KERR. That is correct.

Mr. SALTONSTALL. I thank the Senator from Oklahoma.

Mr. KERR. And I thank the Senator from Massachusetts for his contribution.

Mr. President, there is another Senator who has seen the light; that is my good friend, the Senator from Minnesota [Mr. HUMPHREY]. I should like to state that the extent to which he has seen the light has brought about a reformation, political and philosophical, the like of which I have never seen before. Today there is great hue and cry in the country, by some, "Let us have a tax cut, to give a stimulus to the economy." Mr. President, I wish to state that every day I am interviewed by a new expert, who comes to my office to tell me just what program of tax reduction is necessary if we are to avoid a recession and if we are to provide a foundation for the continued expansion and growth of our economy. The distinguished Senator from Minnesota [Mr. HUMPHREY] has been among those who have spoken the loudest and the most vigorously in favor of the making of a tax cut. He wants a reduction of the taxes on the average wage earner, so that the wage earners will have greater purchasing power and thus will give greater stimulus to the economy. But the Senator from Minnesota has seen the light; he is now advocating a bill which will increase the taxes on the wage earners, without giving them any benefit from that. The Anderson-Javits amendment would increase taxes $2 billion for 1964.

Mr. ANDERSON. Will the Senator from Oklahoma explain how?

Mr. KERR. Yes. There would be an additional tax of one-half of 1 percent on the first $5,200 of wages of every worker, to be paid half by the worker and half by the employer; and there would be an additional 7¾-percent tax on the differential between $4,800 and $5,200, to be paid by every worker and by his employer, 50–50; but three-fourths of it is to be paid entirely by the self-employed; and that one-half of 1 percent will increase the taxes $1,400 million. The Senator knows that under existing law the social security tax applies to the first $4,800 of a worker's income. Under existing law that rate will increase to 7¼ percent on January 1. But under the amendment of the Senator from New Mexico and the Senator from New York and other Senators, that rate, plus the one-half of 1 percent, making a total of 7¾ percent, would be applicable to the first $5,200 of the worker's income, payable half by the employer and half by the employee; but three-fourths of the 7¾ percent would be payable entirely by the self-employed; and that 7¼ percent of the $400 differential represents a tax increase of $810 million; and the total of the two, which would begin January 1, 1964, is $2,200 million a year.

Mr. ANDERSON. Will the Senator from Oklahoma agree that part of that is for old-age insurance?

Mr. KERR. Yes; of the $810 million increased tax on the $400 differential, I believe $390 million goes into the OASDI trust fund, and $420 million goes into the health fund; but the tax increase is in the Senator's bill—a tax increase, Mr. President, when across the Nation leading authorities of a certain classification of thinking and of economic position are saying that what the country must have is a tax reduction; and the Senator from Minnesota [Mr. HUMPHREY] has the most vigorous voice I have heard in favoring it. I want him to go back to the Iron Range in Minnesota, where only about 60 percent of the people are partially or fully employed, and explain to them how it was that he fought all year for a tax reduction, and then wound up by increasing the taxes on their payrolls—on themselves and on their employers. I want him to go back to his farmers—and I want this to be done by any other Senators who support this amendment—and tell them that, too. And I want to say to my great friend, the Senator from New Mexico—and there is no man in the Senate whom I love or respect more highly, or who I think has been more devoted to the welfare of the American farmers—to go back to New Mexico and explain to his farmers how it was that he wanted to increase their taxes by three-fourths of 7¾ percent on the differential between $4,800 and $5,200 and to add one-half of 1 percent on all of it, at a time when most men agree that if there is to be a change in the tax structure, it should be a reduction, instead of an increase. I wonder if it is because he has begun to see the light. And what a magnifying light that must be.

The Senator from North Dakota is sponsoring a bill supposedly to provide nursing home care, and there is not one nursing home in North Dakota that can qualify under this bill—not one. I want him to go back to his people and to his farmers in justification for his voting to increase their taxes by three-fourths of 7¾ percent on the differential between $4,800 and $5,200, and one-half of 1 percent on all of it, for a benefit they could not receive and stay in that State.

One of the great Senators from Utah is sponsoring this legislation, supposedly to provide nursing home care, and there is one, with less than 100 beds, in the State of Utah that can qualify under this bill.

Mr. CURTIS. Mr. President, will the Senator yield?

Mr. KERR. I yield to the Senator from Nebraska.

Mr. CURTIS. Will the Senator tell us what the tax increase in dollars would be for an employee making $5,200 the first year of the operation of this program?

Mr. KERR. If that is the information the Senator from Nebraska asks, if it is an arithmetical exercise he is engaging in, I shall ask a little help from my expert.

Mr. ANDERSON. It is $27.50.

Mr. KERR. The increased cost is $26——

Mr. ANDERSON. Twenty-seven dollars and fifty cents.

Mr. KERR. Twenty-seven dollars and fifty cents?

Mr. ANDERSON. Yes.

Mr. KERR. That is approximately correct.

Mr. CURTIS. That is on the first dollar of earnings. There is no personal or family exemption. Is that correct?

Mr. KERR. There is no exemption.

Mr. CURTIS. A year or two ago there was a debate on the floor of the Senate which started with the idea of raising the personal exemption from its present $600 to $700. That effort was abandoned, because it has a rather cumulative effect when it goes into the high brackets, and the proposal was a reduction in everybody's taxes of $20. I want to point out that this $26 or $27.50—whichever it is—is more——

Mr. KERR. Is more than 33 percent more.

Mr. CURTIS. Than the effect of raising the personal exemption $100 in the lowest bracket.

Mr. KERR. The Senator is correct.

Mr. CURTIS. It would be 1½ times that on the self-employed.

Mr. KERR. The Senator is correct—$27.50, $13.25, $40.75.

Mr. President, there is no medical care provided in this bill. "Oh, but," it is said, "we have nursing home care."

Under the present law known as the Kerr-Mills bill, for want of a better designation, there are 20,000 nursing homes in this country available to the aged for whose care in those nursing homes, if the State implements the law, the Federal Government and the States will pay.

I said a while ago that the Senator from New Mexico has an amendment, proposed after he and the Senator from New York saw the light, that costs more and provides less than his amendment of 1960. In fact, under the King-Anderson bill, which he jointly sponsored with the distinguished Mr. KING of California, in the House, there would be 10,000 nursing homes in America qualified to care for the aged and getting the benefits of the bill as he wrote it. But after he saw the light, he offered the Senate an amendment with reference to which there are only 500 nursing homes in America that can qualify and to which the aged could be sent and nursing home benefits given to them.

What kind of a mockery is it, Mr. President, to say to 17 million aged Americans, "We are going to provide nursing home care for you and we passed a bill,"

and then they go looking for the nursing homes, and they find not one in their State?

I say to the Senator from New Mexico there is only one of them in his State where such nursing home care could be provided.

Mr. President, I remember a passage from the Scriptures, which I think applies to this situation. The Master was talking to the people, according to the seventh chapter of Matthew, and He said:

> What man is there of you, whom if his son ask for bread, will he give him a stone? Or if he ask a fish, will he give him a serpent?

Oh, they ask for nursing care, and they are offered this bill, and they cannot find nursing care with a microscope.

Mr. ANDERSON. Mr President, will the Senator yield?

Mr. KERR. I yield.

Mr. ANDERSON. I would not want the Senator to get off the point of seeing the light and not add a little bit to it. The Senator referred to the Senator from New York and the Senator from Minnesota. Would he not also include the Senator from Oklahoma [Mr. KERR]? I am referring to the fact that when the so-called Javits bill was before the Congress—and I refer to page 17176 of the CONGRESSIONAL RECORD for August 23, 1960—the Senator from Oklahoma voted "nay." Then on July 12, 1962, according to the CONGRESSIONAL RECORD at page 12475, this time when it was offered by the Senator from Massachusetts [Mr. SALTONSTALL]—the same bill identically, and identified as such—the Senator from Oklahoma saw the light and voted "yea." He saw the light.

Mr. KERR. The Senator from Oklahoma voted for the measure as a substitute for the Javits-Anderson bill.

Mr. ANDERSON. It was an amendment to the Anderson bill in 1960.

Mr. KERR. Yes; but the Senator from Oklahoma had a substitute in 1960 that was better than the Javits amendment, because it provided medical care to those who needed it.

Mr. ANDERSON. The Senator from Oklahoma did not have a substitute for the Anderson bill at that time. The Kerr amendment, so-called, was in the bill as reported by the Finance Committee.

The Senator from New Mexico voted for the proposal, in the committee. It then came to the Senate. The language was not offered as a substitute for the Kerr-Mills bill. I voted for the Kerr-Mills bill.

Mr. KERR. The Senator is describing methods of reaching the same point. The Senator from New Mexico offered an amendment which would have stricken out the Finance Committee action.

Mr. ANDERSON. Oh, my, no.

Mr. KERR. I believe the Senator did offer his proposal in addition.

Mr. ANDERSON. I did.

Mr. KERR. I believe the Senator did.

Mr. ANDERSON. Yes; I did.

Mr. KERR. Yes; he did.

Mr. ANDERSON. I only wished to keep the record straight. I did not at any time oppose the Kerr-Mills proposal, so called. I voted for it in the committee because I knew the Senator from Oklahoma was deeply interested in the problem and I thought he had presented a good solution for that portion of the problem he was trying to reach. That is all I wish to say in that regard.

In regard to the nursing homes, if the Senator will permit me to comment, one must provide standards. Many nursing homes are not adequate.

This provision refers to people who come from the hospital, when the hospital has been caring for them. These people would be taken from the hospital, though they would remain under the care of the physician, and would go into the nursing home. We feel that the nursing homes ought to be affiliated with the hospital under those circumstances. That is all that would be provided.

Mr. KERR. Under the King-Anderson bill the language was written so that 10,000 nursing homes would have been eligible.

Mr. ANDERSON. I am sorry; I do not believe that. I will not argue with the Senator.

Mr. KERR. I am quoting from an analysis of the bill by the technical staff. I did not ask the staff to interpret it to support either my position or the position of the Senator from New Mexico.

Mr. ANDERSON. I am sure the Senator did not. This is a point on which there might be a reasonable argument. There was a provision in the bill that standards would be set. It was expected that the Federal Government would set those standards as high as a requirement of affiliation with a hospital would set them, but there was such a hue and cry set up by the nursing homes of the country, that this was an endeavor to let the Government impose its will on people, that we provided specifically in legislative language for affiliation with a hospital.

Mr. KERR. Under the King-Anderson bill the cost for nursing home was estimated to be 0.08 percent, and under the amendments the Senator now sponsors the cost is estimated to be 0.02 percent.

Mr. ANDERSON. I did not say the cost of nursing home benefit would not be reduced. I merely said that the Government was going to set up standards, and the objection made was that those standards would be too difficult to meet in most of the localities. There are many places in my State which would not qualify, and I believe there are many places in the State of the Senator from Oklahoma which might not qualify.

Mr. KERR. That is correct.

Mr. ANDERSON. Nevertheless, it was felt it would be better to provide that payment for skilled nursing home care would be limited to cases in which the people come from the hospitals and go into nursing homes affiliated with hospitals. They could not go into nursing homes without coming from the hospital.

Mr. KERR. They could not be paid under the Senator's proposal unless they were in the nursing home. There are some 500 nursing homes which qualify.

Mr. ANDERSON. Which qualify now.

Mr. KERR. Which qualify now.

Mr. ANDERSON. We are trying to set standards so that others might qualify in the future.

Mr. KERR. Then the Senator's cost estimate of 0.02 percent would have to go up, if they did qualify.

Mr. ANDERSON. I do not wish to get into that, if the Senator will excuse me.

Mr. KERR. I do not blame the Senator.

Mr. ANDERSON. It is not for the reason the Senator seems to imply.

The able Senator from Oklahoma sat with me in the meetings of the Finance Committee when the committee tried to decide on disability insurance in 1956. The able Senator from Oregon [Mr. MORSE] wanted to put in a provision which would not begin with the age of 50. He wished to provide that a person of any age could come under the program. We thought in the interests of safety we ought to put in a limiting provision, that only those above 50 years of age might qualify for the disability insurance. Within 4 years we reversed ourselves and made the program available to everybody.

We think the nursing home provision is all right. If it works out that more nursing homes qualify, undoubtedly there will be a saving in other portions of the program, under the hospital care provisions. It would balance out at a later time.

Mr. KERR. I appreciate the Senator's observations.

I say to the Senator that the experts from the Department of Health, Education, and Welfare tell me that the cost of the Senator's amendments, even on the basis of using 500 nursing homes only, instead of being a half of 1 percent would be 0.68 percent; and, further, that each year the cost would be increased.

The cost estimates are based on the 1961 earnings level. If the 1962 earnings level were used, assuming an annual increase of 3 percent in earnings, one of the following alternatives would have to be provided: either the earnings base would have to be raised to $5,350 and it would be necessary to increase the hospital deductible to $10.30 per day; or it would be necessary to increase the hospital deductible to $12 per day; or it would be necessary to decrease the maximum duration of hospitalization from 90 to 80 days, or, under the 45-day alternative, to 40 days.

Furthermore, the estimates of the technicians of the Department of Health, Education, and Welfare are that by 1964, when the Senator's amendments would become operative with reference to the beneficiaries, one of the following actions would be necessary to restore the estimated actuarial balance of the system: raise the earnings base to $5,700 and increase the hospital deductible to $11 per day; or increase the hospital deductible to $16 per day; or decrease the maximum duration of hospitalization from 90 to 60 days, or, under the 45-day alternative, to 33 days.

Mr. LAUSCHE. Mr. President, will the Senator yield?

Mr. KERR. I yield.

Mr. LAUSCHE. From what is the Senator reading?

Mr. KERR. I am reading from a memorandum prepared for me by Mr. Robert J. Myers, the actuary of the Department of Health, Education, and Welfare. I asked him to provide me with estimates of the cost of the Anderson-Javits amendments in 1963, if implemented, and in 1964 when, under the amendments, the program would be implemented. That was delivered to me from the technicians in the Department of Health, Education, and Welfare. One of them is sitting in this Chamber and if I am incorrect he will tell me so.

Mr. CURTIS. Mr. President, will the distinguished Senator yield to me?

Mr. KERR. I yield.

Mr. CURTIS. Are those figures based upon a continuation of the present level of hospital costs? I think they are.

Mr. KERR. These figures are based on a 3-percent increase in the wage level. I believe the two go together. My adviser tells me that the figures are based on estimates both as to what the earnings level will be and as to what the hospital costs will be.

Mr. ANDERSON. Mr. President, will the Senator from Oklahoma yield to me?

Mr. KERR. I yield.

Mr. ANDERSON. I say to the Senator, as I said a moment ago, these things lead to endless arguments. I should appreciate reading a memorandum Mr. Robert J. Myers, the authority just cited by the Senator, supplied to me:

The actuarial cost estimate for the present cash benefits of the OASDI system are based on the assumption that earnings will remain level in the future. If instead, earnings rise—as past experience indicate will occur—then the cost of the present system applied in relation to taxable payroll will decrease——

Mr. KERR. Will what?

Mr. ANDERSON. Will decrease—

The reason for this is that, because of the weighted benefit formula, benefits will not rise proportionally with the increase in credited and taxable covered earnings, whereas contributions will rise in this manner. Thus, contributions will increase more rapidly than benefit outgo, and there will be a reduction in the cost of the program relative to payroll. Estimates based on a 3-percent annual increase in total earnings and covered employment (per worker) indicate that if 1962 earnings were used in the cost estimated (instead of 1961 earnings), the level-cost of the present system would be reduced by 0.07 percent of taxable payroll. This would more than offset the increase in cost of the health benefits of between 0.01 and 0.02 percent of payroll due to the changed earnings-level assumption. In the same way, the use of projected 1964 earnings levels assumption, would result in a reductoin of the level-cost of the cash benefits of 20 percent of taxable payroll, as compared with an increase in costs of the health benefits of about 0.05 percent of payroll.

I assume that he thought this would come out about right.

Mr. KERR. If I correctly understand the language the Senator has read, it assumes the transfer of that part which under the Senator's amendment would go to the trust fund, to the health fund.

Mr. ANDERSON. Assuming no increase in wages, then there would be no problem. If the wages should go up, the problem could arise. I am not able to predict where wages will go or how they will go.

We say only that we think the proposal is actuarially sound. Mr. Myers has so certified; and I am inclined to accept his figures.

Mr. KERR. The long-range cost estimates have not taken into account the possibility of a rise in earnings levels, although such a rise has characterized the past history of this country. If such an assumption were used in the cost estimates, along with the unlikely assumption that the benefits, nevertheless, would not be changed, the cost relative to payroll would, of course, be lower.

It is important to note that the possibility that a rise in earnings levels will produce lower costs of the program in relation to payroll is a very important "safety factor" in the financial operations of the system. The financing of the system is based essentially on the intermediate-cost estimate, along with the assumption of level earnings; if experience follows the high-cost assumption, additional financing will be necessary.

I say to the distinguished Senator that I read from a memorandum given to me on July 16, 1962. I now ask unanimous consent that it be printed at this point in the RECORD, because it came directly to me from Mr. Robert J. Myers.

There being no objection, the memorandum was ordered to be printed in the RECORD, as follows:

Subject: Changes in health benefits plan under conditions of rising earnings.

From: Robert J. Myers.

The actuarial balance of the proposed health benefits plan is based on the assumption of level earnings in the future. If earnings rise—as may be reasonably expected from past history—and if health benefit costs rise correspondingly, the proposed health benefits would not be in actuarial balance.

Under these circumstances, at least one of several alternatives would have to be done to maintain the actuarial status of the social security system without raising the tax rate assigned to the health benefits program.

The cost estimates are based on the 1961 earnings level. If the 1962 earnings level were used (assuming an annual increase of 3 percent in earnings), one of the following alternatives would have to be done:

1. Raise the earnings base to $5,350 and increase the hosiptal deductible to $10.30 per day.

1. Increase the hospital deductible to $12 per day.

3. Decrease the maximum duration of hospitalization from 90 to 80 days (under the 45-day, no deductible alternative, to 40 days).

By 1964, one of the following actions will be necessary to restore the estimated actuarial balance of the system:

1. Raise the earnings base to $5,700 and increase the hospital deductible to $11 per day.

2. Increase the hospital deductible to $16 per day.

3. Decrease the maximum duration of hospitalization from 90 to 60 days (under the 45-day, no deductible alternative, to 33 days).

Mr. ANDERSON. Will the Senator agree with me that Robert J. Myers has many times certified that the amendment I have offered is actuarially sound and adequately financed?

Mr. KERR. It is only actuarially sound on the assumption that earnings would be level on the basis of the 1961 earnings.

The man is telling the Senator that what I have said is correct.

Mr. ANDERSON. He is not. He is saying that it is not correct. The system would adjust itself as wages rose. As wages rose, old age benefits would improve.

I do not know. I have never examined the books. I know only that committees have been appointed to examine social security, and they have said that social security is sound. I have heard Mr. Robert Myers quoted year after year. He has certified that the program is actuarially sound. If we have lost faith in him——

Mr. KERR. I have not lost faith in him. The Senator's statement is based upon a transfer into the health fund of that which, under his measure, would go into the trust fund. That is the safety factor.

Speaking further with reference to what the Javits-Anderson amendment would not do, it would not provide doctors' care. It would not provide surgeons' care. It would not provide private nursing services. It would not provide physical therapy and related services except those customarily provided in a hospital. It would not provide dental services. It would not provide laboratory and X-ray services except those customarily provided in a hospital. It would not provide prescribed drugs, eyeglasses and dentures, except drugs customarily provided in a hospital or nursing home. It would not provide diagnostic or screening and preventive services, except outpatient diagnostic services. It would not provide any of the medical care or remedial care recognized under State law. Therefore, I say again that the measure is a misnomer. It would not provide those things which are indispensable in a general program of providing medical care for the aged, and which the distinguished Senator from New York [Mr. JAVITS] in 1960 said was the basis of the entire program of care for the aged. It is the most important element in care for the aged.

Mr. President, I invite the Senator's attention to what would very likely be lost if the Senate should adopt the amendment. I am making that statement on the assumption that, if agreed to by the Senate, the amendment would not be accepted by the House. Some Senators have had the opportunity and privilege of serving in the House of Representatives; and consequently they know the procedures in that body. As I understand, if the amendment were agreed to, the measure would go back to the House of Representatives and would be placed on the Speaker's desk. If a request were made to send the bill to conference, the request would have to be agreed to unanimously. One objector in the House of Representatives would prevent the bill going to conference, unless the Committee on Rules should issue a rule to send the measure to conference.

I wonder if the sponsors of the amendment have any assurance that the Rules

Committee would give the measure a rule? Assuming that it did not, the bill to which the amendment is attached, if it were adopted, would die, and with that action the States would lose the following:

In the bill is a provision for 75 percent of the Federal share for a minimum of services, for self-support, self-care, and other nonadministrative services, training, purchases of services from other State agencies, and for preventive services.

There are provided in the bill changes in formula which would send to the States an additional $126 million for the aged. There is provided in the bill inclusion of $34 million a year for second parent and aid to dependent children cases. Last year we passed a bill on a temporary basis that provided that if the wage earner in the home were unemployed, his children would be eligible for aid to dependent children. That assistance expired on June 30. The bill now before the Senate would extend such assistance; $73 million would be provided for aid to dependent children when the wage earner of the family is unemployed. If the bill dies, the extension of that provision is killed.

There is a provision for $4 million for foster care, which would be extended, child welfare, $5 million; adult category, single program, $7.5 million.

In areas of critical unemployment there is now a very worthy program which an unemployed parent can achieve for his children on the basis of aid to dependent children, paid for by the State and the Federal Government. The program would permit a person to work for the benefit that he would receive through the aid to dependent children that would come to him because he is unemployed. That program is now at a standstill because it expired on June 30. The extension of the program is provided in the bill. It is prevented from going into effect by reason of the fact that the bill is held up in the Senate because of the attempt to place the pending amendment on it.

If it goes on it and goes back to the House, and an objection is made to a conference, and the Rules Committee does not give a rule for a conference, that great and worthy program, of such tremendous significance to those who need it the worst, will be lost.

We added an amendment to the bill on the floor of the Senate the other day which gave the States the right to permit those on old-age assistance to earn up to $50 a month without thereby their assistance checks being reduced.

If the situation develops as I have visualized it, that great humanitarian provision will be lost.

Mr. ANDERSON. Mr. President, will the Senator yield?

Mr. KERR. I yield.

Mr. ANDERSON. The Senate added that same amendment once before. It went to the House. Did not the conferees strike it out after a few minutes' deliberation?

Mr. KERR. Yes.

Mr. ANDERSON. Therefore it is not a very great handicap to put it on the bill again.

Mr. KERR. I believe that that provision was mandatory. I am not sure of that, and the Senator will correct me if I am in error.

Mr. ANDERSON. It was not. We had that under discussion the other day.

Mr. KERR. At one time we passed it and it was permissive. Another time it was mandatory. The Senator will remember which is correct.

Mr. ANDERSON. I am not able to say.

Mr. KERR. I mean the Senator's technician would know.

Mr. ANDERSON. The Douglas amendment was permissive. The Senator from Illinois obtained the floor himself to present that amendment.

Mr. KERR. But I believe we twice adopted it.

Mr. ANDERSON. I am not sure. I would merely like to say this to the able Senator from Oklahoma. He is struggling now in the Committee on Finance with the distinguished Senator from Virginia [Mr. BYRD] to bring out a tax bill. The committee has just struck from the bill the withholding provision. The committee will change the bill in other respects. One objection in the House will prevent it from going to conference with the House. That fact did not hold back the Finance Committee from acting as it did. We recognize that one objection in the House prevents such a bill from going to conference. I served on the Ways and Means Committee in the House. I know how they feel about their prerogatives. Nonetheless, there have been occasions when they have accepted amendments. I admit it is a problem. I am not trying to dismiss it lightly. However, we have adopted amendments that the House did not particularly care for.

Mr. KERR. The same amendment the Senator has submitted is the one that is now before the Ways and Means Committee.

Mr. ANDERSON. But they have not taken any action on it for 4 or 5 months.

Mr. KERR. Does the Senator contemplate that if his amendment were sent to the House and the Rules Committee gave a rule and the bill went to conference, the House would be willing to accept the amendment?

Mr. ANDERSON. I hope so. I cannot be certain about it, but I hope that the House would see the wisdom of doing just that.

Mr. KERR. What the Senator has said might be the basis for taking exactly the opposite action to that which the Senator from New Mexico indicates would be his hope.

Mr. ANDERSON. It is possible.

Mr. KERR. I have told the Senate what the bill would not do. I should now like to tell Senators, or remind them, of some of the things that it would do. The amendment would raise taxes $2.2 billion a year on the self-employed and on the workers and employers of America, when everyone knows that we ought to ease the burden instead of increasing it, and when everyone knows that the profit squeeze is on between cost and selling price, and that the profits of the employers, out of which taxes are paid, are being squeezed by increasing costs and increasing competition.

So that what we have before us is an amendment which would increase on a limited group, which the distinguished Senator from New York said in 1960 were "those least able to pay," their part of the $2.2 billion a year in additional taxes.

I request that Senators consider the position in which the amendment would put the younger workers of America. The amendment would place 20 million people in a position to receive the benefits provided by the amendment. There will be about 17 million of them who will be eligible on January 1, 1964. In succeeding years there will be an additional 3 million eligible, who have already earned eligibility for social security retirement purposes but who are not now employed by private industry and who are not now contributing to the fund. So the amendment would make 20 million retirees eligible for benefits who either have not or will not make any contribution to the fund, with the possible exception of those who work beyond 65 years of age and pay social security taxes by reason of that fact.

Yet the benefits provided for the 20 million people will cost $35 billion, which will have to be paid by the self-employed and the younger workers of America and their employers, when these younger workers are already struggling to take care of the health costs of their wives and their children.

Mr. LONG of Louisiana. Mr. President, will the Senator yield?

Mr. KERR. I yield.

Mr. LONG of Louisiana. Is the Senator estimating the $35 billion based on treatment in private hospitals, or in public hospitals?

Mr. KERR. This is the cost estimated, I believe, on the basis of a 3-percent increase every year for a number of years, until it levels off at a level rate. I believe that contingency is in the estimate of the cost.

Mr. LONG of Louisiana. It is important to determine whether the $35 billion is based on experience in private hospitals or experience in public hospitals. In Louisiana we have a situation in which people stay 50 percent longer in public hospitals than in private hospitals, for any given illness. The reason for it is that if a person is paying his own hospital bill he is always asking his doctor, "Doctor, can I go home?" It is important to him, because he is paying the bill.

If he is in a State hospital, the ward leader or someone else is always calling up the doctor and saying, "Do you have to discharge that person? Can't he stay a little longer?" There is the problem also of a person who wants to take a vacation, and in order to do that wants to put his dependent in the hospital and have him stay there longer. He wants his relative to stay in the hospital during the period of time that he takes a vacation.

The cold, hard statistics in Louisiana show—and no one is denying it, not even those who voted for the proposal—that there is a difference of 50 percent be-

tween the length of time a person stays in a private hospital and in a State hospital, because in the one instance it is necessary to work to get patients out and in the other the patients are working to get themselves out. That is the difference.

Mr. KERR. The Senator from Louisiana has called attention to a very significant fact. That is one of the reasons why the technicians speak of the cost of the bill to provide benefits to those who will have made no contribution to the fund as $35 billion. That is their estimate of what the minimum cost will be.

Mr. LONG of Louisiana. I ask the Senator to mark my words that it will be nearer $52 billion.

Mr. KERR. There is no Senator who does not receive correspondence continually from worthy veterans, whom he is trying to help from the standpoint of trying to get them into a veterans' hospital.

What the Senator from Louisiana has said can be corroborated by any Senator from the mail he receives from servicemen and veterans in his State, and from his experience in seeking to obtain for them entrance into veterans' hospitals or the opportunity to continue to remain in veterans' hospitals.

Mr. LONG of Louisiana. Mr. President, will the Senator from Oklahoma further yield?

Mr. KERR. I yield.

Mr. LONG of Louisiana. I should like to support the Senator by saying that some of the most grateful constituents I have are those who relatives I was able either to get into a veterans' hospital or to keep in one.

Mr. KERR. The Senator is correct. While the Senator from Louisiana was speaking, I was thinking of a veteran having a non-service-connected disability, who had a fine family, but one which was not economically fortunate, and of the many hours spent by members of the staff of the Senator from Oklahoma to secure the admission of that veteran to a veterans' hospital.

Mr. President, even the partially employed will have to contribute to the $35 billion. Workers who are employed only half time will have to pay a part of that cost.

Mr. LAUSCHE. Mr. President, will the Senator from Oklahoma yield for a question?

Mr. KERR. I yield.

Mr. LAUSCHE. Does the $35 billion cost envision taking care of beneficiaries during the expectancy of their life beyond age 65?

Mr. KERR. It envisions those who will be eligible but who will not have contributed to the fund. The Senator is correct.

Mr. LAUSCHE. It is predicated upon an estimate of life into the future of persons who are now 65 and until all of them have passed away?

Mr. KERR. Yes; and of those who are not yet 65 but who have earned social security retirement identity, but who are not now contributing to the fund by reason of being otherwise employed, such as being employed by the Government, and the like.

Mr. LAUSCHE. I thank the Senator from Oklahoma.

Mr. CURTIS. Mr. President, will the distinguished Senator from Oklahoma yield?

Mr. KERR. I yield.

Mr. CURTIS. We are speaking of who would pay taxes. If the physically handicapped are employed and earn some wages, will they not pay social security taxes?

Mr. KERR. Yes.

Mr. CURTIS. That includes some of the severely handicapped individuals who are employed in Goodwill Industries and similar institutions, does it not?

Mr. KERR. I believe it does, if they work enough and earn $50 a quarter.

Mr. CURTIS. Yes. Would they not be contributing to the payment of the hospital bills of at least some of the people who are well able to pay the bills themselves?

Mr. KERR. They would contribute to the payment for hospital care for which every retired banker or financier in America would be eligible.

Mr. CURTIS. Such a person would not have to retire; he would simply have to be eligible for the benefits. He could have the highest income of his entire career but still eligible to retire.

Mr. KERR. Then he would be eligible for these benefits.

Mr. CURTIS. That is correct.

Mr. KERR. The Senator is correct. Not only the physically handicapped, but also the blind and the domestic employees. Even the cook in one's house, who received $25 a week or more, would be taxed to pay for the benefits for which people who would not contribute a dime would become eligible. Millions of persons are employing domestic employees who will be making contributions.

Mr. President, I am beginning to see the light. I am not going back to Oklahoma and face the farmers of that State, saying, "I voted to impose on you a tax of 7¾ percent of what you make above $4,800 up to $5,200, and one-half of 1 percent on every dollar you make up to $4,800, in order to provide benefits for millions of retired persons who may be the owners of the farms on which you are tenant farmers."

Many Members of the Senate who are deeply concerned about the agricultural program and the welfare of the American farmers are supporting this measure. If and when it is passed, will they go back home and explain to the farmers why they voted to raise their taxes in order to provide benefits for people who are worth many times what the farmers are worth—people who have never paid a dollar to receive the benefits?

Mrs. NEUBERGER. Mr. President, will the Senator from Oklahoma yield for a question?

Mr. KERR. I am honored to yield to the lovely Senator from Oregon.

Mrs. NEUBERGER. Is not this what a farmer does if he has insurance on his house?

Mr. KERR. I do not know of anyone who has insurance on a house who does not pay for it himself. I am talking about the 20 million people who will not have paid 1 cent for this insurance. It will be paid for and given to them by others.

I say to the great Senator from Oregon that not one thing more is being provided for the old people of her State. She may think there is; but there is one nursing home in Oregon which is eligible under this measure—only one. This proposal is a misnomer. It does not provide for the payment of doctors' bills, dentists' bills, or surgeons' bills. It gives to those who do not need at the expense of the lowest level income groups in America. It gives to those who have contributed nothing at the cost of the disabled, the blind, the domestic workers, the farmworkers, and the farmers of America.

I favor medical care for the aged far beyond what is provided in this measure. But if taxes are to be imposed on the American people to provide benefits for them, then every taxpayer should make the contribution, not only the lowest paid or those having the lowest incomes. Income taxes are paid on a graduated scale; but the Anderson-Javits amendment does not provide a graduated scale of payments. The lowest wage level worker in this country pays the same percentage on what he earns as does the millionaire.

I feel certain that the Senator from Oregon [Mrs. NEUBERGER] does not believe in such a philosophy as the Anderson-Javits amendment contains. It is not necessary to pass this measure in order to provide such help to the aged. It is not necessary to offer bread and then give them a stone, by saying, "Here is a program of medical care," when no medical care is in it.

It is said that under the Anderson-Javits amendment, 45 days of hospitalization will be provided without charge, without even a deductible. What will happen to a person who is over 65 years of age when the 45 days have elapsed? What will happen will be that such a person will be placed in a nursing home that does not exist, or else he will be eligible under Kerr-Mills in States where that act is in force, because that act will pay the doctors' bills. It will pay the hospital bills for a year, if the State will implement the program. It will pay for dental care. It will pay for nurses. It will pay for laboratory and X-ray services. It will pay for any other medical care or remedial care recognized under State law. But the Anderson-Javits proposal would not.

No wonder a group in Rochester, the hometown of the distinguished junior Senator from New York [Mr. KEATING], wrote as follows:

DEAR SENATOR KEATING: Comments attributed to you in the CONGRESSIONAL RECORD are receiving wide dissemination in current discussions regarding the proposed medicare amendment.

This is a carefully prepared, sensible approach to one of our greatest legislative challenges, and there is a very substantial body of doctors who feel that the sound and proper method of financing medical care is under social security.

Says his constituent:

The proposed amendment in my estimation is quite a hodgepodge of methods to take care of part of the expenses of senior citizens, whether they need it or not. It is interesting to note that in your home community of Monroe County there are approximately 38 accredited proprietary nursing homes with a bed capacity of 1,360, none of which could qualify under this proposal. There are also 8 other homes, including the Monroe County Home and Infirmary, St. Ann's, the Jewish Home for the Aged, and so forth, with a bed capacity of 954, of which only St. Ann's could possibly qualify, if, as proposed, that home affiliates with General Hospital.

Mr. KEATING. Mr. President, will the Senator from Oklahoma yield?

Mr. KERR. I yield.

Mr. KEATING. The Senator from Oklahoma has seen fit to quote from a letter sent to me, as apparently a copy was sent to him. All I can say is that I have received plenty of mail on all sides of this issue, in the past 2 years. I have received a significant amount of mail in opposition to the original Anderson bill, and lately I have also received some in opposition to the modified bill. To be specific, I have gotten 10,299 letters in opposition to any form of health care for the aged under social security.

I have also received 382,949 letters in favor either of the original Anderson proposal or of the modified which, in my judgment, is a much improved proposal. Therefore, while every letter is important, any single letter the Senator from Oklahoma might see fit to cite ought to be cited in the context of all of the many thousands of letters I have received.

Mr. KERR. Under the original King-Anderson bill 10,000 nursing homes in America would have been eligible; but under this bill only 500 would be eligible—only 500 in the entire Nation; and there would be only 1—if there were 1—in the Senator's county.

Mr. KEATING. All the hospitals in Monroe County could qualify.

Mr. KERR. Under this bill they could not qualify as nursing homes.

Mr. KEATING. They could qualify if they affiliated.

Mr. KERR. Oh, yes; but if they did, the Senator's estimate of 0.02 percent of payroll would have to be quadrupled, if all of them qualified.

Mr. KEATING. There is a great difference of opinion on that subject.

Mr. KERR. That is the figure provided by the Department of Health, Education, and Welfare technicians.

Mr. President, this bill would give too much to those who do not need it. It would give too little to those who do need it.

Medical science in this country has advanced to the highest degree of efficiency and value—more so than in any other nation in the world. There was a time when American doctors went to Germany to study medicine and surgery. But today, doctors and physicians come from around the world to study in the advanced facilities and courses under the distinguished medical educators of America. Why is that? It is because the American medical profession, the American dental profession, the American surgical profession, and the American nursing profession are free and have the incentive and opportunity to work to improve themselves to provide better medical care for the people. That care should be available to the aged, if they need it and if they cannot provide it for themselves. I would not deny it to a single person over 65 years of age who needs it and cannot provide it for himself or herself. But I would not tax the disabled, the blind, the domestic workers, the garage mechanics, the filling station operators, and the other low-income groups of America to provide a limited program to millions of people for whom they are working, who will not have contributed one dime to pay the cost of the program. I have not seen that kind of light. I will not return to Oklahoma and tell the aged there that I have voted for a program which is a misnomer—which purports to be medical care, but would provide no medical care.

I will cast my vote to make the present medical-care program for the aged more available, on the basis of having the States operate it and on the basis of having freedom of choice for the patient, as to the doctor, the dentist, the surgeon, the hospital, and the nursing home, and also freedom of choice on the part of the doctor, the dentist, and the surgeon, so that they might have a voice in deciding what patient or patients they would serve. But I would vote for such a program for those whose own economics will not enable them to pay for it.

We have heard talk about someone with a $4,000 income who might have a catastrophic illness for which he would not be able to pay. Under this bill he would not be benefited. The other day I heard on this floor an eloquent plea for low-income groups who, with families to support, need a program which, in the case of a catastrophic illness, would provide them with the medical care and the hospital care they require, without bankrupting them. But this bill would not give them such aid, it would keep them in a hospital for 90 days, with some additional time in a nursing home or with daily visitation, and then they would be on their own. A person who had a lingering case would not be benefited under this bill; the bill would not provide the aid needed by such a person. Futhermore, if those in that income bracket want a limited health program, they can acquire it at a minimum cost. Yonder in the Chamber is a chart which shows that for those over 65, the use of this same kind of health program, for which they are paying, has increased 200 percent in less than 10 years.

Mrs. NEUBERGER. Mr. President, will the Senator from Oklahoma yield?

Mr. KERR. I yield.

Mrs. NEUBERGER. By the enactment of this bill, would the Kerr-Mills Act for the indigent be repealed?

Mr. KERR. No. Furthermore, it is not for the indigent, I say to the great lady from Oregon. The Kerr-Mills Act is not for the indigent. A person with a $5,000 medical cost and hospital cost does not have to be indigent in order to be unable to pay that cost. But if a person is worth a million dollars, I do not know of any reason why a tax to provide that person with medical care should be levied on that person's employees who work in the kitchen or on the farm, or why a tax for that purpose should be levied on the blind. But that is what this amendment would do. In the Kerr-Mills Act there is no requirement that one must be indigent in order to receive help. A State can decide that it will provide such help to any couple whose income does not exceed $3,000 or $4,000 or $5,000, if the State wishes to do so. But couples with incomes of that size are not indigent. However, by the time medium-income groups pay the cost of a lingering illness, they will be indigent, because they will have had to pay out of their meager savings medical costs and hospital costs which this bill would not pay for them, and which their own means would not enable them to pay.

Let us not deceive the people of America or ourselves. We are talking about a program that would produce indigence, and not relieve it. The low income groups would get all the benefits under Kerr-Mills. If a member of such a group had a lingering illness, this measure would not keep him from becoming indigent. He would have to resort to the Kerr-Mills Act in order to get any benefit. Yet this amendment would cost $2.2 billion beginning in 1962; and the estimates of the Department of Health, Education, and Welfare are that in 1964 Kerr-Mills would cost less than $400 million for every State that would qualify to give adequate medical care to those who cannot provide it for themselves.

Who would pay for it? Every taxpayer; not the low income groups, not those who would be paying into a fund for which their own employers would be eligible to secure benefits, but with reference to which they had never paid a dime.

Where is the sense of fairness in the minds of Senators who would impose such a mockery?

We should face the responsibility of providing medical care for the aged, but when we do, let us provide adequate medical care; when we do, let us require all taxpayers to pay for it; when we do, let us provide medical care for those who cannot provide it for themselves, and not for those who can provide it easily for themselves, without the tax being a burden on the low income workers of America.

I submit to the Senate that the amendments should be defeated.

Mr. CURTIS. Mr. President, will the Senator yield?

Mr. KERR. I yield.

Mr. CURTIS. Referring to the chart in the rear of the Chamber, it points out that persons over 65 on January 1, 1964, or who might thereafter retire at 65 without having contributed to the health fund would exceed 20 million, and would cost social security $35 billion. Is that correct?

Mr. KERR. In that regard, the only amendment that should be made to the statement of the Senator from Nebraska

is that it is estimated that those over 65 who continued to work could contribute $50 million or more to the amount of $35 billion.

Mr. CURTIS. Who would pay that $35 billion?

Mr. KERR. Younger workers and the self-employed.

Mr. CURTIS. And some who are not born yet?

Mr. KERR. Yes.

Mr. CURTIS. Would the individual whose income is entirely from investments pay one dime of that $35 billion? The social security tax is based on wages and salaries, is it not?

Mr. KERR. Yes; it is based on the salaries or earnings of workers and the self-employed. The Senator is correct.

Mr. CURTIS. Such an individual, regardless of the extent of his capital or income, would be a beneficiary, but would not pay one dime of that amount?

Mr. KERR. He would not be a contributor. The Senator is correct.

Mr. President, I yield the floor.

Mr. McNAMARA. Mr. President——

The PRESIDING OFFICER. The Senator from Michigan.

Mr. McNAMARA. I wish to propound a parliamentary inquiry before I begin my statement.

The PRESIDING OFFICER. The Senator will state the parliamentary inquiry.

Mr. McNAMARA. Is time now controlled? And if I desire to speak on the same subject, must I have time allocated to me?

The PRESIDING OFFICER. The Senate is not now proceeding under controlled time.

Mr. McNAMARA. I thank the Chair.

Mr. President, I have enjoyed very much the presentation made by my distinguished friend from Oklahoma. I agree with him in his basic theory that this measure would not do all the things that elderly people need done for them. The Senator is absolutely correct. At the same time, if it were to do all the things that the opponents of the measure now say should be done, it would cost several times as much as what is already regarded as too high a cost. So I think that argument answers the question.

VOLUNTARY HEALTH INSURANCE AND KING-ANDERSON

Mr. President, there has been a good deal of talk in recent days by opponents of the King-Anderson bill concerning the role of voluntary health insurance in meeting the needs of older people. In essence, two claims have been made. First, that voluntary health insurance is, or soon will be, meeting the need. Secondly, that enactment of the King-Anderson bill will have a disastrous effect on voluntary plans.

The truth, Mr. President, is just the opposite.

Private insurance does not and cannot meet the need unaided.

Enactment of King-Anderson will give a great boost to private insurance, and the combination of the two may well provide the answer we seek.

Older people whose incomes are fixed need comprehensive insurance coverage. Less than 5 percent of all the people in the United States have comprehensive health insurance, far fewer of our older people. The insurance that older people have costs too much of their incomes and provides too little in services covered. The many hearings held throughout the country by our Special Committee on Aging prove this beyond a doubt.

Let it be understood, Mr. President, that this is not the fault of the insurance companies, not even of those private insurance companies who sell individual policies—the only ones available to most older people—and which, for every dollar they take in, pay out only 53 cents for health services.

This results from a simple fact of economic life. Insurance companies must take enough in premiums to pay for the costs of the services covered and, in the case of commercial companies, their profits. Older people cannot afford to pay premiums high enough to cover the costs of the services they need. The result is that insurance premiums are cut to meet the incomes of some older people, services covered are cut correspondingly, and many of the elderly are cut off completely from coverage just when their need is greatest.

King-Anderson, properly understood, is designed and planned to help private insurance meet the need it cannot meet unaided. King-Anderson does not intend or pretend to do the whole job. It would simply relieve private insurance on the necessity to try to meet the greatest, most constant and most burdensome part of the costs of health care for the elderly—the costs of hospital and skilled nursing facility care.

When King-Anderson is enacted into law and our older people need no longer fear the burden of hospital costs, private insurers—profit and non-profit alike—will be in a position to offer insurance coverage for other items of health care at a price which, hopefully, most of the elderly will be able to afford.

The tripartite approach: King-Anderson for hospital costs; private insurance for most other costs; Kerr-Mills to pick up costs that outrun the others, is the logical solution, the only one that promises an acceptable and workable answer.

I hope the basic part of this three-part approach will be added promptly to the two we already have: the two which, of themselves, clearly cannot meet the need.

In conclusion, Mr. President, I ask unanimous consent to have set forth at this point in the RECORD a most interesting table of key facts about the health insurance business which appeared in the June 4 issue of Medical Economics.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

Key facts about the health insurance business

WHICH INSURERS GET THE MOST?

	Premium income in millions
Commercial health plans (group)	$2,104
Blue Cross hospitalization plans	1,773
Commercial health plans (individual)	923
Blue Shield medical-surgical plans	709
Independent health plans	332

WHICH INSURERS GIVE THE MOST?

	Percent paid out in benefits
Independent health plans	96.5
Blue Cross hospitalization plans	92.6
Blue Shield medical-surgical plans	90.4
Commercial health plans (group)	90.4
Commercial health plans (individual)	52.9

Figures shown are for 1960 as reported by Blue Cross, Blue Shield, the Health Insurance Association, and the Social Security Administration.

12 of the Blue's biggest competitors

	Premium income (in millions)	Percent paid out in benefits
Commercial health plans (group):		
Metropolitan	$356	90.6
Aetna Life	351	90.0
Travelers	296	90.4
Equitable	217	88.3
Commercial health plans (individual):		
Mutual of Omaha	189	59.8
Bankers Life & Casualty	114	60.9
Prudential	95	46.2
Continental Casualty	89	51.6
Independent health plans:		
United Mine Workers	62	97.1
Kaiser Foundation Health Plan	53	94.5
Group Health Insurance, New York	25	82.3
Health Insurance Plan, New York	21	99.5

Figures shown are for 1960 as reported by the companies and plans listed.

Mr. BYRD of Virginia. Mr. President, the bill before the Senate (H.R. 10606) would amend existing law providing for so-called public assistance. The pending amendment to the bill would expand the social security system to provide limited medical care benefits for older persons.

In regular procedure the public assistance bill was originated in the House of Representatives, considered by the Ways and Means Committee, passed by the House, and it has been considered and reported by the Senate Finance Committee. The amendment now pending has had the benefit of none of this deliberation.

The fact that the medicare amendment is before the Senate without adequate preliminary consideration involves a situation which I shall review in the opening portion of these remarks. Such a review should be made for the record, and I hope it may be helpful otherwise.

PUBLIC ASSISTANCE

Public assistance has been officially related to social security since the social security system was founded in 1935. In the beginning, public assistance was administered by the Social Security Board. Now it is administered by the Social Security Administration.

It was originally contended that as social security coverage expanded the requirement for public assistance would diminish. Sociay security coverage has been expanded, but—whatever the public assistance requirements may be—the cost of the program continues to increase.

SOCIAL SECURITY

Public assistance is financed by appropriations from general revenue; but the social security system involves the levy of payroll taxes for its support. Despite this fundamental difference, along with

others, the two programs are still officially linked for many purposes.

Legislative consideration is among the purposes for which they are considered to be related. And for this purpose the social security aspects have always predominated to the extent that basic legislation for both programs has been subject to revenue measure procedure.

REVENUE MEASURES

Article I, section 7 of the Constitution says:

> All bills for raising revenue shall originate in the House of Representatives; but the Senate may propose amendments as on other bills.

The Senate knows how jealously the House guards this constitutional prerogative. If evidence is desired, it lies in the record which documents the fate of Senate attempts to intrude. And in view of the record, the chances for passage of the pending amendment seem to be dim.

SLIM CHANCE

There are numerous reasons for us to assume that, even if the medicare amendments were passed by the Senate at this time, the chances for acceptance by the House of Representatives are dim; but two of the reasons I have in mind must be clear to all Members of the Senate:

In the first place, it would raise taxes—not only the social security tax rates, but also the amount of pay on which they would be levied. In the second place, the Ways and Means Committee has been considering similar legislation for months with no action to date.

HOUSE PROPOSALS

The Ways and Means Committee had before it the Forand bill to provide old-age medicare through social security in the 86th Congress, but did not report it; and in the present Congress it has had the King-Anderson bill for the same purpose before it for months—without approval.

Meanwhile, in the 86th Congress, the Senate did successfully amend a social security bill to include the Kerr-Mills provisions. But these established medical aid for older people as a public assistance program to be financed by appropriations from the general fund.

COMMITTEE ACTION

The Senate Finance Committee has gone even further. On January 21, 1962, the committee considered a motion by the Senator from New Mexico [Mr. ANDERSON] that hearings be held on Senate bill 909—to establish a social security medical care program for older persons through the social security system—not later than April 1, 1962, regardless of whether the House of Representatives had acted on an identical bill pending in the House Committee on Ways and Means.

This motion was put to a vote; it failed to carry by a vote of 10 to 7.

The committee then considered a second motion; it was made by the Senator from Oklahoma [Mr. KERR] that prompt hearings be held on this subject as soon as the House of Representatives passes and sends to the Senate for further action a medical care for the aged bill.

This motion was carried with an affirmative vote by all 13 members of the committee present and voting. And this is the status of the matter in the committee at this time. To date the House has not passed such a bill; if and when it does, the Finance Committee will act.

COMMITTEE POLICY

The committee's action on this legislation was in accord with its traditional policy. It rarely holds advance hearings on a proposal when the originating jurisdiction lies in the House, or considers such a bill before the House of Representatives has acted.

The King-Anderson bill clearly was such a measure. It would have raised social security taxes which are being levied on millions of people and withheld from their pay. The pending amendment would do the same thing, and raise the amount of pay to be taxed.

PENDING AMENDMENTS

If the committee had held advance hearings on the King-Anderson bill, it would have spent its time on a bill which, according to the sponsors of the pending amendment, was considerably different from the Anderson-Javits proposal now under discussion.

I submit the Finance Committee has acted properly, in accordance with traditional policy, and wisely on this matter. Under orthodox procedure it has reported the public assistance bill. It has not considered the tax-raising amendment which was originated in the Senate.

NOTABLE COINCIDENCE

The Senate cannot overlook the fact that by 1964 the pending amendment would increase Federal payroll tax collections for social security by more than $2 billion a year—and half of this would be withheld from the pay of the working people of this Nation.

It is a notable coincidence that such a tax increase should be urged here with such vigor, when the propaganda drums are being hammered by those who contend that tax reductions up to $9.5 billion must be enacted to save the country from recession or something worse.

TAX RATES

Under present law social security tax rates will increase, in steps, from a total of 7¼ percent in 1963 to 9¼ percent in 1968. This, as always with social security taxes, would be levied half on employees and half on employers.

Under the pending amendments the social security tax rates would be increased, in steps, from 7¼ percent in 1963 to 9¾ percent in 1968. This would be an increase from 3⅝ percent each, on employees and employers, to 4⅞ percent each.

PAY BASE

Under the proposed amendment the increase in tax rates would become effective in 1964; but the amendment also would increase the maximum amount of pay which could be taxed, and this would be effective a year earlier, in the coming calendar year, in 1963.

Under present law the graduated increases in the tax rate would be applied to a maximum pay fixed at $4,800. Under the pending amendment the increased rates would be levied on maximum pay which would be raised to $5,200.

NO DEDUCTIONS

A payroll tax is a straight tax on employees. There are no deductions. A tax of nearly 5 percent—on pay up to $5,200—is heavy taxation. It is heavy on both employee and employer; and the employee must pay it in addition to regular income taxes withheld from his pay.

With social security taxes rising, as they are, with or without the pending amendments, the question arises: How much higher can these taxes be raised? Let the Secretary of Health, Education, and Welfare, himself, answer that question.

RIBICOFF LIMIT

Former Secretary Abraham Ribicoff, in an interview with the U.S. News & World Report, as published February 5, 1962, said, in a published interview, in part, as follows:

> I have told Senator HARRY F. BYRD, of Virginia, I think we have reached a state of almost maximum taxation under social security. In my mind, I place that at 10 percent of payroll. Under the tax schedule of the present act you will get up to 9¼ percent for employer and employee in 1968. You add this one-half of 1 percent for medical care for the aging under social security, and you've about hit the top of 10 percent. I don't think people will go for more than 10 percent.

A 45.6-PERCENT INCREASE

Under rates fixed in the present law applied to the $4,800 limit, social security taxes on the employee would rise from $174 in 1963 to $222 in 1968. Under rates in the proposed amendment applied to a $5,200 pay limit, social security taxes in 1968 would total $253.50.

For those earning $5,200 and more, this would be an increase on each employee of $79.50—or 45.6 percent to $253.50 in 6 years; the tax on employers would be increased by an equal amount; the Government's take—per employee—would be increased by $159. The total tax would be $507.

EMPLOYEE'S INCREASE

I have prepared a table showing increases in social security taxes to be paid by an employee under the graduated schedule in the present law, and the increases which would be levied on an employee under the graduated schedule in the proposed amendment, and a comparison of the two in both dollars and percentage.

I ask unanimous consent to have this table published at this point in my remarks.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

Social security taxes on an employee under present law rates and maximum pay base of $4,800 compared with proposed rates and maximum pay base of $5,200

Year	Present law rates on $4,800 pay maximum		Under proposed amendment, increasing tax rate + of 1 percent beginning in 1964, and raising maximum pay base to $5,200 beginning in 1963			
	Tax rate (percent)	Amount to be paid	Tax rate (percent)	Amount to be paid	Increase over present law	
					Dollars	Percent [1]
1963	3⅝	$174	3⅝	$188.50	$14.50	8.3
1964	3⅝	174	3⅞	201.50	27.50	15.8
1965	3⅝	174	3⅞	201.50	27.50	15.8
1966	4⅛	198	4⅜	227.50	29.50	14.9
1967	4⅛	198	4⅜	227.50	29.50	14.9
1968 (and after)	4⅝	222	4⅞	253.50	31.50	14.2

[1] Percentage increase figures based on—
1963: Increase in base with no increase in rate.
1964–65: Increase in base and ¼ of 1 percent in rate for medicare.
1966–67: Increase in base and graduated rate increase, plus ¼ of 1 percent for medicare. Percentage increase is lower because medicare rate of ¼ of 1 percent remains constant.
1968 and after: Increase in base and graduated rate increase, plus ¼ of 1 percent for medicare. Percentage increase is lower because medicare rate of ¼ of 1 percent remains constant.

INCOME TAXES

Mr. BYRD of Virginia. Mr. President, consider these increased social security taxes in addition to individual income taxes, and compare them. At present income tax rates, a man with a wife and two children would pay $456 in Federal income taxes on a $5,200 income. Social security and income taxes would be almost equal if the man were making $300 a month.

The social security taxes would be higher if the man were self-employed. Under the amendment, if a self-employed man were taxed on $5,200, he would pay $300 in 1964 and $380 in 1968; and if a self-employed man earned $3,600 in 1968 his social security taxes would exceed his income taxes, at present income tax rates.

SEVENTEEN AND ONE-HALF MILLION

While younger people will pay increased taxes for years before they could receive any benefits, sponsors of the pending amendments are authority for the statement that some 17½ million persons who had paid nothing into the fund would be eligible for medicare benefits in January 1964.

These would include some 15 million persons 65 years of age and more already retired under social security and railroad retirement programs, and some 2½ million outside of Government retirement programs who, under the amendments, would be covered into the program with no previous identification in Federal insurance.

MILLIONAIRES COVERED

Such benefits as the amendments would provide would be available to all persons 65 and over, except Federal employees, aliens, convicted subversives, and so forth. There would be no needs test. Payments would be made to millionaires and the indigent, and all of those in between, regardless of ability to pay.

It is a matter of record that among all of those now 65 and older, only about 14 percent are receiving public assistance payments, and, of course, not all of these require services for which the amendments would pay benefits. This would indicate a majority of the elderly are capable of providing for their own needs.

APPROPRIATIONS TOO

The Anderson-Javits amendments would not only increase social security taxes for so-called medicare; but also would authorize appropriations from the general fund. This would set the precedent of providing general fund appropriations to defray costs of social security programs.

In this instance it is said that the appropriations would be to defray coverage costs for those not previously identified with Federal retirement programs. But the fact is that part of the increased revenue from the pending amendment would be used to "sweeten" regular social security retirement payments.

DISAPPOINTING BENEFITS

Even with increased taxes and appropriations from the general fund, medicare benefits under the pending amendment would be disappointing to millions of older persons who, by the highly emotional, much publicized, nationwide campaign for the King-Anderson bill have been led to expect far more.

The amendments would cost more than $1 billion a year, but it would not pay private doctor fees; it would not pay any private nursing costs; it would not pay for any drugs used outside of hospitals; it would not pay for any nursing home facilities unless they were directly affiliated with a hospital; it would not pay for dental work; it would not pay for eyeglasses; it would not pay for any prosthetic devices, and so forth.

What would they pay for? They would pay for diagnostic services after the patient paid the first $20; they would pay for up to 90 days of inpatient hospital services after the patient paid the first $20 to $90; they would pay for services up to 180 days in a nursing home directly affiliated with a hospital after a patient is released from the hospital; and they would pay for home health care up to 240 visits.

QUESTIONABLE CHANGES

Much has been said in the floor discussion of so-called improvements in the pending amendments relating to participation by private insurance companies and by agencies of State governments. The language in the amendments clearly indicates that participation by States and insurance companies would be limited, indeed.

There has been no testimony as to the reaction of either the States or the insurance companies. This, of course, simply goes to prove the necessity for proper hearings and examination with respect to legislation such as this. Without the evidence and testimony these provisions cannot be evaluated.

KINDLY DISPOSED

Analysis of the pending Anderson-Javits amendments, as was true also with the King-Anderson bill, makes obvious the reasons for proceeding cautiously with this plan despite the fact that it is a proposal which appeals to the sympathies of almost everyone.

All of us want the very best for our senior citizens; no one is unkindly disposed toward them, but the amendments are a misguided effort which could disappoint them and impose hardship on their children. There is every reason to proceed carefully in a matter as important as this.

TREMENDOUS STRAIN

Even with all of the shortcomings in the pending amendments, they would be certain to put a tremendous strain on existing medical institutions, related facilities and personnel. The amendments, of course, make no provision for financing the cost of their expansion. This would come later.

Full payment by the Federal Government for the quality and quantity of medical care which people would expect would be virtually impossible for the simple reason that necessary taxes would be too high. This would be doubly true if secondary costs were to be financed.

ONE HUNDRED DOLLARS EACH

If annual expenditures should average $100 each for the 17.5 million persons covered by the pending amendments, the cost would be $1,750 million per year. With higher taxes, higher pay base, and appropriations from the general fund, this is about the amount to be received in 1964.

The administration estimated that first-year costs of a medicare program similar to the provisions of the pending amendments would be $1.1 billion. With limited medical benefits for persons after they have reached 65, and none for those under 65, rapid expansion of the program could be expected.

Under all of the circumstances, which must be considered, I shall vote in opposition to the pending amendments.

Mr. ANDERSON. Mr. President, there are many, many things with which we could concern ourselves. Quite a bit has been said about there being a misrepresentation of the situation; that we actually would not do what we say we would do; that this proposal is not a medical care proposal.

I have been, I am sure, particularly careful, round after round, to say that

this is not a medicare proposal. The bill which was introduced cites, at the beginning:

This act may be cited as the Health Insurance Benefits Act of 1961.

That was the basis on which it was introduced in the Congress.

The pending amendments provide:

On page 1, line 4, strike out "Public Welfare Amendments of 1962" and insert in lieu thereof "Public Welfare and Health Insurance Amendments of 1962".

We have not attempted to sail under false colors. We have said constantly and persistently that this is a health benefits proposal, a health care proposal. We are not at all talking about medical care.

I was in this august assembly when there was a long discussion over what was known as the tidelands oil bill. That was originally introduced as the Submerged Lands Act. It got nowhere, because the submerged lands had been decreed by the Supreme Court not to belong to the United States.

Then a smart advertising man took charge and changed the name to the tidelands oil bill. That was done because the Supreme Court had held that the tidelands did belong to the United States. Then on the basis of what they called the bill, not on what it was, there were ceded to the States the submerged lands of this country.

I talked at some length against the bill. I fought against it a little, as did many others. One of the things that I resented was that it was called the tidelands bill, when there was not an inch of tidelands involved in the bill. After the Senate finished that, the proponents brought out a submerged lands bill, to take care of the outer shelf.

In this particular case, we have tried hard to get the terminology correct.

I was very much interested in the $35 billion which it is said that the workers of this country—the blind, the crippled, and all the other people—will have to pay. Will they? I think not.

We have had many discussions with regard to the comments of Mr. Robert Myers. Mr. Robert Myers pointed out what would be the amounts of money involved, in a memorandum dated July 12.

This memorandum shows that in 1963 $580 million would be paid in on a cash-payment basis. In 1964, $2,010 million would be paid in. Therefore, something in the neighborhood of $2 billion would be paid in that year.

Under our program, the value of benefits in the aged who contribute insubstantially to the program would be only 0.1 percent of payroll. Of the total of 0.68 percent of payroll collected for health insurance, this amount of 0.1 would go for the current aged. The contribution toward the current aged thus would be 15 percent of total contributions. If these current aged were omitted from the system, health insurance would cost 0.58 percent of payroll. In other words, as things stand, the worker would contribute 0.34 percent of payroll, and to his advantage would go 0.24 percent of payroll from employer contributions.

So the $35 billion would come from the employer. None would actually come from the worker.

If someone is going to shed tears, he should shed tears for the employer and not for the worker. The worker would gain by this procedure. He would not have to pay the cost. The young worker would get more than value for what he would pay in terms of contributions. The employer contribution would in part cover the cost of the worker.

Many things have been said about the need for this program. We prepared at one time a long list of tables. I trimmed them down and trimmed them down, thinking of putting them in the RECORD.

One after another we pick up stories of individuals and people, and what they believe. I will not take the time of the Senate on this problem, except to point out one case which came to the Office of the President. It was about a 77-year-old man retired on social security. His daughter put this statement in a letter:

He has worked all these years to acquire his small home, plus a small amount of savings to supplement his and his wife's needs. He carried no medical or hospital insurance (however, even if he had, the insurance would not cover the costs incurred by his wife's illness). He figured his savings would take care of any emergencies, never figuring the costs of today. He wanted that feeling of independence, and thought he had solved all his problems.

Since his wife's death, the man is now confronted with the following bills: hospitalization for 30 days, $2,962.70; doctors' bills to date, $900; private nurses, $625; funeral expenses—approximate—$1,200.

This man had some problems. We would not solve them all. Nobody claims that we would solve them all under the terms of the amendments.

I give that to illustrate things that need to be done.

Mr. President, we are about to make a great decision—a decision which will mark tomorrow as one of the most memorable days in the history of the efforts of our Government to promote the general welfare—a decision which will be looked upon as a long, firm stride toward the state of well-being to which the people of this country aspire. What we decide will be of tremendous significance to all Americans. But it will be a godsend to the 17 million Americans who have passed their 65th birthdays.

Many of these older people now have as their constant companion the fear that a costly illness will deprive them of everything they have managed to save during a lifetime of hard work and sacrifice. And not far removed from having this fear as a companion are many additional millions of Americans who have reached the time of life when their thoughts go more and more to the problems which will face them after they get old and no longer have an income from work. And let us not forget the importance of our imminent decision to the sons and daughters of these millions of older Americans, who—while struggling to provide modest comforts for their own families, pay off the mortgage on a home, and put a youngster through college—face the day-to-day fear that they may have to go heavily into debt to pay the hospital bills of an aging father or mother. Let there be no doubt that all Americans—the young as well as the old—should attach great importance to what we do on health insurance.

The discussion of health insurance for the aged that has taken place on this floor during the past several days has been most gratifying. The interest displayed in financing the health needs of the aged befits the importance of this subject. It is good that so many facts and ideas have been so thoroughly aired. The fact that the discussion has been of bipartisan character is indicative of the importance of this measure. The extensive improvements over my original bill that are reflected in the proposal now before us are the result of close cooperation on the part of a number of Senators from both sides of the aisle. To my Republican colleagues who are cosponsors of the measure I extend my sincere appreciation.

We are engaged in a serious and strenuous effort to get a good program of health insurance for the aged. Mr. President, let me assure Senators that this is no futile gesture. As surely as I stand here, the efforts we are making will lead to a measure of health insurance for the aged of which we can be proud. We have before us a proposal on which there can be agreement among all who are sincere in wanting to provide an effective method by which the problem of the health needs of the aged can be met. I am convinced that our efforts will be fruitful.

THE PROBLEM

The problem that the health insurance proposal would meet is grave. It also is one that presses for solution.

Today, few people reaching retirement age are free of the fear that an expensive hospital stay will wipe out their savings and, after a lifetime of independence, force them to public assistance, private charity, or dependence on their children.

Let me state for Senators, very briefly, what I believe are some of the significant facts that have now been established.

AGED CANNOT MEET THEIR HEALTH COSTS WITHOUT HELP

There is now general agreement that old people cannot meet their health costs without help. Mr. President, I wish to extend my most sincere congratulations to the Members of this body for their diligence in culling the wheat from the chaff—in getting rid of the utter nonsense that old people do not have a real problem and that a Federal program to deal with it is not necessary. The fact, so well brought out in our discussion, is that old people have health costs which are twice as high as those of younger people and have only half as much income to deal with those costs. That spells "problem" to anybody who has a grasp of today's economics.

I do not want to belabor a point already generally recognized, but I want to repeat a few statistics which make deep imprints on one's conscience. Old people need three times as much hospital care as younger people. One in six aged persons is hospitalized each

year. Nine out of 10 will be hospitalized at least once after reaching age 65. An elderly couple, in a year during which one or both members receive hospital care, can expect their combined medical bills to total about $1,200.

The figures on income and assets are no less disturbing. Half of all aged couples have less than $2,500 in annual income. Half of the aged persons living alone have less than $1,000. Although many have equity in a home, half have less than $500 in liquid assets. Nor is it only the very poor who are threatened by financial disaster by ill health in old age. When serious illness occurs with such frequency after 65 that the average couple can expect 5 periods of hospitalization between 65 and death, ill health threatens the financial independence of almost all the aged.

With health care costs continuing to rise, and the income of the aged rising much more slowly, the problem of the aged in meeting these costs can only become more difficult.

PRIVATE INSURANCE CANNOT SOLVE THE PROBLEM THE AGED FACE

Another fact now well established is that private insurance alone cannot solve the problem that the aged face in financing their health costs. This is a matter of simple mathematics. The fact that old people have high health costs make them a high risk group; it costs more to insure them, and indeed many old people would not be accepted for insurance. The other side of the dilemma is that, generally speaking, old people—even those who would be accepted for insurance—cannot afford to buy adequate health insurance. And the situation is made even worse by the fact that the aged are generally not in employee groups or other groups and therefore must be insured on an individual basis, a quite expensive proposition, sometimes twice as costly as group coverage offering identical protection.

It is not hard to understand why only about half of the aged have health insurance of any kind; and why in many cases the coverage is so restricted as to be no defense against the threat that all older people face—the loss of their life savings, and the loss of the homes they have worked hard to pay for and where they expected to live out their days. What health insurance the aged can afford certainly is often woefully inadequate. The policies available to them frequently have restricted benefits, prohibitively high premiums, exclusion of preexisting conditions for from 6 months to the life of the policy, cancellable features, or a combination of these limitations. Thus, another fact that is now well established is that private insurance alone cannot solve the problem that the aged face in financing their health costs.

Blue Cross, which has long tried to extend protection to the aged by shifting part of their cost to younger groups through "community rating," finds it more and more difficult to compete with the commercial insurers. The latter have increasingly been able to attract the low-cost groups, leaving the higher cost groups to Blue Cross. In recent years, Blue Cross has been paying out $375 million in benefits a year for the elderly while collecting only $200 million from them. Blue Cross has as much as said that it cannot do business on this basis any longer, and has asked for a Federal subsidy for the aged.

Further extension of private health insurance protection for the aged must surmount the barrier not only of the generally low-income, high-cost problem of the aged but of the complication that those not now covered include the worst risks and lowest income people even among the aged. This, Mr. President, is an imposing barrier, and I congratulate the Senate for declining to dance to the tune of those who have sung, "let's wait and see." From the debate and adding those who voted for the Saltonstall amendment to those who support my amendment it seems fair to say that practically all Senators agree that more needs to be done now.

HEALTH INSURANCE THE ONLY PRACTICAL METHOD

Now how does this proposal to meet the problem through social security come about? It comes about because it is clear that social security cannot give security in old age through a cash payment alone.

The monthly cash benefits can meet regular and recurring expenses like those for food, clothing, and rent but cash benefits, even if they were a good deal higher than they are, would be ineffective in solving the problem the aged have in meeting their health costs. This is true because these costs are not evenly distributed from month to month or even from year to year. A person over 65 may have no appreciable health costs for several years and then in a short time have health costs running into the thousands of dollars.

It is not desirable, even if it were possible, to increase the social security cash benefit sufficiently to cover such large expenses. The obvious solution is to even out this expense over time and over all the aged, and the only way to achieve this is through insurance. And that of course is what our proposal is all about. The fact is that the only practical way that basic retirement protection—security for older people—can be furnished is through a combination of a cash benefit and health insurance.

What this proposal does therefore is to add to the cash retirement benefit of social security $8 a month—in terms of a paid up health insurance policy. This is not as much of a departure as some have tried to make out. Many times we have raised social security benefits, for those already 65 as well as those who will become 65 in the future. This proposal constitutes another increase in social security minimum protection. After the passage of this proposal all social security beneficiaries will be entitled to at least the $40 minimum cash benefit and a health insurance policy worth $8 a month. Above these minimums, the benefits vary, of course, in relation to past earnings. This is the theory of our proposal. It is based solidly on past precedent and differs only in that the security of the aged demands that the next increase in the minimum protection under social security be in the form of a paid up health insurance policy.

Now the reasons that social security is the most effective instrument for the purpose at hand is that, just as in the case of the cash benefits provided under the program, people contribute throughout their working lives, when they can afford it, and receive the protection after 65, when they need it most. They receive this protection without further contributions after retirement.

This social security instrument gives protection on a practically universal basis. More than 9 out of 10 people who work, and their families, are protected by the social security program. By 1964, when the proposed health insurance protection would be effective, about 95 percent of the people then attaining 65 would be eligible for social security benefits, and this percentage would rise to an even higher figure thereafter. In the course of a year some 73 million earners now contribute to the program; 86 million have contributed long enough to be fully insured. Coverage is nearly universal and, of course, under this amendment we have provided also for railroad workers and have blanketed in the aged who have not had the opportunity to participate in these systems in the past.

MEDICAL ASSISTANCE FOR THE AGED NOT THE ANSWER

Some Senators who still have reservations about a health insurance program financed through social security have urged that we defer action until the Federal-State medical assistance for the aged programs has been given a further opportunity to deal with the problem. I believe, though, that the viewpoint that medical assistance for the aged cannot, will not, and indeed should not be expected to, solve the problem is the viewpoint of the great majority and is gaining more adherents every day.

It is now nearly 2 years since the enactment of the legislation which permits the States to establish programs of medical assistance for the aged, financed to a considerable extent by Federal grants; yet, only half of the States have established any kind of a program of medical assistance for the aged under the MAA law; and most of those that have been set up are quite ineffective.

In May 1962 only 102,000 persons were getting help under such programs. About 90 percent of the payments are concentrated in four high-income States. A few of the other States have developed modest medical assistance for the aged programs but, generally, very little has been done in the States which have lower income and greater need. These other States certainly want to do the best possible job in meeting the needs of the old people in the State, and the Federal Government puts no strings on the money it will provide. In fact, the MAA legislation put no limit on the funds that could be provided by the Federal Government, subject only to the provision of matching funds by the States.

But the problem is that the States do not have their part of the money neces-

sary to do a good job, and there is no indication that large new sources for State revenues will suddenly open up. The financial burden on the States, if all were to develop full-fledged MAA programs, would be enormous. They would have to raise funds amounting to about three times as much as they are now spending under both the new medical assistance for the aged programs and under the medical vendor payment provisions which have been a part of the old-age assistance programs for more than 10 years.

But in any event, the means test approach is not a satisfactory solution to this problem for the great bulk of American people, who have maintained their independence throughout their working lives.

I have been very much surprised that evidently some of the Senators from the other side of the aisle who are in sympathy with many parts of this proposal have indicated in the debate that they hesitate to support it because it has seemed to them that making the benefits available without a means test or income test was somehow unfair to contributors to the program. But this is to attack our whole social security program and, in my judgment, to attack it on one of the points where it is strongest and most popular. There is no more reason to argue for an income test in the case of health insurance than in the case of cash benefits. Why do these Senators not argue that under social security today we are taxing workers to provide benefits for older people who could buy their own annuities? And why is it that current workers are not only willing, but eager, to continue to pay the social security tax, and in fact generally favor improvements and extensions in social security, even though they know they must pay increased taxes to pay for those improvements?

Mr. President, one reason why the American people overwhelmingly support the social security program is just because there is no needs test or means test or income test. Current workers know the social security taxes they pay are going to help meet the cost of benefits that will be available to them in retirement regardless of what they may be able to add to them in terms of private pensions or individual savings. This is one of the great strengths of the social security program—that it is a base to which people can add other forms of protection on their own through voluntary effort. This is the basis of the great partnership that exists today between the social security program and some 30,000 or more private pension plans. Any income test or means test destroys this partnership for under such tests one loses rights to the basic protection in proportion to one's success in securing private pension protection or in accumulating individual savings. Thus an income test is a disincentive to individual voluntary effort and to saving.

All of this is exactly as true in the area of health insurance as it is in the case of cash benefits. Actually, if we provide health protection for the aged solely on the basis of an income test we will be undermining the partnership between private enterprise and Government effort that has worked out so well in the present social security program. Success in securing good protection under private retirement systems supplementary to social security will mean that the individual does not get the health insurance he has paid toward. Success in saving on one's own would mean that one's contributions to social security for health purposes would come to nothing. This is to set up incentives in exactly the wrong way.

The situation would be the same as if we relied solely on public assistance for cash payments to the aged—those who had taken steps to provide for their own security in old age would be faced with the spectacle of the improvident, as well as the unfortunate, getting assistance that those who had saved could not qualify for. On the other hand, what will be the situation if we provide health insurance under social security without a means test? Secure in the knowledge that his social security health insurance protection will be available to him whatever resources he may have, the worker will have every incentive to provide additional protection for himself, and he can be counted on to do so.

In the argument for an income test much has been made of the fact that wealthy people would have the protection. Actually wealthy people will get very little out of this program compared with what the Government has already provided for them. To a large extent, wealthy older people are already being reimbursed for their medical costs, since all of their hospital and doctor bills can, subject to very liberal maximums, be treated as Federal income-tax deductions. The provision, applicable to younger people, that only medical expenses over and above 3 percent of income can be deducted does not apply to people 65 and over. For an older person in the highest income-tax bracket, as much as 91 percent of his medical expenditures can be returned to him in the form of income-tax savings.

The only alternative to providing health insurance protection for the few older people who are well off would be to provide the protection subject to a means test or an income test of some sort. If a reasonably effective means test were applied, the cost of administering it would be several times as high as the cost of administration without such a test since it would involve individual case investigations. Then even if the better-off people were excluded, very little money would be saved, and the savings would be reduced by the expense of administration. On the other hand, if the test were a loose one—one that did not provide for individual case investigations but relied primarily on affidavits—there would be danger of large-scale inequities.

Underlying everything else, our objection to a means test is that people do not like it because it is inherently humiliating. This is a matter of fact attested to by all who have been through the process or who are engaged in its administration. The fact cannot be set aside by false analogies. For example, it has been argued that a means test for health insurance is basically no different from the investigation of financial status that a person undergoes when he makes application for a loan. This is not so. The two are very different. If you or I apply for a loan, to buy a house, perhaps, or to buy a car, we go into the interview proudly, with the purpose of establishing that we are good financial risks, responsible, able to provide for ourselves—in short, that we are successful in the world of affairs. Only if we establish this about ourselves will we qualify for the loan. What do we have to do when we apply for a means-test benefit? Just the opposite. We have to establish that we have not saved enough to meet our needs, that we cannot provide for ourselves—in short, that we are a financial failure. This is why the means test is by its very nature humiliating, no matter how humanely it is administered. Do we want to require that the person who has worked and supported himself and his family all of his life, whose retirement is provided for through social security benefits earned through work and based on his earnings, must go to the welfare agency, hat in hand, and plead failure because serious illness has struck?

In any case, the problem is not primarily that of the poor. The problem of meeting the cost of medical care in old age is most pressing for the great group of older people who are neither rich nor very poor. It exists for those of average income and those of well above average income. As is well established, the need for high-cost health care at the upper ages is great. Very few indeed are those who reach retirement age with sufficient resources to be secure in the knowledge that they can pay for all the health care they will need in the years from retirement to death. If any plan that is adopted is to provide protection for all who need it, the few who would be excluded would simply not be worth the trouble it would take to exclude them. Barely 3 percent of the aged have incomes of $10,000 or more and most of these have such incomes only in the early part of the period past 65.

Mr. President, we have provided for a health insurance plan for Federal employees, and including Senators, with the Federal Government as the employer bearing a share of the cost. Did any of us seriously consider leaving out the higher-bracket employees from this program? Of course not. People need health insurance protection at all income levels except perhaps for those at the highest 1 percent in the income scale, and some people cannot get what they need under individual plans because they are poor risks.

For all these various reasons I say that the argument for an income test in this program is fallacious and I urge the Senators on the other side of the aisle who are sympathetic to this proposal in other respects to reexamine their doubts in this regard.

There is great value in having the protection available as an earned right—earned through work and paid for out of earnings. There is the value that every-

one, rich man and poor man alike, can apply for the benefits without having to establish that he has been unable to look out for himself. There is the value of the stimulus to self-reliance and independence that is provided when the worker knows he can save, invest, and provide additional protection for himself without losing his Government protection. There is the cost control that is inherent in a system where the worker knows that he and his employer must pay for the benefits. And make no mistake about it—the worker is willing to support this kind of system only because the benefits are payable without a test of income. If you destroy the right to protection, based on earnings and contribution by introducing a test of need, then the payroll tax cannot reasonably be used to raise the money. The consequence is that a large new cost burden is thrown on the General Treasury, and the cost controls inherent in a contributory system are lost.

Yes, Mr. President, fortunately the responsible, conservative way to finance this program is also the popular way because people want the security that comes from participating directly in the financing and in not having a test of need. The agreement is, if you will, reliance on a user's tax in return for protection to the users. If we rule out benefits for payers on the basis that they have saved on their own and that the funds are available only to those of low income, then we have no right to a user's tax and the whole resource of the payroll tax is no longer available for the great social purposes of social security. Mr. President, this is an issue on which I hope all thoughtful liberals, conservatives, and moderates can agree. We want no income test in social security and we want to continue our contributory social security program to which this health insurance protection is a logical and necessary addition.

Let me turn now to a review of some of the detail of this amendment.

(At the point Mrs. NEUBERGER assumed the chair as Presiding Officer.)

BASIC HEALTH PROTECTION UNDER SOCIAL SECURITY

Mr. ANDERSON. I am sure Senators are familiar with the benefits that would be provided by our proposal.

HOSPITAL ORIENTED

Our proposal is focused on hospital services because an illness that necessitates hospitalization is usually the most costly. The medical expenses for aged people who are hospitalized are about five times greater than the medical bills of aged people who are not hospitalized. And among the aged, hospitalization is very likely to occur: 9 out of every 10 persons who reach age 65 will be hospitalized at least once before they die, and 7 out of 10 will be hospitalized at least twice.

DOCTORS' FEES NOT COVERED

Let me remind Senators that physicians' bills to their patients would not be paid for under the proposal. Payment of doctors' fees would require financial arrangements to which most physicians are opposed. Moreover, since the financial base of our proposed program is, like the entire proposal, intentionally conservative, it seems far more appropriate to concentrate the funds on hospital costs rather than doctors' fees, which by tradition are adjusted to the means of the patient. Since only basic health insurance protection would be provided under the amendment, aged people can be expected to purchase private, supplementary insurance against the cost of surgical and other physicians' services.

One of the most significant features of the proposal is that it covers alternatives to inpatient hospital care. Provision has been made for payment for services provided by skilled nursing facilities that have hospital affiliations, home health care, and outpatient diagnostic studies in order to promote the most efficient and economical use of existing health care facilities. Many patients who do not need the type of care that hospitals provide for the acutely ill can receive the care they need in a skilled nursing facility where costs are less than for hospital patients. Many people who need limited professional attention can receive that care more satisfactorily and more economically in their own homes. Complex diagnostic studies, so important in early detection of illness, can be performed on a hospital outpatient basis without incurring the much higher costs of a hospital stay. In providing for payment for these alternative services, the proposed program would reinforce the efforts of the health professions to reserve hospital beds for acute illnesses requiring intensive treatment that can be provided only in a hospital.

FINANCING PROGRAM

The financial soundness of the present social security program is a strong asset to be considered in the plan for adding health insurance to the system. Let me read you a short excerpt from the January 1, 1959, report of the Advisory Council on Social Security Financing:

> The Council finds that the present method of financing the old-age, survivors, and disability insurance program is sound, practical, and appropriate for this program. It is our judgment, based on the best available cost estimates, that the contribution schedule enacted into law in the last session of Congress makes adequate provisions for financing the program on a sound actuarial basis."

The benefits of the proposal would likewise be financed on a sound actuarial basis. The cost calculations have been carefully developed by the Chief Actuary of the Social Security Administration. The actuary's estimates are based on assumptions and methodology consistent with those used for the present old-age, survivors, and disability insurance program.

The social security contribution rates would be increased by one-fourth of 1 percent each for employers and employees, and three-eighths of 1 percent for the self-employed; the taxable earnings base would be increased from $4,800 to $5,200 a year. Raising the earnings base would improve the benefit structure of the system generally and would also provide additional income which together with the income from the contribution rate increase would fully meet all health insurance costs.

DIFFERENCES FROM S. 909

Although I have previously described in detail the ways in which the amendment differs from my bill of last year, S. 909, I would like now to review briefly the general nature of the major changes embodied in our amendment.

PROTECTION FOR THE UNINSURED

One of the important advantages of the proposed amendment is that it gives protection to practically all of the aged—not just those who are eligible for cash benefits under the social security and railroad retirement programs. The proposal would provide health benefit protection to the almost 2½ million older people who have not worked long enough under the social security or railroad retirement program to be fully insured and who are neither eligible for health insurance as an active or retired Federal civilian employee nor receiving care in publicly financed mental or tuberculosis institutions.

The plan under which health benefits would me made available to people who are now outside the social insurance system is a temporary one. It is designed to wash out in a few years.

The cost of health benefits for people not eligible for cash benefits under the social security or railroad retirement programs would be borne by the general funds of the Treasury. I want to emphasize that no social security tax money would be used to pay for the health benefits of these people.

This provision would meet the critical problem facing the uninsured people that will not be met otherwise. Half of the States have not put even modest medical assistance for the aged programs into effect. The history of past proposals which require implementation by State action demonstrates that progress is very slow after the first year. It is clear then that if the health needs of the uninsured people of today are not met through a straight Federal program, their health needs will not be met in a satisfactory manner, nor to a satisfactory degree, and in many cases their health needs will not be met at all.

ADMINISTRATIVE ROLE FOR PRIVATE GROUPS

Second, the proposed amendment would give the Secretary of Health, Education, and Welfare specific statutory authority to delegate some of the more sensitive administrative functions to Blue Cross or to other similar voluntary organizations that are experienced in dealing with hospitals and other providers of services. Advantageous additional administrative functions could be included in the contract between the Government and the organization. These administrative functions would include reviewing hospital fiscal records as a part of the determination of the cost of services, and acting as a center for communicating and interpreting payment procedures to hospitals. With such organizations serving as intermediaries between the Government and the providers of services, those who are concerned that Government might try

to intervene in hospital affairs would feel much more comfortable.

PRIVATE INSURANCE OPTION

Third, the proposed amendment provides an option to beneficiaries to continue private health insurance protection they held before age 65. This provision will afford people a choice between having health insurance coverage directly through social security and continuing their private insurance arrangements into retirement. The provision would facilitate private insurance supplementation of the basic protection afforded under the proposal. A great variety of private insurance policies would fit into this plan. For example, any policy that provided on a "service basis" for at least 45 days of hospitalization would fit into the plan and could provide any number of additional days of hospitalization and other benefits.

NO INTERFERENCE WITH HEALTH PRACTICES

Fourth, the proposed legislation modifies a number of provisions included in the bill that I introduced last year so as to make it clear that the proposed program would do nothing to interfere with medical practices and hospital operations. These modifications are in the nature of technical changes, and their importance is that they make it abundantly clear no one seeks Government authority to regulate medical care.

SEPARATE TRUST FUND

Finally, the new proposal includes a provision for a separate health insurance trust fund. We have made this change because some people were concerned about the intermingling of old-age, survivors, and disability insurance with health insurance funds, even though separate accounts were maintained. The change makes perfectly clear that funds will not be transferable from one program to another.

HOSPITAL STANDARDS

Some critics of the proposal make much of the fact that hospitals would have to meet certain health and safety criteria in order to participate in the program. In testifying for the hospitals themselves, the representative of the American Hospital Association told the House Committee on Ways and Means that the criteria are both reasonable and necessary. If there were no criteria, the proposed program would undermine the health professions' continuing efforts to raise the level of health care in our country.

Under the amendment, the requirements for participation may not go beyond the professionally set and professionally accepted standards established for hospitals, except for the requirement for a review committee.

The original bill clearly anticipated heavy reliance on agencies like the Joint Commission on the Accreditation of Hospitals. Now the amendment goes so far as to name the commission and specifically provides that, with the one exception of the review committee, a hospital that is accredited by the joint commission would be conclusively presumed to meet the conditions for participation in the proposed social security health insurance plans. About 84 percent of the hospital beds in the country are in hospitals that are accredited by the joint commission.

In the course of the debate on this proposal it has not always been understood that, in addition, unaccredited hospitals could participate in the proposed program. We all understand that adherence to the accreditation standards would unreasonably deprive the residents of some localities of protection under the program. The junior Senator from Vermont indicated concern that unaccredited hospitals could not participate. This is not so. He may rest assured that good smaller hospitals, for example, could qualify under this bill even though they do not meet accreditation standards, and any good skilled nursing facility has the backing of the American Hospital Association in seeking affiliation with a hospital and has 2 years to do so. Thus, nursing facilities that wish to qualify and offer skilled service under quality conditions could also participate.

If the proposed health insurance plan were to operate without placing conditions on participation by providers of health services, the health insurance payments that would be made could damage the continuing efforts of the health professions to improve the quality of hospital care available throughout the country. Even more significant is the need for quality protection in the case of nursing homes. It would be regrettable if payment were to be made for health care in institutions whose environment is truly a threat to the lives of their patients.

Madam President, about 75 percent of the so-called nursing-home beds in Oklahoma, to take one State as an example, are in homes not having a licensed practical nurse or a registered nurse. The patients in those homes came from hospitals while they were still under a doctor's care. Yet they had been admitted to nursing homes which had neither a practical nurse nor a registered nurse. Only about 5 percent of the beds are in nursing homes which have registered nurses. These are not nursing home benefits which would go along with medical care.

DRUGS COVERED

The amendment we are offering makes a technical change that would make doubly sure that the measure would not discourage the use of any drugs of therapeutic value. Under S. 909 hospital payments would have been made for any drug or biological that is listed on any one of the three major U.S. drug listings that have been developed by the drug industry and the medical profession. Even though these drug listings are entirely under the control of the medical profession, and new drugs of therapeutic value can be added to the listings at will, some have feared that reliance on this compendia would restrict physicians. The proposed amendment will clear up this matter by providing that payment could be made under the proposed program for any drug not listed on one of the professional drug listings if the drug is acceptable to the drug or pharmacy committee of the hospital in which the drug is used.

FREEDOM OF CHOICE

The fears that the proposed health insurance program would deny patients freedom of choice are groundless. In fact, freedom of choice would be made more meaningful than it now is because a very substantial economic barrier to the exercise of this freedom would be removed. Thus, I can agree, to a point, with those who say that there would be some increase in utilization under the health insurance proposal. More older people would use hospitals because the proposed legislation would put them in the same position—except for having to pay the deductible—as people with Blue Cross. The program would help meet some of the needs of the aged whose low income now keeps them from obtaining the hospital care their physicians would like to see them get. It seems reasonable for the aged to be in an equally good financial position as the young in seeking hospital care.

UTILIZATION OF SERVICES

But there is no basis for believing that hospitals will be overwhelmed by older patients as some critics of the proposal have contended. While older people could be expected to use somewhat more of the total hospital days in the United States than the one-fifth they now use, an increase of even 25 percent, which would be as high as we could expect, would amount to only a 5-percent increase in total usage. In this connection it should be remembered that on an average day only about 75 percent of hospital beds in the United States are occupied.

Nor do I hold any brief for the argument that says that the elderly and their physicians cannot be trusted with health insurance and that enactment of the proposal will lead to unnecessary hospital admissions and overstays. May I point out that the proposed program would take more precautions against payment for unnecessary services than most voluntary plans. The proposed amendment provides that before any services may be paid for, the attending physician must certify, and at certain times recertify, that services are required for medical treatment or diagnosis. Also, the participating institution would have a self-governing utilization review mechanism that would check on the need for hospital admissions, duration of stay, and services furnished.

The third safeguard is built into the program in the types of services covered. Protection is provided against the costs of hospital outpatient diagnostic studies, care in hospital-affiliated skilled nursing homes, and home health services so as to avoid financial incentives that are prominent in other health insurance plans that encourage beneficiaries to unnecessarily use higher cost services when the lower cost services suffice.

Some persons, of course, view the requirement for deductibles as a fourth safeguard against overutilization.

CERTAIN OBJECTIONS THAT HAVE BEEN RAISED

During the course of the debate on this proposal a number of charges have been made against the plan.

NOT SOCIALIZED MEDICINE

We still hear the charge that enactment of this proposal might lead to a program of socialized medicine. This charge has no more validity now than when it was used by some to try to defeat the measure that provided disability insurance benefits under social security in 1956. As the former Secretary of Health, Education, and Welfare under the Eisenhower administration, Arthur Flemming, said recently, the socialized medicine charge is nonsense. Under the amendment the Government would assume no responsibility for providing medical services, but would only help older people finance the costs of their most burdensome health expenses through a program of basic health insurance. Aside from the difference in the method of collecting contributions and the fact that the proposed insurance is only for the elderly, what is proposed is very much like what Blue Cross has been doing for years—paying hospital bills without meddling in hospital operations. Furthermore, the amendment provides specific guarantees that the Government will in no way control, regulate, or interfere with the practice of medicine.

The proposed health insurance program is not proposed as any foot in the door. A basic, Blue Cross-type health protection is provided and should be enough, because older people, relieved of the burden of having to pay for hospitalization insurance, will be able to afford low-cost supplementary protection through private insurance that they will need against surgical and other medical costs.

Nor do I see any basis for believing that some future Congress might someday stretch the proposed program to cover the younger people of our country. Younger people do not have the low incomes and expensive health needs that characterize their elders, and it is a practicable thing for them to protect themselves adequately against their health costs through the various nongovernmental insurance plans that are available.

Madam President, I am opposed, and I know that my colleagues are also opposed, to having socialized medicine in the United States. If we provide health insurance under social security for that group which cannot acquire adequate protection through the private sector, there will be no problem that suggests the need to take the drastic step of turning to socialized medicine. If this proposal has anything to do with socialized medicine, it represents a step away from socialized medicine. If you pass this measure, you are not opening the door to socialized medicine. It is much more likely that you will be closing the door.

Certain objections have been raised by a few Senators which are really objections to our present social security system. I wonder if those who have raised these objections during this debate are aware that they are simply repeating timeworn arguments that have been generated and kept alive over the years by a relatively small group that opposes our social security system and would like to see it repealed. The old arguments that have long since been rejected by most Americans have been revived and, in slightly refurbished form, are now turned against social security as the means of financing health insurance for the aged.

COMPULSORY SOCIAL SECURITY TAX

Some have objected because the contributions to health insurance tied in with social security would be compulsory. The compulsory feature of the social security program is basic to its purpose. Only through making its application compulsory can the tax burden of supporting the system be distributed equitably. Only through making the system compulsory can an unwise decision in youth be kept from penalizing the worker and his wife or widow in old age. Only by making the system compulsory can society assure itself security against demoralization from fear of economic hazard. Security through social insurance consists not only of providing protection against need as it occurs, but also of providing assurance ahead of time that the funds to provide planned protection are available when needed. Because it is compulsory, the social security system is assured of the future financial resources to provide benefits adequate to the time, now and in the future. And, of course, those who argue against compulsion in the social security method act as if the alternative they propose—reliance on general revenue financing of means test assistance—is somehow voluntary. Voluntary for whom? Not the taxpayer. Not the recipient who has no alternative in his extremity of illness but to go to the county hospital or wherever else the welfare department may send him.

The objection has also been made that the social security financing mechanism involves regressive taxation. While this is something of a point in comparison with Federal income tax, I doubt that very many people would view this feature of social security as a defect. Many businessmen whom I know view the social security tax as a safeguard against rash liberalizations, since the cost of such legislation has an immediate impact on workers who have to foot half of the bill.

To labor, on the other hand, the social security tax represents a substantial investment and they are more than willing to make this investment. Labor does not want a program for the poor that is financed by the wealthy. Thus, we find that the social security tax has the wholehearted support of organized labor. As I discussed earlier, a users' tax is fully justified if we keep faith with the philosophy and do not rule out from the benefits—on some extraneous ground such as one relating to income—those who have paid the taxes.

I will also point out that some who have made this argument have supported the use of State general revenues as a way of meeting a large part of the cost of alternative plans. State revenues, of course, are largely derived from the highly regressive sales and other regressive taxes; in 1958, State sales tax receipts amounted to four times the yield from State income taxes.

AMOUNT OF THE RESERVE

Some who object to our proposal try to imply that the money to pay benefits might run out because the social security program is not financed on a full reserve basis—a requirement for private insurance. Private insurance companies are, of course, required to maintain full reserves because they must be prepared at all times for the possibility that they may go out of business. The point to keep in mind is that the social security system is here to stay—we do not have to worry about its going out of business. Social security rights are backed up by the faith and credit of the United States. The return for the contributions paid is secured by the earnings of the working people of the United States.

Let me read from the Finance Committee's report on the social security amendments of 1961:

> It can reasonably be presumed that a social insurance system under Government auspices will continue indefinitely into the future. The test of financial soundness is not then a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather the test is whether the expected future income from taxes and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs. The amount of "unfunded accrued liability" does not have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group.

THE PRESENT AGED WILL NOT CONTRIBUTE ENOUGH

The proposed health insurance program should not be looked at solely over the short run. We are considering permanent legislation here. Over the short run it is true that some people will get health insurance protection in spite of not having contributed significantly to the cost of that protection. Over the long run, though, what we will have is a system under which current workers, with their employers, will pay toward the cost of their own protection—pay for it while they are working, out of their earnings, with the knowledge that the social security taxes they pay are going toward meeting the costs of the hospital care they will need in retirement.

Our social security program for many years has provided for full benefits to people already advanced in years when they were first covered. It has provided, too, for higher benefits relative to contributions for lower paid workers. The way this is done, of course, is that the employer's contribution is used to meet a large part of the cost of benefits for people who have not had an opportunity to contribute long enough to meet the cost of their own benefits or who, as lower wage earners, draw weighted benefits.

So it would be under health insurance. Employees currently working would be paying, to provide benefits for themselves in retirement; and part of the employer contribution toward health insurance, like that toward cash benefits, would provide the benefits for those in the first generation who cannot pay their way.

No one denies that those who are already old have not paid enough in taxes to meet the cost of the monthly benefits they are getting now; and those already on the benefit rolls of course will not have paid enough to meet the cost of health insurance protection for themselves. Yet the addition to the overall cost of the program that results from the payment of benefits to those already on the benefit rolls, and others who will not have contributed substantially to the cost of their protection, amounts to only 15 percent of the total long-range costs of the health insurance plan.

The inclusion of benefits for the older group, then, will in no way prevent the younger worker from getting his money's worth from the additional contribution that he will pay for health insurance protection. And if the younger worker is getting more than his money's worth, how can it be said that his taxes are buying benefits for the rich, as some have said?

CONCLUSION

I submit that the objections to health insurance for the elderly through the social security program do not stand up under close inspection.

The problem that old people face in meeting their health costs is one that they themselves cannot handle entirely on their own. It is a grave and urgent problem. Private insurance alone is not the answer. The retirement benefits paid under social security cannot by themselves be high enough to meet the costs of expensive health care in old age. Medical assistance for the aged, though necessary as a second line of defense, cannot do the job. The only solution, Madam President, is to provide for meeting health care costs in old age through health insurance under the social security program. This is abundantly clear from the evidence that has been presented during the course of this debate and during the extensive study that preceded it.

The social security program offers the only practical mechanism that would enable the great majority of the people of our country to provide for their health needs in old age. Under social security, contributions are spread over the individual's working lifetime; they vary with earnings levels and are shared by employers and employees. In old age the protection is available without further contribution. This is what makes the system so perfectly adapted to this problem, which can be defined in terms of the greatest need for health care coming in retirement—just when incomes are lowest.

The social insurance mechanism also offers a truly conservative approach to meeting basic costs of illness in old age. The scope of the health insurance protection that would be provided would be clearly defined and limited by law, the long-run cost of the program would be actuarially calculated, and revenue sufficient to finance the program would be provided.

The many years of exhaustive study and discussion that have preceded our consideration of this amendment have clearly established the critical need for its enactment. The facts that are needed by Senators in order to make an informed decision on the proposal have been readily accessible to all of us and I know that every Senator is familiar with this information. As some Senators have pointed out, a report on the measure by the Committee on Finance would have been helpful in our deliberations, and I regret that my many efforts to have that committee act on the measure have met with no success. But every Senator also knows that the facts of the matter would not have been changed by committee consideration. I can see no reason why any Senator should be unprepared to take a stand on the vital issue that is before us.

That issue is simple and clear:

Should the fundamental approach to the problem of high health costs of elderly Americans be one that maintains personal dignity or should it be one that demoralizes by requiring proof of poverty?

Should we prevent dependency and the fear of dependency or should we merely try to deal with the pathetic situations of the elderly after they have been reduced to poverty?

Should we provide a way for people to help pay their own way, with incentives to work and save, or should we take away these incentives by helping only those who have little income and savings and can meet a means test?

I have no doubt as to how these questions would be answered by the great majority of the many millions of Americans who await our decision today for I have no doubt how Americans feel about their system of social security.

These are questions that transcend party lines, and I again express my appreciation to my colleagues on the other side of the aisle who have recognized this through their cooperation in developing the proposal before us. The measure we have before us is one on which there can be agreement among all who sincerely want to provide an effective program of health insurance protection for the elderly.

Let us make it abundantly clear by our decision that we, too, reject the idea that people who have lived all their lives in dignity and independence should be required to use up their savings and submit to an investigation of need before they can get essential hospital care.

Let us choose the way that is consistent with the American concept of earning security through work—the social security way.

Mr. McNAMARA. Madam President, I call up my amendment designated "7-13-62—A" and ask that it be read.

Mr. JAVITS. Madam President, before that is done, will the Senator yield? I should like to make a brief comment on the speech of the Senator from New Mexico.

Mr. McNAMARA. The action I have just requested will take but a moment.

The PRESIDING OFFICER. The amendment will be stated.

The LEGISLATIVE CLERK. On page 13, it is proposed to strike lines 13 through 25 and insert in lieu thereof the following:

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

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

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

Mr. McNAMARA. Madam President, will the distinguished Senator from New Mexico modify his amendment by accepting mine? We have discussed this request. He understands that my amendment is merely technical and would correct the wording, particularly as it applies to the definition of "benefit period."

Mr. ANDERSON. I am happy to accept the amendment of the Senator from Michigan. This is another instance in which it was thought the language was as clear as crystal, but the Senator from Michigan found that it was not exactly as clear as crystal. When he looked at it with a different pair of glasses, he received a different impression of it. I am happy to accept the Senator's amendment and to modify my amendment accordingly.

Mr. JAVITS. Madam President, will the Senator from Michigan place in the RECORD a memorandum of explanation of his amendment, so that Senators who read the RECORD may understand his proposal?

Mr. McNAMARA. Madam President, at the request of the Senator from New York, I am very happy to submit an explanation of the amendment, to be printed at this point in the RECORD.

The PRESIDING OFFICER. Is there objection?

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

STATEMENT BY SENATOR McNAMARA

My amendment is a technical one intended to correct wording in the definition of a "benefit period" which would have led, I am sure, inadvertently to results not intended by the proponents of the Anderson amendment.

Studies conducted by the Special Committee on Aging have shown us that there is good reason to believe that many older people, suffering from chronic diseases and who have been hospitalized for long periods, could be better taken care of at home at much greater satisfaction to themselves and at less cost to any one if they could be given intermittent hospital care—say, for 1 or 2 days a month.

While the Anderson amendment quite properly is designed to encourage the movement of patients as quickly as possible from

hospitals to nursing homes and then to their own homes, the language of that amendment, as it now stands, would inflict a serious penalty on people in need of such intermittent hospitalization. It provides that after he had received 150 units of care, a beneficiary would never again be eligible for any services under the bill until he had been out of the hospital or nursing home for a continuous period of 90 days. That could mean that some individuals might receive only one period of benefits throughout their entire retirement lives.

My amendment simply provides that a beneficiary will be entitled to begin a new benefit period after he has been out of the hospital and nursing home for a total of 90 days in a 6-month period. The 90 days would not have to be consecutive. In other words, Mr. President, the older person who did require brief periods of intermittent hospitalization could receive it without endangering his entitlement to future benefits.

I am advised that the Department's experts have agreed that acceptance of my amendment will have an altogether negligible affect on the costs of the program.

I hope the distinguished Senator from New Mexico will accept my amendment.

Mr. JAVITS. Madam President, will the Senator from New Mexico yield to me?

Mr. ANDERSON. I am glad to yield to the Senator from New York.

Mr. JAVITS. First, I wish to express my pleasure at the association which I and other Senators have had with the Senator from New Mexico.

But, more important, two words used by the Senator from New Mexico are critically important. Tomorrow—assuming that I then have an opportunity to speak—I shall endeavor to develop some points in regard to what I understand was a very forceful and typically able speech made by the Senator from Oklahoma [Mr. KERR]. But I should like to comment now on two words the Senator from New Mexico used. One is the word "conservative"; the other is the word "developed." I think those two words are rather key words in connection with my own feelings and, I believe, also the feelings of other Senators who recently have come to favor this way of meeting the problem of medical care for the aged. It is true that when a program is begun, obviously it must be financed in the beginning, just as a railroad train must get underway slowly. I believe that would be accomplished under this bill with a minimum of effort, under the circumstances, especially in view of the urgency of the need and the necessity of making a beginning.

What has impressed me particularly is that this method provides for pay-as-you-go financing, especially since those who have this need give every evidence of willingness to pay for the assistance. From a conservative point of view, since this plan would take care of about four-fifths of the estimated cost for the first year—that is, the social security payments themselves—it is a more conservative approach than the general revenue plan which I and other Senators proposed, especially since I am convinced that those who would pay—those at the lower income scale—are willing and anxious to do so, for reasons which we have discussed many times.

The Senator from New Mexico also made the point about the development which has occurred. This has been an extraordinary development. I understand that the Senator from Oklahoma spoke of it very feelingly. As I have said, I hope tomorrow to make some remarks on that subject.

This measure has been developed in a very effective way; and I wish to emphasize that point in the RECORD to be read by Senators who tomorrow will participate in the forthcoming all-important vote. This measure has been developed; and now, instead of providing a ceiling, as the King-Anderson approach did, this measure provides a plan which is a floor, so that private enterprises and cooperative enterprises in the United States which wish to do so can participate. This is the traditional American way, and this development has been extremely and critically important.

Again I wish to express the gratification which I feel for the openness of mind on the part of the Senator from New Mexico in connection with the efforts he has made to bring the measure to this pass, and also for the development in connection with the coverage. We fought for universal coverage; and I am happy to say that we were successful. But we did not contemplate the plan which now is included in the bill, which gradually will implement those who are to be covered into the social security system. I consider this to be a really brilliant concept, aiding the legislation a great deal and doing it a great deal of good, and putting it on a solid and orderly basis, from which it will prosper.

I wish to add these few words in regard to the distinguished Senator from New Mexico, who has fought so manfully for this matter from its very beginning.

The measure now is conservative as regards its financing. Second, it has developed from being a ceiling into being a floor, which is very much germane to the American way and to the capabilities which inhere for its development and its improvement.

I congratulate the Senator from New Mexico on his usually thorough and extremely able statement; and I express my pleasure at being associated with him in this effort.

I hope all Senators realize the seriousness of the vote which will be taken tomorrow. Let Senators understand that the vote tomorrow will be the payoff vote. This program will be dead, in my opinion—whether for this session, or perhaps even beyond that—unless tomorrow the motion to lay on the table is rejected. All of us realize that that will be the payoff vote as regards medical care for our older citizens. So I hope all Senators will read very closely the arguments which have been made on both sides.

Mr. ANDERSON. Madam President, I thank the Senator from New York, particularly for the kind words he has many times spoken.

A moment ago the Senator from New York spoke of the mechanism by which the inclusion of these additional persons would be financed. If those on the other side of the aisle had not insisted that that was the right thing to do, our group would never have started to look for a way to do it. However, Senators on the other side of the aisle constantly requested that we consider this question very carefully and try to find whether there was a way to do it; and those requests led us to spend many hours on that subject.

The other day it was stated on the floor that this measure was casually drawn; at another time, it was said that the measure was carelessly drawn. But, Madam President, this legislation has not been carelessly conceived. It represents a great many hours of work—more hours than I like to remember—in trying to bring out a bill which is sound, sensible, and workable.

Furthermore, the point the Senator from New York has mentioned is an example of what can be achieved by cooperation, until an amalgam of ideas is achieved. If the group of Senators on the other side of the aisle had not said, "We think this can be done; find a way to do it," we would not have done what we did; but their frequently repeated request led us to continue our studies, day by day and week by week, until we found the solution which the Senator from New York finds satisfactory.

Mr. KEATING. Madam President, will the Senator from New Mexico yield to me?

Mr. ANDERSON. I am happy to yield to the junior Senator from New York, who also has made great contributions.

Mr. KEATING. Madam President, I also wish to commend the Senator from New Mexico for the fine presentation he has made. I emphasize one point which was made by my colleague [Mr. JAVITS]; namely, the significance of the vote to lay on the table, which will be taken tomorrow. In the corridors there has been much loose talk to the effect that "if I vote in favor of the motion to lay the bill on the table, I will not be voting on the merits of this proposal; I will only be voting that it should not be attached to this particular bill." But, Madam President, the answer to that is the resolution the Senator from New Mexico has submitted, which I think should be acted upon promptly; namely, the resolution to extend for 60 days the provisions of the Public Welfare Act. The vote on the motion to lay on the table will be a vote on the merits of health care for the aged; and there is no getting around it. Let there be no doubt about it. Let no Senator who favors a bill of this kind feel that he is assuaging his conscience when he says, "I will vote for the motion to lay the bill on the table at this time, because this is not the appropriate time to bring it up." That argument has been spoken of in some quarters as "hogwash," although I am not sure whether this is an appropriate word to use in this Chamber.

Mr. DWORSHAK. Madam President, will the Senator from New Mexico yield?

Mr. ANDERSON. I shall yield in a moment.

I hope that even Senators who might have some objection to the bill will vote, tomorrow, against the motion to lay on the table, because the Senate should reach a decision on this question, so that the people can decide what the House Ways and Means Committee may do.

Therefore, I think it very important that the motion to lay on the table be rejected, so that we may make certain that a final vote on this question will be taken and a final decision on it may be reached. I hope that Senators who might be opposed to this measure will nevertheless vote against the motion to lay on the table, so that at this time we may come to a decision.

I now yield to the Senator from Idaho.

Mr. DWORSHAK. Madam President, with much trepidation I rise to question whether the two distinguished Senators from New York have a right to impugn the motive of any Senator who does not agree with them on the problem of casting a vote on this very important issue in a crucial political year.

Madam President, every Senator knows that the House Ways and Means Committee does not propose to make a report on the proposed legislation in the near future; and I, as a Member of this body, regret very much that we are not following regular procedure by having a committee of the Senate give meticulous and careful consideration to legislation which has such great importance to the economic welfare of our country.

Mr. JAVITS and Mr. KEATING addressed the Chair.

Mr. ANDERSON. I will yield to either or both Senators.

Mr. JAVITS. Madam President, I was not impugning the motives either of the Senator from Idaho or of any other Senator. Any Senator who sincerely believes he is against this legislation has every reason to vote against it if that is the way he feels. If a Senator is against the legislation, that is one thing; but if he intends to vote against it, because, as my colleague from New York [Mr. KEATING] has said, of the way it has been brought before the Senate, that is another way of saying that the Senator is against it. The country will understand that this is a vote for or against, and not a question of procedure.

That is what I was trying to say, and I was not trying to impugn the motives of any Senator.

Finally, as to the point about the Ways and Means Committee of the House, for which I have great respect, I served, in the House, as did other Senators. When the House wants to do something, it will do it. I sat in the Chamber in 1948 and I watched colleagues vote for the Marshall plan who, a few weeks before, had said they would rather jump out of a 10-story window than vote for it if it were called up; but when it came before them, they voted for it, because their people insisted on it. The same is true in this case. I have no doubt that if constituents want it, it will be voted for. It may not necessarily come out of the House Ways and Means Committee, but there are ways to have it considered by the House, whether by discharge petition, going to conference, suspending the rules and getting a two-thirds vote, or some other way of getting it before the House, if there is a real demand that it be done. There will be no such demand, and it therefore will not get anywhere; unless the tabling motion is defeated tomorrow and the Anderson amendment is thereafter adopted.

Mr. KEATING. Madam President, will the Senator yield?

Mr. ANDERSON. I yield.

Mr. KEATING. I want my distinguished friend from Idaho to know that nothing I said was intended to impugn his motives or those of any other Senator. We assume that the motives of all Members of this body are of the purest. That is the custom, and that is the assumption I am happy to make. If there was anything in my remarks which was felt to impugn the motives of my good friend from Idaho, I deeply regret it.

Mr. ANDERSON. Madam President, I understand the Senator from Delaware and the Senator from Minnesota wish to obtain the floor in their own right, and I therefore yield the floor.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. MORSE. Madam President. I send an amendment to the desk, and ask for its immediate consideration.

It will not be necessary to read the amendment, but I shall explain it.

The amendment offered by Mr. MORSE is as follows:

On page 11, strike out lines 12 through 16.

On page 11, line 17, strike out "(2)" and insert in lieu thereof "SEC. 1704. (a)".

On page 12, line 7, strike out "ninety days" and insert in lieu thereof "forty-five days".

On page 12, line 15, strike out "one hundred and fifty units of service" and insert in lieu thereof "one hundred and five units of service".

On page 12, line 23, strike out "ninety days" and insert in lieu thereof "forty-five days".

On page 32, strike out everything beginning with the last word on line 25 and down to and including the word "and" on line 5 on page 33.

In section 1716 of the Social Security Act, as added by the Anderson amendment (6–29–62—A), and further modified on July 12, 1962, strike out subparagraphs (A) and (B) of subsection (c)(2) and insert in lieu thereof:

"(A) inpatient hospital services, with no more restrictive limitations than are applicable in the case of inpatient hospital services which constitute reimbursable health services, or

"(B) in the case of a plan meeting the requirements of clause (A), (B), (C), or (D) of paragraph (5), inpatient hospital services to the extent provided in subparagraph (A) of this paragraph, except that the plan may provide that payment for such services during any benefit period shall be reduced by a deduction (or that a charge for such services will be made), but not in excess of $20, or if greater, $10 multiplied by the number of days, not exceeding nine, for which the individual received such services in such period, and then only if the limitation on the number of days for which such services will be provided without other charges, or for which payment will otherwise be made with respect to such services, is increased to at least ninety days."

In such section 1716 in the Anderson amendment as so modified, strike out subparagraph (B) of subsection (c)(3) and insert in lieu thereof:

"(B) in the case of a plan meeting the requirements of clause (A), (B), (C), or (D) of paragraph (5), such reimbursable health services, except that the plan may provide that payment for such services during any benefit period shall be reduced by a deduction (or that a charge for such services will be made), but not in excess of $20, or if greater, $10 multiplied by the number of days, not exceeding 9, for which the individual received such services in such period, and then only if the limitation on the number of days with respect to inpatient hospital services is increased from the number specified in section 1704(b)(1) to at least 90 days."

In such section 1716 in the Anderson amendment as so modified, strike out paragraph (2) of subsection (f) and insert in lieu thereof the following:

"(2) In the case of a plan to which subparagraph (B) of subsection (c)(3) is applicable the limitations and conditions of payment for reimbursable health services under the preceding sections of this title shall be modified—

"(A) by application of a deductible amount of $20 or, if greater, $10 multiplied by the number of days, not exceeding nine, for which the individual received impatient hospital services during a benefit period and substitution of a ninety-day limitation of the number of such days during a benefit period for the forty-five-day limitation in section 1704(b); and

"(B) the substitution of a limitation of 150 units for the one-hundred-five-unit limitation in such section 1704(b); and in such case, the provisions of section 1710(a) shall not prevent a provider of services from imposing a charge equal to the amount of such deductible with respect to inpatient hospital services, but such charge may not exceed the amount customarily charged for such services."

Mr. MORSE. Madam President, when I finish my speech, I shall withdraw my amendment. I shall not yield until I complete my statement.

How much time have I on my amendment?

The PRESIDING OFFICER. Thirty minutes.

Mr. MORSE. I yield myself such time as I may need within the 30 minutes.

Madam President, my amendment would simply strike from the proposal before us the provision which would require a beneficiary to pay from his own funds at the time of his illness a part of the hospital bill.

As I have revised it since first introducing it on Friday, it also reduces the number of days of hospital coverage to 45 days.

These so-called deductibles are set forth on page 11 of the Anderson amendment and call for a payment by the patient of from $20 to $90 for inpatient care and of $20 for a series of diagnostic tests.

It is my contention that such deductible charges do not belong in this bill. It could well be contended that deductibles, which serve to deter the poorer patient from getting care as soon as he needs it, do not belong in any prepaid health insurance plan.

Least of all, in my opinion, do they belong in a soundly conceived social security program.

Let us consider for a moment the reasons given for having these deductibles. Usually they are two. One is to prevent abuse of the plan, to stop overhospitalization or unnecessary hospitalization by making the patient pay something for each use of service. The second argument is that deductibles reduce the cost of the plan; that to drop them will require an increase in contributions.

It is my belief that these arguments are not tenable insofar as this program is concerned.

Let us look first at the argument that a deductible is needed to prevent unnecessary hospitalization. Of course, it may prevent hospitalization. The sick person who does not have the $90 will be prevented from going to the hospital. But will it be "unnecessary hospitalization" that is thus prevented, Madam President? Who knows? The man with the $90 can get in—regardless of his need for care, if this is our only protection. The man without the money cannot get in no matter how great his need. And this, Madam President, would completely frustrate one of the basic purposes of the measure—to assure our older people that they need not worry about the costs of necessary hospitalization.

Of course, we need to devise protections against unnecessary hospitalization—protective devices aimed not at the patient, who cannot say when or for how long he is to be hospitalized, but at the doctor, who does make that determination.

This the Anderson amendments do—admirably. Following the recommendations of the American Hospital Association and of the Blue Cross, the proposal requires that all hospitalization be reviewed and approved by doctors under the hospitalization review plan stipulated on page 16—line 11—and spelled out in detail on page 20 of the Anderson amendments. This gives us all the protection we need and gives it in the only form I find acceptable. It prevents unnecessary hospitalization. It does not unfairly penalize any beneficiary as would a deductible.

Madam President, this question of the use of a cash deductible to prevent unnecessary utilization of hospital benefits is, unfortunately, little understood. Far too often people, including Members of the Congress, have been lead to equate it with the deductible provisions of automobile collision insurance. The deductible has worked well in that field. If they are to pay part of the cost, people do think twice before sending the car to a garage to have a dent hammered out of the fender. That is fine. But the question of whether or not the car should be hospitalized for repairs is hardly the same as the one posed when a doctor says that a person or his wife should enter the hospital for a lifesaving operation.

I point out that a person can get automobile insurance without a deductible provision, if he wishes to pay the premium. The deductible provision is offered as a part of the sales talk on the part of the insurance salesman, in order to reduce the premium. Of course, the insurance companies know that in the long run this will save money for them, or they would not offer the option or choice on the part of the insured.

It seems to me it is a false analogy to argue that because in the automobile insurance practice there is a deductible provision, therefore there should be a deductible provision in regard to hospitalization for a human being who is sick and may need hospitalization.

A person does not ask himself then, "Should I lay out the $90 deductible?" He asks only, "Do I have the $90?" Herein lies the great difference. Here we are dealing not with things, but with living, sentient human beings. And here what is done should depend not on what the dollars say but on what the doctors say.

This latter point, Madam President, was well explained in the report on the operations of the Kerr-Mills Act issued from the Special Committee on Aging. That report said, in part:

> The use of deductible provisions often functions to deter necessary care as opposed to unnecessary care. When limited resources are available for basic necessities such as food, clothing, and shelter, the eligible aged individual would tend to postpone necessary medical care in order to apply the $25, $50, or $100 toward those other necessities. Such effect does not encourage the early and timely care that prevents and minimizes serious illness. The problem thus becomes one not of overutilization of services but rather one of underutilization.
>
> The basic answer to controlling unnecessary usage of services is not the imposition of fiscal controls upon the medically indigent which force the individual to judge the necessity and urgency of care in relation to his financial situation. The answer lies in the use of medical controls whereby the aged person's physician and the physicians who comprise medical review boards are responsible for the decisions as to the necessity, appropriateness, and duration of medical care.
>
> It is on the personal physician of the individual that we must place first reliance for seeing to it that a program of medical care is not exploited. It is the physician and only the physician who can decide whether a patient should be hospitalized and for how long. The problems of unnecessary hospitalization or overly prolonged hospitalization, of unnecessary surgery or unduly prolonged care are problems involving the whole of the population and of concern to all of our communities. Any pretense at solving such problems by introducing a financial control on the patient is patently an evasion. It means simply that the virtually penniless patient may be and is denied care regardless of his medical need whereas the patient to whom the deductible cost is not a burden may get the care, undergo the surgery, or occupy a badly needed hospital bed regardless of his medical need.
>
> Controls over these problems must be professional, not lay; ethical, not financial. It is not sound public policy to encourage the medical profession to avoid this responsibility by pretending to have solved the problem through placement of a financial barrier between the patient and the care he may need. In fact, the deductible serves only to bar the poorer patient. In no way does it deter a physician from authorizing the provision of unnecessary services for those who can pay the deductible charges, for whatever services the physician may be willing to let the patient believe he needs, or for services which the physician believes are not needed but which he will countenance. Such actions in effect constitute the perpetration of a fraud on the medical care fund. This behavior cannot be justified

simply because he or his patient find it more convenient or because the physician is afraid of losing his patient to another more complacent, less ethical physician.

We repeat: The prevention of overutilization or exploitation of a medical care program—whether it be Kerr-Mills, Blue Cross, commercial insurance or the Veterans' Administration program—is a responsibility first of the individual doctor and secondly, of the medical profession. Concern is often expressed over the possibility that individual physicians will succumb to the temptation of hospitalizing people unnecessarily for the convenience of the physician or patient. It is on the physician's colleagues, functioning on medical review boards, that we must rely for the imposition of proper and effective disciplinary controls over the presumably few malefactors or irresponsible people in the profession. Any suggestion that a deductible, a financial bar to utilization of services, solves this problem of medical ethics is sheer nonsense.

As that report also points out, both the American Hospital Association and Blue Cross have urged hospitals to establish review boards. The desirability of such committees is virtually self-evident. Doctors—not dollars—should determine the appropriateness and extent of hospital care.

The committee's report is, I believe, a complete and irrefutable answer to the claim that we must have a deductible in order to prevent unnecessary or overextended hospitalization.

On the second claim—that abolishing the deduction would increase the cost—I point out that reducing the hospital days to 45 will bring us out at just about the same cost. Actuarial experts tell me that 90 days with a $90 deductible costs just about the same as 45 days with no deduction.

We have contended, quite rightly, that the passage of this proposed legislation will greatly stimulate the sale of private health insurance because it will take care of that part of the health costs of older people which is hardest to meet—hospitalization. With the basic hospital costs taken care of, the insurance companies will be able to offer supplementary policies at premiums which most of our older people will be able to afford. With the amendment, we would render it unnecessary for our older people to have to "stash away" $90 apiece for possible inpatient hospital care. If my amendment were adopted, the single beneficiary would be able to use his $90 and the elderly couple its $180 to buy supplemental health insurance, most likely to cover doctors' bills.

I point out also that the 45 days' coverage of the amendment would take care of 93.5 percent of all hospital stays by persons 65 and over. Figures furnished me by the Special Committee on Aging show that only 6.5 percent of these people remain in a hospital more than 45 days.

That is the thesis in this whole argument with regard to a 90-day provision and the $90 deductible. It has resulted in giving a false impression to the American people that hospitalization of the older people lasts for a longer period than 45 days. That does not happen to be the case. Hospital stays for this age group are longer than for any other but very few last as long as 90 days.

I wish to read this vital statistic again, because I think it drives a large hole through the argument of those who support the deductible provision.

To repeat, the 45 days' coverage of the amendment would take care of 93.5 percent of all hospital stays by persons 65 and over. Figures furnished me by the Special Committee on Aging show that only 6.5 percent of these people remain in a hospital more than 45 days. Since the bill as now written also gives them additional coverage for stays in a nursing home or for nursing care in their own homes, I expect that the 45-day coverage would in practice prove to be entirely ample.

Let me add that I think the work of the Senator from New Mexico [Mr. ANDERSON] and Senator from New York [Mr. JAVITS] has been outstanding in preparing the Anderson-Javits amendment. I know how difficult it has been to reach agreement on the complexities of this subject.

I am especially gratified that provision has been made for the 2½ million or 3 million people, as some estimates have it, who are already 65 or over and are not covered either by social security or railroad retirement.

The sections dealing with administration of the program also impress me as being very sound.

This deductible feature, however, distresses me, and as a cosponsor of the King-Anderson and Anderson-Javits amendments, I feel that I have an obligation to improve the proposal as much as possible.

Undoubtedly, what I am proposing today is a perfecting amendment. It does not pertain to the basic principle of this whole issue, which is that medical care for the elderly be established as a part of social insurance. I am very anxious that we remove the heavy dependence of the elderly upon charity either from their relatives or from the public for adequate medical care. That situation is a disgrace to our Nation. All that has been said in this debate about advances in private insurance and the Kerr-Mills program does not change the fact that neither of these methods has changed this dependence upon charity by a very large percentage of the elderly.

It has seemed rather unique to me that the basic position of the American Medical Association—and it has been echoed by opponents of the Anderson-Javits amendment—has been that a means test of some kind must remain a requirement of any public medical plan. We have heard this proposal denounced for many days because it is not based on so-called need.

The AMA is the last organization in the world that should be insisting upon an investigation of each individual's income and sources of support before that individual may take part in any governmental medical care system.

I wonder what the reaction of the association would be if it were suggested that every doctor undergo a means test before his bills were paid under Kerr-Mills.

The group of doctors for which the AMA apparently speaks are the loudest in their condemnation of any invasion of privacy, either their own or of what they call the doctor-patient relationship. But they insist that the privacy of the elderly be invaded when it comes to medical care.

The social security approach to the income problems of retirement has proved workable and successful. It permits minimum care for all on the same basis as any insurance program. Of course, that means that not everyone will pay in the same amount and not every one will use the same benefits, but that is true of any insurance-type program.

I think the time is long past when we should put minimum health needs on the same basis.

It is for this reason that I have decided not to press my amendment today. The Anderson-Javits amendment as it now stands is a great forward step. I know that it is understood by millions of supporters throughout the country to provide 90 days of hospital coverage, with $90 deductible, and I can understand that to change that coverage on the Senate floor, even when it does not affect the total cost of the program, would cause considerable confusion among its supporters. So having pointed out some defects in this particular provision of the bill, I shall at the close of my speech withdraw the amendment.

It is my hope and expectation that the Anderson-Javits amendment will not only be passed by the Senate but by the House of Representatives. Once we have established this principle involved in the Anderson-Javits measure, then we can proceed with perfecting it along the lines I have been discussing.

I wish the record to show that I shall discuss the subject before the Senate in the future, because, in my judgment, the Senate is about to pass a measure that will need great improvement in regard to the deductible feature.

I am a realist with respect to the legislative process. I know how important it is though our votes tomorrow and in our subsequent votes on the measure, to place on the statute books for the first time the vitally important principle of medical care for the aged under a social security system. Being a realist, I am aware of the fact that pressing my amendment in regard to deductibility might afford an abili, a rationalization or an excuse for some Senators to vote against the Anderson-Javits amendment because of the Morse amendment on deductibility. I have no intention of jeopardizing and endangering the passage of the Anderson-Javits amendment, which I was proud to cosponsor. But in my judgment after the deductible features of the Anderson-Javits amendment have become understood in our country, there will be an insistent demand on the part of public opinion to eliminate the deductible feature from the law because, in my judgment, it is unsound, unwise, and unnecessary.

I have made these arguments today in support of the principle because I know that in due course of time the Morse amendment, which seeks to eradicate deductibility under the Anderson-Javits amendment, will undoubtedly become the law of our land.

With those arguments in support of my amendment, I now withdraw my amendment.

The PRESIDING OFFICER. The amendment of the Senator from Oregon is withdrawn.

Mr. ANDERSON. Madam President, will the Senator yield?

Mr. MORSE. I yield.

Mr. ANDERSON. I appreciate the attitude of the Senator from Oregon very much. I should like to remind him of an incident that he may have forgotten. In 1956 a question arose with respect to disability. The Finance Committee wrote into the measure at that time an age limit. The Senator from Oregon took the position that the age limit was not necessary. We voted him down. We were experimenting. We were improvising as we went along.

Four years later we discovered that his original proposal was correct. We made the necessary change. Perhaps that will be the process in respect to his amendment. I very much appreciate the attitude he has taken.

Mr. MORSE. Madam President, I appreciate very much the comment of the Senator from New Mexico. As I said in my earlier remarks, I congratulate the Senator from New Mexico [Mr. ANDERSON] and the Senator from New York [Mr. JAVITS] for the great contribution they have made to the legislative process by way of the Anderson-Javits amendment. I go along with them all the way. I have taken the exception I have noted with regard to their amendment. Only time will prove who is correct. I am satisfied that the important thing is to get the principle of a health program under social security into operation. We can perfect the measure at a later date.

Mr. JAVITS. Madam President, will the Senator yield?

Mr. MORSE. I yield to the Senator from New York.

Mr. JAVITS. I should like to express my appreciation to the Senator from Oregon, whose customary understanding of the legislative process is simplifying and, in my opinion, preserving the expectations which we have with respect to the action of the Senate tomorrow. It is quite typical of him. But these things can never be taken for granted. I join with the Senator from New Mexico [Mr. ANDERSON] in expressing not alone our own appreciation, but also what I think is the appreciation of all Senators who support the present effort for what the Senator from Oregon has done to help the program very materially.

Mr. MORSE. I thank the Senator from New York.

I ask unanimous consent that a statement I have prepared in answer to the speech made by the Senator from Connecticut [Mr. BUSH], containing a reply to questions which I raised earlier in a speech in the Senate in connection with the amendment, be printed at this point in the RECORD.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

STATEMENT BY SENATOR MORSE

In his floor speech on July 13 the very able and distinguished senior Senator from Connecticut assembled some excellent answers to the objections I had raised earlier to his amendment. In large part, however, his answers rest on faith that the insurance industry will rise above profits to provide health insurance suited to the needs of the aged at prices they can afford to pay with the help of the $9 payment from the trust fund.

I regret that I do not share his faith, and I therefore find his answers less than pursuasive.

Whiie I do not wish to belabor our debate, there are several points—based on facts rather than hopes—which I would like to get on record because they may weli recur in the days ahead.

Proposais like that sponsored by the Senator from Connecticut are—on their face—either underfinanced or based on the recognition that private insurance carriers wili reject many oider people.

In his floor speech, my friend and colleague said: "I estimate there will be about 12 miilion persons eiigibie under the social security system who would be eligibie for these benefits. We divide that number into $1.2 biilion and arrive at the çost of approximately $100 a year."

Also in the expianatory memorandum accompanying his amendment, he had stated: "The eiigibie popuiation which, it is estimated, wiil take advantage of this program will be 12,200,000 in 1962; 15,100,000 in 1970, and 20,000,000 in 1980."

With reference to the estimate of 12.2 miiion in 1963, it should be pointed out that there will be at that time about 14½ million persons who would meet the basic eligibility quaiifications of the Bush biil—who would be 65 or oider and eiigibie for social security or railroad retirement benefits.

I wouid think that everyone who is eligible would be quick to accept the offer of $108 toward the purchase of health insurance. Why, then, did my friend from Connecticut estimate that oniy 12.2 miiion wiii take advantage of this program? Is it possibie that he contemplated that the other 2⅓ million wiii be rejected by insurance carriers?

Could this be what is meant by not taking advantage of the proposal?

And what about his estimate of 15.1 miiion in 1970 when more than 17 million people over 65 wiii be eligible for OASI alone and possibly another half miiion as railroad retirement beneficiaries?

How in good conscience can the other 2½ million be denied health benefits after they have paid the increase in payroll taxes which is specificaiiy for the health benefits?

If the discrepancy in the figures cannot be charged up to the unwiilingness of insurance carriers to underwrite the risk, one would expect virtually all the eligible group to take advantage of the program. In this case, the costs wouid be much greater than anticipated and the program would be seriously underfinanced.

While stressing the point that costs are unpredictable for the service benefits proposed in the Anderson amendment, the Senator from Connecticut nevertheless recognizes that the $9 monthiy which he proposes might turn out to be too little for those who take advantage of this payment. He states:

"Additionally, the aiiegation that a $9 payment may be worthless 10 or 20 years from now is specious. It applies equaiiy to the existing social securiity system. If iiving costs rise, it may be assumed that existing social security benefits wiii be periodically adjusted by the Congress. If health care costs rise, payments under the Bush amendment would aiso be periodically adjusted."

In reference to the foregoing statement that the passage of years can erode the value of a cash benefit, I might point out that there is an essential difference between the cash retirement benefits paid under the social security system and the proposed cash indemnity for health costs. The formula which determines the retirement benefit is based on earnings, which can be expected to rise in more or less the same manner as prices. This is not the case for proposed cash benefits for health insurance.

One final point. My first objection to the proposal put forth by my friend from Connecticut was—

"Any program that offers a fixed cash, and perhaps worthless indemnity rather than specified medical services cannot meet the special problems of the aged."

In answer, he said: "My repiy is that this is an indictment of the existing social security system, which provides benefits in cash oniy, leaving complete freedom to the individual to spend the money he receives for food, shelter, clothing, and so forth. If this objection is valid, then the existing system should be changed so that the Federai Government would provide all the necessities of life—house the individual in a Federal dormitory, feed him in a communal dining room, buy his clothing, and so forth—instead of giving him cash to spend as he chooses."

Arguments like this have appeared frequentiy enough in the last few days that they can no longer be ignored.

The answer is very simple and very obvious to any one who is not trying to becioud the issue.

The problem of individual financing of health costs is completeiy different from that for such items as food and housing. Housing and food costs recur month after month in more or less the same amount and can therefore be budgeted. Medical costs, in contrast, are uneven in their incidence and—on an individual basis—are largely unpredictable.

The implication that the Government proposes health insurance because it cannot trust older people to spend their money wisely is insuiting to our aged population. Younger people have health insurance—much of it financed by their employers, as a result of collective bargaining agreements. Yet would anyone argue that this is because they can't be trusted to spend their wages wiseiy?

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. FONG. Madam President, there is no subject to which I have devoted more study this year than that of the health insurance problems of our Nation's senior citizens.

For several years this has been a matter of considerable concern to me. So much so that in 1960 I cosponsored a voluntary health insurance program devised by my friend and colleague, the able and distinguished senior Senator from New York [Mr. JAVITS]. In 1961, once again it was my privilege to join with a number of my colleagues on this side of the aisle in an improved version of the Javits voluntary health insurance bill, S. 937.

Last week I joined with the distinguished senior Senator from Massachusetts [Mr. SALTONSTALL] and five other of our colleagues on this side of the aisle to offer the text of S. 937 with minor modifications as a substitute for the Anderson-Javits compulsory social security amendment. Our substitute was, however, defeated on a rollcall vote of 34 yeas to 50 nays.

I have no hesitancy in saying, in my judgment, the approach and the benefits

of the SALTONSTALL substitute and its predecessor bills constitute the most practical, realistic, and suitable program yet presented. Unfortunately, however, the Democratic presidential candidate in 1960 was committed to a social security approach and, as President, he today remains committed to that approach. With all the prestige and power of his high position and with the large majority his party enjoys in the Senate, it is easy to understand why a Republican-sponsored nonsocial security proposal has twice gone down to defeat in the Senate.

During the past 2 years a number of alternative proposals for financial assistance on medical costs for the aged have been advanced. The junior Senator from Kentucky [Mr. MORTON] recommended the Federal Government share with individuals the cost of private insurance policies for persons age 65 and over, with the Federal share graduating downward according to the income taxes paid by the individual.

The senior Senator from Connecticut [Mr. BUSH] also presented a plan providing to persons 65 or over eligible to receive social security and railroad retirement benefits a monthly cash supplement up to $9 for the purchase of voluntary health insurance.

Blue Cross and Blue Shield, private nonprofit organizations, also came forth with new more liberal health insurance plans for senior citizens. Private insurance companies offered to those in the 65-and-over age group new policies with added protection against the costs of illness.

Therefore, although I was a cosponsor of one voluntary plan, I have maintained an open mind on this question of aiding the aged in need of help toward medical expenses. I was receptive to the advantages of the various alternative proposals. I was also made cognizant of the drawbacks of each—and I am sure we all recognize each does have drawbacks.

As I studied the question of health insurance for the aged, I did so having in mind the hundreds of private health insurance plans in effect, having in mind the fact that the Kerr-Mills law enacted by Congress in 1960 which I supported was just getting underway, and having in mind the old-age assistance and many State public assistance programs are already in effect.

I can honestly say I did not entertain any preconceived prejudices against any approach to this problem. On such a complex matter, I felt I should suspend final judgment until I had weighed the available evidence. What I tried to do as I read and examined the mass of information and the volume of correspondence coming to me and the current debate in the Senate was to resolve in my own mind what is the best way to assist our senior citizens to meet their health and medical needs.

The revised Anderson-Javits amendment has been before use only 2 weeks. Yet it is a proposal that goes to the very heart of our system of government and to the relationship between the Federal Government and the private citizen. It is a step from which there is no turning back. So if we err in adopting the pending Anderson plan, we shall err irrevocably.

It is most unfortunate that we are debating this far-reaching proposal without the benefit of committee hearings and without the benefit of thorough ventilation and scrutiny by all interested parties. Such is not the ideal way to legislate on so important a matter.

Based on the information available to me and upon my considered judgment as to the consequences of the Anderson amendment, I have decided to err on the side of caution. I prefer to try to improve and to perfect our existing system of medical care and our existing system of private health insurance while meeting our responsibility as individuals and our responsibility as a nation not only to our elderly citizens but to all our citizens of whatever age who need help in meeting medical costs.

After studying the evidence to date, I have concluded that the compulsory social security approach is neither adequate nor desirable. If the Congress is to do anything at this session we ought not to venture where angels fear to tread. We ought not risk the avenue that leads only to one destination: Government control of the practice of medicine.

The Saltonstall substitute providing voluntary health insurance for the aged avoided these defects. I shall not now repeat my entire statement favoring the Saltonstall substitute, which can be found on page 12466 of the CONGRESSIONAL RECORD for July 12. I shall merely restate the nine principal virtues of the Saltonstall plan, which make it preferable to the Anderson-Javits amendment. I urge the administration to give serious consideration to this proposal which will help those who really need help in contrast to the Anderson-Javits plan which proposes to give assistance to everybody just because some people need it.

First. The Saltonstall plan is voluntary.

Second. It is practical, for it builds upon progress already made by mutual and private insurance organizations.

Third. It is keyed to those of the aged who need financial assistance toward adequate health insurance.

Fourth. It does not put undue strain on the Federal Treasury because it provides for State sharing of the costs and for contributions from individuals.

Fifth. It avoids Federal interference with the practice of medicine. The States would set up their separate programs in accord with the wishes of their citizens, and States would have primary supervision over the structure and administration of the program.

Seventh. It places the burden of the Federal cost on all American taxpayers—unlike the Anderson-Javits plan which puts the burden of costs entirely on the wage earners and employers.

Eighth. It provides benefits suited to the special health needs of the aged: namely, home, outpatient, and nursing home care. It recognizes that different individuals have different medical care needs.

Ninth. It conforms to our traditional American way of caring for health problems. It avoids experimentation in a new approach which is untested and untried and which is fraught with potential dangers to our customary private doctor-patient relationship and to our entire medical and health system, which up to now has made tremendous progress in the battle against disease and illness.

The Saltonstall plan I could support. But in all good conscience, I cannot support the proposal of the junior Senator from New Mexico [Mr. ANDERSON].

As it stands, its benefits are totally inadequate.

As it stands, it will prove very costly.

As it stands, its financing provisions are unfair to the working men and women and insufficient to meet the costs that will accrue.

As it stands, it will overburden hospital and other medical facilities which are already overcrowded.

As it stands, it is a seedling program that will rapidly grow to enormous size, to encompass hospital and medical expenses and doctors' charges for everyone, even for those who can afford to pay their own bills or who can afford to buy adequate health insurance for their own protection.

Inevitably, as I see it, 1 day, whether we like it or not, if we inaugurate the Anderson-Javits plan, we will find ourselves with a system of Government-controlled medicine, a system which history informs us is vastly inferior to our present private practice of medicine.

The fundamental defects and the inevitable consequences of the Anderson plan are to me fatal defects. They constitute bad medicine, not only for our senior citizens, but for all citizens.

I say this without intending any reflection upon those who support the Anderson-Javits plan. Many of these supporters admit the inadequacies of the Anderson-Javits plan. They admit it is not a comprehensive medical care plan, but they contend, limited as the benefits are, they will be of some help.

Many supporters of the Anderson-Javits plan do not foresee adverse consequences. They do not believe this plan will lead to Government control over all practice of medicine.

On the question of consequences, all of us are admittedly peering into the future, which is at best a most difficult occupation. Because man's foresight is notably short, reasonable men find themselves in honest disagreement. I have the utmost respect for those with whom I disagree regarding the impact of the Anderson-Javits plan on the future of our medical care in America. I know they are as sincere in their belief as I am in mine.

There simply is no way to prove the correctness or incorrectness of our points of view. This is a situation frequently confronting the Congress of the United States. Often we Members must vote without full certainty of the consequences of our acts. We must take calculated risks all the time as we legislate.

In this particular case, I believe the risks involved in the Anderson-Javits plan are too great to warrant passage.

Before discussing in greater detail my specific objections to the Anderson-Javits plan, I should like to define the problem of health care of the aged, with which the Senate is now attempting to cope.

There are some 17 million persons age 65 or over in the United States today. A relatively small percentage of these are well able financially to take care of their medical bills. An additional 2½ million of the 17 million senior citizens are eligible for free medical care under old-age assistance programs of public welfare.

Additional persons who are otherwise self-supporting but who cannot pay their medical bills are receiving assistance under the Kerr-Mills Act of 1960, which because State implementing legislation was needed, has only recently begun to go into operation in some States. Others have yet to act. An estimated 1 million persons may be eligible for aid under Kerr-Mills, which is designed to provide very comprehensive and inclusive medical care in the real sense of the word. I ask unanimous consent to have printed at this point in the RECORD a brief summary of Kerr-Mills provisions.

There being no objection, the summary was ordered to be printed in the RECORD, as follows:

KERR-MILLS PROGRAM
(PUBLIC LAW 86–778)

Coverage: Approximately 10 million persons over 65 might meet the eligibility requirements. The number actually affected will depend upon the number of States participating, and the eligibility standards formulated by such States. (S. Rept. 1856, 86th Cong.)

How many benefit: Each State could formulate its own eligibility standards within the State plan, except that benefits must be provided for residents of the State who:

(1) have attained age 65, and

(2) are not recipients of old-age assistance, but whose income and resources are insufficient to meet the cost of the medical services listed below.

Persons under age 65 or persons receiving old-age assistance could not be made eligible under the State plan. The State plan may not require an enrollment fee as a condition of eligibility or impose a lien on the property of a beneficiary during his life or that of his surviving spouse.

Benefits: The State plan for medical assistance for the aged may specify medical services of any scope and duration, provided that both institutional and noninstitutional services are included. The Federal Government would share in the expense of providing the following kinds of medical services:

(1) inpatient hospital services;
(2) skilled nursing home services;
(3) outpatient hospital or clinic services;
(4) physicians' services;
(5) home health care services;
(6) private duty nursing services;
(7) physical therapy and related services;
(8) dental services;
(9) laboratory and X-ray services;
(10) prescribed drugs, eyeglasses, dentures, and prosthetic devices;
(11) diagnostic, screening, and preventive services; and,
(12) any other medical care or remedial care recognized under State law.

Administration: Participating States would be reimbursed for part of their expenditures under federally approved State plans providing medical services to aged persons who are not recipients of old-age assistance, but whose income and resources are insufficient to meet the cost of necessary medical services.

Financing: Federal sharing in State expenses under plans for medical assistance for the aged would be determined according to an equalization formula based on State per capita income in relation to the national average and would run from 50 to 80 percent. There are no dollar limits beyond which no matching will apply. The States would receive in addition an amount to half of their administrative expenses under plans for medical assistance for the aged.

Total cost first year:

Estimated costs for the first year were as follows:

[In millions of dollars]

Federal	60
State	56
Total (S. Rept. 1856, 86th Cong.)	116

Mr. FONG. Madam President, moreover, of the noninstitutionalized aged 65 or over, it is estimated 53 percent have some form of voluntary health insurance. Many of the aged have health insurance protection which is far more comprehensive than the Anderson-Javits bill would provide.

So when we talk of assisting those 65 or over beyond the assistance already provided on the statute books, we are talking about providing help for some 12 million persons of modest income who may need financial assistance toward medical costs.

Is Anderson-Javits the answer? I believe it is not.

Its benefits are very limited, very skimpy. Specifically, it provides for 90 days of hospital care per benefit period, subject to a deductible of $10 per day for the first 9 days but not less than $20; plus 180 days of nursing home care, provided the patient has had previous hospital care; plus 240 home health service visits per calendar year; plus outpatient diagnostic service, subject to a deductible of $20 per diagnostic study.

There is an option whereby a person may elect to continue a private health care plan which would give him the statutory benefit of 90 days of hospitalization with a deductible, or under group and similar plans 45 days of hospitalization with no deductible, in addition to other health care benefits. Under this option the individual may elect to have the Government pay his insurance carrier for those benefits he uses.

The Anderson-Javits plan does not cover cost of a doctor's services in his office or at the patient's home.

It does not cover surgeon's fees and dental bills.

It does not pay for medicines used outside a hospital or nursing home.

It does not cover costs of preventive medicine. Beneficiaries could not collect anything until they were sick enough to go to a hospital or nursing home.

It requires patients to pay the first $20 of costs for diagnosis. The patient could not select the physician to perform the diagnostic services.

In terms of medical needs of elderly citizens, what does the Anderson-Javits plan mean?

Estimates indicate the Anderson-Javits plan covers only 18 to 30 percent of the average medical costs of the aged, based on data supplied by the Department of Health, Education, and Welfare. This means elderly citizens would be faced with paying 70 to 82 percent of their medical bills, if the Anderson-Javits plan is enacted.

Moreover, for every hospital visit, the elderly would have to pay a minimum of $20 or a maximum of $90 under the Anderson-Javits plan.

To be adequately protected against the hazards of costly illness, those 65 and over would need to buy supplementary insurance covering major medical expenses and doctors' and surgeons' charges. The amount of their yearly premium would depend, of course, on the policies purchased.

I predict that, if the Anderson-Javits plan is enacted, some of our senior citizens are going to be shocked to learn they must pay the lion's share of their health bills.

It is because the Anderson-Javits benefits are inadequate—and its supporters admit they are inadequate—and because senior citizens will have to buy additional insurance to be adequately protected, that tremendous pressures will be exerted on the Congress to increase the benefits, to remove the deductibles, to lower the eligible age, and so on. There will be constant pressure for constant enlargement of benefits and liberalization of the program.

My judgment on the inevitable consequences of the pending Anderson-Javits plan is, I think, amply borne out by what one of the originators of this plan publicly has stated. Former Congressman Aime Forand, author of the 1960 social security health insurance plan that was defeated, said very plainly in January 1961:

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

It is only logical that as benefits increase, costs will increase, and, if the health insurance trust fund provided under the plan is to bear any semblance of solvency, that social security taxes on wage earners will have to be raised or the wage base raised or both. There simply is no end in sight to the expense of a Government service program of this nature or to the burden on the wage earner if it is financed out of social security.

Social security financing is regressive in nature. It is not based on the ability to pay principle, the accepted concept underlying our Federal income taxes.

Moreover, it will be wage earners in the lower income brackets that will feel the brunt of these spiraling social security taxes. The secretary receiving $5,200 in wages a year would pay the

same social security tax as her employer who might earn $52,000 a year.

I am advised that 53 percent of the wage earners in America earn less than $5,000 a year. Why does the administration insist on putting the burden on these wage earners rather than on persons earning much more?

Furthermore, according to estimates, some 40 percent of taxable income in the United States is not subject to social security tax. Why allow 40 percent of our taxable income to be free from any responsibility toward medical care of our needy aged?

Isn't it much fairer to finance a national health insurance program out of the general revenues of the U.S. Treasury composed in the main out of income taxes which are levied according to ability to pay?

In fact, one might well promulgate a law of behavior: when Government pays the bills for personal services to citizens, the pressures for expansion are irresistible.

Every nation which has adopted a compulsory government health insurance program has experienced ballooning costs, far exceeding original estimates. In Britain, for example, the first full year of its Government health program cost more than three times the estimated cost before adoption.

Estimates of the cost of the original King-Anderson predecessor to Anderson-Javits plan vary widely. For social security and railroad retirement recipients 65 and older, the Department of Health, Education, and Welfare says it will cost $1,062 million in 1963. The Health Insurance Association of America estimates conservatively, it will cost more than twice as much in 1963—$2,179 million.

For 1964, the Department of Health, Education, and Welfare estimated it would cost $1,098 million; the Health Insurance Association estimates it would cost $2,483 million.

The Department of Health, Education, and Welfare estimated original King-Anderson costs would not reach $2 billion until 1990, when it would cost $2,308 million. But the Health Insurance Institute contends the costs would be $5,438 million in 1983.

Added to these costs must be the cost of including some 2½ million persons who are not social security nor railroad retirement recipients and whose costs would be paid out of general revenue of the Treasury. The Department of Health, Education, and Welfare estimates these costs at $250 million annually. The Department of Health, Education, and Welfare, however, believes public assistance payments will be reduced by some $200 million annually, for a net additional cost to the Treasury of $50 million.

To finance costs of the Anderson-Javits plan for social security and railroad retirement recipients, it is proposed to increase the social security tax by one-fourth of 1 percent on each employee and one-fourth of 1 percent on each employer to be applied against a higher wage base of $5,200. At present the social security tax applies against a wage base no higher than $4,800.

In terms of dollars and cents, the proposed social security tax increase will mean each wage earner taxed at the maximum would pay $27.50 each year. His employer would contribute a like amount. The self-employed would find their taxes raised by three-eighths of 1 percent.

I ask unanimous consent to have printed at this point in the RECORD three tables showing the social security taxes to be paid by employee, employer, and the self-employed through 1968.

There being no objection, the tables were ordered to be printed in the RECORD, as follows:

Present rate, social security taxes

[Based on $4,800 annual earnings]

	Employee pays—	Employer pays—	Self-employed pay—
1962	$150	$150	$226
1963–65	174	174	259
1966–67	198	198	298
1968 and after	222	222	331

Rate if King-Anderson bill were enacted

[Based on $5,200 annual earnings]

	Employee would pay—	Employer would pay—	Self-employed would pay—
1963–65	$202	$202	$300
1966–67	228	228	342
1968 and after	254	254	378

Actual taxes needed to finance bill according to insurance estimates

[Based on $5,200 annual earnings]

	Employee would need to pay—	Employer would need to pay—	Self-employed would need to pay—
1963–65	$232	$232	$343
1966–67	258	258	385
1968 and after	284	284	421

Mr. FONG. Madam President, keeping in mind the low estimates of the Department of Health, Education, and Welfare for the cost of the King-Anderson plan, it is easy to foresee that the health insurance trust fund will soon be in trouble, just as the social security trust funds are in trouble. In 4 out of the last 5 years, payments out of the social security funds have exceeded income from payroll taxes.

The July 2 issue of U.S. News & World Report portrays very graphically the extent of social security deficits under existing programs, even before a health insurance program is added.

Benefits promised to people now covered by old-age and survivors insurance are estimated to cost a total of $624 billion. Reserves on hand total $22 billion. Social security taxes to be paid by workers now covered by social security to support their pensions total an estimated $282 billion.

Combined, the reserves on hand and taxes to be collected total $304 billion. U.S. News & World Report points out that the social security fund faces a deficit of $320 billion which must be paid by the wage earners of the future.

This tremendous future deficit of $320 billion in the social security account alone is greater than the present total debt of the U.S. Government. That total Federal debt primarily stems from expenditures for three great wars. As the health insurance benefits proposed by the Anderson-Javits amendment would inevitably be expended, the social security and railroad retirement taxes would have to be increased.

So the wage earner of the future will be burdened by making up the huge deficit in the social security fund and would be faced with added taxes for constantly expanding health insurance programs.

Under existing law, without any health insurance program, social security taxes on wage earner, and employer combined will total 9¼ percent beginning in 1968.

Add to that another half percent for the health insurance program and the combined percentage reaches 9¾ percent.

In 1949 social security taxes were 1 percent on the first $3,000 of pay. Nineteen years later they will be 4⅞ percent on the first $4,800 of pay.

Social security taxes have more than quadrupled in the past 19 years. Should this pattern prevail for the next 19 years, the social security taxes will be greater than Federal income taxes. And the impact will be even greater than Federal income taxes, for no deductions and no exemptions are permitted in computing social security taxes.

The addition of taxes to finance a health insurance program proposed by the Anderson-Javits plan will add to this burden, for as surely as the sun rises and sets every day, so will health insurance taxes climb steadily upward.

This is the experience of other countries, and there is no reason to believe our experience would be different.

I was very much interested in the figures submitted by my able colleague the junior Senator from Kentucky [Mr. MORTON] which show that in West Germany, the health insurance tax imposed on both employee and employer has risen from 11 to 23.6 percent. In France the tax has risen from 16 to 19.5 percent. In Italy the tax has risen from 13 to 23.6 percent. In Belgium the tax has risen from 14 to 16 percent.

The wage earner of the future would find social security taxes taking perhaps 25 percent of his current earnings. This would certainly be most burdensome.

Unless Congress is careful we will have imposed an intolerable burden on the wage earner. Young workers buying homes, raising children, educating them, and providing all the necessities for day-to-day existence, including health insurance for themselves and their families, will face rough going to keep their heads above water. By the time they pay social security taxes, including health insurance taxes for the aged, Federal and State income taxes and sales taxes, there will be precious little for them to

live on, much less to save for a rainy day.

In all the debate on the Anderson-Javits plan, there may be a tendency to overlook the job presently being accomplished in the health insurance field by private organizations. The progress made in the matter of benefits offered, eligibility requirements, and premiums over the past 5 or 10 years is truly remarkable. The protection offered those 65 and over against medical costs has increased markedly even in the past 5 years alone.

There are 880 insurance companies in America offering health insurance. There are 78 Blue Cross plans and 69 Blue Shield plans. There are more than 300 independent plans in industry, communities, and colleges.

Just this year the American Medical Association developed a new Blue Shield plan for senior citizens and the American Hospital Association a new Blue Cross plan for senior citizens. These plans are far superior to the Anderson-Javits plan and the costs to the individual subscriber very reasonable.

Many senior citizens hospital and health plans do not require a physical examination. Moreover, all policies being written today contain guaranteed renewable clauses. I made inquiry of several sources and was informed that policies written today can be canceled at the option of the company only for failure of the subscriber to pay his premiums. This is a most remarkable advance over the early policies for those over 65. Modern insurance thus affords a great measure of comfort and security to the aged.

Furthermore, a number of policies offered today contain no lifetime maximum. Still there are some which contain a lifetime limit of payments that can be made in behalf of a subscriber. This is a field where improvement is needed, and where I believe improvement will be attained in the near future. For, the fact is, the aged have proved to be better risks than insurance companies once believed.

In order to compare Anderson-Javits benefits with those available under private insurance, I am going to cite several actual cases reported in the press and show what the elderly patient would have paid under the original King-Anderson plan and what he paid under Blue Cross-Blue Shield. The changes made in the original King-Anderson bill by the Anderson-Javits amendments would not, I am advised, alter these figures significantly.

In case No. 1, a retired, middle-class American male gets lung cancer and soon runs up a bill of $7,687.75 during 80 days in the hospital, including private duty nurses, costing $2,373; two surgery procedures—$500 for both—and out-of-hospital expenses totaling nearly $1,000.

Blue Cross-Blue Shield and its major medical plan paid $6,562.33—in other words, all but $1,125.42.

King-Anderson would have paid only $3,392.94—leaving a balance of $4,294.81 to be paid by the patient.

In Case No. 2, a 70-year-old woman falls ill with Parkinson's disease and bills totaling $13,972.77 result.

The Blue plans combined would have paid $11,437.28 and left the patient with $2,535.49 to pay. Under King-Anderson, the patient would have had to pay $10,921.16 because surgery and nurses' care at home are not covered. If the patient had entered a nursing home, however, King-Anderson would cover a much larger percentage of the expenses than if she were cared for at home.

In case No. 3, an aged person collapses with a heart attack and her illness is complicated by intestinal difficulties. In this case the patient had only the basic Blue plans without the major medical coverage. By spending 4 days in a ward and 67 days in a semiprivate room, she cut down on some costs.

Of the total charges of $3,245.02, the basic Blue insurance paid $3,216.02. Under King-Anderson, she would have been required to pay for her surgery—$300—and for other services costing about $100.

If the case had not been complicated by intestinal troubles, surgery would have been necessary, and the basic Blue plans and King-Anderson would have provided almost identical coverage.

These cases were reported in the Washington Sunday Star of May 28, 1962, and go to show in concrete terms some of the drawbacks of the King-Anderson plan, which, despite the amendments now incorporated, remain basically the same. The benefits contained in the Anderson-Javits bill are simply inadequate.

Less than 2 years ago Congress enacted the so-called Kerr-Mills law providing Federal Government grants of 50 to 80 percent to States to help furnish comprehensive medical assistance on behalf of aged individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the cost of necessary medical expenses.

Before this program could go into effect, it was necessary for State legislatures to enact implementing measures. As of May 14, this year, 24 States had Kerr-Mills programs in operation and 2 States have enacted legislation, but a medical plan has not yet been submitted. One State has legislation in process. Twenty States need legislation, and the remaining 3 have authority for the Kerr-Mills program but are not expected to implement it this year.

Undoubtedly, the uncertainty over enactment of another medical program for the aged by this Congress has delayed Kerr-Mills progress in many States.

Under a State law enacted in 1961, Hawaii is participating in the Kerr-Mills program, assisting some 400 to 500 elderly persons each month. Another 1,300 aged persons are cared for under our general State welfare program.

I ask unanimous consent to have printed in the RECORD at this point two statements prepared by the U.S. Department of Health, Education, and Welfare, giving provisions for State public assistance programs under the Social Security Act, including Kerr-Mills medical assistance for the aged.

There being no objection, the statements were ordered to be printed in the RECORD, as follows:

PART 1. MEDICAL AND REMEDIAL CARE FOR RECIPIENTS OF OLD-AGE ASSISTANCE, AID TO THE BLIND, AID TO DEPENDENT CHILDREN, AND AID TO THE PERMANENTLY AND TOTALLY DISABLED

(Department of social services, October 1, 1961—Hawaii)

A. GENERAL DESCRIPTION OF PUBLIC ASSISTANCE PROGRAMS

1. Administrative responsibility: OAA, AB, APTD, and ADC are directly administered by the State department of social services through its four county offices. (Medical assistance for the aged is also administered by this agency. See pt. II.) Non-Federal share of assistance and of administrative costs is met from State funds.

2. Provision of medical care as a part of public assistance: Current plan provisions for vendor payment of costs of medical care are based on a 1961 amendment to the State law, authorizing the agency to make payments directly to the suppliers of medical goods and services. Formerly, State law required such payments to be made through the county governments. In the period before the Territory became a State, the agency had a group prepayment contract with the territorial health department (1961–60). The provisions represent full implementation of the scope of services authorized in the law, but limits have been set on some services because of cost. Policies are generally applicable to all four categories alike.

B. CONTENT AND SCOPE OF MEDCAL AND REMEDIAL CARE

3. Services:

(a) Hospital (in-patient): All categories. Limited to 15 days per illness, with provision for exceptions based on medical recommendation. Vendor payment.

(b) Nursing home care: All categories. Money payment.

(c) Practitioners' services: All categories. Includes services of medical doctor in all settings, dentist, optometrist, and podiatrist. Medical doctor services in rural Oahu and in counties of Maui, Hawaii, and Kauai provided only by State government physicians. Provisions also for specialists' services as necessary. Vendor payment.

(d) Dental care: All categories. Fillings, extractions, and X-rays. Limited to emergency care. Vendor payment.

(e) Prescribed drugs: All categories. Vendor payment.

(f) All other care: All categories have provisions for sick-room supplies, X-rays, restorative services, prosthetic appliances, transportation, and equipment; also private duty nursing services in hospital where medically necessary in exceptional cases. Vendor payment.

C. ELIGIBILITY FOR MEDICAL AND REMEDIAL CARE

4. Persons eligible: Recipient of OAA, AB, APTD, and ADC and persons considered essential to his well-being. Also available to persons otherwise eligible for a category of assistance and in need of aid only because of costs of necessary medical care.

5. Application of income: Recipient's income and resources applied first to needs to be met through the money payment, balance to needs to be met by vendor payment of costs of medical.

D. ADMINISTRATION OF MEDICAL AND REMEDIAL CARE

6. Medical direction: Medical consultant (medical doctor), part time; medical payments program officer (social worker), full time.

7. State and local advisory groups: Committee, now being formed, will include representation from medical, dental, pharma-

cal, nursing, hospital administration, and social work professions together with representation from business and community at large; a total of 15 members; to meet once a month and review and recommend broad policy and procedures.

8. Interorganizational agreements and relationships: Informal agreements and working relationships in effect with: Department of Public Health for nursing service, crippled children services, mental health, and maternal health services; Division of Vocational Rehabilitation; Veterans' Administration; and various private agencies and organizations such as Lion's Club, Society for Crippled Children & Adults, National Foundation.

9. Methods of making payments to suppliers of medical goods and services: Suppliers of medical goods and services submit bills to the State agency and receive payment directly from the agency. Stipends to Government physicians serving in rural areas are paid directly by the State agency using State funds, separately from the public assistance payments, without direct relationship to the number of public assistance recipients served.

10. State-local financing of costs: Assistance and administrative costs, non-Federal share: State funds. Source of State funds: general fund, appropriated to cover all four categories in one fund, with amounts for money and for vendor payments identified separately. Transfer may be made between categories for money payments, only, with approval by State department of budget and review. Transfers may not be made between funds for money payments and those for vendor payments.

PART 2. MEDICAL ASSISTANCE FOR THE AGED

(Department of social services, October 1, 1961 [1]—Hawaii)

A. GENERAL DESCRIPTION OF PROGRAM

1. Administrative responsibility: Medical assistance for the aged (MAA) is directly administered by the State department of social services through its four county offices. Non-Federal share of assistance and administrative costs is met from State funds.

2. Legal basis and general structure: Legislation enacted in 1961 established the base for a program of medical assistance for the aged and placed responsibility for medical care of all needy persons in the department of social services. Services under the program began in July 1961. Eligibility for assistance and need for medical care are determined concurrently, taking into account resources available over the ensuing 12-month period which could be applied to costs of needed care. Cases of persons needing continuing care, such as nursing home patients, are reviewed annually to redetermine eligibility; in other cases, eligibility and medical need are redetermined when additional service is needed or when changes in circumstances require reconsideration.

B. CONTENT AND SCOPE OF MEDICAL AND REMEDIAL CARE

3. Services:

(a) Hospital (inpatient): All general services for necessary care. Limited to 15 days; extensions possible with approval of State agency. Prior authorization required except in urgent situations. Payment based on ward rates plus actual charges for other specified services.

(b) Nursing home care: As recommended by physician, short- or long-term care. Payment based on nursing home's rate provided cost of care required by recipient is lowest available in community at that time, except in situations of undue hardship and/or isolation.

(c) Practitioners' services: Medical doctor in all settings, dentists, optometrist, and podiatrist. In rural Oahu and in counties of Maui, Hawaii, and Kauai, medical doctor services are provided primarily by State government physicians (compensated from State funds as part of medical program). Specialist and consultative medical doctor service also available.

(d) Dental care: Emergency dental services: examinations, X-rays, fillings, extractions, caps. By dentists authorized by the department.

(e) Prescribed drugs: Payments for such drugs made to vendors authorized by the department.

(f) All other care: Outpatient and allied services, including drugs, antibiotics, dressings, diagnostic tests, therapeutic procedures such as special eye care, prosthetic appliances, physiotherapy, X-ray therapy, and opticals. Prior approval required for all services except in emergency situations which cannot await approval, as determined by attending physician. Provision for air transportation to secure necessary care which is available only in another county. Private duty nursing service in medical institution available in exceptional cases where medically necessary.

C. ELIGIBILITY FOR MEDICAL ASSISTANCE FOR THE AGED

4. Eligibility factors:

(a) Age: 65 years of age or older.

(b) Citizenship: No requirement.

(c) Residence: Residing in the State or temporarily out of the State but deemed to be a resident.

(d) Institutional status: May be a patient in a medical institution as permitted under the Federal act, except that no payments are made in behalf of persons with diagnosis of tuberculosis or psychosis nor for persons hospitalized because of Hansen's disease.

(e) Property and income limitations: Income: Insufficient to meet the standards of assistance established for MAA, including nonmedical and medical requirements (approximately $50 per month above the standards of assistance for OAA) and if the resources available to him within 12 months after date of application are insufficient to pay the cost of needed medical care. Assets: Real property—home with tax-appraised value of less than $14,000 is exempt; also other real property with value not to exceed $150. All excess value is considered a resource for payment of medical costs. Personal property—all liquid assets beyond $50 cash savings (of unemancipated minor) are considered available after allowances for payments on obligations contracted for defined essential purposes. May own automobile 4 years old or older or when necessary for essential transportation. Full loan value of life insurance is resource. Under exceptional circumstances, conservation of readily available resources allowed. Health insurance, Veterans' Administration care, workmen's compensation, and similar resources must be taken into account in determining extent to which MAA is needed. (No adjustment or recovery for assistance correctly paid.)

(f) Other: Not a recipient of OAA, AB, APTD, ADC, or State-financed assistance programs.

D. ADMINISTRATION OF MEDICAL AND REMEDIAL CARE

5. Administrative and financial provisions: Administration and financing of the program of medical assistance for the aged is the same as parallel provisions for old-age assistance with respect to (a) medical direction, (b) State advisory groups, (c) interorganizational relationships which are of service to recipients of OAA, (d) method of making payments to suppliers of medical goods and services, and (e) the State financing of the non-Federal share of assistance and of administrative costs. For details of these administrative and financial provisions, refer to the State item in part I.

Mr. FONG. Madam President, on May 10 this year, I wrote to the Hawaii Department of Social Services and requested full details on the State's program of financing cost of medical care of needy persons.

These are the questions I asked:

1. Will you please inform me, at your earliest convenience, the type of medical aid presently afforded the aged sick and distressed of the State of Hawaii?

2. Are you able to tell me whether any person in the State of Hawaii, desirous of obtaining medical aid and hospitalization has been unable to secure such aid?

3. Please list the amount of such medical aid available, both private and governmental, including therein hospitalization, drugs, physicians' care, nursing home assistance, and outpatient service. Is the patient called upon to defray any percentage of the cost?

4. Will you please include in your reply to this letter what medical aid is available to an indigent in the State of Hawaii, regardless of his age?

In reply, Hawaii's able director of social services, Mrs. Myrtle Ward, wrote me as follows:

We do not know of any case in the State of Hawaii in which a person requiring medical care who, because of his inability to pay for this care, has not been able to secure necessary care. The reason for the above statement is the fact that in our State, persons unable to finance the cost of medical care themselves may apply to the department of social services for assistance in financing this cost. The department of social services is, in the State of Hawaii, charged with the responsibility to finance the cost of medical care of indigents and medical indigents.

An indigent person is defined as one who is a recipient of financial assistance to meet the cost of basic maintenance needs, such as food, shelter, and clothing. A medical indigent is a person who is otherwise able to subsist for himself, but is found needy in terms of his ability to meet the cost of medical care.

Under the existing program administered by the department of social services, persons found eligible either as indigent or medical indigent can receive the following services as necessary:

(a) Hospital care as long as medically necessary.

(b) Comprehensive outpatient and allied services.

(c) Physician services.

(d) Unlimited nursing home care.

(e) Limited dental care.

The above services are available to persons in any and all categories of public assistance, including the aged group. There are no residence restrictions.

In addition to the department of social services' program for indigents and medical indigents, payment to meet the cost of specific medical services can be financed by other public, as well as private agencies. Examples of public programs would be the maternal and child health and crippled children services available through the State department of health, the vocational rehabilitation program, and medical care of State and county pensioners through the re-

[1] These provisions are in the State's plan as submitted for approval; they are included here because the program is in operation, as of October 1, 1961, the plan material is being reviewed and the provisions given here are not under negotiation, and when approved the effective date for Federal financial participation will be July 1, 1961.

spective county governments. Private programs include the national foundation program and the Society of Crippled Children and Adults.

The eligible indigent-medical indigent patient is required to pay for the portion of the total of medical care he can afford to pay for himself as determined by a means test. However, if he is unable to meet the cost of any portion of his medical care, the department of social services will finance the total expenditure.

Madam President, I am satisfied that any needy person of whatever age in Hawaii can receive help in meeting the cost of medical care under our State and Federal-State programs.

I ask unanimous consent that the entire text of my letter and the reply from the department of social services be printed in the RECORD at this point.

There being on objection, the letters were ordered to be printed in the RECORD, as follows:

MAY 10, 1962.

Mrs. MYRTLE WARD,
Director, Department of Social Services,
Honolulu, Hawaii.

DEAR MRS. WARD: Will you please inform me, at your earliest convenience, the type of medical aid presently afforded the aged, sick, and distressed of the State of Hawaii.

Are you able to tell me whether any person in the State of Hawaii, desirous of obtaining medical aid and hospitalization has been unable to secure such aid.

Please list the amount of such medical aid available, both private and governmental, including therein hospitalization, drugs, physicians' care, nursing-home assistance, and outpatient service. Is the patient called upon to defray any percentage of the cost?

Will you please include in your reply to this letter what medical aid is available to an indigent in the State of Hawaii, regardless of his age.

Any other information you may have on the subject will be appreciated.

With warm regards and aloha,

Sincerely yours,

HIRAM L. FONG.

STATE OF HAWAII,
DEPARTMENT OF SOCIAL SERVICES,
Honolulu, June 14, 1962.

Senator HIRAM L. FONG,
U.S. Senate,
Washington, D.C.

DEAR SIR: This is in reply to your letter of May 10, 1962, regarding Hawaii's program to finance the cost of medical care of needy persons.

We do not know of any case in the State of Hawaii in which a person requiring medical care who, because of his inability to pay for this care, has not been able to secure necessary care. The reason for the above statement is the fact that in our State, persons unable to finance the cost of medical care themselves may apply to the department of social services for assistance in financing this cost. The department of social services is, in the State of Hawaii, charged with the responsibility to finance the cost of medical care of indigents and medical indigents.

An "indigent" person is defined as one who is a recipent of financial assistance to meet the cost of basic maintenance needs, such as food, shelter and clothing. A "medical indigent" is a person who is otherwise able to subsist for himself, but is found needy in terms of his ability to meet the cost of medical care.

Under the existing program administered by the department of social services, persons found eligible either as indigent or medical indigent can receive the following services as necessary:

(a) Hospital care as long as medically necessary.
(b) Comprehensive outpatient and allied services.
(c) Physician services.
(d) Unlimited nursing home care.
(e) Limited dental care.

The above services are available to persons in any and all categories of public assistance, including the aged group. There are no residence restrictions.

In addition to the department of social services' program for indigents and medical indigents, payment to meet the cost of specific medical services can be financed by other public, as well as private agencies. Examples of public programs would be the maternal and child health and crippled children services available through the State department of health, the vocational rehabilitation program and medical care of State and county pensioners through the respective county governments. Private programs include the National Foundation program and the Society of Crippled Children and Adults.

The eligible indigent-medical indigent patient is required to pay for the portion of the total cost of medical care he can afford to pay for himself as determined by a means test. However, if he is unable to meet the cost of any portion of his medical care, the department of social services will finance the total expenditure.

For further detailed information with regard to Hawaii's program to meet the cost of medical care for the indigent and medical indigent, please refer to Public Assistance Report No. 49 of the U.S. Department of Health, Education, and Welfare, "Characteristics of State Public Assistance Plans Under the Social Security Act," a copy of which is attached.

We hope you find this information helpful. Please do not hesitate to contact us again should further information be required.

Yours very truly,

Mrs. MYRTLE D. WARD,
Director.

Mr. FONG. Yet there remains a group of elderly persons whose savings and other assets, while not large, nevertheless exceed the ceiling established under the Kerr-Mills program. A costly illness could impoverish them unless they are protected by health insurance.

We are told these people strongly favor the King-Anderson or Anderson-Javits social security health insurance plan.

I am not convinced this is so. My personal experience has been that as the defects and drawbacks of the social security plan have been made known, more and more people are opposed to it.

I have received very few letters from constituents urging my support of the Anderson proposal. On the contrary, letters I have received from nonmedical as well as medical persons in Hawaii indicate strong and increasing opposition to the King-Anderson plan and now to the Anderson-Javits plan.

Perhaps these letters do not constitute a representative sample of popular sentiment in my State. Nevertheless, if there were the alleged groundswell of support, I should think my mail would reflect it to some degree. But it does not.

Another indication of voter sentiment appears in a recent Gallup poll which shows that in the March-June period this year support for the social security approach has dropped 7 percentage points. Sentiment is nearly divided between social security—48 percent—and private insurance—41 percent.

I am not suggesting that these percentages are gospel. But I do think it is significant that a nationwide poll fails to turn up a tidal wave of sentiment for social security financing of medical costs for senior citizens. It is more like a ripple.

I was very much interested in an article in the July 1962 issue of Nation's Business entitled "Old Folks Reject Health Plan." The article tells of interviews with elderly persons living in the area of St. Petersburg, Fla., and states:

Residents of this gulf coast area, a survey reveals, are about 2 to 1 against the Kennedy administration's controversial measure now before Congress to raise social security taxes to pay hospital and nursing home bills for some of the Nation's senior citizens.

What is particularly significant is that Pinellas County—the sandy, fast-growing county encompassing St. Petersburg—has the Nation's highest proportion of persons 65 or older and probably the highest mix of those qualified for the proposed Federal health plan.

Interviews with residents here show several other meaningful signs:

Those who oppose health care under social security seem to be informed on the provisions and potentials of the legislation. Many of the most avid supporters are ill-informed about what the bill would do.

Madam President, I think this is a most revealing statement. It supports my personal observation that those who are against social security health care are indeed informed on the King-Anderson and Anderson-Javits bills. The article continues:

Lots of elderly persons who see health care of the aged as a serious national problem feel the administration's bill falls short of meeting the need.

* * * * *

Many of the elderly themselves, whom the bill purports to help, hew to the philosophy typified by a spry 76-year-old widow whose home here is a trailer: "I'll have nothing to do with that Government medicine. I can take care of myself and so can anyone else who has any gumption." She spends $21 a month for private health insurance out of her total income of $60 monthy from social security and $50 from a military survivor's pension.

* * * * *

Pinellas County is a miniature, condensed battlefield for this national issue. The county has a population of more than 375,000. But, unlike most other areas, some 25 percent of the residents here are 65 or older. Not all of them would be eligible to receive health care under the administration's bill. But about one in five of the county's residents would be. So this county has not only the highest percentage of aged but the proportion of its population that would be eligible for health care is twice the national average.

* * * * *

A local man sums up the thinking of many senior citizens:

"I'm 65 and still have a relatively young family to support. I am worried about what will happen to my five children if this philosophy of socialism and control from a central government continues to grow. The expense and human detriment resulting from such steps (as the King-Anderson health care proposal) are more far reaching than most people realize."

Contrary to what the administration would have us believe, there is nationwide awareness among the American people of the parsimonious terms of the King-Anderson and Anderson-Javits proposals and of the potentially adverse consequences of a compulsory medical care plan.

Some changes, or sweeteners, have been made in the original King-Anderson plan in an effort to render the program more palatable and votable. But essentially, in my judgment, the principal defects remain.

As I pointed out before, because of the limited benefits under the Anderson-Javits plan, senior citizens would still have to buy supplementary insurance to protect against surgical costs and major medical charges.

I firmly believe the Anderson-Javits plan will lead ultimately to compulsory Government health insurance for all ages. The signs and portents are quite clear, and we know its most ardent advocates tell us it is only the foot in the door.

Then we will have socialized medicine as in Britain, Italy, West Germany, and other Western European countries. Experience of these nations with government medical care plans warns us to proceed with caution.

Britain, which since 1948 has financed medical care for all citizens, has experienced a substantial flight of doctors from her shores, apparently leaving for lands with less redtape and greater opportunity to develop professional skills. It is interesting to note that a number of these emigrants from Britain settled in Canada, where having experienced government control of the practice of medicine in Britain, they are protesting a similar move in Saskatchewan Province.

In March 1962 a British consultant in medical economics and health services, Dr. John R. Seale, reported:

> Since 1948 unusually large numbers of graduates of the medical schools of Great Britain and Ireland have registered for practice abroad. It is apparent that the majority have remained overseas and should be regarded as medical emigrants from Britain.

I am informed some 600 British doctors seek careers abroad every year.

On the other hand, Dr. Seale found a rapidly rising number of doctors entering England from Spain, Yugoslavia, Syria, and many other countries. He noted that—

> In 1950 only 53 posts in hospitals were filled by foreign doctors; 1953, 498; and in 1960, 1,701. Increasingly, the medical staff of hospitals is a rapidly shifting labor force recruited from abroad, a characteristic symptom of an economically depressed occupation.

Many foreign doctors are in England only temporarily for training and so will not replace the hundreds of British doctors seeking to leave Britain each year.

Thus, Madam President, there appears to be a very strong correlation between the advent of socialized medicine and the departure of British doctors.

Dr. Seale reports that, with the exception of Soviet bloc countries, no nation in the world has a system of medical care so fully socialized as England. The system is keyed to the hospitals whose physicians are appointed by the Government. This in turn controls medical practice, for no doctor can enter private practice in England until he has been appointed to the staff of a hospital.

Because costs skyrocketed the first year in Britain, an economy policy was invoked. Dr. Seals said:

> This policy has not only given us inferior hospitals and equipment, it has also squeezed the incomes of those who work in the health service. It is easy for the Government to decrease real incomes of health workers for they rarely strike or complain * * * As most (health service) expenditure is on people, an effective way of obtaining economy is either to employ fewer people or to pay them less.

Another startling and shocking fact about the impact of socialized medicine in Britain is that, since its inauguration, only one new hospital has been constructed. This is a truly shocking statistic, especially when we consider that, here in the United States during this same period of time, under our private system of medicine 724 new hosiptals were built.

Today in England patients must wait weeks, except in extreme emergencies, before they can be admitted to hospitals. Some have been on the waiting list as long as 3 years to get into one London hospital.

Is this what we want in America? If not, then we must steer clear of Federal Government administration and control of medical practice.

There are indications medical standards have declined in Britain under compulsory government medical care.

Is this what our elderly citizens want? Is this what most Americans of any age want? I think not.

Let us consider some other possible effects of instituting compulsory Government health insurance. The Government will inevitably branch out to control medical research and drugs. There is already a move in the Congress to eliminate patent protections from developers of new medicines and drugs. Is this wise? Experience of other nations that do not offer strong patent protection as America does show how development of new drugs has lagged.

In America, for example, where we have strong patent protection, there have been 60 drug discoveries since 1940. In Great Britain, France, West Germany, and Switzerland, with a combined population almost as large as the United States, but where patent protection is moderate, only 29 drug discoveries occurred since 1940.

But in Italy, which gives no patent protection, not one new drug has been developed in this same period of time.

Inestimable numbers of Americans are alive today only because of drugs and antibiotics developed over the past few years.

Our private system of medicine, together with patent protection, is serving the American people in excellent fashion. We would be foolish and shortsighted to inhibit, restrict, or interfere with the progress of this system.

Indeed, even without the proposed Government health insurance program demand for medicine, serums, vaccines, for services of physicians, dentists, hospitals, nurses, and nursing homes appears destined to grow by leaps and bounds with our rapidly expanding population.

Some facilities are already overcrowded and, if the Anderson-Javits plan is adopted with its emphasis on hospitals and nursing homes, these facilities will bear an even greater burden.

A few days ago the distinguished junior Senator from Louisiana [Mr. LONG] pointed out that the experience of Louisiana shows that patients remain in Government hospitals 50 percent longer than in private hospitals. If this is the pattern nationwide our hospitals would experience tremendous overcrowding.

Personnel shortages will be accentuated if present trends continue and this situation will worsen if compulsory Government health insurance is forced upon our medical system.

For 30 years the supply of dentists has been falling behind population growth in America. In 1930 there were 59 dentists for each 100,000 people. Today there are 43 per 100,000. Dental schools now turn out about 3,200 graduates a year. By 1975 the United States will need 6,000 dental graduates each year, requiring an estimated 22 new schools.

Official estimates show there are about 261,000 licensed physicians in the United States today. That works out to 1 physician for each 760 people. About 7,500 new physicians are produced each year in America, less than the demand. By 1975 we will need 11,000 medical graduates a year, requiring 20 to 24 new medical schools.

The supply of nurses is also declining. It is estimated 300 nurses are needed per 100,000 population. The actual ratio today is 257 per 100,000. At the present rate of training, we will have only 246 per 100,000 by 1975.

The question arises: Where are we going to get enough doctors, dentists, and nurses to serve our people?

Will compulsory Government health insurance increase the supply?

It is very doubtful. In Britain, for example, there was 1 doctor for every 877 persons in 1947, the year before their compulsory government medicare program went into effect. Ten years later, the ratio had declined to 1 to 1,149 persons.

Certainly, we in the Congress ought to avoid like the plague any move that might result in further shortages of these skilled persons. On the contrary, we ought to be encouraging the training of more doctors, more dentists, more nurses, more technicians.

Should a compulsory government health plan be instituted in America, it is doubtful there would be any wholesale exodus of doctors, for there are not many places to emigrate. What is more likely is that our supply pipeline of future doctors and other medical personnel would dwindle to a mere trickle. The incentive for young men and women to pursue medical vocations would evaporate. The prospect of working under the direction of government agencies is anathema to most of them.

Nation's Business reported in June this year that its recent survey of students in 17 public and private medical schools throughout America revealed:

> Greater Federal activity in health care would cause many young Americans to abandon the study of medicine. Others would leave the United States after graduation to practice in countries where the physician has more freedom.

Nation's Business interviewers concluded:

> Medical students overwhelmingly oppose proposals for providing medical care for older citizens under the social security system. * * *
>
> Students by a margin of more than five to one, say they would be less enthusiastic about entering the medical profession if health services were eventually nationalized as they are now in Great Britain.

With that indication that future doctors do not relish the prospect of practicing medicine as Government employees, let us see whether prospective patients have a preference for Government doctors or their own private doctors. Experience under the dependent medicare program of the Defense Department is most enlightening on this point.

When this program first went into effect, dependents of our uniformed military personnel were given the option of using military facilities at no cost or private facilities and private doctors at a nominal fee with the Federal Government paying the entire balance of costs.

What was the result? The dependents overwhelmingly elected private doctors and private hospitals. So great was the rush to private doctors and medical facilities, that the costs of the program mushroomed far beyond first estimates and many military medical facilities had so little business their doctors were not getting adequate practice.

Congress, in fact, had to insist on restrictions in the dependents medicare program so that military medical facilities would not stand idle and so that military doctors would have some patients to care for.

In the relationship of a patient to his doctor, confidence is a big factor. Under socialized medicine, as in Britain, the patient may not select his doctor in the hospitals. There the doctor is assigned. Here in America, I believe the American people do not want a doctor assigned to them. They want to choose their own doctor.

In all conscience I could not vote for a measure whose ultimate destination is socialized medicine as surely as the sun rises and sets every day.

The junior Senator from New Mexico [Mr. ANDERSON] and the senior Senator from New York [Mr. JAVITS], for both of whom I have great respect and admiration, do not believe their plan will lead to socialized medicine. I will agree that the plan embodied in their amendment is not in itself socialized medicine. But I do believe that their plan is the first step toward socialized medicine for all the American people of all ages.

Madam President, in conclusion, may I say that all of us want our elderly citizens to receive proper medical care.

As the senior Senator from Colorado [Mr. ALLOTT] stated so eloquently and movingly last week:

> None of us is insensible to the needs of our senior citizens. All of us are gravely concerned regarding the problems of those who arrived on this earth before us and to whom we owe so much. We who are their sons and daughters have benefited from their labor and sacrifices on our behalf. They provided for us in our early years with the sweat of their brow; they watched over us and they guided us; they nursed us through our illnesses in the far watches of the night and through dark hours of despair. They saw to our education to the best extent of which they were capable, doing without in order that we might have advantages which they to a large degree could not afford themselves.
>
> Even those who were childless were joined with our parents in achieving the scientific breakthroughs, the medical progress, the engineering marvels, the great strides in transportation, in education, in every phase of our modern life, so that we came into a life of advantages far greater than they themselves had enjoyed.
>
> Who are the elderly of today but the workers, the scientists, the engineers, the teachers, the ministers of yesterday? And now, as they reach their sunset years, and as others reach them tomorrow, next year, and the years to come, their security and dignity is on our conscience. Now in the twilight of their years, some of our senior citizens are in need of assistance, and it is and will continue to be the responsibility of all of us to see that they get it. We must see to it that they enjoy their remaining years in peace and dignity, not as wards under the benevolent despotism of an all-powerful Federal Government, but as free citizens able to live their own lives in gracious fulfillment (p. 12370, CONGRESSIONAL RECORD, July 11, 1962).

The Congress must take care not to set in motion programs that will reduce the quality of medical care in America or that will result in a shortage of doctors and nurses or that will discourage medical research.

That would be a disservice to old and young alike.

The Anderson-Javits social security health insurance plan falls very short of meeting the medical care needs of our elderly citizens. Moreover, it would inevitably lead to compulsory Government health insurance for Americans of all ages. The report of the White House Conference on the Aging stated point-blank:

> Compulsory health care inevitably results in poor quality health care.

I cannot believe the American people want the Congress to approve a program which may well jeopardize medical progress, which may deter young men and women from entering the difficult and arduous medical profession, which may discourage construction of hospitals and other medical facilities, which may put an intolerable burden on the working men and women for a national problem that should be solved on a national basis by all the taxpayers.

Therefore, I oppose the pending Anderson-Javits amendment.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

LET US NOT SOCIALIZE MEDICINE

Mr. LONG of Louisiana. Madam President, I rise in opposition to the Anderson-Javits amendment.

Some of my reasons for opposing this proposal for providing medical care to the aged go to the specifics of the pending proposal. But more basically, I oppose the Anderson-Javits amendment

because I strongly believe that it is wrong in fundamental concept.

First, let us look to the specifics of the measure.

Here is what it does:

First. It taxes practically everyone;

Second. It pays certain medical expenses of persons over 65 years of age.

Now let us see what it does not do:

First. It does not pay doctor bills;

Second. It does not pay the first $90 of hospital bills;

Third. It does not pay for medicines outside the hospital, nor for most other outpatient care;

Fourth. It does not directly benefit anyone under 65.

Madam President, here we have a proposal that would tax people to pay for a great amount of medical care which many of them are well able to provide for themselves without the help of the Government or anyone else.

Under this proposal, in a large number of cases we would be taking the butter and eggs from the workingman's table in order to provide medical care for someone else, who has always been both willing and able to pay his own medical bills. In many cases, the beneficiary will be much better off than his benefactors.

This measure would prove to be a great disappointment to aged people who, having been told that the Government was going to provide for their medical care, would belatedly learn that only a fraction of the bill was to be taken care of.

But much more important than the specific defects of the particular measure, Madam President, are the objections which have been raised to the fundamental nature of this amendment. In my judgment, this is the real sticky point.

I, for one, am appalled at the prospect of the giant tree which will grow from this seed. If the Anderson-Javits amendment becomes a law, we will have taken the first step down a road from which there will be no turning back. What we will effect in this amendment will be just the beginning. Next year, without a doubt, we will be confronted with proposals to expand the services—to provide more extensively for those already covered, and to extend benefits to those not covered. Of course, this will call for another increase in the social security tax to pay for the expanded services.

Sooner or later, probably sooner, we would expand the services to include doctor bills and outpatient care, including drugs, eyeglasses, and even false teeth. The program would be gradually extended to take care of everybody's medical expenses.

To finance such an all-encompassing medical care program, the social security tax would be so high that an average wage earner, making about $5,000 a year with three or four dependents and the usual deductions, would find himself paying more in social security tax than in income tax.

By that time, taxes for social security would exceed 20 percent of income. The workingman would be paying more than 10 percent of his income toward retirement and insurance against early death, plus 10 percent of Federal medical care, plus more than 3 percent for unemployment insurance, plus 20 percent for other expenses of Government—defense, foreign aid, and so forth. Thus, the Federal Government would be taking 42 percent of the income out of the workingman's paycheck before he ever sees it. Of the remaining 58 percent, the State, county, and city governments will be taking about 10 percent, leaving the workingman about 48 percent of his income with which to feed, clothe, and house his family, educate his children, and save something for the future, if that is possible.

Some of the tax I have mentioned is a tax assessed against the employer. However, the employer would be forced to pass his tax along in the price of his product to the consumer; so in reality the workingman would be paying the so-called employer's tax as well as the employee's tax.

Imagine that, Madam President. By the time we get through with this cradle-to-grave business, the average man will have only about one-half of his income to spend for himself.

We would be paying for a great amount of doctor's services which are presently being rendered free of charge.

My personal physician is a good example of what I have in mind. He is a cousin. He is the son of an old country doctor. From his father he learned that a doctor should treat everyone who is suffering, whether he is able to pay for it or not. He was also taught that a doctor should treat without charge the families of his fellow doctors in the vicinity as they do the same for him. This is set forth in the American Medical Association's code, "The Principles of Medical Ethics." In addition, he was taught that he should never sue to collect his bill. My brother-in-law practiced medicine for a number of years in the same tradition.

If socialized medicine is to come, these doctors will be filling out Federal forms and charging Uncle Sam for treating each other's brothers, mothers, sisters, and wives, as well as indigents—all of whom they are now treating at no cost today.

As taxpayers, we will be paying taxes to finance a great amount of presently free service. Why do the doctors object? They would be making more money.

They object, first, because they prefer private practice to working for the Government.

Second, they object to the compulsory uniformity which would result.

Third, they object to filling out forms.

Fourth, they object to having Federal bureaucrats prescribe—as will inevitably happen—the way in which they administer treatment to their patients.

Fifth, they object to attending meetings to discuss salary schedules, minimum and maximum fee arrangements, retirement benefits, annual leave, sick leave, disability benefits, and so on, all of which are presently a doctor's own private business to handle as he sees fit.

Louisiana has been described as the Welfare State. More than one-third of State expenditures are for the purpose of improving the public welfare. Federal aid provides most of the money, but there are a number of things that we do for the people without Federal aid. Until recently, we had no Federal aid whatsoever for hospital care. Yet about half of the hospital days spent in the State were spent in the State hospitals, at no cost to the patient.

I have been through many of the State's hospitals; they are magnificent structures of brick and stone, steel and iron, with banks of high-speed elevators and gleaming, shiny floors of terrazzo tile.

In many instances, the State hospitals are more modern and better equipped than private hospitals in the same cities. Even in small cities the State pays doctors or other hospital owners to set aside a number of beds for patients who are unable to pay. The State has free ambulances in every parish to carry the emergency cases to hospitals, and to move the sick to and from the State hospitals.

It is interesting to note that the average patient stays about 50 percent longer in the State hospitals than in private hospitals. This is easily explained. When a wealthy woman, a patient in a private hospital, is able to be moved, she will go home; a nurse will go with her, to care for her until she is fully recovered. This reduces the cost to the patient, and places her back among her loved ones.

On the other hand, when the average woman who has been a patient in a State hospital is discharged and goes home, there is no one there to look after her during most of the day. She cannot afford a private nurse, so she stays in the hospital until she is able to take care of herself.

Madam President, it is not considered remarkable by anyone concerned that the woman who has been treated in a State hospital has, during her entire stay, been the beneficiary of treatment in every respect equal to that provided for the private patient.

In the case of a patient in the New Orleans Charity Hospital, for example, the excellent doctors of the Louisiana State University and Tulane University medical schools will have performed with their usual high degree of competence. These men are teachers at these medical schools. They are, in the nature of their function in training future doctors, completely educated to all the latest developments in medical science.

The point of all this is that, under the pending proposal, the taxpayers of Louisiana would be paying a lot more to the Federal Government in order to pay for a great many things which they are already receiving at no cost, and for a great number of medical services that the patient would not buy if he were paying for it himself, even though well able to do so.

Madam President, much of the criticism which has been directed at the Anderson-Javits amendment goes to the proposed method of financing. The measure would be financed through increased social security payments.

Let us look further at some of the effects of doing this. At present, the

workingman is paying in social security taxes 3⅛ percent of his annual income up to $4,800. This is not counting the one-quarter percent that the Anderson-Javits amendment would add. The amendment would also raise the maximum taxable earnings base to $5,200. Under recently approved increases, by 1968 the workingman will be paying 4⅝ percent. The medical care percentage, if approved, will doubtless have increased at least that much.

In addition, his employer would be paying an equal amount, and the employer would find it necessary to pass the cost along in the price of his product. The consumer, being the same as the workingman in many instances, would therefore be paying about 10 percent of the payroll for social security purposes in 1968.

As the social security system now operates—and the inevitable increases will amplify this factor—the lower wage earners will pay at an increasingly disproportionate rate in order to receive the same benefits as their wealthier fellow contributors.

A regressive rate structure is and will be particularly unfair to the lower income brackets, because they obviously are spending practically all of their income on basic necessities, while those in the upper income levels spend less and less of their total income on such essentials. Yet the poor man must pay a considerable portion of his already earmarked funds just to be medically protected as well as wealthier people who may waste more in a year than a poor man earns.

From the viewpoint of a true Socialist this is not alarming, for the reason that eventually Government will be required to tax away most of what everyone receives, whether he is rich or poor. Therefore, it makes little difference to the Socialist whose property or possessions goes first. Most of it will have to go sooner or later if socialism comes. Yet it makes a great deal of difference to those of us who believe in the more ancient tradition of self-reliance, private property, private practice of medicine, and in going to the Government only when we cannot find the answer for ourselves.

It seems to me that the people are becoming more conscious of this point, judging from the public opinion survey compiled by House Members in their districts and recently reported in the CONGRESSIONAL RECORD. Of 52 polls, including 615,284 responses, 33 opposed use of the social security mechanism to finance health care for the aged, and only 19 favored it. While these results differ from those of the recent Gallup count, they tend to confirm my belief that the number of people supporting the Anderson-Javits approach is dwindling.

The opposition of the doctors of this Nation to the social security approach to a medical care program for the aged has been no secret. Doctors have come in for no end of criticism because of their opposition. Much of it has been highly unfair.

In fact, it has been my impression that much of the propaganda in behalf of compulsory medical insurance comes alarmingly close to the familiar Communist line. The person whose business is about to be nationalized is described as an evil sort—corrupt, insensitive to the needs of humanity and society, unwilling to recognize the just demands of the public. For such reasons, it is contended that he is not to be permitted to continue the private management of his business.

It has been my impression that the doctors of my State render somewhere between one-fourth and one-third of their services without pay. Most of them who are wealthy have made much of their wealth by investing money that they have saved out of their income, just as is true of most successful lawyers and other professional people. There is absolutely no basis for the kind of criticism doctors have received, if we want to be fair about the matter.

As one who supported the Kerr-Mills amendment, it is my judgment that we have already gone a long way when we help the States to provide medical care for persons unable to pay their own medical bills. Undoubtedly the number of aged persons who will require assistance will increase. Yet if we are successful in increasing the income and opportunities of our people, there should be an ever greater proportion of persons both over and under 65 who should be able to pay for their own medical expenses in the future.

The Kerr-Mills approach will, in my judgment, prove adequate. It will accomplish everything which could be done through the social security approach, and more. Most important, Kerr-Mills will not lead to the kinds of evil effects I have undertaken to describe.

The inevitability of these evil effects is the really crucial point. The Anderson-Javits amendment is a big step on the road toward socialism.

Many meritorious bills have in the past been opposed with the cry of "socialism." Madam President, I am not frightened by name calling. It does not impress me to have anyone to shout that something is socialistic, communistic, fascistic, reactionary, or any other such slogan.

It has been my policy to judge measures entirely on their own merits. But I wish to make it crystal clear that I am unalterably opposed to socialism in the true meaning of the word. At the same time, I have complete disdain for those who seek to avoid proper regulation of privately owned utilities in the name of socialism, or who seek to create monopoly and stifle competition with the cry of "socialism."

Such persons remind me of the boy who cried "Wolf" too often. That is not the case with this proposal.

Let us make no mistake about it. When we look at the Anderson-Javits amendment, we are not staring at a sweet old lady in bed with her kimono and nightcap. We are looking into the eyes of the wolf that ate Red Riding Hood's grandma.

Once we pass this intersection, there will not be another place to get off the highway for 50 miles.

Once we agree to pay the medical expenses of everyone over 65, whether he needs it or not, we are locked in a trap. We cannot refuse to extend the same principle to eliminate the $90 deductible feature. We cannot refuse to extend hospitalization beyond 90 days. We cannot refuse to do the same thing for everyone who appears to be disabled. Nor can we, with the slightest degree of human charity, refuse to do the same thing for everyone who is truly unable to pay his own doctor, hospital, nursing, and drug bills.

This is truly a foot-in-the-door measure, carefully drawn to wedge the door so far open that it cannot be forced closed again.

Adopt this measure and it will never be possible to stop its progress before you have 10 million people daily in hospital beds under treatment, convalescing and resting with more than 10 percent of your work force devoted to their care on a full-time basis.

Adopt this amendment and we will overflow every hospital in America with cases, many of which should be in their own homes under the care of their families and relatives. Already that result is being achieved in Louisiana under the Kerr-Mills law. Once you take the position that everyone over 65 is entitled to 90 days of hospitalization at Government expense, many of the aged will make their plans to spend their summer vacations in the hosiptal, while their sons and daughters take the grandchildren away for their vacation.

Some of this sort of thing is happening already. Hospitals will become social clubs, with the corridors, waiting rooms, and wards crowded with people who have no crowded need of hospital care by present-day standards.

In Louisiana our own experience proves that a patient stays 50 percent longer in the hospital when the Government is paying the bill.

This represents a 50-percent penalty on taxpayers as a starting point, not to mention the cost of middlemen, such as tax collectors, investigators, Federal standard providers, regulators, and so forth.

As stated by the senior Senator from Oklahoma [Mr. KERR], I would be willing to vote for any taxes and appropriations necessary to care for those who are unable to care for themselves. I am not willing to vote for taxes and appropriations for medical care for those who can and should provide it for themselves.

In summary, Madam President, the Anderson-Javits amendment should be defeated for a number of reasons.

Insofar as it provides medical care for persons unable to pay their own bills, we have a number of measures at the State, Federal, local, and private levels which are already capable of meeting this problem. Beyond that point, the Anderson-Javits proposal would enormously increase Federal expenditures to pay the expense of people who should be paying their own medical bills. This is something the Federal Government should not do.

This proposal will increase by at least 50 percent the cost of providing medical services by encouraging people to consume medical attention of doctors,

nurses, and hospitals—which services have traditionally been provided by the family.

Eventually it will result in much greater evils.

It will heap upon the taxpayers' backs the problem of paying for services which doctors are presently rendering at no charge to their relatives and to indigent persons.

It will increase by more than 50 percent the most of all medical services, including the cost of doctors, by encouraging the patient to stay longer in hospitals rather than seeking his own early release.

It will result in payroll deductions which, together with State and local taxes, will exceed 50 percent of a worker's gross income.

It will socialize one of our truly fine professions and lead toward State management and control of others.

For these many reasons, this proposal should be soundly defeated.

Mr. DOUGLAS. Madam President, tomorrow the Senate will have its long-awaited opportunity to vote on a proposal to provide basic health care protection for aged citizens. It is satisfying that the proposal on which the major vote will come is the plan to provide financing under social security. This is the sensible approach; and in its rejection of the amendments in the nature of substitutes, which were offered last week, I believe the Senate has shown that it regards social security financing as superior.

Social security financing of health protection for the aged is a system of social insurance under which the costs of protection would be spread over a large number of persons, each of whom would make small contributions over a long period of time to pay for the insurance. Like insurance against the burden of disaster by fire, small contributions by the many can provide low-cost social insurance against at least a part of the burdens of the illnesses which are the disasters of old age.

I hope very much that this proposal will be discussed as health care, and that the medical care name, which has been held over from earlier proposals, like the Forand bill, will be dropped. The appropriate and accurate name for the proposal is health care. It is unnecessarily confusing to continue the habit of talking about medicare when physicians' and surgeons' fees have been eliminated from the plan.

I was somewhat amused by the comments of the distinguished Senator from Louisiana [Mr. LONG], who in the first part of his speech pointed out, correctly, that the proposed plan did not include medical or surgical care, but in the latter part of his speech insisted that this was a socialistic medical provision. The truth is that the proposed plan merely provides for hospital care, nursing-home care, and nursing in the home.

Mr. LONG of Louisiana. Madam President, will the Senator from Illinois yield?

Mr. DOUGLAS. I yield.

Mr. LONG of Louisiana. I believe I made my position clear that this is a foot-in-the-door proposal. It is not a good proposal, either, as far as it goes. What it would lead to would be far worse.

I hope the Senator from Illinois understood my argument. I do not expect him to agree with it, but I hope he understood it.

Mr. DOUGLAS. The argument of the Senator from Louisiana reminds me of Stephen Leacock's story about the man who mounted his horse and rode off in all directions.

Mr. LONG of Louisiana. The Senator from Illinois well knows that he and other Senators who agree with him on this measure are already seeking amendments to extend it to cover other features which I covered in my speech. Once such action is started, it will have to be expanded to include service costs. Congress will have to increase taxes until all other phases of medical care are covered.

Mr. DOUGLAS. Well, we can deal with those issues when they come up. But I have always thought the Senator from Louisiana was right in the general principle which he laid down; namely, that we should not be deluded by abstract adjectives, and we should consider each proposal on its merits.

Mr. LONG of Louisiana. Yes; but I also would say that when we find something which is as clearly a matter which will require implementation as this one is, we should be fair enough to admit it in the beginning.

I am one of those who made the fight, as a member of the committee, along with the Senator from Illinois, to provide Federal social security protection for disabled persons over 50 years of age, but there was never the least doubt in my mind at the time that if we did that we would extend it to those below age 50, and, from my viewpoint, the day we voted it through, I was ready to offer a proposal to extend it to those below age 50, because I think the proposal was basically sound.

So I hope the Senator from Illinois is not supporting this measure without giving full recognition to the fact that it will require implementation. It will require implementation in order to apply it to more people and to have it provide more services.

Mr. DOUGLAS. Well, I am not certain that that is the case. However, that will be taken up when the issue arises.

I do not wish to tax the Senator from Louisiana with being inconsistent, but he has been a very persistent advocate of permitting the veterans to purchase Government life insurance, and, therefore, for the Government to enter into competition with private life insurance companies. He has been called a Socialist for taking that position, yet the Senator from Louisiana has not been afraid to do it, because he believes in it as a correct principle, and he believes that the provision of lower cost insurance for veterans does not mean that it has to be extended to the entire population.

Mr. LONG of Louisiana. Of course that will not happen in connection with my proposal for such insurance.

But I really do not believe that the Senator from Illinois is in doubt that this proposed program will be extended, because if it is enacted into law, certainly it will be extended until it covers everyone's medical bills. Of course, the Senator from Illinois also knows that the prime mover behind this has been a very able man by the name of Cruikshank, who formerly was with the Department of Labor, in the old social security days, when it first began, and presently is associated with the AFL–CIO. There is no doubt as to how Mr. Cruikshank feels about this matter. He feels that this program should cover everyone's medical insurance.

Mr. DOUGLAS. But Mr. Cruikshank is not making the decision for the Senate, although, as the Senator from Louisiana has said, he is a very able and, I believe, a devoted man.

But why not vote on this measure in the way the Senator from Louisiana does on most measures; namely, consider it on its merits, and if thereafter other questions or issues arise, consider them on their merits.

Mr. LONG of Louisiana. I have made clear to the Senator from Illinois, I think, that I am opposed to this measure, both for what it is and for what it might mean.

Mr. DOUGLAS. The first part of the Senator's statement is quite logical, but it is not logical for him to include in the same statement the second part—in other words, after criticizing the plan for what it is, then proceed to criticize it for what it may lead to.

Mr. LONG of Louisiana. I think it is proper to do so, for the reason that some persons have given the impression throughout the country that this proposal—and I state frankly that my position is opposite that of the Senator from Illinois—will take care of the medical costs of all the people. Of course, it will not do so.

Mr. DOUGLAS. And that is what I am trying to clarify at the very beginning. This program should be called a program of health care for the aged, not "medicare." That is why I include this statement in my remarks. The program is not a "medicare" program. It is a program of hospital care for up to 90 days, subject to a $90 deductible; nursing-home care for up to 180 days; and nursing in the home for up to 240 days. That is all it is—no medical care and no surgical care.

Mr. LONG of Louisiana. I believe that the Senator from Illinois and I understand each other, although we do not particularly agree as to how we shall vote on this issue.

Mr. DOUGLAS. Madam President, as one who has worked and hoped for many years for the enactment of a fundamental plan of health care for the aged, I want to warmly commend the junior Senator from New Mexico [Mr. ANDERSON] for his dedicated efforts in developing and promoting his bill and for his special efforts to work out in recent weeks an amendment of wider acceptability and greater quality. Our expectation might well have been that any at-

tempt to give the Anderson-King bill a broader base of support would weaken its already conservative provisions. But the happy fact is that the new measure is distinctly superior with respect to coverage, and the administration and private option additions give every indication of being reasonable accommodations.

The fact that the new accommodations are reasonable and superior is also a mark of the fine leadership and humane principles of the senior Senator from New York [Mr. JAVITS]. His contribution to the proposal now before us is massive; and his efforts in support of this measure—both intellectual and in advocacy within his party—have been a keystone of its progress.

Let me also say that, in my opinion, the Senate is greatly in the debt of the senior Senator from Michigan [Mr. MCNAMARA], who has provided us—through the Special Committee on Aging, which he chairs—with a comprehensive investigation of the needs of our aged people. Without the excellent labors of this committee and its staff, we would not be in a position to make an informed judgment on this issue.

While I have some mild reservations about certain aspects of the pending amendment, I am confident of the sound loyalty to principle of the Senator from New Mexico, and I know that the compromise proposal he led in drafting adheres to the basic legislative values essential to the success of this program. I am therefore proud to be a cosponsor of this amendment.

The RECORD should be absolutely clear that there have been reasonable efforts to have Senate hearings on the Anderson bill, but that this was prevented by the familiar partisan alliance. Senator ANDERSON moved in the Finance Committee on January 31 that the committee hold hearings on the health care for the aged bill by April 1, regardless of what the House did.

The vote was 7 yeas to 10 nays. The yeas were Senators LONG, ANDERSON, DOUGLAS, GORE, MCCARTHY, HARTKE, and MORTON; the nays were Senators BYRD, KERR, TALMADGE, FULBRIGHT, SMATHERS, WILLIAMS, CARLSON, BENNETT, BUTLER, and CURTIS.

While committee hearings again this year would have been preferable, the refusal of a few members of the House and of the Senate to let such hearings be held should not be permitted to defeat this important legislation.

At the same time it is correct to say that this proposal, generally and quite specifically, has been given thorough study by Congress, not to speak of the many private groups which have gone into the various aspects of the proposals. As the Senator from New York [Mr. JAVITS] pointed out in his comments of July 12, last Thursday, the printed records of at least 10 congressional hearings on this matter, held during the last 3 years, as well as 8 additional studies and surveys, are available. And I may point out that two full-scale Republican substitutes to the Anderson bill were offered—and defeated—last week. The fact that these were offered can well be taken as evidence that knowledge of the health-care needs of the aged is widespread and alternative ways of dealing with them have been systematically prepared and well understood.

THE GENERAL PROBLEM: NEED IS EVIDENT

The facts about the aged in this country show that the need for the Anderson bill is evident. They show, first, that the number and proportion of the aged have increased rapidly. More than 17½ million people today are over 65 years of age. By January 1964, there will be 17,877,000 persons over age 65 in the United States. In the decade from 1950 to 1960, the aged population grew by about one-third. In some States—that is, Florida and Arizona—it more than doubled. In 1900, only 1 person in 25 was 65 or more; today, the proportion is 1 in every 11. Of the 17½ million, more than one-third are over age 75. One million are over 85.

Second, the facts also show that the aged have more serious illness and more need for health care than do younger groups. Those over 65 spend 3 times as many days in the hospital each year than do those under 65. The average aged person has a 1 in 6 chance of going to a hospital in any given year.

Chronic illnesses occur with greater frequency at older ages. These affect the activity of more than one-third of all persons aged 65–74 and more than one-half of those 75 or older.

In its 1962 publication, "The Health Care of the Aged: Background Facts Relating to the Financing Problem," the Department of Health, Education, and Welfare has reported thoroughly on the question of need. I refer now to the charts standing here, based on facts reported in this publication from the U.S. National Health Survey. Chart No. 1 illustrates the fact that persons aged 0 to 64 years require annually 883 days of hospital care per 1,000 persons; and persons aged 65 and over require 2,332 days of hospital care per 1,000 persons—or almost 3 times as much.

Third, it is well known that hospital costs have risen very greatly; compared to the resources of the aged, they are very great. Thus, annual costs per hospital day increased from $9.39 in 1946 to about $36 in 1962.

It is also true that older couples and older persons living alone have far less income than two-person families with the family head under age 65. For two-person families with the head under age 65, the median cash income is $5,314; with the head over 65 years, $2,530; for aged persons living alone, $1,050.

Hospital stays are much more costly for the aged. Of aged couples with one or the other hospitalized, the total medical bill exceeds $500 in over half of the cases. Only 5 percent of the bills in these cases are under $200.

Fewer older people have their hospital bills paid by insurance. Of hospital charges with over three-fourths of the bill paid by insurance, 54 percent were for people under age 65; only 30 percent were for people over age 65.

The average monthly old-age benefit under OASDI is about $76 for those on the rolls, and about $80 for those coming on the retirement rolls.

Benefits for widows are considerably lower on the average—about $58.

Old-age assistance recipients receive an average of $72, of which about $58 is in the form of money payments, and a little over $14 is in the form of vendor payments for medical care.

A recent survey of aged couples who were OASDI beneficiaries showed that their average net worth, exclusive of equity in their homes was $1,300. The average equity in their homes was about $8,362—but not even the Kerr-Mills Act requires the aged to sell their homes, to provide health care.

With such low incomes, the aged cannot afford the high premiums for private insurance, particularly if they have not continued a policy from a younger age. For those over 65, a moderately decent policy will cost at least $13 a month or $156 a year—or $312 per couple. Couples with income of $2,500 a year cannot afford this; single persons with $1,000 cannot afford it.

Under some private insurance policies, benefits are terminable when certain calamitous diseases are suffered, or are reducible at a certain age, even if the policy is paid up.

It bears repeating that those of us who support the Anderson amendment are not criticizing the private insurance industry for doing a bad job or for not wanting to do as much for the aged person as they can. Rather, we are expressing our concern with the special difficulties the private insurance industry faces with respect to the aged population's health-care needs and its inadequate resources. We are saying that we believe the Federal Government can help to establish a sound foundation plan for meeting the basic health-care needs of older citizens, and that such a foundation plan will work to the benefit of the private health insurance industry, as well as aiding the aged population. We have good cause to believe that the public foundation program will benefit the private industry, for the experience of this Nation with the social security system has yielded just this result for the private retirement and survivors insurance industry.

The inadequacy of private insurance to deal unassisted with the health care needs of the aged is particularly worth noting. A chief characteristic of the aged is that not many older people are part of a convenient occupational group for health insurance purposes. Thus, the only policies they can get are individual ones. But individual policies are generally high in cost, and the return in benefits is very low—an average of about 50 or 60 percent of the premiums taken in. This compares to returns in benefits of about 90 percent of premiums for the best commercial group health plans, 92.6 percent for Blue Cross hospitalization plans, and as high as 97 and 99 percent for some independent group plans. These are under the United Mine Workers and Health Insurance Plan, NW, respectively.

These facts make it quite clear that for nearly all of the aged, with their low

incomes and very high need for care, individual private plans are much too costly.

With respect to present coverage under private plans, health insurance for the retired aged is held by all too few, and for most of those who are covered, the benefits are grossly inadequate. Only 46 percent of all aged persons in 1959 had any kind of hospitalization insurance, according to a Public Health Service survey. This contrasts significantly with the 67 percent of the general population which had hospital insurance. Also, as the chart illustrates, the insurance carried by aged people generally pays much less of their hospital costs as compared with the population under age 65.

Thus, of the aged persons discharged from short-stay hospitals, three-fourths of the bill was paid in only 30 percent of the cases, while for persons under 65 years, three-fourths of the bills was paid in 54 percent of the cases.

The health care needs of the aged and the inadequacy of present provisions for meeting them are well recognized. Only the wholly doctrinaire person or the indifferent and inhumane maintain that no governmental assistance is necessary. It only remains to spell out what basic protections can reasonably be offered and under what conditions.

BENEFITS UNDER THE ANDERSON BILL

With respect to health care for the aged benefits, the Anderson amendment provides a conservative minimum of basic protection. To my knowledge, its sponsors and supporters have never claimed more than this. In fact, the truth is that there has been a substantial cutback on benefits from the original proposals of several years ago, including the elimination of physicians' fees and the requirement of so-called deductibles. Nonetheless, I believe the present proposal is reasonable, and is deserving of support.

In summary, the bill provides that payment would be made for these services to covered individuals:

First. Inpatient hospital services for up to 90 days, subject to a deductible amount—paid by the patient—of $10 a day for up to 9 days, with a minimum of $20; hospital services would include all those customarily furnished by a hospital for its patients; payment would not be made for the hospital services of physicians except those in the fields of pathology, radiology, physical medicine, and anesthesiology provided by or under arrangement with the hospital, or services provided by an intern or resident-in-training under an approved teaching program.

Second. Skilled nursing services—in a hospital-affiliated skilled nursing facility after the patient is transferred from a hospital, for up to 180 days.

Third. Outpatient hospital diagnostic services, as required, subject to a $20 deductible amount for each diagnostic study.

Fourth. Home health services for up to 240 visits during a calendar year. These services would include intermittent nursing care, therapy, and part-time homemaker services.

An individual could be eligible for up to 90 days of hospital services and 180 days of skilled nursing facility services in each period of illness, but subject to a maximum of 150 "units of service." A unit of service would be equal to: 1 day of inpatient hospital services or 2 days of skilled nursing services.

The basic public plan provides for payments to medical facilities for services rendered to eligible individuals, and an individual may "choose" to rely solely on these benefits provided in the bill. Of course, the "choosing" will more likely be an economic necessity for a great many.

But for those who can, an individual may choose to subscribe to or continue a private insurance policy or membership in a prepayed group plan which offers medical, surgical, or other benefits in addition to the benefits provided in the public plan. Under this option, no premium would be charged for the public plan protection, but the public plan would reimburse the private carrier for services rendered under the public plan protection.

In addition, under the Javits amendment adopted last Thursday, an individual would also have the option of choosing a group or nonprofit plan providing a 45-day hospitalization benefit with no deductible charge.

Again I want to congratulate the Senator from New York [Mr. JAVITS] and the Senator from New Mexico [Mr. ANDERSON] on their fine and extensive efforts which have produced this adjusted formula acceptable to a large number of Senators. I endorse this formula of basic benefits as a reasonable proposal, but I do have some general reservations about two aspects of this which I shall discuss in a moment.

COVERAGE

The authors of the Anderson amendment deserve praise for their action in bringing into coverage for aged health-care benefits the 2½ million persons not now under social security. Indeed, it is the principal irony of the attack against the Anderson proposal that its main result has been an enlargement of coverage. The AMA originally tried to have it both ways—to claim, on the one hand, that the Anderson-King bill was too radical a departure from accepted principles; but to say on the other hand that the proposal was a "sham" and a false promise because it did not include those who were outside the social security system. Even without the blanketing-in provision, the social security approach, with its promise of nearly 95 percent coverage in a few years, would have been by far the best approach.

But in the Anderson amendment we have gone the "extra mile" of humane planning. Now. at the outset of the program, there will be complete coverage of the entire aged population.

FINANCING

Probably no aspect of social security financed health care for the aged has been so misunderstood—or intentionally misrepresented—as the increases in social security taxes required to support the program. The variety and audacity of some of the allegations made about cost have been simply amazing. Under the pending amendment, of course, there are two cost coverage proposals. First, there is the increase in social security contributions for the approximately 15 million persons covered under social security and railroad retirement. Actuarial experts of the Department of Health, Education, and Welfare last year reviewed the financing provisions and have suggested changes which will insure that the full costs of the plan will be covered. While their previous estimates on hospital care costs were reaffirmed, new conservative assumptions about the costs of nursing home and home health care services made the revisions necessary. Under the Anderson amendment, the contributions made for health care for the aged would be assigned to a trust fund entirely separate from the social security trust funds. This would make sure that complete information about the actuarial soundness of the new system will be available.

It is estimated that the health care benefits now described in the Anderson amendment will have a long-range cost, on the so-called percentage of payroll basis, of 0.34 percent of payroll for employee and 0.34 percent of payroll for employer.

This cost will be met by first, an increase for the employee—matched by the same increase for his employer—of one-fourth of 1 percent in the present social security tax; and an increase of three-eighths of 1 percent for the self-employed; and second, an increase to $5,200 in the present taxable base of $4,800.

These increases in the social security tax on the employee's earnings will yield, in new contributions, $27.50 from the employee who makes $5,200 or more a year. The contributions by employers will be equal to this, and those who are self-employed will pay 1½ times as much.

EXPLANATION

First. The present rate of the social security tax is 3⅝ percent. Applied to the $400 of increased tax base, this will yield $14.50

Second. The new one-fourth of 1 percent applied to $5,200 will yield $13. Total will be $27.50.

These increases will, for the individual making $5,200 a year or more, increase his employee contribution to all three social security accounts—old-age and survivors insurance; disability insurance; and aged health care—from the present $174 to—in 1964—$201.50.

But it is important to note that this increase of $27.50 has a dual purpose: First, to pay for the health care for the aged program; and second to improve old-age, survivors, and disability insurance benefits. Of the $27.50, only $17.68 goes to the aged health care account. The difference of $9.82 is necessary to pay for the increases in maximum OASDI benefits when the taxable base is raised from $4,800 to $5,200. This increase in regular social security benefits is desirable because of recent cost-of-living increases which were taken account of last year when the minimum benefit was increased by $7. Under the administration's proposal, the maximum benefit

similarly would be increased by $7, and the $9.82 would pay for this.

While the maximum in new employee contributions for health care for the elderly will be $17.68, not all will pay this much. In 1961, of all covered workers—including the self-employed—68 percent earned $4,800 or less. Of the male "four quarter" workers, 45 percent earned $4,800 or less.

Thus, roughly one-half of all covered workers will pay not more than $12 a year or about $1 a month for health care protection after age 65, and roughly one-half of all covered workers will pay up to a maximum of $17.68 a year or less than $1.50 a month.

Some confusion has resulted because of already enacted social security tax increases which will go into effect between now and 1968. These are the facts.:

First. Including these already enacted increases, the employee now making $5,200 or more will pay in 1968 $31.50 more a year than he now pays, if the King-Anderson bill with administration-recommended financing is enacted. The social security tax on employees is now 3⅝ percent; in 1966, including King-Anderson it would be 4⅜ percent; by 1968, with King-Anderson it would be 4⅞ percent.

Second. Of this $31.50, $17.68 will go to the health-care-for-the-aged account. This is the same amount as would be paid for this purpose in the first year the King-Anderson bill would take effect. All the automatic increases scheduled to go into effect by 1968 under present law ($13.82 maximum per employee) will go for old-age and survivors insurance and disability insurance benefits.

Thus, under the benefit program proposed in the Anderson amendment, there should be, according to the best expert advice, no increase in social security taxes above the initial maximum of $17.68 a year to pay for the health-care-for-the-aged program. The average employee will pay for this protection, in 1964 and in 1968, a little more than $1 a month. This low cost is possible under this program of social insurance because the employee and employer will be paying in small amounts over a long period of time and because a very large number of people, including both good and bad risks, will be participating.

For covering the uninsured group of 2½ million aged persons who are to be "blanketed in," the gross cost for 1964 is estimated at $250 million.

It is estimated that this would be partially offset by "savings" of medical payments under existing programs of roughly $200 to $225 million.

The figures of the Committee on the Aging give an estimate, for 1964, of $228 million in savings as follows: $127 million under Kerr-Mills MAA; $41 million under old age assistance medical care; $60 million, veterans.

Under this estimate the savings would be distributed with respect to Federal and State-local expenditures, as follows: $145 million Federal total; $72 million MAA—Kerr-Mills; $13 million, OAA; $60 million, veterans; $83 million, total State and local; $55 million, MAA; $28 million, OAA.

It is also important to note that there would be substantial reductions in State and local aged medical care expenditures—other than for mental and TB hospital care—under other State and local programs. The States and local governments spend annually about $200 million for programs outside the federally assisted programs.

Thus, the blanketing in of the 2½ million persons would have a probable net additional cost of roughly $25 to $50 million if these savings are taken into account. It is not claimed that the above estimates are precise. They are, rather, approximations which may have a considerable margin of error. But there would be appreciable savings.

SOCIAL SECURITY FINANCING IS BOTH LOGICAL AND ECONOMICAL

Financing the basic part of this program of health care protection for the aged through the social security system is both logical and economical.

First. Social security financing is the best way of assuring the development of the principle we are trying to establish: spreading the cost of protection over a very large number of persons—about 73 million earners and their employers contribute each year—each of whom makes a small contribution over a long period of time.

Second. The coverage will be nearly universal, under social security, in a few years. Ninety-five percent of the aged persons in the Nation will soon be covered under social security and railroad retirement. Of course, with the blanketing-in provision of the Anderson amendment, all aged persons not covered under these retirement benefit systems will immediately have the same health care protection as those covered for social security retirement benefits, and this will be paid for by direct appropriations. Of course, the net cost of this extended coverage will be reduced as more and more persons come under social security.

Third. The social insurance approach has the advantage of being a tried and effective method in which we can have confidence.

Fourth. People become eligible for protection by working and by paying in small amounts while they are working. So payments for protection are made when the individual can best afford to pay, rather than during the period of sharply reduced income in later life.

Fifth. Social security benefits are paid as a matter of earned right, regardless of income from savings, investments, and other retirement benefits; so the worker is not discouraged from supplementing his basic protection with whatever other protection he can afford. What can be more sound or more American than thus encouraging each worker to meet his needs beyond the basic protection, to the degree he is able to do so?

Sixth. The worker, himself, pays for his health-care protection in later life. Somehow, opponents of social security financing seem to have lost sight of this basic fact that the Anderson plan is a self-paid one, not a gift of benefits from the general taxpayers. The presently retired population covered under social security will, of course, receive protection without having paid into the health-care account, but they have been paying into social security for retirement and disability benefits. This immediate extension of coverage is, in fact, one of the chief advantages of the social security plan. It provides that an improvement in meeting today's problems can be extended to those who meet the requirements through previous covered work by charging a small additional social security contribution for those now working. Benefit increases and other new benefits, such as disability benefits, have been passed on immediately to those who meet the requirements. This principle is followed with respect to civil service and Armed Forces retirement benefits, as well as in social security. I believe that younger workers approve of this approach and are willing to pay the small additional contribution in order to provide a more secure life for their parents. In general, I believe, they approve having all the younger families share in the health costs for the aged, so that the burden of catastrophic illness does not fall wholly on individual families.

Seventh. Using the payroll tax to finance the program permits easy adjustments in contributions, to meet current levels of living and current prices, and provides for an automatic increase in contributions as the worker's income increases up to the taxable maximum.

Eighth. Since the method of collection is automatic, collection costs are low and there is no selling cost as under private insurance. Collection, administrative, advertising, and profit costs for individual hospital insurance policies come to over 40 percent, while for group plans, the overhead costs are usually about 10 or 12 percent. Under social security, with its automatic and established collection procedures, the overhead administrative costs will be only about 3 percent. This is a remarkable and extremely important fact: administrative costs will be only about 3 percent.

So both logic and economy are served by the social security financing system. Without doubt, the private option aspects of the revised Anderson bill will result in some increase in overhead costs, but the principle of keeping these to a minimum is best protected by adopting this method of financing through social insurance.

BENEFITS TO PRIVATE INSURANCE

I want to repeat that these superiorities of social insurance for the aged over private insurance are not meant as a criticism of the private insurance industry. I have outlined these superiorities merely to show the great problems which private insurance faces with respect to this most needy group, the aged.

Adoption of the Anderson proposal will, indeed, be a boon to the private insurance industry. When social security was established 27 years ago, its opponents charged that it would seriously handicap the development of private pension plans and annuities. Of course, it has become thoroughly clear to everyone that the private industry has been in fact stimulated by social security. The facts are that between 1940 and 1960, the number of workers covered un-

der private pension and deferred profit-sharing plans increased from 4 million to 22 million and the number of annuities in effect increased about 1½ million to about 6 million. In the same period, the benefit value of life insurance in effect grew from $115 billion to $586 billion—an increase of more than five times. Life insurance per family grew from an average of $2,700 to one of $10,200—an increase of about four times.

This encouragement to private industry was not an accident. By providing benefits paid without regard to the supplementary protection a person is able to invest in, the individual is encouraged to build further on his basic protection. If an individual did not have this basic protection, he might well be less inclined to establish any self-paid private protection because of his fear it would be subtracted from any public assistance under a means test. Moreover, had not the basic costs been met under social security, many of the private plans in operation today might never have been established because the employers would have been unable or unwilling to pay for the cost of setting up retirement plans which would provide the entire protection.

There is every reason to believe—especially with the private option provided in the revised Anderson proposal—that the benefits of health care for the aged under social security will be an even greater stimulant to the industry providing private insurance for health care than was social security to its private counterpart.

WHAT ABOUT KERR-MILLS?

In supporting the Anderson-King bill, I have tried to make it clear to my correspondents and others that this proposal is not an attempt to destroy or replace the Kerr-Mills Act program for medical aid to the aged enacted 2 years ago.

But let us be frank: the Anderson proposal is needed, in part, because the Kerr-Mills program does not meet the whole basic need.

The evidence on this point is very clear. In its nearly 2 years of operation, Kerr-Mills has helped a dismayingly small number of aged persons, and it has forced those who were helped to submit to a means test, it has resulted in excessively uneven distribution of Federal funds. It has failed to inspire about half the States to put programs into operation, and many of these States have put into operation only minimum programs providing inadequate protections, and requiring prohibitive deductibles and a mystifying variety of restrictions on care. And many of the States are failing to provide programs in what I believe to be a most vital area authorized under Kerr-Mills, namely, nursing home care. Only 18 States are taking advantage of Kerr-Mills aid for this type of program.

Only 27 of the 54 States and other jurisdictions had set up programs under Kerr-Mills by April of this year. Legislatures of 21 of the States and other jurisdictions have not passed enabling legislation and 3 others have not provided appropriations for this purpose. Dring the month of May, 1962, only 102,378 persons in the country were recipients of benefits under the aged medical care provisions of Kerr-Mills, and these were concentrated in five States, New York, California, Massachusetts, Michigan, and Pennsylvania. Forty-two percent of the total amount spent under Kerr-Mills MAA plan in May went to New York State alone.

Mr. CLARK. Madam President, will the Senator yield?

Mr. DOUGLAS. I yield.

Mr. CLARK. In Pennsylvania Kerr-Mills program has been a complete failure.

Mr. DOUGLAS. I thank the Senator for that statement.

In my own State of Illinois, the deficiencies of Kerr-Mills are well demonstrated. In the first 6 months of the operation of Illinois's medical care program under Kerr-Mills, only 209 payments totaling $214,000 were made. In more recent months, payments have increased—to 323 payments in May totaling $106,572—but the Illinois Public Aid Commission estimates that of the nearly 1 million residents of Illinois 65 and older, 300,000 would qualify under Kerr-Mills as unable to pay their medical and health care needs. Kerr-Mills therefore meets only a very small percent of the need.

Mr. CLARK. Fewer than 6,000 in Pennsylvania are having their health care paid for under the Kerr-Mills Act, out of 1,190,000 persons over 65.

Mr. DOUGLAS. I thank the Senator.

Illinois's Kerr-Mills program is, in fact, a "minimum" program according to the rating system of the bureau of family services. The State law to take advantage of Kerr-Mills is "comprehensive," but lack of State funds has resulted in the failure to implement all five services authorized under Kerr-Mills. Of these five services—hospital care, physicians services, nursing home care, prescribed drugs, and dental care—Illinois is able to provide only hospital care, physicians' services in the hospital, and posthospital physicians' care.

Illinois is not alone in this deficiency; only three States—Hawaii, Massachusetts, and North Dakota—have comprehensive plans providing all five services under Kerr-Mills.

But most serious of all, the Kerr-Mills programs grant protection only to those who can pass a "means" test. An aged person must show he is without resources by opening up for examination by Government inspectors every financial aspect of his and his family's personal lives. In some States this is almost equivalent to taking a pauper's oath. In many States, the income and property of the children can be held responsible while the homes of those assisted can ultimately be realized upon to pay back the assistance.

All this is degrading and unnecessary. It is no substitute for a plan under which a worker prepays for health care protection in his later life and receives benefits, as under old-age security, as a matter of right.

I fail to see any convincing defense of the means test. Those who support it argue that the rich should not be entitled to aged welfare benefits under a public program. First, not many of the aged can be classed as wealthy. But those who are wealthy can now deduct nearly all their medical expenses from their taxable income. A means test discourages an individual from saving or investing for his own retirement. A means test often results in an arbitrary cutoff point under which even a dollar may mean the difference between qualifying and not qualifying for benefits.

Means tests are inefficient and costly to administer because personnel must be paid to conduct exhaustive inquiries and repeated checks of the resources and income of the individual and his family. The average cost of administering the means tests under Kerr-Mills, for example, is $42 per case.

The means test is, in fact, a wasteful and offensive principle on which to base health care for our aged population. It is no substitute for the self-respecting and self-supporting plan of prepayment under social security. The Kerr-Mills Act can be used to supplement the Anderson benefits for medical and surgical costs for those who are medically indigent.

ARE DEDUCTIBLES NECESSARY?

The authors of the amendments now before the Senate have done a remarkable job, and I am pleased to be a cosponsor of their proposal. Two aspects of the proposal, however, deserve critical examination. These are the questions of deductible charges and the requirement that a beneficiary may have nursing home benefits only when he is transferred from a hospital where he has been treated for the same condition.

My concern with these provisions of the amendment is not an expression of dissatisfaction with the amendment taken as a whole, but merely a concern that these provisions may be somewhat in conflict with certain other basic principles which I regard as fundamental in this proposed legislation.

Under the Anderson amendments, as under the previous Anderson bill, there would be deductible charge for hospital care of a minimum of $20 or $10 a day up to a total of $90. A deductible of $20 would be imposed for each diagnostic study under benefits for outpatient hospital diagnostic service. And, of course, since nursing home care is dependent upon discharge from a hospital, the hospital deductible provision applies to this type of benefit also.

Insurance benefits under social security never have been, and preferably should not be, dependent upon the ability to pay charges in addition to the regular insurance contributions.

As I have pointed out, one-half of the aged single men and women have less than $1,000 in annual income, and one-quarter have less than $500. It is almost certain that these lower income aged will have great difficulty in meeting these deductible charges. These charges are actually price tags attached to the hospital and diagnostic service benefits. If the benefits are to be available as a matter of right, the deductible provisions are inconsistent with this basic principle.

Also, it has been pointed out that most of the aged are unable to afford the laboratory and other clinical tests required by modern medicine, and that knowing this, doctors must do without them in many cases. The requirements of deductibles will, therefore, effectively limit the doctor's use of the diagnostic service benefit to the higher income patients.

Moreover, if our objective is to reduce hospital admissions and shorten the duration of hospitalization—as I think we should do—then the attending physician ought to have available full diagnostic services without limitation of the patient's ability to pay a deductible. The deductible provision may have the effect of preventing sound decisions with respect to hospitalization on the one hand, and of delaying the discovery of serious difficulties at an early stage of development.

It is interesting to note that in conjunction with the Javits perfecting amendment adopted last Thursday, it has been stated that hospitalization benefits of 45 days without deductible charges could be offered at about the same cost to the plan as the presently provided benefits of 90 days with deductibles. The staff of the Special Committee on Aging also states that of all the aged who enter a hospital, only 6½ percent remain longer than 45 days. These facts indicate that a 45-day hospitalization benefit could be offered without exceptional disservice to the principle of insurance against the high costs of hospital care for the aged.

In fact, the charge for deductibles introduces an element of providing for only catastrophic sickness, which is not the objective of this proposed legislation as I see it. If we were considering health insurance for the general population—which we are not—then the catastrophic illness protection would be applicable, but for the aged I do not think it is a sound or appropriate qualification. For the aged do not have the current income which those in the active years enjoy and hence are far less able to pay for normal costs.

But having made these criticisms, let me say at once that I do not direct them at the Senator from New Mexico, or the Senator from New York, or any of the cosponsors of the amendment. I am well aware that the deductibles provisions is a concession to those who want an assurance in this way against overutilization or against a too-liberal plan. I disapprove of the deductibles provisions for the reasons I have stated, but this is a real world and I am ready to accept the practical judgment of the Senator from New Mexico. But I also want to serve notice that in my opinion the effects of this provision must be watched very closely so that in our future consideration the Congress may be guided by experience rather than by the requirements of assembling a majority.

IS THE THRUST OF THE HOSPITAL DISCHARGE REQUIREMENT FOR NURSING HOME BENEFITS IN THE WRONG DIRECTION?

One of the chief concerns to those who take a long view of the health problems of the aged is preventing the hospitals from becoming warehouses for the senile aged and for those who are almost continuously ill. Nothing could be more disastrous and more callous than to let this happen. The aged are increasing as a proportion of our population and are living much longer. More and more of our older people will continue to live into the period of likely chronic illness and aimless living. To let these folks simply accumulate in the hospitals will unecessarily overburden our limited hospital facilities, keeping out our younger population and will deprive the senile aged of a usually more enjoyable and much less costly although properly cared for life.

This problem raises directly questions about the requirement in the Anderson amendments that a beneficiary may have nursing home benefits only if any when he is transferred from a hospital. It has been asserted that this requirement of prior hospitalization at expense to the plan, will send patients into the hospital for at least a few days whose illness could well be cared for from the start in a far less expensive nursing home.

I think this is a probable defect in the plan, but again one that does not cancel the basic validity of the proposal taken as a whole. Perhaps the danger I have described is more a defect in our overall approach to the problems of the aged than a defect of the Anderson amendments.

As a general principle, I am impressed with the importance of practical nursing in the home as the primary method of caring for the continuously sick and senile aged. In fact, I believe the sequence of methods should often be the reverse of what seems to be described in the pending amendment, namely, that the chronically ill or senile individual would be cared for by home nursing insofar as possible, then through residence in a skilled nursing home in more serious circumstances, and then in hospials only when the individual's condition is most serious. The Senator from Michigan [Mr. McNamara] has put forward this sequence as being preferable, and I have come to believe he is correct.

The question is whether the plan proposed in the Anderson amendments moves in a sequence contrary to the principle I have described. The prior hospitalization requirement does seem to move in the opposite direction.

The answer would appear to lie in the primary objective of the proposed health insurance legislation. I believe its principal authors would state that the primary objective is to provide health insurance protection against the costs of hospital care because these are the most burdensome health expenses older people face and the appropriate point for concentrating a program of basic health insurance. Under this theory, the major reason that the legislation would also make payments for skilled nursing facility care and for visiting nurse services is that these less expensive forms of health care can be substituted for hospital care in some cases and that these lower cost alternatives are an incentive for using less of the more expensive hospital care services.

If hospitalization care when necessary is the primary and more or less exclusive concern with nursing home care only an afterthought, then perhaps it is unfair to criticize the plan as failing to supply in sufficient quantity or with proper sequence a nursing home care program which it does not intend to establish. Of course the provisions for visiting nurse services in the home does not require prior hospitalization and will perhaps meet this deficiency part way.

It is perhaps more reasonable to take the hospitalization insurance as the principal objective, and accept the prior hospitalization requirement for the nursing home care, but insist that a study be made of our overall efforts to encourage nursing home care. For example, we may want to examine the possibility of Federal assistance for training nursing home administrators or perhaps putting the emphasis on the training of nursing home personnel through the manpower development and training program.

With the Anderson plan in operation, it may well be useful to review our programs for aiding and encouraging the construction and operation of nursing home facilities. We now have three programs in this area:

First. SBA direct loans for the construction and operation of proprietary nursing homes. There were 277 approved applications to March 31, 1962, with a dollar value of $18.6 million.

Second. FHA-insured mortgages up to 90 percent of estimated value under section 232 of the Housing Act—7 projects with 482 beds and mortgage insurance of $1,970,000 completed, and 27 projects with 2,357 beds and $13,018,000 in mortgage insurance under construction.

Third. Public Health Service administered grants to the States under the Hill-Burton Act for construction of long-term care facilities with average matching by the recipient of 50 percent—311 nursing homes were completed to June 30, 1961.

There are several deficiencies in these approaches to the problem of providing adequate nursing home facilities. The FHA and SBA programs serve the higher income groups which can afford charges in the area of $300 a month or more, while lower income facilities assistance is left to the Hill-Burton program. Also, nonprofit groups, which are already experienced in building housing for the elderly, may be interested in building nursing homes, but they are not eligible under FHA and SBA programs and often are not able to raise in advance the matching funds for a Hill-Burton grant. Or funds in their State may be insufficient to meet the demand.

The success of the health care plan proposed in the Anderson amendment may well depend on our willingness to encourage the development of adequate nursing home facilities so that the hospitals do not become crowded with the aged, and I hope the Congress will pursue this matter.

THE ANDERSON AMENDMENTS SHOULD BE ENACTED NOW

The need for the Anderson proposal for health care protection for the aged is well demonstrated. The people are for it, and with the adjustments made recently, it is clear the private insurance industry can easily "live with" the proposal. But opposition to this legislation persists, mainly coming from the American Medical Association and assisting groups like the American Manufacturers Association and the American Farm Bureau. All of these groups have opposed social security plans in the past. The AMA has been opposed to group practice, and to prepayment plans for medical costs. After social security went into operation spokesmen for the AMA denounced it as "socialistic." Later, it opposed providing aid for the totally disabled through social security. It is now adopting a policy that is consistent with its universal past policy.

But there is nothing socialistic or foreign about this proposal. Actually the precedent for a prepaid social insurance system against health care costs was established in this country as early as 1798. For Congress in that year passed a bill providing that deductions would be made from the salary paid to U.S. marines to pay for medical care.

The United States is the last of the free Western nations to get around to providing social insurance for hospital care for its aged citizens who are most in need of this protection. The proposal before us is sound, conservative, and necessary. The Senate has before it an opportunity which it should not turn down. I hope we will defeat the motion to table and that we will send this essential legislation to the House for action.

Mr. CLARK. Madam President, I rise in support of the revised Anderson amendments. Before stating my reasons in support of my vote tomorrow, I commend the Senator from Illinois [Mr. DOUGLAS] for making it very clear that we should not call the amendments "medicare." Medical care is not included in the amendments, and the use of that phrase would deceive the people into believing it is.

In my opinion, health care for the elderly is probably the simplest phrase with which we can describe the quite complex, but I believe thoroughly desirable, provisions of the pending amendments.

Madam President, the arguments for and against the pending revised Anderson amendments to establish a program of hospital care for the aged have been presented ably and at length in this debate. The debate has illuminated the points of disagreement, but it has also revealed a rather surprising consensus.

The consensus is that a major national problem does in fact exist, and that the Federal Government must be involved in its solution. The debate is now centered not on whether the Federal Government should have a health care program, but on the kind of benefits that should be provided, who should be eligible to receive them, and how the program should be administered.

This is progress—indeed, spectacular progress. A few years ago, when Representative Forand, of Rhode Island, in the House and the distingiushed senior Senator from Michigan [Mr. MCNAMARA] and others members of his Subcommittee on Problems of the Aged and Aging began talking about this problem, the opposition was not ready to concede that anything at all needed to be done. Spokesmen for the American Medical Association were then loudly contending that every old person in America who needed medical care was getting it—that we could just go to sleep and forget about the whole thing. Now the organized doctors have shifted their ground, and are arguing that if only the Kerr-Mills Act were allowed to work, all of the sick, old people would be taken care of. It appears that the problem does exist, after all, and simply will not go away.

Those of us who served on the subcommittee headed by the Senator from Michigan, and those of us who are now members of the Special Committee on Aging, also under his energetic leadership, learned about this problem first hand.

We went all over the country, and we did not merely listen to the experts; we listened to the old people themselves. We invited them in to talk to us at what were called "town meetings." And we found out that the greatest worry that haunts the senior citizens of our country—the concern that burdens them most in what should be years of peace and serenity—is, "What happens to me if I get sick?" I defy any Senator to set through one of those "town meetings" and come away saying there is not any problem.

Of course, the old people could always ask for charity. But I sometimes wonder if the opponents of the Anderson-Javits amendments have any real comprehension of how deep seated is the resistance to asking for public charity on the part of self-respecting Americans who have been independent and self-supporting all their lives. Many would, literally, rather die—and they do.

Of course, they could appeal to their children for help. But I wonder if the opponents of this measure know how many old people would prefer to remain sick and untreated rather than ask their children—who are struggling to make ends meet to buy houses, and to send their children to college—to underwrite huge medical expenses.

And they are huge. Witnesses at our hearings have stood up and shown us hospital bills in the hundreds and even thousands of dollars. The American medical profession provides the finest medical care in the world. But that care does not come cheap.

Now let us look at the income of these old folks. Over 50 percent of our retired people have incomes of less than $1,000 a year. The average social security benefit is $76 a month. Nearly half of our families whose heads are over 65 have liquid assets of less than $500, and average yearly medical expenses for people over 65 are double those for people under 65.

How can anybody say that the answer lies in hospital insurance to be purchased by these old people out of incomes like these? Whatever is spent for insurance must be taken directly out of what is needed for other necessities. And that means food and clothing, because it cannot come out of shelter—the rent must be paid.

We have before us a bill which will provide health care benefits for every person 65 and over not already covered by a Federal program, in a manner totally in keeping with the dignity of the individuals involved. I am honored to be among the cosponsors of this measure—known as the Anderson-Javits amendments to the public welfare bill—which contains several significant improvements in the original King-Anderson bill introduced early in the last session. Most notably, our amendments exclude no one from health care benefits and provide even more elaborate safeguards—if these were necessary—against any possible Government interference in the administration of hospitals and other health institutions. It utilizes the experienced private health insurance organizations in administering the program, and it permits an individual to choose between the Government program and certain private health insurance plans.

But the amendment retains the fundamental requirement of any measure which is going to be successful—the benefits are financed through the social security system.

It seems to me there are four advantages in the social security approach:

First, it provides an effective means whereby the major health costs after retirement can be prepaid during working years. After all, it is only during their working years that people earn, and that is the only time they can make provision for their retirement years. This system will simply assure that they do so, automatically.

Second, the Federal social security system provides uniform coverage in every State. If we leave this question to the 50 States to solve, we will have 50 separate plans and become entangled in residence requirements. If an elderly person goes to live with a son or daughter in another State, he may suddenly find he is ineligible for benefits. This problem now exists under the Kerr-Mills Act.

Third, it is consistent with the dignity of the individual. Care is provided without the humiliation and embarrassment of a means test, investigation of the financial resources of relatives, and what amounts to a pauper's oath.

Fourth, it provides for lower overhead cost. As the Senator from Illinois so wisely pointed out a few minutes ago, there would be no promotion cost, no sales cost. The total overhead cost would be around 3 percent, as opposed to as high as 40 percent for privately financed plans.

Against these overriding considerations, I am at a loss to find opposition arguments that have any real merit at all. Frankly, the opponents seem to be frantically grabbing for arguments on all sides of the issue in an effort to stay

afloat in the rising current of public opinion which favors enactment of this proposal. Some of these arguments strike me as being quite out of touch with reality.

The main argument that is being used is not even directed against this amendment. It is being directed against a proposition that is not even before us—to wit, socialized medicine. Of course, the amendments are not socialized medicine, and those of our opponents who are both informed and conscientious do not say that it is. Instead, they use the more sophisticated argument that this is an entering wedge for socialized medicine and one thing will lead to another in due course.

This argument was made as persuasively as it could be by the able Senator from Louisiana [Mr. LONG] a few minutes ago. I felt that the Senator from Illinois [Mr. DOUGLAS] answered him convincingly. I invite the attention of my friend from Louisiana to the comment of that distinguished Republican, Mr. Arthur Larson, formerly of President Eisenhower's White House staff, who wrote in a Republican magazine recently:

> There was never yet a good action which could not have been attacked as an entering wedge for a bad action.

I well remember that, when I was younger, arguments were made against that wisest of all of the New Deal measures, the insurance of bank deposits. We were told that if the Government insured bank deposits this would be the entering wedge toward the Government taking over the banks. Madam President, that was approximately 30 years ago, and on the whole, the banks of America, I am happy to say, are still being operated well and efficiently under the private enterprise system. That particular argument did not apply in that case. I do not believe the present argument applies in the present case.

I agree with the Senator from Illinois that we should consider each of these measures on its merits, and not be afraid to take a good action because we are concerned about it being an entering wedge for something else which we do not have to enact unless we see fit to do so.

I note that doctors have been imported from England to travel around the country lecturing to county medical societies, with full press coverage, about the horrors of socialized medicine in Great Britain. Nothing could be more irrelevant to this debate. Under this proposal, doctors are not going to go to work for the Government. Nothing in this measure would affect the way that medicine is practiced. This proposal deals only with financing health care, not with providing it.

In that connection, Madam President, I invite attention to a news article published July 14, 1962, in the New York Times, entitled "British Call Views of AMA Nonsense," and I ask unanimous consent that it may be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. CLARK. Madam President, in that article the British Medical Journal dismissed as "vulgar, cheap, and nonsense" attacks by the American Medical Association on England's National Health Service.

The Journal, published by the British Medical Association, said that the AMA attempts to depict the program as "socialized medicine" as a cover "to distract attention from the weaknesses of American medicine." I share the views of the British Medical Association.

Next, we hear that the Kerr-Mills program offers the proper approach and should be given greater opportunity to demonstrate its effectiveness. The Kerr-Mills program, as Senators well know, involves grants to the States to help pay for certain health services for those among the elderly who are considered indigent enough, according to the eligibility requirements of the separate States. However, as has been reported in the evaluation prepared for our Special Committee on Aging, the Kerr-Mills program—unlike the measure pending before us—does interfere with the doctor-patient relationship and the free choice by each patient of his own physician.

I ask unanimous consent to include in the RECORD at this point in my remarks the summary of that staff report to the Committee on Aging entitled "Performance of the States: 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program."

There being no objection, the summary was ordered to be printed in the RECORD, as follows:

SUMMARY

(The brief statements made herein are developed in the chapters which follow:)

INTENT OF KERR-MILLS ACT

The Kerr-Mills Act has two facets—one representing a relatively minor improvement in an already existing program of aid for people on relief—and the other representing a major innovation.[1] The primary purpose and feature of Kerr-Mills was the establishment of a new category of public assistance—medical assistance for the aged. This program, Kerr-Mills MAA, offered an opportunity for the States to secure substantial Federal grants applicable toward meeting the medical expenses of older citizens who had previously been ineligible for help—the "medically indigent" aged. The "medically indigent" are those persons not on relief, who, presumably, have sufficient resources to meet their ordinary living expenses but who are unable to cope with the costs of medical services.

It was the intent of Congress that the MAA program would result in providing broad medical services to the many aged needing such help but ineligible or unwilling to apply for relief.

Achievement of such a goal would require that (1) all States establish an MAA program which (2) would include a comprehensive range of medical services consistent with the needs created by the chronic health conditions faced by the aged with (3) eligibility requirements determined on the basis of their medical costs, income, and health conditions and (4) with its benefits made available without humiliating or degrading our older people.

Based upon the evidence available after 1½ years of Kerr-Mills operation, the congressional intent has not and will not be realized.

LIMITED USE OF ACT

Only 24 States and 3 territories, as of June 1, 1962, had operating programs under MAA.[2] All States have had an opportunity to consider Kerr-Mills. All indications are that any new MAA programs will be few and far between.

All States are not capable of financing MAA programs. At least five States—Florida, Missouri, Ohio, Rhode Island, and Wyoming—have pointed to the potential cost as the principal reason for their not establishing MAA programs. More than 2 million Americans aged 65 and over live in these 5 States alone. An additional 5 million older people live in the other 21 States and the District of Columbia which do not have MAA programs in operation—a total of 7 million in 26 non-MAA States.

Many States cannot or do not now finance adequately what they themselves say are the basic needs (not including the health needs) of those of their citizens who are on relief. Certainly those States cannot or will not be expected to adequately finance health services for a new group neither on relief nor eligible for it.

Only 88,000 aged persons received MAA help in March 1962—one-half of 1 percent of the Nation's elderly citizens. Thousands of these people had received care or were eligible for care under relief programs existing before enactment of Kerr-Mills.

Further, as a result of the means tests in those States which have MAA programs, the number of people who can receive help is severely limited.

THE MEANS TEST

Every State with an MAA program requires an applicant to submit to a means test—an investigation of his income and assets. The means test is the basis of all relief programs. In most States, the tests, apart from any degrading qualities, exclude from help many of the aged who are desperately in need of assistance. There are at least 15 States in which the means test for MAA would serve to eliminate even those people who qualify for relief in those States.

Twelve States have "family responsibility" provisions which, in effect, also impose means tests upon the relatives of those who might be tempted to seek aid from the MAA program.

Nine States—including those with, by far, the largest number of people receiving help under Kerr-Mills MAA—have recovery provisions in their programs extending to the homes of people receiving help, and collectible after death. This committee's hearings have shown us that Americans now of retirement age equate "free and clear" ownership of one's home with self-respect. The idea of a State taking a claim on that home is completely unacceptable to them.

FREEDOM OF CHOICE RESTRICTED

Even those relatively few aged persons who are declared eligible for some help under MAA frequently find that they cannot get the care they need and in some cases that

[1] Since 1950 the Federal Government has assisted the States with funds to be used toward payments to suppliers of medical care for people on relief. The first part of the Kerr-Mills Act simply increased the amount of Federal funds available for this purpose.

[2] It is sometimes claimed that 38 States are participating. The 24 States and 3 territories which have MAA programs in operation are: Alabama, Arkansas, California, Connecticut, Guam, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Utah, Virgin Islands, Washington, West Virginia.

they cannot get care from the doctors of their own choice.

Many of the MAA programs, in fact, contain explicit and implicit limitations affecting the quality of care provided, the patient's freedom of choice, and the doctor's freedom to treat his patients in an individual way. All of the foregoing are affected by the relative willingness of hospitals and physicians to negotiate and accept MAA payments—which are often below the "going" rates. In one State, doctors were on the verge of refusing to care for MAA patients because the State found it necessary to reduce fees paid. In the same State, doctors were demanding the right to charge the MAA patient a fee in addition to that paid by the State. In another State, some hospitals were restricting the number of MAA patients they would admit. At least four of the jurisdictions with MAA programs require that services can only be secured from specified physicians or facilities. As a practical matter, the failure of many jurisdictions to cover in-hospital physicians' services means that a large percentage of MAA beneficiaries must depend upon the services of hospital and clinic staff doctors.

LIMITATIONS ON BENEFITS

The States often sharply limit their programs in terms of types of care provided, the duration or quantity of services supplied, in addition to specifying that benefits will be available only for certain kinds of illness or injury. One State provides only 6 days of hospital care and only if the applicant for MAA has an "acute, emergency, or life-endangering condition"; another State affords 10 days of hospital care per year if the person concerned is suffering from "acute illness or injury," and only after the aged individual has paid the first $25 of hospital charges.

Only 3 States—Hawaii, Massachusetts, and North Dakota—of the 24 with MAA programs in operation, have plans which meet the Department of Heaith, Education, and Welfare's definition of a "comprehensive medical care program."

Where nursing home care is provided, the payments are often no more than enough to provide a poor quality of custodial care, and are totally insufficient to pay for any skilled nursing care. MAA funds were and are intended to purchase medical care. In these cases they are being used for an altogether different purpose.

In some States, the medically indigent person is required to make cash contributions from his meager resources toward the cost of care. Occasionally, he must make such payments before he can even qualify for MAA help. Such provisions are contradictory and self-defeating.

UNEVEN DISTRIBUTION OF FEDERAL FUNDS

While the formula under which Federal grants are made to the States was intended by Congress to favor the States with low per capita incomes—where needs are greatest—in actual practice, a few wealthier States are getting the lion's share of MAA funds. Some of the States wtih the lowest per capita incomes in the Nation are, in effect, contributing toward the cost of MAA programs in the wealthier States—while their citizens receive in some cases, nothing, in others, relatively little in return. Almost 90 percent of all MAA payments are being made in just four States—California, Massachusetts, Michigan, and New York. One hundred percent of the States must contribute to the program's support.

From the inception of MAA through March 1962 Federal and State expenditures under the MAA program totaled $167 million. Not even this thoroughly inadequate sum represents new expenditures for a new program. MAA money is being used to pay for care, previousiy provided under relief programs, for tens of thousands of peopie who were already on relief. It was not the intent of Congress when it authorized MAA that new Federal funds be used to relieve States and communities of a responsibility they had already accepted. Congress intended that this help be extend to an entirely new group of citizens—not to those already on relief. Congress offered to assume the major share of a new responsibility in the belief that the States wouid be eager to assume the rest.

HIGH ADMINISTRATIVE COSTS

MAA's unavoidable administrative expenses constitute a substantial drain upon the limited resources of the States, which might otherwise be devoted to purchasing medical care. In one State, such expenses amounted to $1.24 for each dollar that was actually spent on medical care. In other State, these expenses were 64 cents for each dollar of medical benefits provided. Those States which have the highest costs for administration are the States which can least afford the expense—those with very low per capita incomes. The Federal Government pays only 50 percent of the costs of administration while it may pay as much as 80 percent of the dollars going for actual medical care. Thus, only a relatively small portion of a State's funds may go for medical care while a substantially greater amount may have to be allocated to administrative costs.

It costs a great deal of money to run a program with complex limitations on eligibility and benefits. Very careful "screening out" is required under such circumstances. In essence, simple, and inexpensive administration is an impossibility in those States which cannot afford to offer comprehensive MAA programs with liberal requirements for eligibility—the very States whose older people have the lowest incomes and the greatest need for care.

A year and a half of experience indicates clearly that the strained financial resources of the States—and the competition for those funds by other pressing public needs such as education, housing, roads, and so forth—make the well-intentioned aims of the Kerr-Mills legislation incapable of realization in all the States of the Union. It proves that Kerr-Mills cannot, of itself, solve that problem which our committee has found to be the most persistent and frightening one confronting millions of older people and their children in all parts of the country—the problem of assuring economic access to medical care for all our older people on a decent, self-respecting basis.

Mr. CLARK. Madam President, another curious contradiction is that among the most vigorous opponents of our health care amendment are many groups and individuals who constantly sound the alarm against Federal spending and demand a balanced budget. The alternatives to social security financing would, of course, require annual appropriations from the general fund of the Treasury and would constitute a major item on the debit side of Federal and State ledgers. The Kerr-Mills program is already costing $167 million a year. If we shift more of the burden to the already hard-pressed State budgets, a tiny number of people in the wealthier States will get care, and we will continue to deprive the aged in most States of the care they deserve.

After a year and a half, only 24 States have implemented the Kerr-Mills Act and are now providing assistance to their needy elderly. In Pennsylvania, only one-half of 1 percent of the people over 65 have received assistance. I cannot believe—in view of the letters I have received and the testimony presented to our committee—that of the 1,190,000 people aged 65 and over in our Commonwealth, fewer than 6,000 need help in paying for their health care. The Anderson amendment would enable all 1,190,000 to be protected by a Federal health insurance program.

Those who may be wondering why so few are seeking Kerr-Mills aid may find the answer in a letter from one of Pennsylvania's senior citizens, which is included in testimony presented to a subcommittee of the House Banking and Currency Committee. It explains more eloquently than can I how retired people feel about bartering their self-respect for assistance in the form of charity. I ask unanimous consent that her letter be printed in my remarks.

A new argument that has just been advanced is that adoption of our amendment would have an immediate adverse effect on the national economy—which, I agree, should not at this time be subjected to strong deflationary policies by the Government. I am happy to note that the intrinsic responsibility of the Government for maintaining a healthy economy is becoming more widely accepted. However, those who are concerned about the effects of the measurc now before us have little to fear.

Of course, under social security principles, it is necessary to build up a trust fund out of which benefits in future years can be paid. Therefore, in the first year after enactment of the Anderson-Javits amendment the additional income to the social security program will exceed the additional outgo by $560 million, and by about $1 billion in the next year.

The effect of the net increase in the excess of income will not be as immediately deflationary as a quick glance at these figures might suggest. The added income to the system in the first year will be received mostly in the third and fourth quarters of the calendar year 1963. By that time, there is every reason to assume that our economy will be moving ahead in high gear. If it is not, then the deflationary effects of this measure will need to be—and easily can be—offset by other fiscal measures.

The last argument we have all heard against the Anderson amendment is that the whole issue is purely political—simply the newest Democratic vote-getting trick.

I am glad to note that on the revised Anderson amendment we have the strong and helpful support of a number of our Republican colleagues.

If the measure is indeed a votegetter, then perhaps this is evidence that it is a good bill which should be enacted. That is how our democracy more often than not works. Sometimes we in Congress have a duty to reject a measure which we know is highly popular. But that is not the case in regard to this bill—the instincts of the people are absolutely right. If we do not heed the people, it is quite proper for them to penalize us next November.

Madam President, I shall be before the people of Pennsylvania for election next November. My mail is presently run-

ning from 2 to 1 against the revised Anderson-Javits amendment. Yet I am confident that it is inspired mail. I am confident that competent polls which we have taken across the State in the last 6 months clearly reveal enough to convince me that the overwhelming majority of the people of the Commonwealth of Pennsylvania strongly support the social security approach to health care for the elderly, and therefore will strongly support me when I vote against the motion to table the Anderson-Javits amendment tomorrow. I hope I shall have an opportunity later to vote on the merits. I should like it clearly indicated that I fully support the Anderson revised amendment.

Many doctors and insurance agents—whose national organizations purport to represent the unanimous sentiments of their members in opposing health insurance through social security—support as individuals the President's program. I have received an increasing number of letters to this effect, and I ask unanimous consent that three I have selected as samples and two excerpts from Pennsylvania newspapers—an editorial from the Harrisburg Patriot of July 9 endorsing the Anderson-Javits amendment and a news story from the York Gazette and Daily on the defects in the Kerr-Mills program—be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 2.)

Mr. CLARK. Madam President, in conclusion I urge the Senate to support the revised Anderson amendment. We are the only civilized country in the world which does not have some form of Government insurance to provide health care for its older people. No one could have been in the Senate Chamber during the past couple of days and seen the marvelous chart depicting hospitallization costs of older people without coming to the conclusion that the older citizens of our country cannot pay for private health insurance. On the chart we see that two-person families, 65 years of age and over, have a median cash income of $2,530, while individuals living alone who are 65 and over have a median cash income of hardly more than $1,000. How can it be pretended that his large group in our older population can possibly have their health care needs taken care of under anything other than the Social Security System?

We have been told that there are 17½ million elderly people in our country 65 years of age and over. Surely less than half of them are able, under the wildest optimism, to have their health needs taken care of in any way other than by being blanketed in under the Social Security System, as the revised Anderson-Javits amendment would provide. I urge my colleagues to support the able Senator from New Mexico [Mr. ANDERSON] and the able Senator from New York [Mr. JAVITS] to defeat the motion to table and to see to it that the amendment becomes law, insofar as the Senate is able to do it.

EXHIBIT 1

BRITISH CALL VIEWS OF AMA NONSENSE

LONDON.—The British Medical Journal today dismissed as "vulgar, cheap and nonsense" attacks by the American Medical Association on England's National Health Service.

The journal, published by the British Medical Association, said that AMA's attempts to depict the program as "socialized medicine" were a cover "to distract attention from the weaknesses of American medicine."

The publication vigorously defended the Kennedy administration's medical care for the aged plan, the King-Anderson bill, which has been widely attacked by the AMA.

"We have watched with some dismay," a Journal editorial said, "the mushroom growth of the AMA's public relations activities and the collossal sums spent by it to defeat what our American colleagues call 'socialized medicine.'

"The dismay is at the probably inherent weakness of American medical services if such a vast effort has to be expended on misrepresentation of what is happening in Britain."

The Journal admitted that the National Health Service had its faults, but said "socialized medicine (is) a term whose exact meaning no one has yet defined."

The Journal said it was certain "that a great many doctors in the United States deplore, as we do, the vulgarity and cheapness of its (AMA) past and present attacks on the National Health Service."

EXHIBIT 2

CLARK MILLS, PA. I am 70 years old, never married. I was not raised in an age when people expected handouts from the Government or elsewhere. In fact, people had too much pride to do anything but provide for themselves and their families—to accept charity humiliated one.

At 58, I suffered a tragedy which left me with no home, no money, no job, only distant relatives who were little or no help financially. I went to teaching (having been certified years before), sold cosmetics, hosiery, books—any odd job that was respectable—often did not have proper food because I was saving every penny to get some kind of security, and in 3 years' time saved the price of a farm, the house on which was so bad I wonder now where I got courage to say I would take it, and the grounds had at least 25 years wild growth—a real jungle. But I felt it would be mine, and with a garden and a few chickens, I wouldn't starve. I scrubbed, cleaned, painted, papered until midnight and after over a period of years, still teaching, selling, paying for each improvement as I went along—never borrowing, but paying off one thing before I started another, until I had in the house, electricity, water, siding, cleared ground, etc. and in 10 years a home good enough for anybody—a lovely place. A wealthy woman gave me furniture and clothes.

Now I am really enjoying my home, am getting social security for which I am grateful, which meets my needs minus luxuries that I do not crave, but my pace is slowing down. I still fire a coal furnace in winter, carry out ashes, carry in wood, shovel coal, mow grass, plant, etc. But how many years can I keep this up?

Then our Congressmen and Senators, when they begin fighting this out on the floor of Congress, talk about Government help for the indigent.

I do not think anybody could call me indigent, after 10 years as briefly described above, yet I dread the thought of going to a doctor, and unless I am driven there by pain or fear, I just doctor myself with home remedies the best way I know how. I sometimes wonder if, when I am actually in the process of dying, should it extend over a period of time, I will be able to have a doctor, or fight it out alone with the few kind neighbors that may drop in.

Or, I wonder, if I might die in this home, every inch of which I love because it was miraculously earned and accomplished with so much of my own hard work, or will I just have to get rid of it, in order to be indigent, and then be taken to the poorhouse.

As I understand the Kerr-Mills bill (and as I said, I have never seen a clear version of it) that is just what would happen—I would have to get rid of anything I have saved beyond a small amount that wouldn't last a week, perhaps, in order to be medically indigent.

I think the status of medical care for the aged is tragic. Surely, when those citizens who have lived their lifetime making every effort to provide for themselves, as I have done, and many, many others have done, and abhor being termed indigent, or going on relief for nothing other than plain handouts, should be provided with a way of dying that will permit them to die with dignity, the dignity they have lived, the dignity that has been perhaps an unrecognized contribution to the greatness of this great country.

MARY R. JAMISON.

POTTSTOWN, PA., *June 9, 1962.*

Senator JOSEPH S. CLARK,
Senate Office Building,
Washington, D.C.

DEAR SENATOR CLARK: You will receive a number of letters, like the one inclosed, from some of the Pottstown doctors. I think you can well afford to ignore the political force of these letters. They only represent the mumblings of the AMA which has long since ceased to represent (if it ever did) the political or religious beliefs of its members.

Quite illegally and unconstitutionally (see Supreme Court ruling on AMA) many hospital staffs are intimidating the young doctors by inserting the clause in their bylaws, that in order to retain their membership on the staff they must be a member of their county medical society.

Many of our best young doctors are afraid to speak up in staff meetings and society meetings because of this clause. For the same reason they will send you a letter on anything they are told to send even though they whisper the opposite sentiments in private.

What I and most doctors really want is to see social security made universal and medical aid to the aged put on a social security basis right across the board.

Very truly yours,

THOMAS H. POWICK, M.D.

DEAR (REPRESENTATIVE OR SENATOR): Both President Kennedy and the American Medical Association have asked the citizens of this country to inform their respective representatives in Congress as to their position about the King-Anderson bill, H.R. 4222.

I am familiar with the pros and cons about assistance for the medical care of those over 65 years of age.

I am convinced that if the Kerr-Mills law, already in effect in Pennsylvania, is given a fair chance, the care of those people covered thereby will be adequate and equitable for all concerned.

On the other hand I am convinced the King-Anderson bill, H.R. 4222, contains gross inequalities and injustices; also, it would set up yet another expensive branch of the Federal Government, one the people do not need and the cost of which would be

exorbitant. For these reasons I am opposed to it.

Respectfully yours,

——— ———.

WOMAN'S MEDICAL COLLEGE
OF PENNSYLVANIA,
Philadelphia, May 10, 1962.

Hon. JOSEPH S. CLARK,
U.S. Senate,
Washington, D.C.

DEAR SENATOR CLARK: Both my wife and myself are licensed physicians in the State of Pennsylvania.

We would like to express our very strong support for the King-Anderson bill. We feel that this bill attempts to remedy a serious problem. The objections voiced by the spokesmen for the several groups of organized medicine do not reflect our opinions, and we are convinced that they do not reflect the opinions of numerous other physicians. We regret that the only way for those of us who disagree with these spokesmen to express ourselves is by way of individual letters.

We hope that others of our colleagues will join us in writing to their respective Congressmen in voting their support of this bill, so that you will be aware of the considerable support that actually is present within the medical profession itself when you consider the vote.

Sincerely yours,

BERNARD CZERNOBILSKY, M.D.
HELEN CZERNOBILSKY, M.D.

PHILADELPHIA, PA.

Senator JOSEPH S. CLARK,
Senate Office Building,
Washington, D.C.

DEAR SENATOR CLARK: The insurance industry, particularly those companies whose main volume of business is health insurance, urges all insurance men to write our Congressmen to oppose the King-Anderson bill.

Yes, I do write, but only as a freethinking American citizen instead of a tool representing selfish, biased interests of the AMA and insurance industry.

There is not one company who provides adequate medical coverage nationwide for those age 65 and over; the plans are very limited. Insurance companies decline applicants with preexisting conditions or waive the coverage of existing conditions. However, even if the applicant can qualify, the premium in this age bracket is especially high for the majority in this low-income, retired category.

We must defeat the lobbyists who selfishly worship only one thing, the almighty "buck".

At a time when our senior citizen population is growing we must provide hospital-medical care for them with the respect and dignity they deserve.

Please do everything you can to pass the King-Anderson type legislation.

Cordially yours,

——— ———

Insurance Agent.

[From the Patriot, Harrisburg, Pa., July 9, 1962]

A GOOD MEDICAL CARE BILL IS NOW BEFORE THE SENATE

The spotlight on the hard-fought issue of medical care for the aged has swung from the House to the Senate.

Because the King-Anderson bill still is lodged in the limbo of the House Ways and Means Committee, a bipartisan group of 21 Senators has introduced legislation designed to preserve the heart of the Kennedy program and at the same time meet some of the objections to it.

This is a praiseworthy compromise measure. Embodying some of the ideas advanced by New York's Gov. Nelson Rockefeller and Senator JACOB JAVITS, it would provide an option for private insurance coverage, Blue Cross participation in the program's administration and benefits for old people not covered by social security.

It is worth noting that Senator JAVITS and four other liberal Republicans are among the sponsors. So is Senator CLINTON ANDERSON, Democrat, of New Mexico, coauthor of the original legislation.

In appealing for support of the measure, Senator ANDERSON said "the AMA should stop worrying" about the program.

It should, but it isn't. It comes as no surprise that the AMA already has gone on record against the revised administration-backed bill for the simple reason that the social security system remains as its major fiscal underpinning.

There's a time to stop trying to satisfy people whose policy is one of blind opposition. In the case of the AMA, that time has come, and the Senate should act accordingly.

The President already has made it convincingly clear that social security financing is the heart of the program. And last week, in a press conference otherwise marked by a soft-spoken approach to controversial subjects, he pinpointed in crisp terms the major fallacy of the AMA position.

Asked about the decision to exclude payment of doctors' bills in the program, he said it was made for the simple reason that organized medicine is so leery of Government involvement in what the AMA calls the doctor-patient relationship. He added:

"It is because we have not included doctors that I found it very difficult to understand why the American Medical Association has found this legislation so unsatisfactory. It does not involve them directly. It involves the payment of hospital bills. And in view of the fact that the Federal Government participates in the construction of hospitals through the Hill-Burton Act from which doctors benefit in their practice, I found the AMA's extreme hostility to this bill somewhat incomprehensible."

At this point no one approach to the medical problems of the Nation's aged could satisfy all the participants in this controversy. But the bipartisan Senate measure, overcoming as it does major shortcomings of the King-Anderson bill, should appeal to a majority of Americans who believe that any medical care program should pay its own way.

[From the Gazette and Daily, York, Pa., June 25, 1962]

FOURTH OF STATE'S APPLICANTS FOR MEDICARE DISCOURAGED BY THE RULES IN KERR-MILLS BILL

More than a fourth of the State's elderly persons who applied for medical care under the Kerr-Mills program failed to go through with their applications—mostly because of a means test, State and local welfare officials report.

Some applicants were rejected by the State department of public welfare, administrator of the program. Other applicants voluntarily declined completing applications after learning their children would become involved in the agreement with the department of public welfare, their estate might be called upon to reimburse the department, and their present income could not exceed $125 per month.

"They want medical care," one welfare official said of the aged, "but when many find out what they must go through to get it, they either decline to go further or are disqualified."

The reason for being disqualified in most cases, a York County welfare official, said, is that a prospective patient refuses to "drag his children into it."

Under the program, as in receiving public assistance, the patient must indicate his children's income. If it is more than a stipulated amount, the children are called upon to contribute toward the cost of hospitalization.

"Often," one caseworker said, "this causes all kinds of trouble within a family."

A single person may not have an income in excess of $125 per month and a couple's income can not exceed $200 monthly to qualify for full benefits under the law.

Half of any annual income in excess of those limits must be applied against the hospital cost.

A patient may not have more than a $500 life insurance policy without all of the portion above that amount being charged against the hospital bill.

"In other words," a welfare official said, "if you had a $1,000 insurance policy and a $900 hospital bill, we would only pay $400 of the hospital bill."

The official pointed out that any amount over $500 in insurance is considered "available" money.

Liens on property is another involvement to which the elderly are objecting, welfare officials said.

Under the Kerr-Mills bill, the State may reclaim what it expends for the patient's hospital care after the death of the patient and his spouse.

Many elderly persons are objecting, welfare officials said, to committing any portion of their property to later claim.

"Many elderly people don't understand," one welfare official said, "that we won't touch their property until both husband and wife are dead."

Many elderly applicants are reported to answer that they don't want to have the State touch their property at all.

Some of the patients offer to pay back the State for medical care, one caseworker said.

In the 5 months the Kerr-Mills program has been operating in Pennsylvania, about half the applicants actually went through with the program—10,532 out of 21,684.

Of the remainder, 5,358 were rejected by the State for failing to meet its means test, 1,014 voluntarily withdrew their applications and the rest are still pending final disposition.

During May, 2,928 persons completed applications under the Kerr-Mills program out of 4,279 who applied. Of these, 1,832 were rejected and the remainder are pending.

In money, the State set aside $11 million for the 6 months ending June 30. So far, slightly less than half that amount has been spent on the program.

Gov. David L. Lawrence has several times repeated his charge, made last year when he signed enabling legislation for the Kerr-Mills bill, that its provisions are inadequate to meet the needs of Pennsylvania's elderly citizens.

Norman V. Lourie, deputy director of the department of public welfare, said the answer to the medical care problem for aged persons in the State is the social-security-based King-Anderson bill, now being debated in Congress.

"Under the plan spelled out in the King-Anderson bill," Lourie said, "the worker would pay while employed and receive benefits when he retires."

The provisions of the King-Anderson bill, Lourie said, are more extensive than those of the Kerr-Mills bill. The bill would benefit more than 14 million Americans over 65 who are eligible for social security.

The King-Anderson bill provides for inpatient hospital care for a period up to 90 days, while the Kerr-Mills bill provides for 60 days of hospitalization.

During hospitalization the King-Anderson bill calls for "nursing services and other related hospital facilities * * * drugs * * * biologicals * * * supplies * * * appliances and equipment."

Further, the bill calls for diagnostic and therapeutic services. Kerr-Mills provides for

hospital care only. No provision is made for medicines, clinic, and rehabilitative services.

The Kerr-Mills bill provides for hospital service at home of a type now existing only in Pittsburgh and Philadelphia. It also provides for visiting nurse care.

The administration backed King-Anderson bill provides for 180 days of care in a nursing home following hospitalization.

During those 180 days, the aged patient may receive physical, occupational, or speech therapy, medical social services, drugs, biologicals, supplies and appliances.

Visiting nurse services provided under Kerr-Mills are also provided under the King-Anderson bill.

The patient will pay the first $90 in hospital charges.

Lourie said of the King-Anderson bill:

"If this spread-the-cost, share-the-risk system were set up on a national basis, one of the major hazards of advanced age would be removed."

The bill, opposed by the American Medical Association as "a cruel hoax" is now before the U.S. House of Representatives Ways and Means Committee, whose chairman is Representative WILBUR MILLS, author of the Kerr-Mills bill.

Welfare officials said that persons wishing to "cast a vote" for the King-Anderson bill may do so by writing to ask the committee to report the bill out for a full vote by the House.

Letters on the bill may be sent to 19th District Representative GEORGE A. GOODLING, Loganville, whose Washington, D.C., office is in the House Office Building, Washington, 25, D.C., or at York post office.

Mr. CLARK. Madam President, I send to the desk an amendment to the Anderson amendment to the pending bill, to eliminate the requirement that eligible skilled nursing facilities also be "affiliated or under common control with a hospital."

I appreciate, of course, that the Anderson proposal from the start has included nursing home care among the services for which benefits are available only when the homes provide highly skilled nursing care suitable for those transferred from hospitals. I agree with this limited purpose.

I do not think, however, that the hospital-affiliation requirement, which was not in the original Anderson-King proposal, adds a requirement that necessarily contributes to the degree of skill required by the nursing home in order to participate. Probably most hospital-affiliated nursing homes are among the homes providing skilled nursing care, but they certainly do not have a monopoly of such skills.

Furthermore, I think there is an unfortunate problem created in passing legislation which is widely billed as including nursing home benefits, when such a tiny fraction of the nursing homes in the United States meet the stated requirements.

I am apprised that only about 5 percent of the nursing homes in the country are presently hospital affiliated"; whereas perhaps 20 percent of all nursing homes provide "skilled nursing services" meeting all other requisites of the bill.

In Pennsylvania, I have been advised by the department of public welfare, there are only 7 nursing homes with hospital affiliations, although there are as many as 65 homes providing registered nurse service around the clock and presumably meeting the other requirements of the Anderson amendment.

I see no reason why any homes providing skilled nursing services in Pennsylvania or elsewhere should be excluded from coverage under the bill.

The PRESIDING OFFICER. The amendment will be received and printed, and will lie on the table.

Mr. HRUSKA. Madam President, I rise to speak in opposition to the Senate of the Anderson amendment to H.R. 10606, the welfare bill. I am deeply concerned with its implications.

I need not point out to my learned colleagues that the amendment contains much to ponder, for they have had at least a brief opportunity of glancing over it. Yet, as important as the amendment is substantively—and no measure which has come to the Senate floor this year contains matter of more importance—I feel that the manner in which the amendment was brought before us demands an even higher priority in our deliberations.

We are confronted here with a carefully calculated attempt to avoid the Senate committee entrusted with the responsibility of dealing with such measures. The junior Senator from New Mexico, himself a member of the Finance Committee, is presumably fully aware of that committee's function, of that committee's duty, and of that committee's competence. It is, therefore, even more surprising that he has bypassed the Finance Committee and offered his amendment in this unusual fashion.

I know that if I were privileged to be the chairman of a Senate committee under these circumstances I would take this action as a personal affront.

Its effect is to force the Senate to a vote on a highly controversial measure without the benefit of the committee's hearings, findings, and recommendations. It is an attempt to usurp our deliberative function and to stampede this body into hasty, ill-considered action.

Congress possesses the exclusive power to legislate. But it becomes obvious that this exclusive power is being challenged by the Executive, which would not otherwise press this amendment in improper fashion.

At issue here is whether the Senate of the United States is to legislate as the Constitution intended, or whether this body will henceforth function as an unwilling cosigner of the Executive's notes.

At issue is whether the Senate blindly places a rubberstamped seal of approval on all administration directives, or whether the Senate will defend its constitutional prerogatives against the heaviest Executive pressures.

The Senate's committees are the Senate's eyes. Without them we cannot see our way, for no single Senator can comprehend the vast quantity of complex and diverse measures upon which we must vote "yea" or "nay."

I submit that this body's insistence upon orderly procedures is essential to its continued existence as a deliberative body. And I will go one step further, Madam President:

Unless these incursions into the powers and prerogatives of Congress are resisted and beaten back, this will become a ceremonial body at the beck and call of the executive branch of government.

Let us consider separately the two pieces of legislation now before us, forcibly wedded at shotgun point.

H.R. 10606 is a complex measure 102 pages long which would amend 4 titles contained in the Social Security Act. Whether the Senate passes this bill into law or not, the Senate will at least know what it is doing. For this bill has been subjected to the full measure of legislative testing upon which the Senate is accustomed to rely.

It was originally introduced by the administration as H.R. 10032 and sent to the House Committee on Ways and Means for consideration. That committee held hearings—3 full days of them, morning and afternoon—and heard the testimony of 47 witnesses who appeared in person.

Also entering into the committee's deliberations were the 113 written statements submitted by interested and informed persons and groups. From this material, the House Ways and Means Committee then fashioned a bill—a bill so substantially changed that it was assigned a new House number, H.R. 10606, before it was moved to the floor. This means that opportunity to present, argue, and incorporate conflicting views was fully accorded.

Accompanying the bill, as is usual, was the committee report explaining in detail the effect of each provision.

Members of the House were then given ample time to study not only the committee report, but the 697 printed pages of the hearings. No member, therefore, could plead a lack of familiarity with H.R. 10606 by the time it reached the floor of the House. Each vote cast could be as informed a vote as the Member troubled to make it.

Even so, the technical nature of the bill required that it be released to the floor under a closed rule. But there it passed, after 4 hours of debate, by a vote of 319 to 69. Several Members of the House nevertheless expressed their regret that amendments could not be offered.

H.R. 10606, 81 pages long by now, then came to the Senate and was duly referred to the Finance Committee. Once more it was subjected to hearings—this time for 4 full days. Once more witnesses appeared before a committee of Congress—36 of them at this time, and again additional written statements were filed with the committee for its collective digestion.

In due course the Finance Committee reported the bill, amended in a number of important ways. And it comes before us as the thoughtful product of many men's judgment, critical faculty, knowledge of the subject, exposure to the opinions of witnesses pro and con, as well as adaption of committee members' diverse views after full discussion.

It is ready for the Senate's consideration. Our distinguished colleagues on

the Finance Committee have done their part, and what they have placed before us represents a distillation, a refinement, a synthesis, an informed recommendation.

Regardless of whether H.R. 10606 were to be accepted or rejected by this body, we shall consider it in the full illumination of the committee's familiarity and study. We shall not be required to grope for our best course of action in the twilight of half-knowledge or the darkness of ignorance. We shall have a law with a seasoned, well considered legislative history—something valuable to go by in applying it.

Regardless of whether H.R. 10606 is passed or not, this bill represents the legislative process at its very best—often productive of wisdom, never infallible, usually the best workable solution that able legislators can evolve.

If this procedure cannot eliminate error, at least it can minimize it. In this imperfect world we can and must do our best for the people with whose lives and property we are dealing.

Let us now contrast H.R. 10606 with the Anderson amendment which hangs like an albatross around its neck.

We shall be required to vote on the amendment pretty soon. What do we know about it?

We know that it represents major modifications of the King-Anderson bill, and that it has been attached to H.R. 10606 for political reasons considered good and sufficient but above all highly politically expedient by the administration.

Very well. What do we know about the King-Anderson bill?

We know that the House Ways and Means Committee held hearings on it last year. That the committee was reported by the press to be lined up, 15 to 10, against discharging the bill to the House floor; that 4 volumes of printed hearings containing over 2,000 printed pages are available to any Senator who wishes to read them prior to casting his vote, but that they shed no light on radical changes made in the bill by the Anderson amendment.

When the so-called King-Anderson amendment was submitted on June 29, it was not even fully written; it was not even fully and completely formulated. That is pretty well indicated by the remarks and characterizations expressed by various Members of the Senate at the time the so-called King-Anderson amendment was submitted.

For example, at page 11416, of the CONGRESSIONAL RECORD, this language appears. It is by the junior Senator from New Mexico:

> We do not completely agree on the option provision. We have found it extremely difficult to handle. I thank the Senators on the Republican side of the aisle who have allowed this amendment to go forward, so that it may be printed for information only, without saying that we agree absolutely with everything it may contain.

At another place, on the following page in the CONGRESSIONAL RECORD, there appears this language by another Senator:

> We shall be working further on the option plan in an effort to come to an agreed position on that point.

On the next succeeding page, another Senator said:

> We are working to secure further improvements in this section of the bill.

On the following page there is a further statement by a Senator, who said:

> As that measure is debated and refined we can improve upon the option provision.

Finally on the next page of the CONGRESSIONAL RECORD, I find this statement:

> I do not believe that this provision—
>
> The option provision—
>
> goes far enough. I have coauthored the Javits-Anderson amendment with the understanding that our good faith discussions will continue and that when this matter is considered in the Senate we shall have the opportunity to strengthen this particular aspect of the proposal.

Therefore we can see that although there are 2,000 printed pages of testimony taken before the House committee, they cannot possibly shed too much light on a bill which was not even in existence at the time the 2,000 printed pages of testimony were made a matter of record.

We know, also, that the King-Anderson bill, as originally formulated is still under consideration by the House Ways and Means Committee; and that the Senate Finance Committee voted 10 to 7 against considering the bill until the House had been given the opportunity of taking action.

What else do we know that might prove helpful as we prepare to consider the Anderson amendment on its merits?

Well, Madam President, we know that the King-Anderson bill is the successor to the Forand bill and that the Senate Finance Committee once held hearings on that particular piece of legislation.

My learned colleagues may also remember that in 1959 the Senate Finance Committee voted 12 to 5 against releasing the Forand bill to the floor—this after thorough study. The Senators may also remember that an effort to overrule the committee's action was made by the junior Senator from New Mexico, and the then Senator, but now President of the United States, John F. Kennedy. Together they proposed an amendment to H.R. 12580, the addition of a modified version of the Forand bill.

The Anderson-Kennedy amendment was beaten.

But the President's cosponsor, the distinguished junior Senator from New Mexico, is back to the well once more—this time with the message that "unless favorable action is taken now, health insurance for the aged could become a major issue in the fall elections, and next year a bill will be passed." I am quoting now from the Senator's statement made on the floor last Friday. The Senator continued, in part:

> But the problem that confronts our aged people is so pressing that I hope we will not delay a solution another year.

I find this entire presentation confusing, Madam President. In the first place, the Anderson amendment would not, even if it became law, take effect until January 1, 1964. It seems to me, therefore, that there is sufficient time between now and then to follow the admittedly slower but infinitely wiser procedure of the Senate, which requires the orderly progression of legislation from the House committee to the House floor, from the House of Representatives to the Senate, and from the Senate to the appropriate committee of the Senate.

I am also somewhat at a loss to understand the distinguished Senator's reference to the fall elections, which hardly seem germane to the legislative process of this body. In a federated republic such as ours, in which the will of the people is determined by democratic, constitutional procedures, what can any Senator find as horrendous and undesirable as the reference of a multi-billion dollar measure to the electorate of the Nation? Not only a very expensive bill in terms of dollars, Madam President, but also one which will deeply, sharply cut into the daily lives of every citizen of this Nation. In the minds and strong belief of many knowledgeable persons, the impact of that measure as law would adversely and irretrievably affect the well-being and the mode and span of life of our entire population. But effort is being made to do away with seasoned and proper deliberation and treatment, in the "world's greatest deliberative legislative body."

In any case, however valid the sponsors' reasons for embarking upon their present course, we are still faced with the unpleasont prospect of voting on their amendment. It will be unpleasont because we cannot do so knowledgeably.

It is possible that the sponsors envision the Senate as a committee of the whole which, because it outnumbers the members of the Finance Committee so substantially, can thereby speed the legislative process by sheer weight of numbers. But if this is the case, and if I am right in my assumption that this is their reasoning, I must beg leave to differ with him.

We cannot, within the few days allowed us by an impatient administration, do more than cross our fingers, cast our votes, and hope for the best. Certainly we cannot know what we are doing.

It is generally accepted that the Social Security Act—all 15 separate titles of it—comprises one of the most complex and technical laws on our books. It is also accepted that title II of the act, the title dealing with the old-age and survivors disability insurance programs, is the most difficult and complicated section of the entire law.

The Forand bill, about which we know a little something; the King-Anderson bill, about which we know very little; and the Anderson-Javits amendment, about which we must so hurriedly learn, all affect title II.

To whom shall we turn for knowledge, Madam President? Because the administration is willing to present its own bill without hearings, must the Senate accept the Executive will as an adequate substitute? If the administration feels, as I am persuaded it does, that it is unable to dragoon the committees of Congress, must we therefore accept its right to dragoon the Congress itself?

I believe Senators on both sides of the aisle will agree that this effort by the

Executive to cut Congress down to its own small size and caliber degrades the authority which is reposed in the legislative branch by law.

Let me also set straight, for the record, any suggestion that the Senate Finance Committee has lacked diligence in the discharge of its duties.

Not for many years has the committee been faced with a more demanding schedule. It has thus far held hearings almost daily and discharged a number of the measures bearing a high priority rating from the administration. To be specific, the Senate Finance Committee has heard witnesses on the President's new tax bill; the reciprocal trade bill; the debt limit bill; the sugar bill; the extension of the Renegotiation Act; two tax extension bills; and H.R. 10606, which is now before us.

Few committees of the Senate, if any, have worked harder and more intensely. Few members, if any, of the Senate Finance Committee have been more tireless in the discharge of their duties than the committee's own chairman, the great Senator from Virginia [Mr. BYRD].

No, Madam President. We cannot take the Finance Committee to task for any fault. Nor can we say that the House Ways and Means Committee and its able chairman have been derelict.

The committees of the Congress are still functional, still responsible, still capable, still hard working. If they are to be ignored by the administration we must look further for a reason than the Executive impatience with an unhurried process.

Perhaps there is a clue in the nature of the legislation itself.

Senator ANDERSON has expressed concern that if his amendment is not passed this year, it will become an issue in the fall election. At the risk of sounding cynical, I wonder, Madam President, if this is not the administration's intent?

Certainly I have heard no administration spokesman thus far who has sought to quiet controversy on the subject of health care for the aged financed through a social security tax. To the contrary: I have heard Cabinet officers, top administrators, municipal officials, petty officeholders, and Members of Congress as well as the President himself merge their voices as an administration chorus.

We have heard them as they shouted from the rooftops, urging the crusade for passage of the King-Anderson bill. We have watched them circulate the petitions, hand out the literature, lean on the doorbells, pass out the post cards for mailing to Members of Congress. We have seen them coordinating their plans with the leaders of labor, of employees, and other organizations, organizing the aged into pressure groups, grinding out the releases—and using every communications medium except the tom-tom.

Is it possible that the administration forces were unaware that elections will be held this fall? Surely not, for the administration prides itself upon its grasp of practical politics.

The fact is, the administration has sought to apply the hammerlock of public pressure on both Houses of Congress. It has hoped thereby to force the King-Anderson bill into law—to use it, and the fall elections, as the stick with which to beat the donkey or the carrot with which to tempt him.

The Anderson-Javits amendment is simply more of the same. It is one more effort to bully Congress into legislating on the basis of emotion rather than reason.

The Executive is not concerned that not a single word of testimony has been heard from the public this year. The Executive is not upset at the prospect of the upcoming vote, which must necessarily be based upon the insufficient knowledge of the Senators. And the Executive is not alarmed at the prospect that the Senate, if successfully buffaloed, will lose forever some considerable portion of its authority and stature.

The committee system is an old one, Madam President, and it has withstood many an assault before this one. It has done so because it has been strong enough to do so, and it has derived its strength from the individual Members of the Congress it has been designed to serve.

I am sure the administration knows that the Legislative Reorganization Act of 1949 formally assigned the Senate Finance Committee jurisdiction over the national social security program. And I am equally sure that the administration is aware that tax legislation must originate in the House of Representatives.

Not too many days ago it was brought out by the Senator from Oklahoma and the Senator from Utah that if the King-Anderson bill in its present version were to become law the increase in the taxes springing therefrom would be on the order of about $810 million a year for its first full year of operation. It was the estimate of the Senator from Oklahom that this is the largest single increase in taxes which has confronted Congress in many years.

I do not seek to advise the administration as to the means it should employ to further the passage of its favored measures. However, I do seek to remind Senators that the extraprocedural attempt to adopt the Anderson-Javits amendment is not the product of the administration's innocence or lack of knowledge. Instead, it is a massive assault upon the dignity, prerogatives, and responsibilities of Congress and the people to whom Congress must answer.

Long after all of us have been replaced as Members of this body, the Senate will remain. Whether or not it remains authoritative and responsible, independent but coordinate with the executive branch of government, will depend upon the steadfastness with which we resist this and future efforts to bring us to heel.

Without reference to the merits of the proposed amendment, but on procedural grounds alone, I urge that the Anderson-Javits amendment, as modified, be rejected.

Mr. COOPER. Madam President, I ask unanimous consent to have printed in the body of the RECORD, a transcript of a discussion between Senators ANDERSON and JAVITS about the proposal before us, which was broadcast over New York television stations yesterday, Sunday, July 15, 1962. I do so because I think this discussion by the chief sponsors of bipartisan proposal of health insurance for the aged explains in a clear and understandable way the issue upon which the Senate will vote tomorrow.

There being no objection, the transcript was ordered to be printed in the RECORD, as follows:

CHANGES IN THE MEDICARE BILL

Senator JAVITS. This is Senator JACOB K. JAVITS with a report from Washington and we New Yorkers have the great privilege in having as our guest on this show, Senator CLINTON P. ANDERSON, of New Mexico, the chairman of the Committee on Interior and Insular Affairs of the Senate, former Secretary of Agriculture, a very distinguished Senator, businessman, insurance executive, and famous in our country today as one of the principal authors of the bill for medical care for those over 65. I'm sure most everyone knows now that Senator ANDERSON and I have gotten together on our ideas for the medical care program. We are looking forward optimistically to the voting this week and the expectation that the Senate will pass what Senator ANDERSON has kindly referred to as a greatly improved bill. Senator, would you tell us a little about the changes in the bill, as you see them?

Senator ANDERSON. Well, thank you. First of all, I want to say to the people of New York that I am very delighted to be associated with you in this endeavor. It has been a real pleasure to work with you and to realize the extent to which you have great interest in this problem. Now to talk about some of the changes. I think the principal change, probably the first change I should mention, is the fact that we have addcd about 2½ million more to the 15 million that are already covered. In other words, we have complete coverage now of all people past 65 who are in need of assistance. For example, in New York State there are about 1,811,000 people who are past 65 and all but 30,000 of those are sure to be covered now by the bill that you and I have been working on jointly. And I say this, it is a great improvement. It is taken directly from your proposals, and I am very happy that we have done it, because it permits us to say now that the aged will have a real change. We have given them all sorts of chances to choose from a package of benefits, through private insurance, through group practice, other voluntary plans. I think this is extremely important. Those of us who worked on the original bill were not so worried about group policies and what might happen in the differences in the packages. You have recognized that there are people of different financial means who look upon these things in a different way. And therefore, by these changes that we have put into it, and by the options that you have insisted upon, we have been able to make far better coverage for the people who are going to be under it. The fundamental benefits still stand—90 days hospital care, 180 days skilled nursing home care, 240 visits a year that might be placed for health purposes—but you have added an option to these and perhaps you ought to tell about the changes because it is yours.

THE OPTION PROVISION

Senator JAVITS. First, as Senator ANDERSON emphasized, and it can't be emphasized too much, this is now well-nigh universal coverage. As far as it goes, that is, for hospitalization, nursing home, and home health care, it will cover all those over 65, whether or not social security beneficiaries. That was one of the big things which I and Sen-

ator KEATING; Senator COOPER, of Kentucky; Senator KUCHEL, of California, have been contending, and we've always been joined by Senator CASE, of New Jersey, who's been on this bill going way back to August 1960. Now the option which we are offering is for the beneficiary who wants to join a private plan, group practice unit, Blue Cross operation, a trade union, a pension and welfare fund, or a group policy which he's been carrying before he became 65. The option will entitle him to hospitalization for 45 days without any deductible amount. Senator ANDERSON's bill calls for 90 days with the first $90 of cost paid by the individual himself, but the option provides that a private insurance carrier can write a plan for 45 days' hospitalization without any deductible and without any payment required for first cost care. Now this is extremely valuable because the carriers, these insurance companies and similiar organizations, can then give insurance over, above, and beyond hospitalization, nursing home care, and home health care, for a very small premium. For example, it's been estimated that for as little as $3 a month, services of a physician and surgical services may be added to the basic hospital package. The way in which this has been accomplished is by entitling the private insurance company to recover from the Government for whatever it pays out in benefits under the plan. In addition to the two really landmark improvements of covering those not on social security and the option to everyone to carry a private plan with some more benefits, Senator ANDERSON's bill also has been improved to include the creation of a separate trust fund through which this whole plan will be administered so citizens can see the cost very promptly. Also, a large share in the administration of the plan goes to the States as well as to cooperative organizations, like Blue Cross. There are other improvements which Senator ANDERSON will tell us about, with respect to accreditation of hospitals, and similar matters.

ACCREDITATION OF HOSPITALS

Senator ANDERSON. Well, I'm going to say that of the things we ran into, one was that people would quote an old statement made by Nye Bevan, of Britain, many years ago that if you can control hospitals, you may be able to control the doctors. Now you and I don't want to control doctors, and we have agreed on that thoroughly. So, therefore, we looked at our bill and said, "What is there in this that worries people?" And we found it might come on the accreditation of hospitals. And therefore, we set up a joint committee on accreditation of hospitals, to determine if hospitals were qualified to provide the care carried by this bill. And the group that will look at it would be the American Medical Association, the American Hospital Association, the American College of Surgeons and the American College of Physicians. Now nobody could say we're trying to stack the deck. That's absolute evidence that we want what we say we want, mainly good health care for the aged. And we're not trying to persuade them to follow any particular line of philosophy, just to get well.

ROLE OF INSURANCE COMPANIES

Senator JAVITS. Well, Senator, while we are finishing off a discussion on the terms of the bill itself, I would like to make it clear to my fellow New Yorkers, that though there are not too many insurance companies and even cooperatives and other carriers who say now that they're going to use this option which we spent so much time and effort developing, I think it's very sound and very important, and knowing life as we do, we have every right to expect that just as the insurance companies embraced coverage for Government employees, when they had the choice, you'll find a lot more people interested in this business once a bill like this becomes law.

Senator ANDERSON. Oh yes, and I go back, of course, quite a long way, because I was around here when we were discussing the original passage of the Social Security Act. Many of us contended then that this would be very beneficial to the insurance companies in selling policies for retirement, for annuities and increasing the amount of life coverage. It's worked out exactly that way, and I predict to you that the greatest boon in the sale of health insurance that this country has ever known will follow the passage of this act. Because it would take care of basics and then people could say: Now in addition to the basics, I would like to buy for myself certain other types of services. And the means to do that has already been provided.

AN AMALGAM OF IDEAS

Senator JAVITS. Well, I would say, Senator, that between us we have probably proved what the people often know better than legislators—that these things do cross party lines, and that the pooling of ideas to the ultimate attrition of debate works out best for the American people.

Senator ANDERSON. Oh, without any question. What I've been amazed at is the way we were able to bail out an amalgam of our ideas, our thoughts and our desires. We have now what I regard to be an extremely good bill.

THE VOTING NEXT WEEK

Senator JAVITS. Well, Senator, could we take a look at next week's voting, because I think the whole nation's kind of waiting on that, and would you give us your view as to how we'll do in what will probably be the showdown vote, which is a motion to table this bill we're talking about?

Senator ANDERSON. Well, I believe and I hope and I have reason to believe that the motion to table will not carry. Now the motion to table is an ingenious thing. It permits a person to vote to kill something and then say, "But I never voted on that; I voted on a parliamentary procedure." We've got to be sure that the country understands, this is not a parliamentary procedure, this is a question of life and death for a bill that gives adequate care to the aged. So we believe that vote will go our way. If it does, then after 4 hours more debate, I hope we will then come to the real question of the amendment which will take care of the aging. On the motion to table, it's a close vote, we need the help of every person we can get, but I believe it will succeed. Beyond that, of course, it will go to the House, where you and I have both served, and you and I both understand the problem which exists there.

CHANCES OF HOUSE PASSAGE

Senator JAVITS. Well, Senator, of course, the House will never have a chance to do anything about it unless we pass it in the Senate, and I think it's extremely important that people keep their eyes clearly on the performance of every Senator in this respect: this is not a partisan issue any more, whatever may have been said about it before. It is very effective and strong and deserves bipartisan support. Now I predict with you that we will win these showdown votes and that this bill will pass the Senate. And it will then be up to the House. But it will not happen unless the public, which has been writing you and me and many others thousands upon thousands of letters, is keen and alert to what each of these votes mean. Now in regard to the tabling vote, some people may try to excuse themselves from voting the wrong way on the ground that this represents an effort to tack something on to another bill in the Senate which did not actually go through the House or that it hasn't had enough hearings. Now there's a whole library full of hearings upon this very proposition over the past years, and we've shown that to our colleagues on the Senate floor. The Library of Congress has made a study showing that there are countless instances where the Senators acted and put a measure of this character on another bill that came over from the House, the House has then acted concurrently and the bill has become law. There's no reason in the world why the House shouldn't act in this matter, and I would like to say to you, Senator, and I know New Yorkers would be very interested in your views on this, that notwithstanding all the predictions about the fact that whatever we do, the House won't pass this bill, I believe that if the Senate passes it, and the people will take that as their signal to move into this situation strongly, they will insist that the House must pass it too, and we'll get a law in this session of Congress.

Senator ANDERSON. Yes, I think so, I want to tell you why, Senator JAVITS. It's because we have joined in a bipartisan venture. If we had left it as a political issue, then we would find, of course, that there was no real reason why maybe the House members of the Ways and Means Committee should reverse their former positions. But you have greatly improved the bill, and working together, we have developed a much better bill, a bill that truly is a bipartisan venture, and therefore, I think that if the Ways and Means Committee were called upon to act upon the bill, and with all your packages in it, that we can expect a favorable House reaction. I was on the Ways and Means Committee of the House of Representatives. I know it's very sensitive to public wishes, and we would be able in this event, I am sure, to prove that the public wants this kind of a bill. I picked out of the old oath of Hippocrates these words: "Healing is not a matter of time, it is sometimes a matter of opportunity." And if we don't give the aging a chance to have the opportunity to get healing, then we haven't treated them properly in my opinion.

AMA OPPOSITION

Senator JAVITS. And Senator, you have made it crystal clear that this opposition which we know exists from the American Medical Association is just not warranted by the facts. They are seeing hobgoblins as to what this might amount to someday if it's continued to expand and expand and expand. I cannot see anything in this bill whatever, which represents any compromise of the private relation between doctor and patient. I can only see the concrete base for better medical care for the aging than ever before, including those who can't afford it.

Senator ANDERSON. Yes; I want to join you very sincerely in that expression. I'm probably alive today because of fine doctors. I've gone to fine doctors all my life. I have had no animosity and I say to you that if I thought this was going to hurt the medical profession, I would not be joining with you in sponsoring it. It will not. It will help. It will be a fine thing for this country, and it's something that you and I are going to be very happy about in the years that lie ahead.

Senator JAVITS. Well, I'm very happy, Senator ANDERSON, to have joined with you and to have made it possible for Republicans to vote on this measure without any feeling that they are voting on some partisan Democratic or administration bill. It deserves and should get universal support, and the people can largely see to that. Senator, thank you very much, and I know I say this on behalf of every New Yorker, for all you've done on medical care for the aging.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

MEDICAL CARE FOR THE ELDERLY

Mr. SALTONSTALL. Mr. President, I intend to vote to lay the Anderson amendments on the table. I shall do so because I do not believe we should put medical care for our elder citizens on a social security basis.

Last week on Thursday I offered an amendment which would have extended services for medical care of our citizens over 65 on a voluntary basis, subject to annual appropriations by the Congress. The amendment would have extended the Kerr-Mills Act, adding a number of additional services for our elder citizens who need medical care. It would have modified the means test by increasing the number of people who would be eligible for benefits, thus putting it on a more realistic basis.

I believe we should give the Kerr-Mills Act a further trial. It is working effectively in Massachusetts. I believe some 24 States have adopted the program, but in 4 States, of which Massachusetts is one, it is used more extensively. In fact, these four States account for 90 percent of the cost to the Federal Government of the Kerr-Mills Act at the present time. It is State-administered, voluntary, and provides a comprehensive program of medical benefits. I would prefer to wait and give this law an opportunity to be implemented in more States and expanded in others rather than to embark on a new plan which would be federally oriented, costly to administer, and would impose a regressive tax on employment.

The Anderson amendment would put medical care on a social security basis, run by the Federal Government through a new Federal bureaucracy, with an extraordinary increase in the cost of social security over the years to come. Such a system would be difficult to repeal even if it did not work. It would be difficult to change. If, on the other hand, the program were subject to annual appropriations on a voluntary basis Congress could more readily change it by changing the amount of the appropriation if Congress thought it was not being fairly administered.

For these reasons, very briefly stated—a summary of what I said in full last Thursday in connection with my amendment—I shall vote to lay on the table the Anderson amendments.

Mr. AIKEN. Mr. President, I doubt there is much more that can be said for or against the Anderson-Javits amendments, on which we shall vote at 3 o'clock. In the final analysis how we vote on the motion to lay the amendments on the table will depend upon how they would affect our own people, our own neighbors, our own friends who live in our communities.

My colleague [Mr. PROUTY] has already pointed out that of the 192 nursing homes in the State of Vermont which qualify under the Kerr-Mills Act in the old-age assistance program only 3 could qualify under the Anderson-Javits amendments as they now stand.

Very generally, Mr. President, the Anderson-Javits proposal would be favorable to the urban areas, but I think it would be discriminatory so far as the rural areas of this country are concerned.

In addition to the inability of nursing homes in my State to qualify, there are many other serious defects in the proposal. The method of raising funds to pay the costs is a discriminatory method, in that it would make the entire cost payable out of a tax on people with low incomes in this country.

In order for country people to take advantage of the benefits offered by the Anderson proposal it would really be necessary for them, when they reach a certain age, to migrate to the cities or the larger centers of population. Our people, who have been raised in the villages and on the farms of Vermont, do not want to move to town to take advantage of new Federal programs. They want to stay with their neighbors, where they have spent the best years of their lives. If they are sick, they want people to take care of them in their homes. They could not get that treatment under the measure on which we are asked to vote.

If the criteria established by these amendments should stand—they now would require all nursing homes which participate in the program to be absolutely fireproof—the next logical step to be taken would require all people to live in strictly fireproof homes. That is not

too farfetched, but it is something we are not ready for, and for which we will not be ready for some time.

Vermont has established a program under the Kerr-Mills Act. It is an experimental program. I think that at present it is probably an inadequate program. The director of the program under the Kerr-Mills Act has been given authority to amend the State legislation, to try out whatever he has to try out, until the legislature meets next winter, when his recommendations can be firmed up. It looks as if the Kerr-Mills program which permits the people to stay at home and get medical care and other care, is superior to any program which would make it virtually necessary for them to move to large towns or cities to secure full benefits.

For this reason, because I am going to vote for what I think is best for the people of my State, I feel I shall have to vote to table the Anderson-Javits proposal.

Mr. DIRKSEN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DIRKSEN. Mr. President, I ask unanimous consent that further proceedings under the quorum call may be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

RECOMMENDATIONS ON FINANCING OF HEALTH COSTS FROM THE WHITE HOUSE CONFERENCE ON AGING

Mr. McNAMARA. Mr. President, during the course of his floor speech on July 11, my able colleague and good friend the senior Senator from Colorado [Mr. ALLOTT] stated that the majority view emanating from the White House Conference on Aging opposed the financing of medical care under social security. He was concerned that "in the deliberations which are now taking place in this Chamber we are disregarding the considered judgment of experts" who formulated the White House Conference recommendations.

I too am concerned that our deliberations should not ignore the considered judgment of these experts; that we should clearly understand that the majority of the White House Conference delegates charged with developing the recommendations on the financing of health costs unequivocally favored the use of the social security method as the basic program.

I feel it essential that I correct the record, because the document from which my colleague drew his erroneous impression was a committee print issued by the Senate Special Committee on Aging containing the basic policy statements and recommendations of the 1961 White House Conference on Aging.

The correct information is in this document. My colleague, however, simply read from the wrong pages—from pages 37–38, headed "Policy Statement and Recommendations—Institutional Care," and not from the pages beginning with 12, which reported the policy statement and recommendations of "Section 2. Income Maintenance, Including Financing Health Costs." This section—section 2—was the White House Conference section which had been specifically charged with responsibility for developing the recommendations on the financing of health costs.

The recommendation of section 2, the only recommendation on financing of health costs that can be properly labeled as the majority view emanating from the White House Conference, read as follows:

FINANCING HEALTH CARE

The problem of furnishing an adequate level of high-quality health care for the aged is so large and so complex that its solution will require the use of a variety of approaches, including individual and family resources, voluntary health insurance, industrial programs, social security, public assistance, and a variety of other programs.

Present Federal legislation providing governmental aid for recipients of public assistance and for the medically indigent is desirable and should be strengthened so as to provide a high-quality health care program. The States are urged to take full advantage of this legislation.

Voluntary health insurance for the aged should continue to be expanded. Industry should be encouraged to expand its health care programs and extend to retired persons the medical care protection afforded to current workers.

Private voluntary effort and public assistance can contribute much to the solution of the problem of health care for the aged. However, they will continue to fall short of meeting the basic medical care needs of the aged as a whole. The majority of the delegates of section 2 (by a vote of 170 to 99) believe that the social security mechanism should be the basic means of financing health care for the aged.

Establishment of a program of health benefits financed in the same way as OASDI cash benefits would give to the aged the assurance that the costs of essential health care will be met when their working years are over. The mechanism of contributory social insurance, under which contributions are made by workers during their working years, will then provide health care to protect them in retirement. Such legislation would help to ease the problems of hospitals, public assistance programs, and private philanthropy and would relieve voluntary insurance programs of the burden of carrying this high-risk group.

The minority believe that social security should not be used to finance health care; that such use would interfere with the physician-patient relationship; that it is unnecessary because of the potential growth of voluntary insurance; and that all needy aged can be cared for by public assistance through the recently enacted Federal program of health care for the low-income aged. In addition, they believe that the social security program should provide for cash benefits and not for services of various kinds.

I cannot understand how the Senator from Colorado happened to miss this major recommendation. The introduction to the report from which the Senator read had flagged the fact that the financing of health costs was the most discussed problem of all those considered by the conference and had made clear that the recommendation would be found under the heading of "Income Maintenance," by stating:

Seven work groups in the section to which the matter was assigned by the National Advisory Committee—income maintenance—devoted their full attention to the problem. Six of the seven work groups voted to support the principle of paid-up health insurance through the social security system. Their recommendation was adopted by the section, and reported to the total conference at one of its final plenary sessions.

What my colleague from Colorado thought were the majority views of the White House Conference were, in fact, the views coming out of "Section 5. Health and Medical Care, Including Institutional Care." This section had no responsibility for the general area of the financing method. Its responsibility was "the character, quality, and cost of personal health services, facilities, and personnel, and the implications that the financing method has upon them." In that connection, the sentence stating "Compulsory health care inevitably results in poor quality health care" was allowed to remain in section 5's policy statement. This is the sentence the Senator from Colorado has mistakenly labeled the view of the majority of the conference.

In all fairness, it should be pointed out that section 5—composed heavily of doctors—also had a minority report which read in part:

It is distressing to be told by organized medicine that the quality of care the individual physician renders will be influenced by the source of payment. We do not believe this is so.

The confusion of the Senator from Colorado is probably attributable to the unwillingness of opponents of the social security method to recognize that doctors are not the group best qualified to solve problems which are primarily economic and social. A concerted effort prior to the White House Conference on Aging tried—but failed—to remove the subject of financing of health costs from the section on income maintenance, where it had been assigned by the National Advisory Committee at its initial meeting in June 1959 and to place it in the section on health and medical care where, under the chairmanship of Dr. Leonard Larson, president of the AMA, the doctors could control the formulation of the recommendation on financing.

I never cease to marvel at the assurance with which organized medicine attempts to determine our Nation's solution to problems that are primarily economic. Doctors seem to think that medical training makes them better qualified than any political scientist or economist to decide a course of action that involves economics, society, and government.

Our doctors are well trained in medicine. They approach problems of diagnosis and therapy and care with unemotional, objective, scientific reason. And they have disciplined themselves—most of them—to handle only ailments within their competence. They refer decisions on matters on which they are not expert to those who are.

The average general practitioner or even the average surgeon will not undertake an intricate operation inside the heart or the brain. He will refer the patient to a superspecialist in such operations. Confronted with a difficult metabolic upset, he will send a patient to an internist. Given a complicated behavior problem, he has learned to turn to the

psychiatrist, just as he calls in an opthalmologist when he suspects an eye disease.

He has learned to rely on himself in areas in which he knows he has knowledge and to get expert help and opinion in areas beyond his training.

And above all else, the doctor has learned to distrust his own judgment in any matter in which his own personal emotions might be involved. That is why no good doctor undertakes to treat himself or his family.

These are fine principles that our good doctors follow, as individuals and while practicing medicine. We like and we trust them for it.

But when they act as a group and in realms outside their competence, when the AMA takes over for them and gets into areas in which they have had no training and all too little education, then these fine principles go down the drain.

Confronted by a problem of paying for medical care—the economics of medicine—does the AMA refer for advice and guidance to a panel of specialists? Does it ask a group of unbiased economists to diagnose an economic situation and prescribe a remedy? It does not.

Does it, when the problem involves its relationship with Federal, State, or local government, ask the American Political Science Association to set up a panel of trained, objective experts to suggest an informed course of action? It does not.

In matters involving both its heart and its pocketbook, does it distrust its own judgment and seek unemotional, objective counsel? Of course not. Invariably, in these matters in which it has no competence whatsoever, it proceeds to diagnose its own case and to prescribe a course of treatment not only for itself but also for the Nation.

The people whose lives are at stake and who must put up all the money involved are told it is none of their business. If a doctor is involved, then, even if the question involves not medicine but money, the AMA claims the sole right to speak. The AMA reaches down into its bundle of last century's economic and political placebos, chooses the ones it thinks might best divert or tranquilize the people, and then calls in not economic consultants but public relations experts to persuade us to swallow them.

If a doctor followed such policies in approaching the problems of his patients the AMA would be the first to say he was wrong. The AMA follows just those policies and the AMA has been just as wrong.

The Senator from Colorado, apparently unaware that the AMA was not given responsibility for drafting the White House Conference on Aging recommendation on financing of health costs, said in his floor speech:

> I repeat "Compulsory health care inevitably results in poor quality health care." I would like to point out, for the benefit of any of my colleagues who might have entered this Chamber toward the end of my statement, that I was not reading from the Republican platform of 1960. I was reading from the committee print published by the Special Committee on Aging, listing the recommendations of the White House Conference on Aging of January 1961.
>
> The minority views hold to the contrary, and urge what is tantamount to medical care under social security, although it is not specifically referred to as such. It is worth noting that in July of 1962, just as in the early days of 1961, the people of this country continue to hold steadfastly to the view reflected by the majority in the White House Conference.

Now that we have cleared the record on what the majority view actually was—that it strongly supported the establishment of a basic program for financing health care for the aged within the framework of the old-age and survivors disability insurance system—I would agree with my friend, the Senator from Colorado, that—

> In July 1962, just as in the early days of 1961, the people of this country continue to hold steadfastly to the view reflected by the majority in the White House Conference.

There is one other point on which I would like to correct the record. This relates to the misconception of the role of the Special Staff on Aging of the Department of Health, Education, and Welfare. The Senator from Colorado said:

> In the event that the successful implementation of Kerr-Mills has not proceeded with such dispatch as its detractors would wish, the responsibility must, in part, at least, be borne by HEW. Under questioning by Representative MELVIN LAIRD and Chairman JOHN E. FOGARTY at recent hearings of a House Appropriations Subcommittee, Secretary Ribicoff admitted he had hired only 1 professional staff member, although Congress had provided $145,000 to employ a staff of 18. Further questioning also brought out that little has been done by the Department to implement the 600 recommendations of the White House Conference on Problems of the Aging. One of them, dealing specifically with medical care for the aged, I discussed a moment ago.

The accusation of failure to use the money appropriated for staffing relates to DHEW's special staff on aging, a staff that has no administrative responsibility for carrying out the Kerr-Mills program. The responsibility for the Kerr-Mills program is lodged in the Bureau of Family Services of the Social Security Administration.

I would agree that the Special Staff on Aging of the Department of Health, Education, and Welfare has an important responsibility with respect to the 600 recommendations from the White House Conference on Aging—to stimulate action where indicated, and to keep a running summary of actions taken by the appropriate agencies; thus at all times to be able to report progress in implementation of the recommendations. But it would be completely improper for that staff to take over the administrative functions of Kerr-Mills or of any other operating program.

Perhaps now that my colleague from Colorado has been informed that the majority recommendation of the White House Conference on Aging favored financing of health costs through social security, he will not be so anxious to prod the special staff and the Department into activity to implement the recommendation.

I ask unanimous consent that the RECORD show, following these remarks, the relevant excerpts from the official report on "Income Maintenance Including Financing of Health Costs From the White House Conference on Aging." No corresponding report from the section on health and medical care has ever been printed.

There being no objection, the excerpts were ordered to be printed in the RECORD, as follows:

EXCERPTS FROM "INCOME MAINTENANCE INCLUDING FINANCING OF HEALTH COSTS," A STATEMENT OF PROBLEMS, ISSUES AND APPROACHES TOGETHER WITH RECOMMENDATIONS FROM THE 1961 WHITE HOUSE CONFERENCE ON AGING—REPORTS AND GUIDELINES FROM THE WHITE HOUSE CONFERENCE ON AGING

CONFERENCE ACTION

Work groups III–7—Financing of Medical Costs

At the initial meeting of the National Advisory Committee in June 1959, 20 subjects were identified around which the Conference would be organized. In defining the scope of each of the 20, responsibility for the area of medical care financing was placed in the income maintenance section; responsibility for the general subject of the costs, quality, and availability of medical care was placed in the health and medical care section.

Specific interpretations of the areas of responsibility of the two sections were worked out later for purposes of correctly classifying the State recommendations that would be considered by the respective sections at the White House Conference. To work out the lines of demarcation, representatives of the chairmen of the two sections reviewed and classified more than 100 relevant State recommendations. They then formulated the following general principles which they had used in the classification of specific recommendations, illustrating the application of the principles with examples drawn from the State recommendations:

Income maintenance section responsibility

The responsibility of this section for financing of medical costs encompasses the methods of financing and raising money for personal health services (but not for the financing of the construction and staffing of facilities).

Health and medical care section responsibility

The responsibility of this section is the character, quality, and cost of personal health services, facilities, and personnel, and the implications that the financing method has upon them.

Several efforts were made to acquaint the States and national organizations—and the delegates themselves—with the respective responsibilities of the two sections. In the "Descriptions of the Scope of the Subject Matter Sections," which the States and national organizations used in making the assignments to the 20 sections, the description of the topics to be considered by the income maintenance section included a topic on the financing of medical care. The descriptions of work-group topics used by the delegates in making their selections were equally explicit. The covering letter sent to delegates who had been assigned to the health and medical care section contained the statement: "Included under each heading where indicated will be consideration of scope, quantity, quality, cost, and effect of method of financing. The financing of medical care will be discussed in another section—income maintenance."

Similarly, the covering letter sent to delegates assigned to the income maintenance section and the other 3 sections in group I read in part: "* * * financing medical costs, for which the income maintenance section has responsibility (consideration of the financing aspect in the health and medical

care section will be limited to the effect of the financing method on the availability, quality and cost of care)."

One further effort was made to insure that the respective responsibilities of the two sections were clearly understood in advance of the Conference. The White House Conference regional representatives and other staff members contacted States and national organizations to make certain that their assignment of delegates had been based on the correct understanding and, if not, to provide an opportunity for reassignment.

Composition of the work groups: Each group I delegate was given his first choice of work-group topics. To accommodate the heavy demand for the controversial topic on the financing of medical care, seven identical work groups were set up.

For the advance registrants, the occupational code was used to spread the delegates among the seven work groups, giving each of the seven approximately the same number of doctors, businessmen, social welfare representatives, and representatives of organized labor. For delegates who registered at the time of the Conference, however, the planned method of assignment obviously could not be carried out. Hence the occupational distribution for some work groups only roughly resembles the distribution of the seven combined.

For the 194 delegates participating in the formulation of recommendations on the financing of medical costs, the occupation was reported as follows: business executives, 9.3 percent, physicians or dentists, 14.4 percent; other health services, 3.1 percent; education, 8.2 percent; insurance, 11.3 percent; social welfare, 9.8 percent; labor organizations, 19.6 percent; clergy, 2.6 percent; other, 14.9 percent; not reported, 6.7 percent.

The work-group discussions: Between Monday afternoon when the work groups met briefly to organize and Tuesday morning when they began their intensive discussions, two major Conference addresses had been delivered that undoubtedly had an impact on the thinking of the delegates.

The first was by Marion B. Folsom, formerly Secretary of Health, Education, and Welfare, and Under Secretary of the Treasury, who called social security financing of medical care the logical plan and stated that there is no basis for describing it as "socialized medicine." Under the social security program, he told the delegates with conviction, "The individual would still have the same free choice as to hospitals and doctors that he now has." The other speaker who advocated the social security approach to the problem was Arthur Larson, former Under Secretary of Labor. At a special Conference session on Monday evening, he defined the proper role of Government as doing for people what needs to be done but what they cannot do at all or do so well. Social security, he said, is not accomplishing its purpose of protecting individuals from becoming social problems if hospital and medical charges consume wage-loss benefits.

Perhaps no two of the seven work groups went about their assigned task in exactly the same manner. Some proceeded to hammer out their position by adopting a series of recommendations. Others postponed action on any facet of the subject until the members had agreed to certain basic premises, with all the considerations on the table and after full opportunity to discuss the pros and cons of the various proposals.

The work groups had one common denominator. All, apparently, arrived early in the discussion at agreement that a problem existed. As one work group stated: "The very fact of this Conference, and of this section in particular, is an indication that a significant problem does exist for a significant number of people in the matter of meeting the costs of adequate health care for older people, and that, therefore, there is need for the development of new and better vehicles for meeting such costs."

A number of work groups also arrived at an early recognition of the impossibility of solving the problem through a single approach. Here one report reads: "It is unanimously agreed that it is the sense of this work group that the problem of furnishing an adequate level of high-quality medical care for the aged is so large and so complex that it will require for solution the utilization of voluntary health insurance, of individual and family resources, and the combined resources and instrumentalities of local, State, and Federal governments."

Some delegates heard reports of the outstanding efforts by one State—Colorado—in working toward a solution to the financing of medical costs for public assistance recipients and the medically indigent. There were observations from firsthand knowledge of the success that had been achieved in other countries and of the dangers that lie in foreign approaches to the problem. One group balanced an article from the Wall Street Journal entitled "Federal-State Medical Program for Elderly Is Off to Slow Start" against a statement entitled "Compulsory National Health -Insurance," the opening sentence of which reads "Social security medical care is socialized medicine." Another discussed at length the services needed by the aged and the importance of insuring "health" costs, including costs for nursing services, and not just "medical" costs.

Important in shaping the findings of the groups were the voices of State legislators and State government officials who pleaded inability on the part of the States they represented to finance—even with considerable help from the Federal Government—adequate health services for those aged who cannot, under existing arrangements, finance their own health costs.

The work group recommendations: The seven work groups met together toward the end of Tuesday afternoon to report to the section chairman on their conclusions. This, in essence, is what they said:

Work group I–1

While the Kerr-Mills legislation is a step in the right direction, it is not the adequate solution and does not in any way meet the essence of the major problem; namely, "a dignified prepaid medical insurance approach." Voluntary health insurance should continue to expand and improve coverage for the aged, but "it is our belief that private health insurance programs can never give adequate protection to the aged due to the fact that the aged are a low-income, high-cost, high-risk population and that in order to provide adequate health insurance for them, private insurance programs would be forced to charge prohibitive premiums." Against these considerations, the group went on record, by a vote of 17 to 11, "in support of the establishment of a program of health benefits for social security beneficiaries in the framework of the existing social security system."

Work group I–2

The second work group framed its recommendations against a conviction that "continued appropriations by the Federal Congress to the several States of funds for various programs on a matching basis have about reached the point where maximum efforts are being put forth by the individual States to meet and qualify for such funds." By a vote of 17 to 12, it adopted the following recommendations:

First: There is a recognition and need for additional provision for the medical care of the aging and indigent.

Secondly: That further expansion of a program be financed under the Federal social security program.

Work group I–3

The third group reported the adoption, by a vote of 14 to 10, of the following resolution: "That the social security system be the basic vehicle for providing the costs of health care for the aged, rather than depending primarily upon the States." By virtually unanimous vote, the work group also called upon the States "to implement all existing Federal legislation providing medical assistance for the aged, to cover persons not covered under the OASDI program," and it commended the present trend of extending group insurance coverage into the postretirement period "as a means of helping provide adequate health protection in retirement."

Work group I–4

This work group stresseed the need for health services of a comprehensive nature, to which all persons should have access regardless of ability to pay. It recommended that "all States be urged to make prompt, liberal, and maximum utilization of the provisions of the Kerr-Mills Act (Social Security Amendments of 1960) as is possible." In recognition of the valuable contributions made "by voluntary community prepayment and the commercial insurance system of financing medical care for the aged," the group urged the strengthening and expansion of those plans and recommended "that employers and labor organizations recognize the importance of providing to retired employees continuing coverage on the same basis as that provided for active employees." By a vote of 14 to 9, it did not endorse social security financing of health benefits.

Work group I–5

The work group agreed unanimously that all health insurance covering the aged should be noncancelable (except for nonpayment of premiums) and should be broadened to include: outpatient diagnostic service; nursing home care, home and office calls of doctors, dental care, and visiting nurse care. By a vote of 22 to 3, it was agreed that existing medical care for the totally indigent "is adequate; that it should be improved, expanded, and extended by taking maximum advantage of all provisions of all existing laws; that it is a joint responsibility of local, State, and Federal agencies to provide this care; that citizenship and residence requirement should be removed." The majority opinion favored social security financing of basic health care, agreeing, by a vote of 16 to 12, "that this work group go on record as supporting the use of the social security (OASDI) mechanism to finance basic hospital and related health care for the aged." The group agreed further (by a vote of 15 to 13) that State and local governments be urged to take all steps necessary to implement and take full advantage of the medical assistance for the aged program and the expanded old-age assistance program provided in the 1960 social security amendments.

Work group I–6

This work group started from agreement that health services should be comprehensive and that they should be available on a prepaid basis to all persons over 65. It concluded that the problems of medical care for older people are such that Government must participate in providing medical care for the aged. The members unanimously commended and urged the expansion of private voluntary health insurance plans and strongly recommended, in addition to any publicly financed health care programs and private voluntary health insurance, that:

1. Local communities support programs contributing to the health of older people, such as home care and meals on wheels;

2. Industry carry medical insurance for retired employees;

3. Family responsibility be maintained for its members in need of medical care; and

4. Individuals, to the extent possible, retain for themselves responsibility for their own health services.

In what it calls its "key action," the work group approved by a vote of 12 to 8 a motion which said in effect that the provision of adequate health service for older people was a very complex and difficult matter; therefore, each of the following methods should be used to provide medical care for older people as a right:

Voluntary prepayment health plans.

Plans based upon the principle (KERR-MILLS) of Federal grants-in-aid to States to provide health services to needly individuals.

A minimum health service plan financed through social security taxes.

The group reported a tie vote of 10 to 10 on the following motion: "It is better that Government intervention for purposes of providing health service for older people, implement to the fullest extent possible, the principle of a self-reliant contributory contract between the whole people and their Government through OASDI, than the principle of needs test relief to dependent individuals."

Work group I–7

Starting from general acceptance that the problem of medical care for a great proportion of the aging is a serious one, the work group reached unanimous agreement on the following five criteria which need to be satisfied in any program for medical care for the aged:

Must be beneficial to all aged who qualify for medical care as prescribed by any program.

Must permit each recipient to retain his dignity and self-respect as an individual.

Must permit each recipient to receive medical care as prescribed by the physician of his choice to prevent a third-party intervention in the doctor-patient relationship.

Must be possible to maintain without creating an unbearable financial burden on the working or retired populace or the Nation as a whole.

Must permit the opportunity for developing individual responsibility and self-reliance.

The group then unanimously agreed that no one of the three major approaches alone can handle the problems. In recognition of the existence of a difference of opinion within the work group as to the methods which appeared to have the greatest potential and on which major reliance should be placed, the members were polled. Those who favored the social security approach polled 11 votes; those who were for the voluntary approach (in its broadest sense) polled 10 votes.

In summary, then, these were the results of the work group deliberations as reported to the section chairman for his use in developing the policy statement. On the basic issue, six of the seven work groups had reported majorities favoring the use of the social security approach, with a total of 96 votes for and 77 against. The minorities in a number of the work groups had prepared minority statements which were reported along with the other essential conclusions of the work groups.

At the conclusion of the seven reports, Dean Schottland summarized his understanding of their essence to assure that the policy statement he would draft would correctly reflect the work groups' conclusions. His summary pointed to general agreement on the need for a more adequate program, and agreement that this would require a variety of approaches: (1) Promotion of voluntary methods, (2) development of a public assistance program for the indigent along the lines of the Kerr-Mills legislation, and (3) use of the social security mechanism. Both voluntary and governmental efforts were needed and, within government, a cooperative relationship of Federal, State, and local governments. The majority, he concluded his summary, favored the use of the social security mechanism.

STATEMENT OF POLICY—ADOPTED BY THE SECTION ON INCOME MAINTENANCE AND THE FINANCING OF HEALTH COSTS

The income security of older people is an important objective of American society.

The security of older people, like the security of all Americans depends upon a strong, sound and secure economy capable of providing a high level of goods and services. The first principle of a constructive approach to the income maintenance needs of the aged, therefore, is that the measures taken to promote old-age security be in harmony with broad economic objectives.

The second principle of a constructive approach to the income maintenance needs of the aged is that there should be opportunity for productive employment for those who are able and want to work. Employment is frequently more satisfactory for the individual than retirement on a pension, and such employment contributes to the economy and reduces the cost of pensions. We urge a reexamination of policies of compulsory retirement and also urge that industry and Government plan for both the full-time and part-time use of an increasing number of older persons.

Although there is agreement that, to the extent possible, the aged should have a chance to work, it is recognized that on the most optimistic assumptions the number of nonearners among the aged will not only remain very large—about 12 million of the 16 million persons now over 65 have no income from work—but will grow as the number of aged grows. Employment is largely out of the question for the very old, the severely disabled, and for many of the older women who spent their younger years as homemakers. Increasing opportunities for employment of the aged cannot, therefore, be a substitute for income maintenance programs for those who retire.

In providing income for the retired aged we believe that the pluralistic approach we have established in this country, with the individual saving on his own, the individual and his employer joining in private pension arrangements, and the individual and his Government joining in social insurance and assistance programs is the best approach.

Income protection for old age has been made available for practically all workers through social security, on terms which reinforce the interest of the individual in helping himself. Differential pensions based on a work record are a reward for productive effort, while the knowledge that the benefits will be paid irrespective of whether the individual is in need, supports his desire to add his personal savings to the basic security he has acquired through the social insurance system.

We believe also that the establishment and development of private pensions should be encouraged and that individuals should be encouraged to save on their own.

Our goal should be, insofar as possible, to prevent dependency. It is recognized, however, that there will continue to be persons whose needs are not met in any other way and will continue to need help through the public assistance program. This program, therefore, should be improved with the view of assuring all aged persons a reasonable minimum level of living under conditions which preserve their dignity and self-respect.

In summary, we favor improvement of job opportunities for those who can and want to work, development of private pension plans and individual savings building on top of the social insurance system, and, for those whose needs are not met through other methods, an adequate system of public assistance.

In furtherance of these general policies, we favor the following specific actions:

Old-age, survivors, and disability insurance

Old-age, survivors, and disability insurance, now covering 90 percent of all gainfully employed and protecting over 70 percent of the present aged group, should be extended to all who work. The level of benefits should be adjusted from time to time in the future as it has been in the past in order, at the very least, to maintain the purchasing power of the benefit. Beyond this, we believe that the aged should participate in increasing levels of living in the community and that when these increases take place benefits should be liberalized so that the retired aged, too, can participate in improved productivity. Also, as wages rise, the maximum limit on the amount of earnings that are taxable and creditable toward benefits should be reviewed. Benefits for widows should be increased to the same amount as benefits for retired workers. We believe that, by and large, the funds of the social security system should be reserved for those who have substantially retired and that the principle of a retirement test should be maintained, although some liberalization may be desirable from time to time.

Public assistance

Public assistance, under which income is provided for those among the aged—now some 2 million—whose needs exceed any income they have from social security or other sources, is an essential residual program.

The present arrangement of joint financing by Federal and State Governments is sound and should be continued. In many States, however, standards of assistance are below minimum needs. States should be encouraged, or if necessary required as a condition of Federal matching, to provide sufficient income for necessary food, clothing, shelter and other essentials (a motion to make this a requirement lost by a vote of 140 to 112). Many needy aged today do not receive income they need because of restrictive residence requirements. Such requirements are undesirable and should be abolished. The Congress should amend the Social Security Act to make women eligible for old-age assistance at the age of 62 (by a vote of 138 to 69). The Federal Government should participate financially in general assistance on the same basis as it does in other categories of public assistance.

Private pensions and individually provided retirement income and resources

The expansion and improvement of private pensions should be strongly encouraged since they can reflect directly in retirement incomes the growth and productivity of various segments of the economy. Tax incentives to encourage private savings for retirement and continuing pension plan development should be expanded. Vesting provisions constitute a desirable improvement. All persons should be encouraged to plan for their own retirement and to build on their own whatever retirement income they can to add to that available under social security and private pension programs.

Financing health care

The problem of furnishing an adequate level of high-quality health care for the aged is so large and so complex that its solution will require the use of a variety of approaches including individual and family resources, voluntary health insurance, industrial programs, social security, public assistance, and a variety of other programs.

Present Federal legislation providing governmental aid for recipients of public assistance and for the medically indigent is desirable and should be strengthened so as to provide a high-quality health care program. The States are urged to take full advantage of this legislation.

Voluntary health insurance for the aged should continue to be expanded. Industry should be encouraged to expand its health care programs and extend to retired persons the medical care protection afforded to current workers.

Private voluntary effort and public assistance can contribute much to the solution of the problem of health care for the aged. However, they will continue to fall short of meeting the basic medical care needs of the aged as a whole. The majority of the delegates of the section (by a vote of 170 to 99) believe that the social security mechanism should be the basic means of financing health care for the aged.

Establishment of a program of health benefits financed in the same way as OASDI cash benefits, would give to the aged the assurance that the costs of essential health care will be met when their working years are over. The mechanism of contributory social insurance, under which contributions are made by workers during their working years, will then provide health care to protect them in retirement. Such legislation would help to ease the problems of hospitals, public assistance programs, and private philanthropy and would relieve voluntary insurance programs of the burden of carrying this high risk group.

The minority believe that social security should not be used to finance health care; that such use would interfere with the physician-patient relationship; that it is unnecessary because of the potential growth of voluntary insurance; and that all needy aged can be cared for by public assistance through the recently enacted Federal program of health care for the low income aged. In addition they believe that the social security program should provide for cash benefits and not for services of various kinds. (See the minority report below.)

Collection and analysis of essential information

Provision should be made at all levels of Government to assure an adequate program to collect and analyze all essential information bearing on the income status and budgetary needs of aged persons.

Conclusion

The delegates feel that these principles, conclusions, and recommendations can form the basis of a sound program of income maintenance for the aged and that they would, if implemented, go far in assuring to America's senior citizens a more economically secure and therefore happier old age.

MINORITY REPORT: FINANCING OF HEALTH CARE

It is our conviction that emphasis on the voluntary approach to the financing of health care, supplemented by adequate public assistance for those in need is the only method which is—

1. In accord with official expressions of the majority of State conferences on aging.
2. The only one which allows complete flexibility of action to meet the changing health needs of the aged.
3. Capable of utilizing the immediate advantage of present legislation for a cooperative action of State and Federal Government.
4. The only one through which diverse segments of our society, including the individual, family, church, social organizations, employers both public and private, labor, and others can be encouraged to participate along with providers of health care.
5. The only one which does not unnecessarily further burden the taxpayer.

For these reasons, we believe that the Kerr-Mills medical aid for the aged law, passed by the last Congress, effectively meets the needs of those of the aged who need help and that proposed alternatives, under social security, are unnecessary and unwise.

SUPPORTING RECOMMENDATIONS—ADOPTED BY THE SECTION ON INCOME MAINTENANCE AND THE FINANCING OF HEALTH COSTS

Our aged population's share in expanding productivity

1. It is a basic assumption that the individual will assume primary responsibility for self-reliance in old age. In our society, there are many groups and institutions which have responsibility for the assurance of dignity and well-being in old age.

2. The most satisfactory protection for the aging is the continuance of gainful and productive employment, whenever possible. Additional opportunities should be developed in all areas of employment through both governmental and private initiative. Further studies should be initiated on methods of effective elimination of discrimination in hiring based on age.

3. Encouragement should be given to the development and distribution of education programs assisting all of or citizens in preparing themselves for the financing of the period of their retirement.

4. It is reasonable that older people who have contributed effectively to the enhancement of national productivity during their working lives should share in the advantages of a further enhancement of national productivity occuring during the period of their retirement.

5. That, so far as Government intervention is necessary to protect the increasing number of aged persons in our population, it is better that such intervention implement to the fullest extent possible the principle of a self-reliant contributory contract between the whole people and their Government, for example through OASDI, than the principle of needs-test relief to dependent individuals.

6. In an economy characterized by rising wages and salaries it is necessary to give periodic review to the maximum amount of earnings subject to contributions and credited toward benefits under OASDI, since this maximum determines the proportion of the covered payrolls available to finance the program and is a major factor in determining the extent to which the program pays benefits reasonably related to the past earnings of the individual.

7. The level of benefits under OASDI should be reexamined periodically in the light of changing economic conditions with appropriate recognition of the impacts of any change upon the economy.

8. Old-age assistance should be continued and its administration constantly improved as a residual method of protection when other methods have not proved sufficient to meet the specific needs of the individual aged person.

OASDI: Benefit levels, coverage, eligibility requirements, and the retirement test

1. It is recommended that the Conference express strong support of the OASDI system as being constructed along fundamentally sound and desirable lines, including the principles of financing through employer and employee contributions and providing a basic floor of protection to be supplemented by individual savings and private pensions.

2. It is recommended that Congress should continue its practice of periodically reviewing the system to insure that benefit levels and the soundness of the financing structure, including the earnings base, be adjusted in accordance with changing economic conditions, including changes in the wage level and living costs.

3. It is recommended that, on a transitional basis, all persons aged 65 and over at the present time who are not eligible for benefits under the OASDI system or any other Federal retirement system established by law, and who were employed (or whose spouse was employed) for a substantial period in an occupation that is now covered by the OASDI system shall be eligible for the minimum benefit payment under OASDI. The cost of financing these proposed benefit payments shall be accomplished in such a manner as not to weaken the financial soundness of the OASDI system.

4. It is recommended that the benefit formula for widows be revised from 75 to 100 percent of the deceased workers' primary benefit.

5. It is recommended that the coverage of the OASDI system be extended to all areas of employment and self-employment remaining excluded provided that Congress take some account of the prevailing view of the groups involved and of the reasons for the present exclusions. (A motion to delete this recommendation was defeated by 86 to 72.)

6. It is recommended that when increases in benefits are adopted, the present minimum benefit of $33 a month should be increased to a greater proportionate extent than benefits generally.

7. It is recommended that, since some people are eligible for benefits from both OASDI and one or more other Government retirement and disability systems, Congress should provide for a study designed to determine the feasibility of coordinating OASDI and other governmental benefit systems.

8. It is recommended that careful consideration should be given to the experience which develops under the new retirement test of the Social Security Act. If, as a result of this experience, it appears that further changes along the lines of the 1960 revision are desirable, such changes should be made, with appropriate financing changes to keep the OASDI program on a financially sound basis.

Public assistance for the aging [1]

It is proposed that assistance to needy aged people should continue as a Federal-State partnership. After 25 years of operation under the Social Security Act, too many OAA recipients are receiving too little assistance to insure a minimum standard of health and decency. To remedy this defect and to come closer to achievement of a decent healthful life and a maximum degree of dignity for public assistance recipients, the following recommendations are made:

Standards of assistance

1. That the Federal Government continue to provide leadership to the States in developing and adopting adequate and proper standards for the amount of assistance and, for the purpose of assisting the States to achieve such standards, additional Federal matching funds be made available.

2. That the Federal Government maintain recommended standards of minimum living costs for persons in different age brackets geared to the costs, needs, and habits of various areas for use as standards for Federal evaluation of all income maintenance programs.

3. That Congress amend the Social Security Act to allow States, on a permissive basis, to establish a $50 monthly earned income deduction for each applicant for or recipient of old-age assistance.

4. That Congress amend the Social Security Act to provide for Federal participation in general assistance.

Relatives' responsibility

5. That State provisions on relatives' responsibility in public assistance be equitable, practical, and designed to contribute to strengthen family life. The contribution re-

[1] See minority statement on citizenship requirements following those recommendations.

quired of the family should not be deducted from the assistance payment unless the relative actually pays it. If the relative does not pay, it should be the responsibility of the State to secure the payment.

Residence requirements

6. That the ultimate goal be the elimination of all residence requirements.

7. That the immediate goal be a reduction in maximum residence requirements to a period of 1 year and with the provision that for those applicants who do not meet such a year's residence requirement, 100 percent Federal funds be available to meet the costs of needed assistance.

8. That the formula for Federal participation in the cost of OAA and related services shall include a factor to offset increased costs beyond 1 year in those States experiencing an immigration of persons over 50 years of age which exceeds the immigration of younger age groups.

Personnel in public assistance

9. That the Congress make permanent the present authorization in the Social Security Act providing for the training of public assistance personnel and that the Federal Government pay 100 percent of the costs of such training in accord with the practice followed in other federally assisted programs.

10. That Congress make available funds to educational institutions and to States for the support of training programs.

Social services for the aged

11. That Federal matching funds be made available to State welfare departments to meet costs to develop, secure, or operate consultative, protective, and rehabilitative programs for the aged. These programs should not be limited to assistance recipients.

12. That to provide for effective casework services, Federal matching funds for administration be on the same variable basis as the assistance costs with a minimum of 50 percent Federal financial participation in such costs.

Relationship between OAA and OASDI

13. That OASDI represent the basic income maintenance program, with OAA representing a supplementary income maintenance program for those not eligible for OASDI and for those with special needs which bring their total needs to more than OASDI benefit. To further this recommendation, it is recommended that OASDI benefits be increased in accord with increases in costs of living.

Eligibility age for women

14. That the Congress amend the Social Security Act to make women eligible for old-age assistance at the age of 62.

Minority statement on citizenship requirements for public assistance

The restrictions against aliens, noncitizens, who are not now eligible for public assistance in certain States, should be removed by Federal law.

We bring aliens into many States to work. They have traditionally made, and continue to make great contributions to the American economy.

It is inconsistent with American public, democratic social policy to exclude these people from public assistance benefits.

Financing of health care for the aged

1. It is agreed that adequate health services should be available to all aged persons irrespective of ability to pay.

2. It is further agreed that the problem of financing an adequate level of high quality health care for the aged is so large and so complex that it will require for solution the utilization of voluntary health insurance, of individual and family effort and resources, and the resources and instrumentalities of local, State, and Federal Governments.

3. It is the recommendation of the majority that to assure adequate health care for the aged with certainty and dignity, there should be established a basic program for financing health care for the aged within the framework of the old-age, survivors, and disability insurance system.

4. A minority oppose the use of the OASDI method.

5. Both those who place major reliance on the social security mechanism and the others agree that—

a. The medical assistance for the aged program adopted by the 86th Congress should be promptly implemented by the States.

b. Voluntary prepayment methods should be used to their full potential.

c. In all programs, the individual's freedom, dignity and self-respect should be protected.

d. Individual responsibility, self-reliance and thrift in preparing for later years should be encouraged.

(The vote of the section was 170 ayes and 99 noes.)

Private retirement income

1. Vesting is the right of an employee to deferred retirement benefits from his employer's contributions, as well as his own, even though his employment under coverage of a pension plan terminates before retirement. Vesting gives the employee greater security and permits the useful mobility of labor. We recognize that if vesting is made compulsory through enactment of legislation, the growth and development of pensions for more and more employees may be retarded. We therefore recommend that the inclusion of vesting provisions in pension plans should be strongly encouraged as a voluntary action.

2. The Social Security Administration should study the feasibility of noting on a worker's account record that he has a vested pension right based on previous employment, so that upon retirement he may be reminded of all his accrued pension rights. This suggestion is for voluntary reporting by private pension plans and would not involve financing or supervision.

3. Private pension plans should be encouraged by appropriate policies which recognize that such saving for old age is in the public interest.

4. To encourage pension programs, the income should be taxed when received as a pension, not when the moneys are set aside.

5. The Congress should be requested to provide by legislation the same tax determinant for self-employed persons, with respect to earned personal income set aside for personal pensions, now provided for employees who are participants in tax-qualified pension and retirement plans.

6. The income allowed as a tax credit for Federal income purposes on retirement income—now $1,200—should be increased.

7. For aged persons whose medical expenses are large in relation to their income, Federal and State income tax laws should allow a carryover to succeeding tax years of a deduction of that portion of medical expenses of the limit allowable for the year in which they are incurred.

Measuring resources and income needs

More statistical information is needed for assessing the income position and resources of the aged population.

To carry out these objectives, we recommend the following:

1. That budgets and indexes for elderly people be developed. Cooperation and coordination among Federal, State, and local agencies is essential. The appropriate Federal Government agency should have the responsibility for organizing and carrying out the studies, data collections and preparation of the budgets and indexes. In the event that State or local bodies fail to cooperate in initiating or carrying out their responsibilities, the Federal Government must. Appropriations to finance this work are recommended.

2. That an advisory committee be established to assist Government agencies in the development of the concepts of budgets for the elderly.

3. That a consumer price index for the elderly be established. Once established, continuing research and study should be carried out to evaluate the need for continuing and/or revising the index.

4. That special emphasis be given to making available in summary form statistics relating to income and other resources of aged persons, defined by age levels, sex, family, structure, race, and other important variables.

5. That the State and Federal Governments cooperate in making available in summary form statistical data derived from the experience of individual States on such programs as medical care and housing for the aged, and the effects of such programs on the budgets of elderly persons.

6. That implementation of the suggested programs for the development of better measures of the resources and income needs of the aged must in no way interfere with the full continuation of programs to improve the economic and social status of the elderly.

7. That a clearinghouse be established at the Federal level for the collection and dissemination of data on the aged from Federal, State, and local groups, both public and private, on an annual, continuing basis.

SECTION 2. PROGRAM PARTICIPANTS

Section chairman: Charles I. Schottland, dean of the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University.

Technical director: Dorothy McCamman.

Section recorder: Arthur L. Crookham, retired newspaper editor, Oregon.

Recommendations committee: Eveline M. Burns, professor of social work, the New York School of Social Work at Columbia University; J. Douglas Colman, president, Associated Hospital Service of New York; Fedele F. Fauri, dean, School of Social Work, the University of Michigan; Margaret S. Gordon, associate director, Institute of Industrial Relations, University of California; Orville F. Grahame, vice president and general counsel, the Paul Revere Life Insurance Co., Massachusetts; William C. Greenough, president, Teachers Insurance and Annuity Association and College Retirement Equities Fund, New York; H. Harold Leavey, vice president and general counsel, California-Western States Life Insurance Co., California; Norman V. Lourie, deputy secretary, Department of Public Welfare, Pennsylvania; Charles E. Odell, director, Older and Retired Workers Department, United Auto Workers, AFL–CIO, Michigan; Stanley Ruttenberg, director, AFL–CIO Department of Research, Washington, D.C.; Herman M. Somers, chairman, Political Science Department, Haverford College, Pennsylvania.

The work group leadership

Work group: "Our Aged Population's Share in Expanding Productivity: How Much and Through What Methods?"

Chairman: H. Bruce Palmer, president, the Mutual Benefit Life Insurance Co., New Jersey.

Discussion leader: J. Douglas Brown, dean of the faculty, Princeton University, New Jersey.

Recorder: Helen Fisher Hohman, lecturer, Department of Home Economics, Northwestern University, Illinois.

Resource: Gordon W. McKinley, executive director of economic and investment research, the Prudential Insurance Co. of America, New Jersey.

Robert M. Ball, Deputy Director, Bureau of Old-Age and Survivors Insurance, Social Security Administration, Department of Health, Education, and Welfare.

OASDI: Benefit levels, coverage, eligibility requirements, and the retirement test

Work Group

Chairman: Orville F. Grahame, vice president and general counsel, the Paul Revere Life Insurance Co., Massachusetts.

Discussion leader: William H. Wandel, director of research, Nationwide Insurance, Ohio.

Recorder: Benjamin B. Kendrick, assistant director of research, Life Insurance Association of America, New York.

Resource: Wilbur J. Cohen, professor of public welfare administration, School of Social Work, the University of Michigan.

Elizabeth G. Sanders, program planning branch chief, Division of Program Analysis, Bureau of Old-Age and Survivors Insurance, Social Security Administration, Department of Health, Education, and Welfare.

Work Group

Chairman: Karl T. Schlotterbeck, director, economic security program, Chamber of Commerce of the United States, Washington, D.C.

Discussion leader: E. B. Schultz, coordinator of retirement policies study, Cornell University.

Recorder: James Brindle, director, Social Security Department, United Auto Workers, AFL–CIO, Michigan.

Resource: Margaret S. Gordon, associate director, Institute of Industrial Relations, University of California.

Robert J. Myers, chief actuary, Social Security Administration, Department of Health, Education, and Welfare.

Public assistance for the aging

Work Group

Chairman: Raymond M. Hilliard, director, Cook County Department of Public Aid, Illinois.

Discussion leader: Milton Chernin, dean, School of Social Welfare, University of California.

Recorder: Rev. Robert A. Ford, director, Family Service Division, Catholic Charities of the Archdiocese of New York.

Resource: J. M. Wedemeyer, director, State Department of Social Welfare, California.

Dorothy West, Operating Statistics Branch Chief, Bureau of Public Assistance, Social Security Administration, Department of Health, Education, and Welfare.

Work Group

Chairman: Ronald H. Born, director, San Francisco Public Welfare Department, California.

Discussion leader: Norman V. Lourie, deputy secretary, Department of Public Welfare, Pennsylvania.

Recorder: Ruth B. Flanagan, executive secretary, Duval County Welfare Department, Florida.

Resource: Ralph Atkins, director of public assistance, Public Welfare Board of North Dakota; Cornelia M. Dunphy, principal assistance standards specialist, Bureau of Public Assistance, Department of Health, Education, and Welfare.

Financing medical costs

Work Group

Chairman: Rev. John R. Anschutz, Christ Episcopal Church, Washington, D.C.

Discussion leader: Fedele F. Fauri, dean, School of Social Work, the University of Michigan.

Recorder: Ludwig Jaffe, director of research and education, New York State AFL–CIO.

Resource: Herman M. Somers, chairman, Political Science Department, Haverford College, Pennsylvania; Ida C. Merriam, director, Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare.

Work Group

Chairman: Charles E. Odell, director, Older and Retired Workers Department, United Auto Workers, AFL–CIO, Michigan.

Discussion leader: Wayne Vasey, dean, Graduate School of Social Work, Rutgers University, New Jersey.

Recorder: H. Harold Leavey, vice president and general counsel, California-Western States Life Insurance Co., California.

Resource: Herbert Notkin, M.D., medical director, Onondaga Department of Public Welfare, New York; Charles E. Hawkins, Legislative Reference Officer, Social Security Administration, Department of Health, Education, and Welfare.

Work Group

Chairman: Walter U. Kennedy, M.D., surgeon and president of Henry County Welfare Board, Indiana.

Discussion leader: I. Jack Fasteau, professor of public administration and social work, Graduate School of Public Administration, New York University.

Recorder: Hyman Bookbinder, legislative representative, AFL–CIO, Washington, D.C.

Resource: Barbara N. Armstrong, professor of law emeritus, University of California; Ellen Perkins, Assistant Chief, Division of Program Statistics and Analysis, Bureau of Public Assistance, Department of Health, Education, and Welfare.

Work Group

Chairman: J. Douglas Colman, president, Associated Hospital Service of New York.

Discussion leader: Alton E. Linford, dean, School of Social Service Administration, University of Chicago, Illinois.

Recorder: Irwin E. Klass, director of information and public relations, Chicago Federation of Labor, Illinois.

Resource: Mathilda Scheuer, R.N., president, American Nurses' Association, New York; S. David Pomrinse, M.D., M.P.H., Chief, Health Professions Branch, Division of Public Health Methods, Public Health Service, Department of Health, Education, and Welfare.

Work Group

Chairman: Raymond W. Houston, commissioner, New York State Department of Social Welfare.

Discussion leader: Vernon R. Burt, chairman, Governor's Commission on Aging, Ohio.

Recorder: M. S. Robertson, retired professor and associate director of research, College of Education, Louisiana State University.

Resource: Katherine Ellickson, assistant director, department of social security of AFL–CIO, Washington, D.C.; James C. Callison, program analyst, Social Security Administration, Department of Health, Education, and Welfare.

Work Group

Chairman: Walter F. Foody, Jr., vice president, Continental Casualty Insurance Co., Illinois.

Discussion leader: John W. McConnell, dean, New York State School of Industrial and Labor Relations, Cornell University.

Recorder: John F. Pletz, chief, Bureau of Standards and Procedures, Division of Welfare, State Department of Public Health and Welfare, Missouri.

Resource: John Tamayko, director, pension and insurance department, United Steelworkers of America, Pennsylvania; Milton Forster, Director of Reports and Statistics, Veterans' Administration.

Work Group

Chairman: Judge George Schwolsky, member of Connecticut Commission on Services for Elderly Persons.

Discussion leader: Eveline M. Burns, professor of social work, the New York School of Social Work of Columbia University.

Recorder: Kenneth E. Pohlmann, rehabilitation consultant, UMWA Welfare and Retirement Fund, Washington, D.C.

Resource: J. F. Follmann, Jr., director of information and research, Health Insurance Association of America, New York; Agnes W. Brewster, medical economist, Division of Public Health Methods, Public Health Service, Department of Health, Education, and Welfare.

Work group: Private pensions and individually provided retirement income and resources

Chairman: William C. Greenough, president, Teachers Insurance & Annuity Association and College Retirement Equities Fund, New York.

Discussion leader: Robert S. Lane, manager, employee benefits, Socony Mobil Oil Co., Inc., New York.

Recorder: Ted F. Silvey, research associate, Research Department, AFL–CIO.

Resource: Robert Tilove, senior vice president, Martin E. Segal & Co., Inc., New York; Edmund M. Daggit, economist, Debt Analysis Staff, Office of the Secretary, Department of Treasury.

Work group: Measuring resources and income needs of aged persons

Chairman: Paul L. Winsor, commissioner, Department of Health and Welfare, Alaska.

Discussion leader: Sidney Goldstein, professor of sociology, Brown University, Rhode Island.

Recorder: Moses Gozonsky, economist, United Steelworkers of America, Washington, D.C.

Resource: Stanley Ruttenberg, director, Department of Research, AFL–CIO, Washington, D.C.; Helen Lamale, Consumption Studies Branch Chief, Bureau of Labor Statistics, Department of Labor.

Mr. JAVITS. Mr. President, I shall have an opportunity to address myself to the debate in due course when the appropriate point is reached. However, there are two points in which Senators may be interested in respect to the debate upon which we shall enter in a definitive way in a short time.

The two points which have been made to induce Senators to vote for the sudden death motion to table are, first, that there have been no adequate hearings on the question of health care for the aged and, second, that this is a most unusual procedure in which the Senate is being asked to attach a very major measure to another major measure by way of amendment.

On the first point, which is the subject of hearings, I should like to refer specifically to the fact that the hearings which have been held on the question of medical care for the aged, and concerning the precise methods of financing and techniques which will be discussed in the debate, and have been discussed for some days now, are the following principal hearings:

First. Hearings on H.R. 4700, the Forand bill, July 13 to 17, 1959, before the House Committee on Ways and Means.

Second. Hearings before the Committee on Finance of the Senate on the Social Security Amendments of 1960, H.R. 12580, June 29 and 30, 1960.

Third. Hearings on H.R. 4222, health service for the aged under the social security system, before the Committee on Ways and Means of the other body, July 24 to August 4, 1961.

There was a series of hearings, and there were individual State reports, to the Special Committee on the Aging, headed by the distinguished Senator from Michigan [Mr. McNamara], which took place in 1960 and 1961, and up to 1962.

Finally, there was a report of the performance of the States in 18 months of experience with the Kerr-Mills program on June 15, 1962. All those hearings are available. Obviously, Senators cannot read all of them, but certainly the physical evidence itself is formidable, and is before the Senate.

On the other subject, concerning our right to attach a major measure to another major measure, and the considered precedents, let me point out that such action has been taken on many occasions in connection with some very significant and important questions. For example, in 1937 we attached the Tydings Resale Price Maintenance Act, which amended the antitrust laws, as a Senate rider on a House bill, a very important measure of Federal law.

In 1925 we put a Senate rider creating the initial Federal Corrupt Practices Act on a House bill.

We did the very same thing with a number of civil rights amendments, including the continuance of the U.S. Civil Rights Commission.

We did the same thing in 1958 with a postal pay increase bill, which was placed as a Senate rider on a House bill.

We did the same thing in 1933 with the Buy America Act, which was placed as a Senate rider on the Treasury Department appropriation bill.

We did the same thing in 1912 to repeal a reciprocity act with Canada.

But what is even more pertinent is the fact that only a few days ago, during the controversy over proposed sugar legislation, no Senator protested or argued that it was improper to select a bill related to honey bees and amend it with a very important provision of the whole sugar legislation program.

I therefore submit, on the basis of longstanding precedents which are considered, that we have previously attached major legislation to House bills when we thought it was desirable to do so, and we shall do likewise in the future. The present situation certainly commends it; and the only Senators who will complain will be those who are against the measure.

So I now make the point, which I hope to make again before the debate is concluded, that no one has any idea that the country will look at the vote as other than a vote on the merits. The vote will be sudden death or it will be life for the measure which promises some health care for our aging citizens. No vote can be disguised in this regard upon procedural or technical grounds, whether it be with relation to hearings or with relation to attaching a major measure as an amendment to a House bill.

Mr. COOPER. Mr. President, will the Senator yield?

Mr. JAVITS. I yield.

Mr. COOPER. While the example I am about to cite may not be on all fours, is it not also correct that in 1957 the Senate considered and passed the Civil Rights Act of 1957 without referring the measure to a committee?

Mr. JAVITS. The Senator is exactly correct; and that fact should be a part of the record.

The PRESIDING OFFICER. The time of the Senator from New York has expired.

Mr. COOPER. Mr. President, on June 29, at the time the Anderson-Javits amendment was introduced, I spoke briefly, giving my reasons for supporting and cosponsoring the health insurance plan which the amendment provides.

Since that time many Members of the Senate have spoken for the amendment and against the amendment, and the arguments on both sides have been developed ably.

In the short time that is available to me today, I do not intend to repeat the great volume of necessary statistical information which has been adduced in a comprehensive fashion by the Senator from New Mexico [Mr. Anderson], the Senator from New York [Mr. Javits], the Senator from California [Mr. Kuchel], and others who support the amendment, as well as by those who oppose our amendment. But this information has developed facts about the status of medical care for those over 65 years of age which we in the Congress must recognize.

First, I think it is clear that there are millions of people over 65 years of age who, because of their financial circumstances, cannot secure the extent of hospital and other medical care which is available to those more fortunate. Today, there are 17.5 million people over 65 years of age; by 1970, there will be 20 million; and by 1980, 25 million. It is estimated that 1 out of 6 of this group will be hospitalized every year, and 9 out of 10 during their lifetime. Over 75 percent of these persons have a cash income of less than $2,000 per year. These figures prove the truth that there are millions among those now over 65 years of age, and millions who will reach 65 in the years to come, who will not be able to bear the immense expenses of hospitalization.

The second fact developed in this debate is that there is no method, other than social security insurance, which can provide, even on a minimum basis, for the hospital expenses that millions of persons over 65 years of age must bear.

Many in the medical profession oppose this bill, and I am sure with sincerity. But humane and noble as their efforts have been to provide care for those who are unable to pay, it is, of course, clear that the medical profession cannot pay the hospital costs of millions of our citizens.

Private insurance plans have done much to provide protection for older persons. But as the Senator from New Mexico [Mr. Anderson] pointed out yesterday, private health insurance for the aged generally requires higher premiums and restricted benefits for aged persons, and places higher costs upon insurance companies. He pointed out that in recent years Blue Cross has been paying out $375 million in benefits a year for the elderly, while collecting only $200 million from them. And many private insurance policies can be canceled by the company, leaving older persons uninsured, and without hope for the future.

The third fact which I think clear, is that the Congress will not adopt a comprehensive system providing adequate medical care financed by general revenues.

In 1960, the Senator from New York [Mr. Javits] introduced such a bill, which I cosponsored with others to be financed from general revenues and designed to meet the objections of the medical profession and the insurance companies. We offered it as a substitute for the Kennedy-Anderson social security bill, but it was defeated in the Senate by a vote of 67 to 28. As far as I know we had little support from the medical profession, even though the bill was of a voluntary nature.

I ask unanimous consent that I may continue for an additional 5 minutes.

The PRESIDING OFFICER. Is there objection? The Chair hears none, and the Senator may proceed.

Mr. COOPER. Mr. President, in the last 2 weeks two medical care plans, to be financed by general tax revenues, have been submitted to the Senate—and have been overwhelmingly defeated.

In 1954 President Eisenhower submitted a bill to the Congress providing for a program of limited Federal reinsurance of private health plans. I was a member of the Senate Committee on Labor and Public Welfare at the time, and while it seemed to some of us that the Eisenhower plan had large possibilities, it did not have the support of either the insurance companies or the medical profession. It was never called up in the Senate for a vote, and in the House it was recommitted on July 13, 1954, by a vote of 238 to 134.

These efforts, all rejected by the Congress, lead to the conclusion that the Congress, the medical profession, insurance companies, and the general public will not support medical care bills which would require the annual appropriation of sums reaching into billions of dollars. And yet, without such appropriations, there is no legislative method of providing even minimum care through a non-social-security approach.

It may be said that the Kerr-Mills Act provides such care. It is financed out of general revenues; it provides for Federal grants to the States, to be supplemented by State funds, to be used for the medical care of individuals 65 years of age or over. It does, in theory at least, provide complete health services for its beneficiaries, including the payment of initial costs, doctors' fees, and medicine and drugs. It has value, which I do not derogate. But it also has its limitations. Poor States are unable to provide the funds needed, even if they are willing to do so. In practice, the States have provided a means test; consequently, its assistance is available only to persons in the lowest income scale, and in fact to those who are classified as indigents. The medical profession and many others applaud this limiting provision, but it is a fact that the increasing cost of hos-

pital care can be as catastrophic for those who do not meet the means test.

Funds to finance the Anderson-Javits plan, which I support, will be provided by a tax of one-fourth of 1 percent on earnings up to $5,200 a year of the approximately 76 million workers who pay into the fund, and a like amount by employers. The plan will place no charge upon general revenues, other than the estimated $250 million needed to temporarily finance benefits for some 2.5 million persons over age 65 not covered by social security. It will give assurance to these workers that minimum health care will be available to them when they become 65. It will mean that they will not have to find themselves sick and broke before knowing whether help will be available.

I am aware of the objections made to the Anderson-Javits amendment, which I cosponsor. It has been said that workers and employers paying into the social security fund will be required to pay for benefits which may accrue to persons who are over age 65 at the time the bill becomes effective January 1, 1964, and who will not have paid into the fund for health care. This is correct. In answer, I say that I do not believe Congress would pass any measure, whether financed by a social security tax or by general revenues, which would leave out of its coverage the millions of persons who have reached age 65 at the time that the bill would become effective. If the Anderson-Javitz amendment becomes law, it will provide benefits for those who have reached the age of 65, whether or not they have contributed to the social security system. But it will also provide the assurance of hospital, nursing home, and home care for mililons who now and in future years will contribute to the social security fund.

The medical profession as a whole makes the charge that the Anderson-Javits amendment, or any bill based upon the social security system, would now or ultimately interfere with the free process of medical care, and make of them Federal doctors. Our amendment does not provide for fees to doctors. The Kerr-Mills Act, which receives the support of the medical profession, provides for payments to doctors. It seems to me that Kerr-Mills would be more likely to make of them Federal doctors than the Anderson-Javits amendment.

The objections made to the Anderson-Javits amendment derive basically from opposition to a medical care plan financed through the social security system upon the grounds that such a measure is compulsory and socialistic.

I do not question the sincerity of those in the Congress who take this position. But I say that these same arguments have been and can be applied to the social security system, which has been effective since 1937. Its purpose is to provide cash benefits to persons reaching the age of retirement, to help them meet their minimum needs for food, clothing, and housing. I consider health care as being similarly a basic need. Who can argue that health care for persons over 65 who are sick, injured, or desperately ill is less important to them than the provision of cash benefits to others for food, clothing, and housing?

It is argued also that the social security approach will enable the rich and well-to-do to enjoy its benefits. Facts have been placed in the RECORD to show that only one-half of 1 percent of persons over 65 have an income exceeding $50,000; 96.5 percent have incomes less than $10,000 annually, and 75 percent of all persons over 65 have a cash income less than $2,000 per year. The Anderson-Javits amendment insures that all those who contribute to its financing shall have the same equality of treatment for health care insurance benefits, as is now provided to those who receive cash benefits under the social security system.

We can argue statistics at length. But whatever may be one's position on this amendment, it cannot be controverted that there are millions of people over 65 years of age in this country, and there will be millions of people over 65 in the years to come, who will not have the financial resources to secure as extensive hospital care as millions of their more fortunate fellow citizens.

I do not need any statistics to know this is true. In my experience as a local official in my own State, in my experience as a Member of the Senate traveling throughout my State, from my own knowledge of the plight of dozens of families that I have known, I know this to be true. I have been in their homes and have seen these people. I have been in the hospitals and know that those with meager resources are often the first to be moved from the hospital to their homes, while those who are able to pay can remain longer.

We are dealing with a human problem. Can a great country like ours—the wealthiest in the world, the country with the greatest medical facilities, the greatest program of medical research, a country possessing great doctors and nurses, a country which provides the most complete and painstaking care for those who are able to pay—can this country delay longer in taking steps to provide a minimum of hospital care for millions who are unable to do so?

Like many others in this body, I have been concerned about the proper method of providing this care. But I have made up my mind that I will vote now to assure at the very least a minimum of hospital, nursing and home care for millions of people over 65 years of age who may be stricken by disease and suffering. I would not want to leave the Senate without having voted for legislation to provide assurance of some health care—limited as it may be—to these millions of people. I see no way of doing this without the passage of this bill.

I shall vote against the motion to table. I sincerely hope the motion will be defeated and that the Anderson-Javits amendment will be adopted.

Mr. HUMPHREY. I wish to commend the Senator from Kentucky on his very moving, cogent, and pertinent remarks in relation to the health care plan which is now before the Senate. I also wish to commend the Senator from New York on his remarks. He has given us a good deal of legislative history of the hearings and other matters relating to this type of legislation. I shall speak later on the pending motion.

Mr. JAVITS. I did not wish to interrupt the Senator from Kentucky, because he had so little time. However, I wish to join the Senator from Minnesota in commending the Senator from Kentucky for his contribution to the discussion of this subject. Between how many stools must the aged fall before we do something about this problem?

Mr. HUMPHREY. I surely wish to commend the Senator on his remarks.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

AMERICA'S AGED CITIZENS DUE MEDICAL CARE

Mr. YARBOROUGH. Mr. President, generally, the older people get, the less they are able to earn. The older people

get, the more often they need hospital and medical care.

Therefore, with each passing year, an aging person faces mounting health problems with a thinner purse, and with each passing year, the cost of medical care goes up, up, and up.

So nearly everybody over 65 who does not have a lot of money is faced with this frightening prospect:

That the restoration of a degree of health—that life itself—may become a luxury he cannot afford.

This is the great American tragedy, and the Democratic administration has been charged in an election-day mandate to do something about it. Yet the scavengers of time—all the ailments that come with increasing age—are bipartisan in nature. There is nothing Republican or Democratic about a weakening heart, fading vision, the loss of hearing, or pains that wrack aging bones. Nor should there be anything partisan about the steps we take to safeguard our aged citizens.

In this country about 17 million people are over the age of 65, some 700,000 of them in my State of Texas. Among them are many whose hands, hearts, and minds helped to bring this country forward to a state of prosperity in which they are now forbidden by circumstances to share equally.

I am not talking about 17 million digits in a Government census book, but about fathers and mothers and grandparents who need our help, even though some are too feeble to ask for it and are drowned out by the concerted shouting of those who oppose humanitarian legislation. I am talking about the aged Americans whose children cannot carry the burden of ever-increasing medical care for the aged alone. By 1980 the number of Americans over 65 may reach 26 millions.

Back in 1854 Abraham Lincoln wrote that the legitimate object of government is to do for the people what they need to have done but cannot do for themselves as individuals. I subscribe to this view.

Medical care for the aged is a legitimate object of government by any humane standard of reasoning.

The program now under discussion for the medical care for the aged, would provide a means to pay for hospital and outpatient care and nursing home services. It does not pay doctors, nor would it affect the free choice of a doctor. The doctor-patient relationship is not affected, except to this extent: As a patient is better able to meet his hospital bills through a pay-as-you-go social security system, not requiring the outlay of meager cash resources, he is then better able to pay his doctor.

Mr. President, this is not an antidoctor bill. The bill would enable patients to pay the fees of doctors of their free choice.

It is my belief that a program of pay-as-you-go social security insurance to provide the aged with a means to help themselves will benefit the aged with a means to help themselves will benefit the patient, the hospital—faced with climbing costs of equipment and facilities—and the doctor, who already spends much time treating patients unable to pay.

This whole subject was covered in the 1960 platform of the Democratic Party. I read into the RECORD a part of item No. 6 from the 1960 platform, under the caption "Health."

6. "The right to adequate medical care and the opportunity to achieve and enjoy good health."

Illness is expensive. Many Americans have neither incomes nor insurance protection to enable them to pay for modern health care. The problem is particularly acute with our older citizens, among whom serious illness strikes most often.

We shall provide medical care benefits for the aged as part of the time-tested social security insurance system. We reject any proposal which would require such citizens to submit to the indignity of a means test—a pauper's oath.

For young and old alike, we need more medical schools, more hospitals, more research laboratories to speed the final conquest of major killers.

Medical care for older persons—60 million Americans—more than a third of our people—have no insurance protection against the high cost of illness. For the rest, private health insurance pays, on the average, only about one-third of the cost of medical care.

The problem is particularly acute among the 16 million Americans over 65 years old, disabled workers, widows, and orphans.

The Republican administration refused to acknowledge any national responsibility for health care for elder citizens until forced to do so by an increasingly outraged demand. Then their belated proposal was a cynical sham built around a degrading test based on means or income—a pauper's oath.

The most practicable way to provide health protection for older people is to use the contributory machinery of the social security system for insurance covering hospital bills and other high-cost medical services. For those relatively few of our older people who have never been eligible for social security coverage we shall provide corresponding benefits by appropriations from the general revenue.

In this respect the Democratic Party platform unites with every humanitarian consideration, with the instincts of the American people for caring for the aged, and with sound economics, to impel the vote for the Anderson amendment for the medical care of the aged. Now is the time for action. I intend to vote for action.

REBUTTAL TO SENATOR ANDERSON'S MISLEADING CHARGES

Mr. BENNETT. Mr. President, the junior Senator from New Mexico [Mr. ANDERSON] on last Friday, July 13, beginning at page 12674 of the CONGRESSIONAL RECORD, called upon me to point out when the Senate Finance Committee conducted hearings on the Forand bill. He said: "I do not recall any hearings on the Forand bill." Mr. President, I am willing to produce evidence that hearings were held on Forand-type legislation. If the junior Senator from New Mexico will obtain from the committee staff a copy of the hearings on H.R. 12580, he will find that the Senate Finance Committee, on July 29 and 30, 1960, held public hearings. During these hearings Forand-type legislation was discussed by several witnesses. One such example was the testimony of Nelson Cruikshank, director, Department of Social Security, AFL–CIO. In fact, in the middle of page 234 the following words can be found:

FORAND-KING-ANDERSON BILLS IDENTICAL IN PURPOSE

No, sir, it does not; because what we are really proposing is that a Forand-type amendment, if you wish to call it that, be added to the provisions of—

The junior Senator from New Mexico again challenged me to explain another portion of my remarks during the Senate debate last week. I had stated that the junior Senator from New Mexico and the then junior Senator from Massachusetts, John F. Kennedy, in 1960 sponsored to H.R. 12580 an amendment of the Forand-bill type, which was defeated. This is a fact; and the junior Senator from New Mexico certainly cannot deny that he voted for the amendment, which was defeated by a vote of 51 to 44. The amendment involved was almost identical with the Forand bill. It, too, was proposed to be financed by social security at the same rate of increased tax, and had virtually the same benefits as the old Forand bill.

The junior Senator from New Mexico again challenged my statement regarding the 10–to–7 vote in the Senate Finance Committee in January of this year. However, the Senator now describes as misleading my statement regarding the motion before the Senate committee, which was defeated. Regardless of how the junior Senator from New Mexico chooses to interpret the motion, the effect of the motion, had it passed, would have been to call for Senate Finance Committee hearings at a time when the House Committee on Ways and Means had not acted in this area. I choose to follow the Constitution of the United States, which guarantees to the House of Representatives the authority to originate revenue-raising legislation.

KNOWLAND AMENDMENT NO PRECEDENT FOR ANDERSON PROPOSAL

Mr. President, on July 13, at page 12675 of the CONGRESSIONAL RECORD, the junior Senator from New Mexico [Mr. ANDERSON] called attention to an amendment to H.R. 6000 offered in 1950 by Senator Knowland of California; and the Senator from New Mexico claimed that that amendment established a precedent for approving the present Anderson amendment which has been offered to H.R. 10606.

In speaking of the Knowland amendment, the Senator from New Mexico stated that it was "a very far reaching amendment to the social security bill, H.R. 6000." However, in checking, Mr. President, I find that the amendment involved only two short paragraphs. This is a far cry from the comprehensive 77-page Anderson amendment, plus the Javits amendment and the other amendments which have been offered to the Anderson proposal.

Also it should be pointed out that Senator Knowland's amendment was offered only after an urgent request for its enactment had been received from the Interstate Conference of Unemployment Compensation Administrators.

The purpose of the amendment was to prevent abuse of authority vested in the Secretary of Labor to withhold grants and impose penalties on the States for nonconformity with Federal administrative decisions involving the unemployment compensation law. The Knowland amendment had widespread support throughout the United States, and was approved by the Senate by a vote of 45 to 37.

At this point in history, I do not wish to debate the merits of H.R. 6000 of the 81st Congress with the junior Senator from New Mexico. However, in keeping with his claim that Senator Knowland's amendment in 1950 should be regarded as a precedent, I should like to call attention to the fact that the junior Senator from New Mexico voted against the Knowland amendment. If he follows the precedent which he has cited, then to be consistent, it would seem to me that he would now be bound to vote against his own amendment to H.R. 10606.

Mr. President, again I urge the Senate to reject the Anderson amendments and to approve the welfare bill as reported by the Senate Finance Committee.

WELFARE RECIPIENTS WILL SUFFER AS RESULT OF ADMINISTRATION'S DELAY ON H.R. 10606

Mr. President, I have been concerned that as a result of Senator ANDERSON'S medical care amendment to H.R. 10606, the public welfare amendments of 1962, welfare recipients would suffer because of the delay in enacting this legislation. I know from talking with other Senators that this is certainly a critical matter in the larger, more populous States, and to a lesser degree in my own State of Utah.

Last week, Mr. President, I called the Utah Department of Public Welfare, and talked with Commissioner Lamont B. Gundersen concerning the status in Utah of funds to continue welfare programs during the coming weeks and months. I was informed that there is an urgent need for the U.S. Senate to pass immediately H.R. 10606, because the funds in Utah are rapidly running out. It will be necessary for Utah to modify or discontinue most, if not all, of its welfare programs, unless Federal funds are made available not later than July 30, 1962.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD a copy of a letter dated July 11, 1962, received from Mr. Lamont B. Gundersen, commissioner of public welfare of the State of Utah.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

THE STATE OF UTAH,
DEPARTMENT OF PUBLIC WELFARE,
Salt Lake City, Utah, July 11, 1962.

Senator WALLACE F. BENNETT,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR BENNETT: In accordance with our telephone conversation regarding the welfare bill before the Congress, I submit the following:

As soon as the ADCUP program terminated on June 30, 1961, the full financial burden for this program was placed on the State. This will seriously deplete State welfare funds in the middle of the biennium. The amount of Federal money the State of Utah receives for the above-mentioned program and ADCFC and the recent increase of $1 Federal matching on the remaining Federal matched programs amounts to approximately $60,000 per month which the State of Utah will not receive because of the expiration on June 30 of these programs. This will make it necessary for the State of Utah to abandon these programs by July 30, 1962, unless Federal funds are available.

I am very pleased to respond to your request and hope that the information will be of value to you.

Kindest personal regards.

PUBLIC WELFARE COMMISSION,
LAMONT B. GUNDERSEN,
Commissioner.

The PRESIDING OFFICER. The hour of 1 o'clock having arrived, the unanimous-consent agreement, as modified, goes into effect; and the time now is controlled in accordance with the agreement.

Mr. HUMPHREY. Mr. President, I ask unanimous consent that when the absence of a quorum is suggested, the time required for the quorum call not be charged to the time available to either side under the unanimous-consent agreement; and that after a live quorum has been obtained, the debate for 2 hours be had, and that the time for the taking of the vote be extended accordingly beyond 3 p.m.; in other words, that the time required for the live quorum not be taken from the time available to either side under the agreement; that 2 hours for debate be available thereafter; that the vote be taken after the two hours, at whatever time following 3 p.m. that may be; and that the time during the 2 hours be controlled, pursuant to the further agreement entered on yesterday, by the majority leader and the minority leader.

The PRESIDING OFFICER. Is there objection?

Mr. HICKENLOOPER. Mr. President, reserving the right to object, let me ask whether I correctly understand that the Senator from Minnesota is proposing that 2 hours after 3 o'clock be allowed.

Mr. HUMPHREY. No, 2 hours after the completion of the quorum call.

Mr. HICKENLOOPER. And when will the quorum call be had?

Mr. HUMPHREY. Now.

The PRESIDING OFFICER. Is there objection to the unanimous-consent request propounded by the Senator from Minnesota? The Chair hears none; and, without objection, it is so ordered.

Mr. HUMPHREY. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk called the roll, and the following Senators answered to their names:

[No. 120 Leg.]

Aiken	Byrd, W. Va.	Dodd
Allott	Cannon	Douglas
Anderson	Capehart	Dworshak
Bartlett	Carlson	Eastland
Beall	Carroll	Ellender
Bennett	Case	Engle
Bible	Chavez	Ervin
Boggs	Church	Fong
Bottum	Clark	Fulbright
Burdick	Cooper	Goldwater
Bush	Cotton	Gore
Butler	Curtis	Gruening
Byrd, Va.	Dirksen	Hart
Hartke	Mansfield	Robertson
Hayden	McCarthy	Russell
Hickenlooper	McClellan	Saltonstall
Hickey	McGee	Scott
Hill	McNamara	Smathers
Holland	Metcalf	Smith, Mass.
Hruska	Miller	Smith, Maine
Humphrey	Monroney	Sparkman
Jackson	Morse	Stennis
Javits	Morton	Symington
Johnston	Moss	Talmadge
Jordan	Mundt	Thurmond
Keating	Murphy	Tower
Kefauver	Muskie	Wiley
Kerr	Neuberger	Williams, N.J.
Kuchel	Pastore	Williams, Del.
Lausche	Pearson	Yarborough
Long, Mo.	Pell	Young, N. Dak.
Long, Hawaii	Prouty	Young, Ohio
Long, La.	Proxmire	
Magnuson	Randolph	

The PRESIDING OFFICER. A quorum is present.

Mr. DIRKSEN. Mr. President, the hour is 1:15. It is my understanding that, under the unanimous consent agreement, the Senate may proceed for 2 hours from now, and then will come the vote on the motion to table, the time to be equally divided and controlled by the majority leader and the minority leader. Is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. MANSFIELD. Mr. President, will the Senator yield?

Mr. DIRKSEN. I yield.

Mr. MANSFIELD. I would like to turn over the control of the time on this side to the distinguished Senator from New Mexico [Mr. ANDERSON], who has been the leading advocate of the health care plan. I make that unanimous-consent request.

The PRESIDING OFFICER. Without objection, it is so ordered.

Does a Senator yield time?

Mr. ANDERSON. Mr. President, I yield 12 minutes to the Senator from New York [Mr. JAVITS].

Mr. JAVITS. Mr. President, I consider it an honor to lead off in this debate in behalf of the proponents of the Anderson amendments, to which many Members of the Senate have very kindly added my name.

I say this because I think it is our opportunity to do something for the people of America which the people of America have long waited for. If we make the mistake, for reasons which are so easy to rationalize—because it is an amendment on another bill, because of the lack of hearings, or because of other procedures some of us may not be satisfied with, although I am—and let this measure go down the drain, whether it can be re-created or not is a real question. The real sufferers will be those over 65 who need medical care.

I read with the greatest of interest the views and the arguments made with respect to this bill, and they are summed up, as I see them, into four arguments:

First, that this is an important departure in national policy.

Second, that physicians' care and other types of care are needed other than those provided by this amendment.

Third, that if the amendment is put on the public welfare bill, it will be lost in the end; this amendment is tagged to the public welfare bill; it is not going to get anywhere in the House; why bother with it?

Fourth, the Kerr-Mills Act will do the job.

Mr. President, I should like to spend the time allotted to me in answering those points. First, and very importantly, that this is an important departure in national policy: It is an important departure in national policy, and i is a departure that ought to be made.

The reason why it ought to be made, in my view, is that it now can be safely made, having had added to it what it did not have before, and what I am proud to say my associates and I added: First, universality of coverage, and in a very brilliant way, in implementing the measure so that those who would not have been covered under the King-Anderson bill, those who were not under the social security system over a period of 10 years, are covered, taking advantage of the fact that, as the system now functions, 95 percent or more will be under it within a few years.

Therefore, it was not necesary to twist or torture the plan at all in order to include the nonbeneficiaries by phasing them in over a period of years.

This is an important departure in American policy, but a beneficial one, and it is high time we made it.

The reason for that is that this is the solid rock on which the act must be built, as I see it. The question is not whether the Anderson bill is right or wrong; I think the question is, What are the alternatives to the Anderson bill?

The alternatives leave the vast number of aged over 65 who need and require medical care, without coverage, where there exists a national responsibility to give them medical care. I asked a minute ago—and I think it was a perfectly proper question—when the Senator from Kentucky [Mr. COOPER] was speaking, How many stools must the aged fall between before we let them be helped? The hard nut of the matter, which is the crucial question, is that Kerr-Mills has not done the job, and will not do it if it were to have an expense three times as much as at present and a host of beneficiaries which the plan does not have.

What are we going to give those people? Stones and straw, even if those stones and straw are gold plated because of the cost of Kerr-Mills, or medical care?

If this program is a departure in national policy, it is one which is well justified, now that it has been architectured in the American tradition and spirit.

Second, it is argued that many different types of care are needed; that physicians' care is needed. I have argued that. It is absolutely right. Surgical and other types of care are needed.

We have a right to ask the question. If basic hospital care is not given, what is there to build on? On the other hand, if hospital care is given and this system is opened up, as our amendments have done, to the whole private enterprise system—pension plans, cooperative, Blue Cross, Blue Shield, private insurance plans, whatever is available—the Anderson plan will completely transform it.

We will have made it into a floor, rather than a ceiling, which it was before. It will be a floor upon which other things can be built.

I have actually given, in detail, the cost of the packages of additional aid it would be possible to build upon the plan inherent in the amendments, to show how inexpensive it would be to give the additional and important effective items of care. One can get a very liberal package, with all kinds of medical care and physician's services, for about $7.50 a month per person. One can get a minimal package of surgical and medical care and other types of benefits, which would make this a very fine program for anybody who has it, for as little as $3.30 per month per person.

This will become a very solid floor, because of its design, on which a medical care for the aged program can be built.

Third, and very importantly, it has been said that the public welfare bill will die, or that the House will not pass the bill.

Mr. President, would it not be even more certain that the House will not pass the bill if we do not pass the bill? Would that not really be the death knell of our medical care for the aging, and nobody knows for how long?

Mr. President, if we want the public welfare bill to pass, there are many ways to get it. We can get it by action in the other body; whether it be on a motion to suspend the rules, whether it be as the result of a petition signed by a majority of the Members, whether it be by a rule granted for a conference—and I shall come to that in a moment—whether it be by normal committee action, or whether it be by a 60-day extension of the public welfare amendments, which the Senator from New Mexico [Mr. ANDERSON] proposed, in which a number of us joined.

Once the Senate manifests its will, we shall have an opportunity to go somewhere. If the Senate does not manifest its will, then the program will be dead.

This will be the payoff vote, I repeat—here and now—on the motion to table.

The fourth argument is that the Kerr-Mills law will do the job. Let us look at the record. The Kerr-Mills law has been in effect for 2 years. It covers 102,378 recipients in about half of the States of the Union. The overwhelming majority of the money is spent in and the overwhelming majority of the recipients reside in the rich States, including the State of New York, in which over 90 percent of the money is now being spent.

In addition, the Kerr-Mills approach is the poorhouse approach. It is better than nothing, but let us understand it. It is the means test approach, or the poorhouse approach. If a person is indigent, if a person is broken down and has no one to help him, if a person cannot do anything else, he may get aid. He never knows in advance whether he will get it. Only when he becomes really sick is it possible for him to qualify.

The whole virtue of what we are trying to do is that a person will know where he is, based on the insurance principle. This is the fundamental and critical difference between what we are trying to do and the Kerr-Mills approach.

One hundred and two thousand recipients are taken care of under the Kerr-Mills law. Let us compare that number with the number in need. There are 12 million people over 65 years of age who have incomes of less than $2,000 a year. The average expense of a medical character for the individual who is over 65 years of age is $177 a year. Obviously, those who have incomes of under $2,000 a year cannot afford that expense.

One-third of the persons in that income and age bracket have some insurance protection. That leaves us with a figure of 8 million people who properly are eligible for some kind of care. One out of six of those goes to a hospital every year. That gets us to a figure of about 1½ million people. That is the very minimum number of those who need help.

Let us compare that figure with the 102,000 recipients under the Kerr-Mills program in half of the States, who are qualified after a period of 2 years.

Mr. President, the answer is to be found in the vote to be taken. The motion to table is said to be a sudden death motion. Mr. President, it will be sudden death, but sudden death to what? Will it be sudden death to the amendments alone? Not at all. It will be sudden death to the hopes and aspirations of those who are 65, who at last have begun to see the beginnings of some kind of national responsibility for their health care. That is the sudden death it will be.

One other point, Mr. President. My colleague, the Senator from Oklahoma [Mr. KERR], in what was for him a typically brilliant speech yesterday, asked the question of what kind of mockery it would be if we should give to the aged in this country care under the amendments but not all the care he thinks they ought to have, not all the care a few are getting under the Kerr-Mills program.

I ask, Mr. President, what kind of a mockery would it be to leave those people with stones in their mouths and to give them nothing, if the Senate defeats the amendments today? At the very least this is the fundamental base, this is the floor, which would give to those people the very minimum one-third of their health care. That would be an appreciable beginning in this country.

Finally, Mr. President, I wish to say a word to my colleagues on the Republican side of the aisle about conservatism in regard to this proposal. I have heard Senator after Senator argue that it would be more conservative to proceed by general appropriations. Mr. President, if we should multiply the cost of the Kerr-Mills program, which today is about $200 million a year, by the number of people who ought to be eligible for that kind of care, which is about 10 times the number who are eligible now, that would give us a cost of over $2 billion a year. Half of that cost would have to be appropriated by the Federal Government. That would be a billion dollar appropriation.

Mr. President, would that be more conservative or less conservative than the pay-as-you-go approach, with contributions by people who are fighting for the opportunity to participate and to pay, through a slight increase in social security taxes?

Mr. President, many Senators have argued that social security taxes will go up if the amendments are enacted. They will go up anyhow. They will go up whether we pass the amendments or not.

When we pass the amendments, and the social security taxes go up slightly more than they otherwise will go up, people then will get tangible and real benefits.

Why is it that the aged people of this country, on the whole—a clear majority of them—are fighting for this program? Why is it that the younger people—a great majority of them—are fighting for this program?

They are fighting for two reasons, Mr. President. The first is that the aged need medical care and they are not getting it. They will not get it, Mr. President, unless we provide a program. Let us not forget that. Let us not forget that there are people who do not go to the hospitals because it is too expensive, and they get sick and die sooner than they should.

Let us remember that the younger people, children and relatives of the aged, are supporting them. They are interested in this proposal. Let us remember that the younger people are paying the social security taxes, and they look forward to this program.

The PRESIDING OFFICER (Mr. METCALF in the chair). The time of the Senator from New York has expired.

Mr. JAVITS. Mr. President, may I have one-half minute or 1 minute more?

Mr. MANSFIELD. Mr. President, I yield one-half minute to the Senator from New York.

The PRESIDING OFFICER. The Senator from New York is recognized for one-half minute.

Mr. JAVITS. Let us also remember that the younger people will pay the social security taxes, and they look forward to doing so with dignity and capacity, on the basis of self-assurance, which is the highest form of self-reliance and of individual private enterprise, especially since we have now protected the amendments by opening them up to the whole competitive private enterprise system.

This is an opportunity we may never have again. I hope very much that the Senate will decisively defeat the motion to table the amendments.

Mr. President, I ask unanimous consent to have printed in the RECORD at this point as a part of my remarks an article entitled "Nursing Home Evaluation and the Question of Hospital Affiliation," written by John A. Hackley and published in Hospital Topics for March 1962.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

NURSING HOME EVALUATION AND THE QUESTION OF HOSPITAL AFFILIATION

(By John A. Hackley)

As is often repeated, the term "nursing home" means many things to many people. And it should. Existing nursing homes serve their respective communities in such a variety of capacities that no narrow concept of a nursing home, as we know the institution today, can exist. The nursing home as a facility has emerged to meet many varying needs of people. In this rather undirected emergence there has come a quite recent national concern.

Perhaps this concern about nursing facilities, their patients and their services is merely symptomatic of a slowly dawning realization that many professions and health services not only are interested in nursing facilities and their patients but actually have an undeniable responsibility to such facilities and primarily to the patients they serve.

The origin of many of the problems and needs of nursing-home patients does not necessarily lie in nursing-home institutionalization. Rather, these often are vocational, social, medical, and economic problems which an individual faces wherever he is. A recognition of the fundamental kinship between health services and those more commonly regarded as health-related services—even though the latter may be social or economic in purpose—will constitute a long step forward toward the time when the health and welfare of a human being and the public of which he is an integral part will be literally indivisible.

COORDINATION IN THE COMMUNITY

Perhaps one of the greatest deterrents to a realistic integration of health and health-related services is the factor of considering integration and coordination—and even affiliation with the hospital—in the light solely of administrative structure and the administrative problems that might arise. If, instead, we were to plan the organization of services simply from the standpoint of what the patient himself requires for timely, effective care, the problems of coordination would be far less complex and discouraging.

The term "nursing home" itself should not be an exclusive one but rather an inclusive one referring to proprietary, voluntary, and public facilities, whatever the auspices or legislation or administrative structure. By the same token, "community health resources" should embrace all types of agencies and resources: public, voluntary, or private, regardless of whether they are directly or indirectly health-related in terms of their specific services or objectives.

Perhaps the most important emphasis is that, although the nursing home's place and function in the community seem to be ever changing today, ultimately it will be rather clearly defined and adhered to. And if this character of the nursing home and its place in the community is not spelled out by the nursing-home profession itself in a realistic and professional way, then rest assured it will be delineated by others who may be less directly affected or less experienced to do so.

WHAT IS A NURSING HOME?

"When we opened this nursing home," one administrator has remarked, "we planned our service for certain kinds of patients; but we have never been able to serve exclusively those particular groups." His comment has found ready concurrence in the experience of Illinois Rehabilitation Education Service, a Public Aid Commission program, in the many discussions between its staff and administrators. In some cases, perhaps, those who planned and established the nursing facilities did not do a thorough job of community exploration. But even where relatively adequate planning has preceded the development of a nursing facility it is still infrequent to find the facility in real control of the kinds of patients it admits.

The community itself, its hospitals and physicians, and certainly its agencies, have virtually dictated the intake policies of the institution. It is as much the way in which the community uses its nursing homes as it is the homes' own limitations and strengths which has shaped many of our present facilities into what they are today. The immediate needs of the community are a dominant force in forming the character of the nursing facility.

From community to community, locality to locality, nursing homes—whatever their sponsorship—may function as chronic-disease hospitals, nursing-care facilities, homes for the aged, sheltered-care homes, day-care centers, room-and-board situations, or—as in one community—a place in which hospital patients were put to die so as to reduce the mortality status of the large county general hospital.

Many nursing homes are the only medical-care facility (or one of a very few health care resources) in a given area. Approximately 18 percent of the nursing homes cooperating in a research program of the rehabilitation education service were the only such homes in their communities. Several were the only facilities serving sick and disabled people in their area.

Coupled with this is the increasing acceptance of the theory that more and more patients are institutionalized in nursing homes for lack of a more appropriate facility. Case studies often discover that it was not the diagnoses and current health picture of a patient which precipitated his institutionalization; rather, it was the compounding of his total situation by his pressing social and economic needs that brought him into the nursing home.

THE MUCH-DISCUSSED SUBJECT OF CLASSIFICATION

All of this brings up (although only briefly here) the subject of classification of nursing homes. Classification is a device which has been frequently tried in many different States with varying degrees of failure. Unfortunately, current proposals for regulation often seem an attempt merely to use new tags—new nomenclature—in the effort to upgrade nursing-home standards and guarantee a certain level of performance that current rules and regulations do not seem totally capable of achieving.

Many groups (Joint Council To Improve the Health of the Aged, the American Hospital Association's Council on Professional Practice, the Public Health Service, to name a few) are investigating the idea of nursing-home classification. Not the least of these is the current congressional interest. Just as any Federal legislation for health care of the aged will very probably incorporate nursing-home care, so it would also include the need for national uniform nursing-home standards, now lacking.

Certainly, two admonitions must be made in developing any system of classification: (1) standards used to evaluate hospital facilities cannot be totally translated to nursing homes: some modification is needed; (2) any system of classification should be acceptable to the facilities but applied by an outside agent: real pitfalls are inherent in self-accreditation and classification.

For the present, though, until the role and function of the nursing home are more clearly defined, the responsibility continues to fall to the nursing home to provide answers—however inadequate they may be—to a wide range of the medical, social, and economic problems of the chronically ill, disabled, and aged receiving care in these institutions.

ALLIANCE WITH THE HOSPITAL

It is becoming trite to say that the nursing home should not be a place where people are sent to die. In practice, however, this is exactly the way many nursing homes have been used by the community, whether death has occurred in 3 weeks or 30 years, and whether it was due to an immediate medical reason or merely came as a climax to 30 years spent in an institution out of lack of more appropriate accommodations.

If nursing homes are to be institutions which serve patients only for that relatively

limited amount of time when the special services associated with nursing-home care are required; if medical care, nursing care, and the innumerable allied services and resources of the community are realistically conceived as a continuum available to all for whatever length of time and in whatever degree required—then there should be no doubt of the nursing home's position in the medical-care spectrum of the community.

When, on the other hand, the nursing home is seen as a substandard hospital, or a less-than-acceptable substitute for a general hospital, it cannot be intelligently employed in the case of the chronically ill and the aged.

Although the nursing home cannot be expected to provide the intensive acute care concomitant with hospitalization, it would be both foolhardy and disastrous to assume that the nursing service of the home need be any less comprehensive than that traditionally attributed to the hospital. The very nature of those long-term illnesses and disabilities which legitimately warrant nursing-home placement may actually require a greater degree of nursing service. However, often this also implies a reduction in the need for services rendered by registered nurses or more highly skilled personnel and an extension of those of licensed practical nurses, graduate nurses, and less professionally trained people. As numerous studies and the graphic evidence of individual patients testify, some patients were institutionalzed in the nursing home primarily because the hospital facilites were neither geared nor equipped for care of the long-term patient.

The value of affiliation between community hospitals and nursing homes has been frequently discussed. Proponents of such a move say it would bring about a more clearly defined and objective appreciation of the nursing homes' role in the community medical picture, and, in line with the philosophy of progressive patient care and coordinated community services, would also facilitate transmission of patients to the most appropriate facility. These stated reasons may imply to some persons that a nursing home can achieve status by becoming identified with a general hospital and can in some vague way enhance the quality of its care through closer association with a larger medical facility.

By contrast, the advantages accruing to the hospital through affiliation with a nursing home are rarely discussed. Yet how can we talk about coordinated community care and progressive patient care and limit ourselves to progression in one direction only? This kind of planning is a deception to the public, for our actions belie our protestations.

SOME POSITIVE ADVANTAGES

Just what could the hospital gain by affiliation?

Today we have discovered the truth in the concept of treating the whole person; but we have also recognized (strangely enough) that in order to see the patient as a person and provide the kind of care that serves him best, we must also know him. So one fundamental facet of affiliation is the establishment of a channel of communication by which a current, comprehensive, and useful account of the patients' needs and wishes in all appropriate areas can be exchanged. In this way the patient will not lose his identity, and we will not lose sight of the complexity of his needs.

Affiliation which provides an uninterrupted program of care for patients makes the staffs of the participating institutions coworkers and—with proper administrative climates—copartners in the teamwork required for effective care. By a free interchange of visits, personnel of the affiliated institutions can become acquainted with a patient and his current program of care before he is transferred to the other facility. No small side effect is the reassurance the patient receives with such a practice and the resultant minimization of his problems in adjusting to a new setting.

Beyond direct care to individual patients, the device of affiliation can work to strengthen feelings of mutuality of interest and effort. Affiliated institutions in a community can become the aggregate spokesman on behalf of all the long-term, disabled, and aged patients, serving as their interpreter to the community and its health resources. As a spokesman, too, the institutions can be a dynamic factor in stimulating community development of the necessary programs and resources which presently are inadequate or do not exist.

Another mutual benefit of affiliation is the interchange of professional knowledge, skill, and experience. For example, provisions for scheduled educational staff meetings and other in-service training are needed in most nursing homes, and the hospital personnel should be made available for this training. Likewise, the staffs of hospitals—particularly those which either contemplate or have recently developed a nursing facility for long-term patients—have much to learn about the complex needs of nursing-home patients for which the experience of the home's personnel will be invaluable.

One of the most difficult problems in providing the right care, in the right setting, at the right time, centers around the need for a well-organized, well-functioning central referral service in the community. Proper affiliation among medical facilities—and facilities includes clinics, day-care centers, family agencies, as well as hospitals and nursing homes—will familiarize each one with an accurate understanding of the services of the others.

THE PRIMARY CONSIDERATION

If we truly believe that so long as people live they deserve the kind of care that gives substance to their days and meaning to their existence, then we must do all in our power to establish, maintain, and improve those standards that will accomplish these things for the thousands of chronically ill and older people who are dependent on institutional care as a way of life.

Mr. DIRKSEN. Mr. President, I yield 20 minutes to the distinguished Senator from Nebraska [Mr. CURTIS].

The PRESIDING OFFICER. The Senator from Nebraska is recognized for 20 minutes.

Mr. CURTIS. Mr. President, I thank the Senator from Illinois.

Mr. President, I am for hospital and medical care for our aged citizens. I want that care to be the best that our fine, traditional American system of medicine can provide. I want the great advances made in medicine and in drugs to continue for the benefit of all mankind. The record in this country is unsurpassed.

I do disagree with the proponents of the administration plan as introduced by the Senator from New Mexico [Mr. ANDERSON] and other Senators as to how we should provide this medical care for our citizens over 65. Without boring Senators with statistics, I believe they will agree that among those over 65 there are some people well able to pay for their own hospital and medical care or to secure private insurance to provide the same. There are also some older people who are unable to provide hospital and medical care for themselves. Let us consider each group.

The first question is: Should Government provide medical care, including hospital care, for our older citizens who are unable to provide for such care themselves? I would answer that question with an emphatic "Yes." For many years our destitute aged have received hospital and medical care at public expense. That should be continued. I would go further. I would include those people over 65 who may have some funds and are self-supporting, but who cannot pay a costly hospital and medical bill. This group has sometimes been referred to as the near needy.

Such a program to provide hospital and medical care for the near needy, including drugs and other essentials for sick patients, has been enacted. It is known as the Kerr-Mills law. I voted for it. Under this law, any State desiring to provide medical assistance for people over 65, who are near needy, can do so and the Federal Government will share in the cost. It follows the same pattern that has been followed for many years in the cases of actual need. The near needy are not required to be paupers in order to be entitled to the benefits.

Under the Kerr-Mills law a program can be set up to fit the specific needs of a patient. If he needs help in having medical prescriptions filled, that can be provided. If he must be sent to the hospital, that can be taken care of. Government can pay the costs of having the doctor call at his home or surgery can be provided. In fact, the Kerr-Mills law is not limited to fine print benefits. It is intended to take care of people over 65 who need help and who are and should be the concern of government.

A careful look at the figures indicates that the States have moved with considerable speed in availing themselves of the benefits of the Kerr-Mills law. As of the end of June this year a period of 21 months had elapsed since the first funds became available under the Kerr-Mills law and 24 States have inaugurated a program. Let us see how this compares with similar action taken following the 1950 amendments when vendor payment provisions for medical care were added to the old-age assistance program, to the aid to dependent children program, and to the program for the aid to the permanently and totally disabled. After 21 months, 10 States had set up a program to include vendor medical payments in their ADC program, 7 States had inaugurated the program with reference to the aid to the permanently and totally disabled persons, and 10 States had inaugurated a program for vendor medical payments in their program of old age assistance. This has moved twice as fast as other programs. It is reasonable to expect that the Kerr-Mills law will very shortly reach the majority of our States because they have moved faster with this program than the others.

The other basic question to be asked, which is the central proposition, is: Shall Government provide hospital and medical care for people over 65 if they are well able to provide it for themselves?

This is a fundamental question. It means, should we tax future workers, the young workers, the middle-aged workers, and the aged if they are still working, to pay the hospital bills and some related medical expenses for all older people, including those who are well able to pay for it themselves? My answer to that question is, "No." I do not believe, for instance, the Government should tax young people who are raising a family, buying a home, and educating their children to pay the hospital bills of individuals who are financially able to pay their own bills. This is the essence of the Kennedy administration's proposal.

Some very interesting statistics were complied by the Bureau of Labor Statistics and published in the Monthly Labor Review for August 1960. These relate to the city workers' family budget. To work from a norm the statistics relate to a family of four, an employed husband of 38 years, a wife not employed outside the home, and two children, a girl 18 and a boy 13. The study is designed to arrive at a dollar amount which will give such a family an adequate living, including health, efficiency, nurture of children, and participation in social and community activities. The level is described as "modest but adequate." The average income before taxes is estimated between $7,000 and $7,500 annually.

This study went on to show what such a family would pay for the various items in their cost of living. This included an item for medical care. Medical care was described as including health insurance paid for by the head of the family, medical costs not covered, dental costs, and medicines. It was based on a study conducted in 20 cities across the country. Medical care in the 20 cities surveyed ranged from $250 in Scranton, Pa., to $424 in Los Angeles, Calif. Medical care in Houston was $309 annually and in Chicago $314 annually.

In November 1960, the Monthly Labor Review published a compilation made by the Bureau of Labor Statistics entitled, "Interim Budget for Retired Couple" which was similar to the one made in August concerning the family of four. The same cities were used for the survey.

This retired couple "budget family" assumed a husband and a wife, age 65 or over, who maintain their own two- or three-room rented dwelling in an urban area. The couple is assumed to be self supporting, in reasonably good health, and able to take care of themselves. The budget takes into account social and psychological, as well as physical needs, so it is not a minimum subsistance budget. On an annual basis for this hypothetical couple's living expenses runs from $2,641 in Houston, Tex., to $3,366 in Chicago, Ill.

The cost of medical care for retired couples in these 20 cities is described in this report as being between $222 annually in Scranton, Pa., to $366 in Los Angeles, Calif. The annual cost of medical care for retired couples includes a weighted average cost with hospital insurance coverage for 45 percent of this group. This covers the same broad range of medical and dental costs included in the "family of four" concept. Medical care for the "family of four," according to Bureau of Labor Statistics computes between 6 and 7 percent of the annual budget. For the "retired couple" it computes to an average of 9 percent of annual budget.

I believe these figures are very pertinent and that they deserve recognition.

It is obvious that, while many hardship cases exist in the age bracket of 65 or over, hardships for medical expenses are by no means limited to that group.

It is obvious that many young fathers and mothers raising families encounter medical expense that is overwhelmingly burdensome.

If the administration proposal is enacted it will mean a man can have an annual income of a hundred thousand dollars or more, unlimited capital assets, need not be retired, yet if he is 65, his hospital bill and certain related medical expenses will be paid. By whom will it be paid? It will be paid by the workers and the self-employed and the employers of the country.

We would tax the physically handicapped, the blind, and the aged who are still working to pay hospital bills for people who are well able to pay them themselves. That is the essence of this proposal. That is its central theme.

I am opposed to this proposal for several reasons:

First. The proposal would provide hospital care for aged without considering whether they could afford to pay their own hospital expenses.

Second. The proposal would finance such a program through the social security system, thus overburdening the present system.

Third. The proposal would increase withholding taxes, primarily on the young, making it more difficult for them to meet their current medical expenses, much less provide for future expenses.

Fourth. The enactment of the Kennedy proposal would result in a poorer quality of medical service for all of our citizens.

In citing established facts and figures in support of my position, I want to give credit to certain of my colleagues. Representative TOM CURTIS, of Missouri, has been a leader in research on the subject of hospital and medical care for the aged, and I want to pay tribute to him.

Let us consider just what the administration's proposal would do for the aged. It would pay for hospital services up to 90 days and certain nursing home services up to 180 days, plus additional home health services and outpatient diagnostic services or, as Representative GRIFFITHS says:

> This program adds up to the payment of the costs of hospital care and economical substitutes for hospital care.

It should also be pointed out that the first cost of hospital expenses, ranging from $20 to $90, would have to be paid by the aged person himself.

The administration proposal would not pay for most doctor bills incurred in the hospital.

The administration proposal would not pay for calls at the doctor's office.

The administration proposal would not pay for doctor calls at the home.

The administration proposal would not pay for surgery.

The administration proposal would not pay for prescriptions, or medicines, or drugs of any kind outside of the hospital. The administration proposal would contribute nothing significant toward the problem of catastrophic illness.

The administration proposal would not provide any benefits for people confined to a mental or tuberculosis hospital.

A study has been made as to what portion of the costs of illness would be paid if the administration plan were enacted into law. This has been established as being 25 percent of the expenses of illness of persons eligible for the benefits. In other words, for the people covered, whether they are in need or not, it would not pay 75 percent of the expenses incurred.

My colleague, TOM CURTIS, has very aptly pointed out that a medically indigent person is no more able to pay 75 percent of his medical expenses than he is to pay 100 percent of such expenses.

Unfortunately, the issue of medical and hospital care for the aged has been confused by a great deal of misinformation. I am satisfied that many of the proponents of the measure in Congress do not realize its shortcomings. I am thoroughly satisfied that many of the people back home have been misinformed. It is not uncommon for a constituent to write in support of the administration's proposal citing, as a reason for its need, the high cost of his doctor bills and his medicine. The fact is, the proposal being offered would not pay any part of either one.

Either the administration proposal is a delusion and will be a disappointment to our people, or they must admit it is merely a foot in the door for a larger program. The estimated cost of the first year of operation is a billion dollars. It is based upon the premise that Government should tax all of our people to pay hospital bills and some related medical bills of individuals, some of whom are much more able to pay those bills than the people paying the taxes.

I want to compliment the distinguished Senator from Tennessee [Mr. GORE] for the candor he displayed in acknowledging that if we pass this proposal now before us it will be but a beginning. The program will be enlarged. In the CONGRESSIONAL RECORD for July 9, 1962, page 12061, the distinguished Senator from Tennessee said:

> If the Senator from Wyoming will permit me to do so, I wish to comment on the two points the able Senator from Louisiana raised. One was that if the program of insurance, hospitalization, and medical care were enacted, those of us who support it should take the responsibility of considering it as only a beginning. I am pleased to accept that responsibility; I think it would be the beginning of a sound program.

The administration proposal disregards the great advances that have been made in private health insurance. As of June 1, 1962, 136 million of our civilian population was covered with

some form of health insurance. As of January 1, 1962, 55 percent or 9.3 million of the aged population had some kind of private health insurance. The Department of Health, Education, and Welfare has estimated that, by 1965, 70 percent of the aged will have some private health insurance.

This estimate of the Department of Health, Education, and Welfare to the effect that by 1965, 70 percent of the aged will have some private health insurance was made back in 1959. It was based upon the increase in health insurance coverage of social security beneficiaries as reported in 1951 and 1957.

Since 1959 a number of the private insurance carriers have inaugurated programs of mass enrollment of hospital and medical insurance for aged people. These programs alone, since their inauguration, are estimated to have enrolled well over 1½ million older people. Thus, it is apparent that the estimate of the Department is very much on the low side.

The PRESIDING OFFICER (Mr. METCALF in the chair). The time of the Senator has expired.

Mr. DIRKSEN. I yield 5 additional minutes to the Senator from Nebraska.

Mr. CURTIS. Mr. President, it is my opinion that if the American people had an opportunity to express themselves on the question as to whether or not the future workers, the present workers, including the near aged and the aged who are still working should be taxed to pay the costs of hospitalization and medical care for individuals over 65 who are able to pay their own such costs that the answer of the majority would be in the negative. The overwhelming majority of expressions that have come from the people of Nebraska have been against this proposal before us today. Countless groups have taken a position on it. For instance, in the June 1962 issue of the Nebraska Union Farmer I find an article which begins as follows:

> Nebraska Farmers Union delegates to the 1962 convention adopted a clear and precise statement concerning proposals for Federal medical aid programs as follows: *"Resolved,* That we oppose the inclusion of medical aid under social security."

I include that one position taken by a distinguished farm organization as typical. Thousands of such communications could be supplied.

Many well-meaning people have believed hospital and medical insurance should be provided under the social security system. Many of these people are not aware of the true nature of social security. They have accepted the mistaken notion that people are paying for their own benefits under our social security system.

Our social security system is a program of social benefits for the aged, their widows, and for minor children, financed by currently taxing workers, employers, and the self-employed. An accurate and very informative article on the workings of our social security system was published in the U.S. News & World Report on July 2, 1962. In that article, referring to our present social security system and the proposal to add hospital benefits U.S. News & World Report says:

> The tab for the cost would be picked up, as it is being picked up for old age and survivor insurance, by employers and by those who go on working. In the end the cost will fall on employers and on generations not yet working.
>
> In a word, social security programs, to date, represent a gigantic bargain for persons retired, soon to be retired, or fairly well along in years.

Mr. President, I ask unanimous consent that the article in the U.S. News & World Report to which I have referred may be printed at the end of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. CURTIS. Mr. President, we should not forget that if we never add any new benefits to the social security law and if we never increase benefits, the tax increases that we, the Congress, have already imposed will amount to a 48-percent increase between now and 1968. But many new increases and additions are being advocated.

In order that we might understand the true nature of our present social security program, I want to cite some basic statistics. These will show that it will be the young workers and our future workers who will bear the costs of this program. To add hospital and medical care to the social security program will be so costly that it might well endanger the program.

The PRESIDING OFFICER. The time of the Senator from Nebraska has expired.

Mr. DIRKSEN. Mr. President, I yield 3 additional minutes to the Senator from Nebraska.

Mr. CURTIS. Mr. President, let us take the case of a worker who retired on July 1, 1962, at the age of 65. Let us suppose that he has paid the maximum he could have paid since the program began in 1937 and that he has a wife who is of the same age. The total expected value of the benefits for this man and his wife would be $32,600. The total amount of employee taxes that this individual has paid is $1,584.

A couple of similar age retiring on July 1, 1962, having been covered by social security for the very minimum amount that the law recognizes will be entitled to benefits having a total expected value of $11,100 and the employee taxes that this individual would have paid from 1937 to date would be the sum of $79.13.

The average benefit paid to a beneficiary and his wife on the roll as of June, 1961, was about $125 per month. It is estimated that the husband of this average couple is 74 years of age and his wife is 69. They have drawn benefits for years, yet the total expected value of the future benefits to them is about $16,300. It can be said that a worker could have obtained his average benefits and paid less than $60 in employee taxes in order to qualify, and in any case he could not have paid more than $1,000 in order to qualify for such benefits.

A self-employed individual first covered in January, 1955 at the age of 63 having a wife the same age and retiring at age 65 would have paid in a grand total in self-employment taxes of $252. Such a couple has already received $11,215 in benefits and the value of their future benefits is estimated at $23,700.

There are some individuals still living and drawing benefits who went on the benefit rolls of the social security program back in 1940. If such an individual paid the maximum taxes that he could pay as employee from 1937 to 1940 it would amount to a total of $90. If that individual were a single individual, he has already drawn $16,644. At the present time his monthly benefit is $89 per month, or just $1 less than the total amount that he has paid in in taxes in his entire life.

All of these figures have been provided me in a letter from Mr. Robert J. Myers, chief actuary of the social security system.

Mr. President, I do not oppose the social security benefits that these deserving old people are receiving. I merely suggest that we face the program realistically and recognized it for what it is. It is a program of paying benefits to our aged citizen by taxing workers, employers, self-employed, future workers, future self-employed, and future employers. Social security benefits are not paid for by the beneficiary but are paid for by others.

Again I point out the one very fundamental question that we must face in passing upon the administration's proposal now before us is: "Shall we tax these workers and future workers to pay the hospital care of people over 65 who are well able to pay for it themselves?" If that question were to be put up to the people of all the States of the Union it is my guess that the overwhelming majority would answer it in the negative. I believe that this Senate should likewise answer it in the negative.

It is obvious that many persons 65 years of age and over are entirely competent to bear the costs of their medical care, so, we are faced with the proposition of enacting class legislation for one age group—not to meet a need but to extend a privilege to many who have no need.

The problem of medical and hospital care for the aged can best be met through existing law, including the Kerr-Mills bill, which takes care of the "near needy," and through the channels of private insurance. Let us not forget that the Government has failed in every business operation it has started.

The enactment of the Kennedy proposal means Government medicine. If Government funds are spent to provide hospital and related medical care, the Congress must give directions as to how that money will be spent. There will be rules and regulations. There will be contracts with hospitals and doctors.

The enactment of the Kennedy proposal now before Congress will mean a poorer quality of medical service not only for our aged, but for all of our citizens. History is on our side in this argument.

Every country of Europe has some sort of government medicine. Let us see what has happened. Europe no longer

leads the world in medical science, yet 30 years ago medical students from this country and from all over the world traveled to Europe for advanced medical education. They no longer go to Europe; they come to the United States because our private practice of medicine means better medical education and better medical care.

When Great Britain adopted their program of government medicine in 1947, they had 1 doctor for 877 people. Britain's government medicine caused such a deterioration in the practice of medicine that 10 years later they had 1 doctor for every 1,149 people. Here in the United States, in spite of our population explosion, the ratio of physician to patient for 1962 is 1 for every 703 people.

The PRESIDING OFFICER. The time of the Senator from Nebraska has expired.

Mr. DIRKSEN. Mr. President, I yield 1 additional minute to the Senator from Nebraska.

Mr. CURTIS. Mr. President, I am convinced that a careful gathering and study of the facts will show this proposal to be unwise and not in the best interest of our citizens, either those over 65 or those under 65.

If it is heresy to say I believe in the competence, the integrity, and the skill of my family doctor, my family druggist, my dentist, and my insurance agent, let it be heresy. I want our system to continue to make advances in saving lives, relieving pain and suffering, and adding to the length of life in the future as it has in the past.

The Anderson amendment should be defeated.

EXHIBIT 1

THE UNTOLD STORY OF YOUR SOCIAL SECURITY

Check your own social security and you'll probably find you are getting a bargain. Check your grandson's, and it's a different story. Reason: Pensions for this generation must be paid, in large part, by future generations.

This is to be the untold story of your social security. It concerns the pension to which you are entitled in retirement, or if disabled, and to payments to your survivors in event of death.

Social security is a vast system. Old-age and survivors insurance alone in this year will involve benefit payments of more than $13.2 billion. And the total is to grow steadily over the years ahead.

In 4 of the last 5 years, payments to persons drawing benefits have been exceeding income from payroll taxes. Some alarm has been expressed about this deficit between outgo from the social security reserve fund and income into the fund.

That, however, is not the story to be told.

Payroll taxes rose on January 1. They go up again on next January 1. Money flowing into the reserve fund, as a result, once again will begin to total more than money flowing out. Fears about the safety of the fund will subside.

A FACT—AND QUESTIONS

A hard and little-understood fact, however, will remain to raise questions.

The fact is this: Benefits promised to people now covered by old-age and survivors insurance total an estimated $624 billion. Reserves now on hand total around $22 billion. Taxes to be paid by people now covered by social security to support pensions are to be an estimated $282 billion.

That leaves $320 billion in benefits to present policyholders to be paid by someone else. Who will that be?

The answer, in simple terms, is that this deficit, if it is to be paid, will have to be paid by future workers at tax rates now in the law. Otherwise, persons now in the pension system would have to pay sharply higher taxes.

Pension bargains for people of the present are to become pension burdens for workers of the future.

[Statistics accompanying article in chart form]

Pensions for today's workers: a burden on future generations?

	Billions
Under social security insurance programs for old age and disability:	
Pension money required. Value of future benefits to present beneficiaries and workers now covered by social security	$624
Amount on hand: Now in social security trust funds to meet future obligations of the system	22
Taxes coming in: Value of future contributions to be made by present workers and their employers through payroll taxes	[1] 282
The gap: Deficiency to be made up by taxes to be paid by future generations of workers and employers	320

[1] The obligations and taxes shown above are amounts that would be needed today to equal the benefits to be paid out and taxes to be collected in future years if the sums were invested at 3-percent interest.

What this means is that people now working are not paying their own way under social security. The typical worker today will get back far more in personal and family benefits than he and his employer will contribute in payroll taxes. In the future, after the program matures, millions will get back less than they and their employers will contribute.

IS YOUR SOCIAL SECURITY A BARGAIN?

Here are some examples:

Example A: A worker who retired in 1940 at age 65. Wife the same age. Before retirement, worker and employer had paid social security taxes for 3 years. Total tax, worker and employer combined: $180. Since retirement, this man and his wife have been drawing benefits for 22½ years. Total benefits to date: $24,973.

Example B: A worker who retired last January 1 after paying the maximum social security tax since 1937. Total tax paid by worker and employer: $2,868. Add interest at 3 percent, and this contribution to the pension fund becomes $3,714. Pension from now on will be $121 a month for the worker, plus $60.50 for his wife if she also is 65 years old. If both live out their normal life expectancy, then total benefits for man and wife: $32,074.

Example C: College graduate starts working in 1962, pays maximum social security tax until retirement in the year 2005. Total tax paid by worker and employer: $18,564. Add interest at 3 percent, and this contribution to the pension fund becomes $36,226. Pension for man and wife, after retirement, will be at a rate of $190 a month. Total benefits, normal life: $33,664.

Example D: Young man gets a job in 1968 pays the maximum tax from then until retirement in the year 2011. Total tax, worker and employer: $19,092. With interest at 3 percent, this is worth $37,954. Assume this man is a widower, with no dependents. He lives 2 years after retirement, and dies at age 67. Total benefits, 2 years: $3,048.

Social security taxes and how they grow

	Rate paid by worker, matched by employer	Maximum paid by worker, matched by employer
1937–49	1 percent on 1st $3,000 of pay	$30.00
1950	1½ percent on 1st $3,000 of pay	45.00
1951–53	1½ percent on 1st $3,600 of pay	54.00
1954	2 percent on 1st $3,600 of pay	72.00
1955–56	2 percent on 1st $4,200 of pay	84.00
1957–58	2¼ percent on 1st $4,200 of pay	94.50
1959	2½ percent on 1st $4,800 of pay	120.00
1960–61	3 percent on 1st $4,800 of pay	144.00
1962	3⅛ percent on 1st $4,800 of pay	150.00
1963–65	3⅝ percent on 1st $4,800 of pay	174.00
1966–67	4⅛ percent on 1st $4,800 of pay	198.00
1968 and after	4⅝ percent on 1st $4,800 of pay	222.00

NOTE.—The social security tax on self-employed persons, first covered in 1951, is 1½ times the tax on employees.

ANOTHER INCREASE COMING?

To provide for hospitalization and nursing-home care for the aged, President Kennedy now urges an extra one-quarter of 1 percent in the payroll tax. The tax "base" would rise from $4,800 to $5,200. The maximum tax then would be raised to $201.50 next January 1, and go on up to $253.50 by 1968.

ONE MORE WINDFALL

These workers of the future will pay substantially higher taxes on their earnings—taxes earmarked for social security. They will work over a longer span of life, paying higher taxes all the way, in order that the 68 million others now covered by social security can enjoy pensions and other promised benefits.

It now is proposed that hospital insurance for retired persons be added to the social security system. Once again, if this type of insurance is added, older people will get a bargain. Those retired when the plan would take effect would become entitled, at no cost, to hospital and nursing care valued at thousands of dollars.

Here would be a windfall for persons now retired and those who will retire in years shortly after the plan takes effect.

The tab for the cost would be picked up—as it is being picked up for old-age and survivors insurance—by employers and by those who go on working. In the end the cost would fall on employers and on generations not yet working.

In a word: Social security programs, to date, represent a gigantic bargain for persons retired, soon to be retired, or fairly well along in years.

For relatively small payments these people are assured of an income on retirement. Men are assured that, when they die, their wives will go on getting an income. There is further assurance that minor children will get checks in event of the man's death. A binding promise is made of a monthly check in event of total disability.

Once the hospital-care program is in the law, pressure will grow to cover hospital costs for all persons covered by social security, whether working or retired. The final step might possibly be to cover doctor bills as well.

IDEA: PAY LATER

In each case, planning rests on the idea that future generations will get and pay much of the bill for those who are getting, or stand to get, the bargains of the present.

All of this is part of the strong trend toward special advantages for older people at the expense of the Nation's younger people.

Young people with children to educate, with a house to furnish and pay for, with saving to do if there is to be any venturing, with insurance payments to make, get few favors. Payroll taxes, increased eight times

in the past 13 years, will be increased three more times for old-age and survivors insurance. Hospital insurance would mean another tax. Then, at some point, there will be unpaid bills from social security promises to meet.

Old people, all of the time, are getting more and more advantages. People age 65 and older get a double exemption on personal income tax. If retired, they get a special retirement credit against income tax. The social security pension—for which they paid little—bears no tax. All their bills for medical and hospital care are deductible for income tax purposes.

All of this raises the question whether young people with more votes than old people will go on giving the breaks to the elderly.

FOR YOUNG: ALTERNATIVES

Two courses would be open to them if ever they wanted to get out from under what is to be a growing burden.

1. Inflation of prices can be accepted while a determined effort is made to keep individual pension benefits from rising. In this way, inflation could be used to reduce the pension burden, since pensions would represent a smaller part of an inflated national income.

2. Taxes could be used to take away some of the advantages enjoyed by retired persons. One tax "reform" now under study calls for taxation of social security income. There is some pressure to end many other special deductions extended to older people.

However, experience in the United States and Europe indicates that old people will go on getting their bargains and young people will continue to bear their rising burdens. In Europe there is a strong trend toward shifting to employers a larger and larger part of the social security burden.

The generous attitude of young people is attributed to two factors.

One of these factors is the realization that sometime they, too, will be old and will want some favors.

The other factor is that the young people see social security as a means of spreading the risk that comes from being forced at some point, for most, to care for their own parents.

AS IT'S DONE ABROAD

To fill out the untold story of social security, U.S. News & World Report asked its staff members in Europe to explain how those countries—with long experience—have met the rising burden of welfare programs.

West Germany

The idea of national pension plans got its start in Germany. Two World Wars, ending in two defeats and destruction of currency, destroyed the pension systems. Yet each time these systems have come back stronger than ever.

To finance old-age pensions, employers and employes each contribute 7 percent of the gross wage. For health insurance they each contribute an added 4.8 percent. An added 0.7 percent goes for sick pay, special leaves, family allowances. On top of it all, employers contribute an average of 16 percent for other fringe benefits. Payroll additions for social security amount, overall, to approximately 45 percent.

Benefit payments in recent years have been adjusted to compensate for price rises. Young people do not appear to object to the burden they carry.

Great Britain

Welfare costs now account for more than a third of all Government spending. Workers covered by welfare programs and their employers pay special taxes that pay less than half of welfare costs. In the case of health insurance, $3 out of every $4 come from general taxes

Government subsidizes the whole welfare program, and political pressure is constantly on the side of larger benefits. There is pressure to cut down defense spending so welfare can expand.

Sweden

A 6-percent sales tax was introduced in Sweden 2 years ago to help meet the skyrocketing costs of welfare. Social-security benefits now account for 15 percent of national income, compared with 7 percent before World War II.

In 1960, Government, central and local, carried 69 percent of welfare expenses, workers 20 percent and employers 11 percent. Now the pressure is to increase the employers' burden.

France

Social welfare in France extends from maternity grants, family allowances, rent allowances and hospitalization to old-age pensions and death benefits. The expense falls mainly on employers, who pay about 30 percent on their payrolls. The employe contributes about 6 percent on maximum pay of $1,920 a year.

Italy

Social security in Italy includes old-age pensions, unemployment insurance, health insurance, maternity benefits, family allowances and some subsidized housing. The Government contributes 25 percent to the retirement pension fund.

Employers' contributions amount to a tax of about 50 percent of payrolls. Workers contribute approximately 11 percent of their earnings.

In Western Europe as a whole, social security benefits now approximate 15 percent of national incomes. The range, according to official figures, is 12.6 percent in the Netherlands to 16.4 percent in France.

The trend in Europe is toward more and more social services, with heavier and heavier taxes on employers, plus larger contributions by the Government out of general revenues. This suggests that, in the United States, as the years go on, the Government, too, will be called upon to support the pension fund in addition to the payroll taxes that now are scheduled.

The reserve behind your old-age pensions as it is now figured by the size of old-age and survivors insurance trust fund

End of year:	*Million*
1937 (start of system)	$766
1940	2,031
1950	13,721
1960	20,324
1962	18,713
1963	19,528
1964	20,787
1965	22,206
1970	40,064
1980	79,346
1990	105,517
2000	137,779
2025	271,717

Mr. ANDERSON. Mr. President, I yield 2 minutes to the distinguished junior Senator from Michigan.

Mr. HART. Mr. President, we have been reading and hearing a good deal recently about the strike of doctors in Saskatchewan, Canada. I fear that in many quarters this news has been interpreted as a rebellion against the kind of proposal for health insurance for the aged that we are considering here today. I want to make it very clear that this is not the case, and I do it now, as we approach a decisive tabling vote.

Today the Senate is considering a proposal which would help those citizens who are over 65 years of age pay the costs of hospital and nursing home care.

The Province of Saskatchewan has had in operation since 1947 the Saskatchewan Hospital Services Plan which provides similar benefits, not just to those over 65, but to the entire provincial population.

This plan has been operating successfully for over 15 years and has had the full support and cooperation of the medical profession. In fact, the plan proved to be so popular that the Canadian Government in 1957 enacted a program for Federal participation in the provincial hospital insurance plans.

The doctors in Saskatchewan are now striking against a new system which would cover doctors' fees for persons of all ages—a system which the doctors feel strikes at the very heart of their profession.

We do not need today to debate the merits of this system or the moral position of a doctor on strike, because the proposal before us would not pay doctors' fees or interfere in any way whatsoever in the traditional relationship between doctor and patient.

Mr. President, I am a cosponsor of the Anderson amendment because I believe it represents an improvement over the original King-Anderson bill. It preserves the social security financing principle, while extending the coverage to those 2½ million people over 65 who are not now covered by the social security or railroad retirement systems.

Including these persons under a Federal health insurance program will substantially reduce the present financial burden on the States and enable the States, especially the less wealthy more effectively to utilize the Kerr-Mills program for aid to those individuals whose medical needs go beyond the scope of the Federal program. To kill this proposal, as we are asked to do by the motion pending, would be a most unfortunate action; disappointing young and old, healthy, and ill, in this country.

Mr. President, I have received many letters from citizens of Michigan urging my support of a health insurance program. I ask unanimous consent that a few of the more recent of these letters be printed at this point in the RECORD.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

DETROIT, MICH.,
June 7, 1962.

HON. PHILIP A. HART.

DEAR SENATOR: I write to you about the medicare bill. It seems that the best argument for the bill has not been brought out. It is that satisfactory insurance is not available to most older people. Sure, policies are offered, but so many older people are excluded.

I was offered catastrophe insurance by Mutual. But, my wife is excluded because of a cardiac condition, and my case the exceptions make the policy worthless. So, old people can get insurance, if they are in perfect health. What a paradox.

I am amazed that this central argument has not been used.

I trust that this note may be useful.

With all good wishes I am,

Sincerely,

LAWRENCE CROHN.

ST. CLAIR SHORES, MICH.,
May 20, 1962.

Senator PHILIP A. HART,
Senate Office Building,
Washington, D.C.

DEAR PHIL: Remember the fuss about social security. When President Roosevelt got that through, you would think it was going to ruin everyone and what a blessing it has been along with so many other things that were passed at that time. Thank God for people like Roosevelt and Kennedy.

I hope and pray it will be passed into law this year.

Sincerely,

HELEN MACMILLAN.

KALAMAZOO, MICH.,
June 14, 1962.

Hon. PHILIP A. HART,
Capitol Building,
Washington, D.C.

SIR: In the course of my work as a psychologist, I have had occasion to see a goodly number of medically neglected persons, who because of lack of funds, go untreated.

I have reason to believe—human behavior being what it is—that lack of foresight and too little self-discipline loom large as factors for many of these persons.

The medicare bill now under consideration would, obviously, help prevent these human failings from affecting one's medical care after retirement.

I see the present ineffectiveness of the Kerr-Mills Act as being in large part due to the fact that it fails to take into account that important psychological thing known as self-esteem. Few people, I would guess, suffer feelings of self-disrespect and worthlessness when their monthly social security check arrives. And likewise I believe it would be with medicare under social security.

I hereby earnestly solicit your support for the medicare bill.

Very truly yours,

FRANCIS J. APOTHEKER.

YPSILANTI, MICH., *May 31, 1962.*

Senator PHILIP A. HART,
Senate Office Building,
Washington, D.C.

DEAR SENATOR HART: I have been much concerned to notice the large amount of advertising carried by our local papers and sponsored by the American Medical Association in opposition to the King-Anderson bill. Since no agency is strongly supporting the affirmative side of the proposed medical aid bill, I am afraid that the public response may not be representative of the actual majority opinion.

It is my sincere hope that you will exert your influence toward passage of this legislation. I am a young university staff member and as such command a salary sufficiently large that medical care is not likely to present a financial problem to me personally. However, with the cost of medical care as it exists today, I can see no alternative to a program financed through social security to provide a means for the average wage earner to avoid relief assistance in the case of extended illness in old age.

It is my observation that the majority of my associates, other than doctors, favor the proposed legislation. I hope to learn that you are doing all possible for the passage of the King-Anderson bill.

Thank you for your help in this important matter.

Sincerely,

FLOYD C. ELDER.

PAINTERS UNION INSURANCE FUND,
Detroit, Mich., May 29, 1962.

Senator PHILIP HART,
Washington, D.C.

DEAR SENATOR: The trustees of the Painters Union Insurance Fund urge your support of the King-Anderson bill because it would greatly assist our senior members and our fund. Our jointly administered labor-management fund covers approximately 5,000 members in the Metropolitan Detroit area.

Funds providing hospitalization insurance for senior citizens, such as provided by our fund, offer only limited coverage for these people who go to hospitals more often, stay longer in hospitals and have a great need for coverage outside our limited facilities to help them.

We have been providing a limited coverage for our senior members over 65 years old for some 12 years and it is placing a terrific burden on our reserves. We require that they pay a premium of $10 per month per family and our loss experience on this group has increased steadily until now we pay approximately $35 per month for limited hospital and surgical care. Our fund provides its senior members with hospitalization of $14 per day for 45 days for themselves and 31 days for their dependents. At the present time, we have some 365 members over 65 years old and we are faced with the problem of dropping coverage of these needy members because of the drain on the fund.

Would you please consider the need and human dignity of these people and support the King-Anderson bill.

Your cooperation will be most appreciated.

Sincerely,

Trustees of the Painters Union Insurance Fund: Stanley Gill, Chairman; Alex Harris, Trustee; Irving Bronson, Trustee; Lawrence Jacott, Trustee; Alex Madias, Secretary; Joseph Weber, Trustee; Max Weisman, Trustee; Henry Weitz, Trustee.

DETROIT, MICH.,
June 12, 1962.

Senator PHILIP HART,
U.S. Senate,
Washington, D.C.

DEAR MR. HART: I believe the difficulty medicare program is having is largely due to the emphasis placed by those in favor of the program on defending the proposed bill involving social security payments. That bill is weak and makes an excellent target for the opponents.

What medicare proponents should be doing is to expose the weaknesses—and they are numerous—of the voluntary insurance program such as AARP with its 400,000 members. Their hospital program is a joke and the outside medical program a masterpiece of defensive underwriting. My wife and I pay $324 a year yet the maximum one of us could collect from a 31 day stretch plus an operation in the hospital would be $635. The actual cost might well be $2,500.

The amount of the premium means that only those with plenty of money or a substantial income could afford it.

Yours very truly,

LEE GRANT.

Mr. HART. Mr. President, I have before me an interesting article entitled "Insurance Firms Can Compete With Medicare for Aged," which, assuming the motion to table will not prevail—and I certainly hope it will not—may be persuasive upon those who vote to table. I ask unanimous consent that the article, which was published in the Chicago Sun Times of May 20, 1962, be printed at this point in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

INSURANCE FIRMS CAN COMPETE WITH MEDICARE FOR AGED

"Ever since I've been in the business," said Roy Tuchbreiter, "insurance companies have been worried that Goverment action would ruin them."

Tuchbreiter, chairman of the board of the Continental Cos., was speaking at a seminar of insurance executives on the Continental's new "over 65" health and accident policies.

"First it was the Workman's Compensation laws that were going to put insurance companies out of business. Then it was social security. And then came the GI life insurance. All that did was accentuate the need for life insurance and helped the industry more than it hurt.

"Now a program for medical care for the aged is before Congress. In the long run, should it be passed, I don't think that will hurt us either."

Tuchbreiter says it is not true that there is no profit in health and accident insurance sales to the over 65 age group.

"We have over 500,000 people on our health and accident books now who are over 65 and we intend within the next 60 days to come out with an 'over 65' program to reach a larger segment of that group."

Tuchbreiter says that Continental Casualty Mutual Benefit Health & Accident Association, and Fireman's Fund are the three companies with the strongest over 65 programs.

"One reason we can make money on the over 65 policies is that we have installed IBM machines which process the policies at a cost of 7 cents each. By hand, the cost would be 59 cents per policy.

"There are tremendous possibilities for insurance sales in the over 65 group," Tuchbreiter says.

"We don't sell and aren't interested in selling competitively with the Government," he added, "we are interested in the segment of society who can pay premiums and might also buy insurance for their grandchildren or their children from our salesman."

He said that health and accident insurance would naturally be more costly for the over 65 age group than for younger applicants.

Mr. ANDERSON. Mr. President, I yield 3 minutes to the distinguished junior Senator from Massachusetts.

Mr. SMITH of Massachusetts. Mr. President, I should like to discuss today some facts concerning medical care for the aged in my home State of Massachusetts. In particular, I shall mention the coverage which the Kerr-Mills Act and private insurance companies have provided for the senior citizens in my State. The evidence I believe, will show that they have not—and cannot—do the job of providing these people with adequate medical care.

Massachusetts is 1 of 11 States in the country with over one-half a million senior citizens. In the decade from 1950 to 1960, those people 65 years of age and over increased by 22 percent. The problem of providing them with proper care is an important one in my State.

These people are faced with the same financial problems that confront all our senior citizens. The majority of them depend on social security, savings, and perhaps a private industrial pension for their income. This income is "fixed," and is vulnerable to inflation. At best, it is adequate. At worst, it is substandard.

The average elderly person in Massachusetts living on social security gets $80 a month. This increases to $102 under old-age assistance. Yet, it costs him an estimated $145 monthly to live adequately in a large city like Boston.

This senior citizen, while trying to maintain a decent standard of living on this income, has been squeezed over the last 15 years by a 30 percent rise in the price of basic necessities. The rise in his medical expenses has been far worse. In the same period, medical care costs for people in the welfare case load soared 400 percent.

Hospital costs have gone from $8 a day to as high as $35 for welfare cases. A doctor's home visit costs them $5, but it can run up to twice as high for those not on relief.

This is only the beginning. A doctor from Quincy, Mass., who asked that I support the Anderson proposal, told me that the average general hospital has a continuing occupation of 30 percent or more by citizens 65 years or over with bills in three and four figures. Another doctor from Boston, also a supporter of this bill, said it was "a common experience" for an elderly patient with heart or other trouble to spend 3 to 6 weeks in the hospital, with a bill running from $1,000 to $3,000. This, he said, "is obviously insupportable by most people."

Massachusetts has done everything possible within its means to help these people. My State has traditionally led the country in the field of welfare legislation. It has been equally progressive in setting up programs to take care of its senior citizens.

In 1953, Massachusetts adopted a program of medical care for the aged which gave medical care the same priority as clothing, food, and shelter. All needy persons receiving financial assistance to live on were also given comprehensive medical services.

Again, when the Kerr-Mills Act was passed, the Commonwealth set up the most comprehensive program of benefits of any State in the Union. During the first year of operation, Massachusetts was one of three States spending $.92 out of every dollar of Kerr-Mills funds.

The program cost the people of Massachusetts over $20 million. Yet, at no time during that year were more than 3 percent of the Commonwealth's senior citizens receiving its benefits.

Administrative expenses alone were $150 to $250 per case, and one quarter of this was paid to process over 7,500 cases which were held not eligible for assistance. On top of this, the State still had to pay medical bills for thousands of other senior citizens who did not fall within the Kerr-Mills Act provisions.

The Kerr-Mills Act has not done the job in my State, and it has cost the citizens of Massachusetts over $20 million to find this out.

Massachusetts is not an isolated example. Today, the Kerr-Mills Act is operating in only 24 States. Of these, one will only pay for hospital care in cases where life or sight is in danger. Others have reported caseloads of less than 30 people.

The program in West Virginia got into serious financial troubles and had to be cut back. Governor Swainson, of Michigan, which had one of the best Kerr-Mills Act plans in the country, wrote President Kennedy this winter that the program in his State was a "significant failure" and should be absorbed by the King-Anderson program.

It is obvious that the States, with their limited financial resources, have not been in a position to put the Kerr-Mills Act into full use.

The senior citizens in Massachusetts, like all others, have also bought private insurance to cover their needs. Again, it has not been sufficient to provide them with the comprehensive medical care they need and deserve.

Many of the retired aged have learned that the policies can be—and often are—abruptly canceled. At hearings which I held in Springfield, last fall, on the problems of the aging, a retired railroad worker told how two policies he had held for 40 years were cut off when he was 70 years old. At the age of 79, he had to stop work, with no medical insurance whatsoever.

Another man from Springfield, who had three policies, had a heart attack. After this, the companies would no longer pay him for any illness expenses connected with his heart, although his premiums remained the same.

Private insurance is often unable to handle the enormous expenses of modern medical or nursing-home care. Hospital coverage in Massachusetts often pays for less than half the $35 to $40 daily cost of a hospital in the State. Drugs are not included; yet they make up a growing share of medical-care expenses. A woman from Boston wrote me that she had $1,800 in medical bills, in 1 year alone, above her Blue Cross and Blue Shield coverage.

The private policies also do not cover nursing-home care, which is so important to our senior citizens.

Finally, only slightly over one-half the people in the United States hold private health insurance policies. Those not covered are largely either in low-income brackets or are older, poorer risks. The insurance companies consider the latter group such a high-risk group that they will not write reasonable or adequate medical coverage for them.

Private insurance, then, has not given the senior citizens in my State the coverage they need, nor has the Kerr-Mills Act.

These programs are simply inadequate to meet the goal we are pursuing today—namely, to make good health as fundamental to the life of every American senior citizen as decent food, warm clothes, and a good home.

We need an entirely new approach to the problem of providing medical care for our senior citizens. We must begin by attacking this problem from a broad base—not by trying to build up present programs, which already are stretched to their limits.

The Anderson amendment would supply this case, just as the original Social Security Act provided the workers of this country with a broad base of life insurance. The Kerr-Mills Act and the private insurance companies could build from there. The companies could provide those services and could cover those persons they could afford. They now do this very successfully in the field of life insurance.

States which adopted Kerr-Mills Act programs would not have to pay for programs beyond their means. Massachusetts alone would have saved an estimated $17 million, last year, of the funds it spend on its Kerr-Mills Act program, if the Anderson plan had been in effect.

Finally, and most important, the many millions of people covered by the Anderson amendment would be assured of permanent, lifelong insurance coverage.

There is nothing radical or dangerous about this proposal. It is based on sound accounting principles. It uses a system of financing that has worked well for many years. Every patient would have his free choice of the doctor or hospital he would use. Every doctor would have his free choice of what treatment to use.

This is a conservative program. Similar programs have been operating successfully in European countries for as long as 80 years. Yet, this principle of medical care through social security has been the target of a violent, unthinking, but well-financed campaign, spearheaded by the American Medical Association.

One AMA leaflet which a constituent of mine sent me ends with the line, "Let's keep politics out of medicine." But this has not kept the AMA from getting up to its ears in politics. Last year this group listed lobbying expenses of $163,400—the second largest of any Washington lobbyist. The majority of this was spent on attacking the medicare proposals. This money paid for expensive booklets such as this one, plus thousands of leaflets. This attack has included dire warnings of socialized medicine and of politicians telling doctors what to do. It has also included outright lies—that the Anderson plan would limit a patient's free choice of hospital and physician.

Many other misconceptions and half-truths have been spread about medical care under social security. Today I should like to reply to a few of them.

Opponents of this program say that it would limit the patient's choice of doctor and hospital and would ruin the doctor-patient relationship. This is not true. All it would do would be to permit a third party to pay for the bills for certain hospital and nursing-home services.

Opponents of this program say that the use of federally administered funds in medicine would result in Federal control of medicine and in a decline in the quality of medical care. The record shows that this is not so. The Federal Government has been concerned with medical care for its citizens since 1798. It now spends millions of dollars yearly through the Hill-Burton Act, the Public Health Service, the Veterans' Administration, and other programs.

No one accused the Agriculture Department of jeopardizing patient-doctor relationships when it developed penicillin. No one from the AMA has yet told me that the $700 million of health research being done this year at the National Institutes of Health will contribute

to the decline of medical care in this country. And I have not yet heard any complaints from the Massachusetts Medical Society about the 8,000 hospital beds which my State has built with Hill-Burton Act aid.

Opponents of this program say that under it, medical facilities would be swamped. However, it is carefully designed to encourage the use of outpatient facilities and nursing homes. It is also being supplemented by a number of programs, already in effect, to increase outpatient facilities and protect the hospitals from unnecessary burdens. In the Community Health Service and Facilities Act, passed by Congress last year, we authorized the appropriation of millions of dollars annually to increase State health services for the chronically ill and aged to improve outpatient services. This program has already begun; and work on these facilities will be underway before this bill is passed.

Finally, the leading opponent of this program, the American Medical Association, has represented the doctors of America as being strongly opposed to it. I do not believe this is true. No one knows better than the average doctor of the enormous expense of modern medical care. And no doctor, I am sure, is less aware of the economic misery of disease than of its physical pain.

Many of the doctors in my State, I am glad to say, have not let the American Medical Association do their thinking or talking for them. Over 350 of them have declared themselves in favor of this program. Many have written me personally to protest the American Medical Association's stand on the Anderson amendment and to announce their support of it. They have described in vivid detail the costs that face their patients and the failure of the private insurance companies to offer plans within the reach of lower income workers. These doctors have added their voices to the overwhelming support which already exists for this bill in Massachusetts.

I intend to heed this support and to vote for the Anderson amendment. I will vote only for a plan that provides coverage under the social security program. From the hearings I held, the mail I have received, and the many people to whom I have talked in the Commonwealth, I feel that this program is the only one that will give the senior citizens of Massachusetts proper medical care.

I shall be glad to back any sound amendment to strengthen this coverage as it now stands. But these amendments must contain proper safeguards for the consumer and a guarantee for him of lifelong, noncancelable benefits.

There is more at stake in this bill than simply medical care for those who cannot now afford it. The benefits of this program will reach far beyond those who receive its direct assistance.

It will help the States, by removing from their backs a financial responsibility that they cannot meet. It will help the insurance companies by providing low-income families with a base from which to build additional coverage. It will help the young, who often see their savings eaten away and their futures ruined by the prolonged illness of an older relative.

Most important of all, it will give our senior citizens peace of mind and confidence against the day when illness strikes.

A couple from Belmont wrote me:

> We have worked hard and have been thrifty, but feel we are living on the brink of a precipice because of the fear of a long and expensive illness.

I say that there is no need for people to live this way in the United States, today. This program will remove this fear from their lives, and will give them the opportunity they have earned to live the remainder of their lives with dignity and honor.

The PRESIDING OFFICER. The time yielded to the Senator from Massachusetts has expired.

Mr. WILLIAMS of New Jersey. Mr. President——

Mr. ANDERSON. Mr. President, I yield 2 minutes to the Senator from New Jersey.

The PRESIDING OFFICER. The Senator from New Jersey is recognized for 2 minutes.

HEALTH CARE FOR THE ELDERLY

Mr. WILLIAMS of New Jersey. Mr. President, I should like to say a few words on behalf of the pending compromise Anderson amendment to provide health insurance for the elderly. I hope the Senate will defeat the motion to lay on the table this most important and vital measure.

Mr. President, it is interesting to contemplate the fact that as we debate this bill today, about 1,000 more men and women will join the swelling ranks of the 17.5 million persons who now are 65 years of age or older.

We are debating one of the most urgent problems facing this age group, for the onset and the continuation of serious illness at a time of minimum income have made a mockery of the pursuit of happiness for millions of Americans in their last years of leisure.

With only subsistence income and a little savings to carry them through their years of retirement, thousands upon thousands of our elderly men and women have seen their modest dreams for a decent life go up in smoke with the receipt of no more than a single hospital bill.

There are, of course, vast quantities of statistics to document the seriousness of the problem. We know that the aged suffer two to three times as much chronic illness as do the rest of the population under age 65. We know that their expenditures for all kinds of health care are at least twice as great as those for the rest of the population. We know that medical costs have, since 1947, been rising twice as fast as has the cost of living as a whole. And we know that the incomes of those over 65 are hardly adequate to cover the bare costs of normal living, much less the special costs of a serious and chronic illness.

More than half of all persons 65 or older had less than $1,000 cash income in 1960. Less than 25 percent had incomes of more than $2,000.

About 30 percent of the elderly have no liquid assets at all. About 20 percent have assets of less than $1,000, making a total of 50 percent who have less than $1,000 to spend on a medical emergency without having to "hock" the family car or the living-room furniture.

About 47 percent of the elderly population have no health insurance at all, and countless numbers more have health insurance policies with so many loopholes that they may be excused for wondering what they are getting for their money.

Mr. President, recently I received a letter from a resident of New Jersey, commenting on the television rebuttal of President Kennedy by Dr. Annis, of the American Medical Association. I should like to read a portion of that letter:

> He (Dr. Annis) praised the system of private insurance, a subject on which I know a little, having been in the insurance business for 37 years. What he did not say is that 90 percent of all disability insurance is written on a cancelable basis, and I can cite you many cases where after a serious illness, the policies were canceled, and the policyholder left without protection at a time and age when he needed it most. He did not say that many policies reduce the benefits for the same premium at the age of 65, and many more become invalid after age 70. He did not state that most private insurance policies require a year or more to elapse before a new claim may be made, and many policies have benefits that end after 1 year, or 2 years in the aggregate, so that after one or two claims the policyholder is without any benefits whatsoever.

Mr. President, it is because of these virtually inherent difficulties under our present system in providing reasonably adequate health coverage at reasonable cost for such poor-risk people as the aged that Congress is being asked to take the constructive action that I believe the Anderson amendment represents.

The alternative is to decree through inaction continued economic hardship, and often more painful and shorter lives, for the men and women who nurtured us, sacrificed themselves for our benefit, educated us, fought our wars, built our country, and made possible everything that we are able to enjoy today.

If nothing else, simple humanity should compel us all to find some way to guarantee our elderly citizens the quiet dignity, the peace of mind, and the freedom from medical catastrophe that they so clearly deserve.

Yet we are faced with an intensive campaign of opposition to a proposal that would not even stiffen the bristles of the most conservative Tory in Great Britain.

Mr. President, history is replete with instances of indomitable opposition to change which provided the pressure for changes of a far more drastic nature than would have been the case had some sort of accommodation and constructive action been taken promptly in the face of demonstrated need.

I think there is a lesson to be learned from the tragedy of death and suffering arising from the Saskatchewan doctors' strike. They, too, had a serious problem; and, under public pressure to do something, the officials of Saskatchewan went all the way to socialized medicine for

everyone. The Saskatchewan plan was not limited to hospital and nursing-home care; it also included the payment of doctors' fees, and thus the regulation of their wages and their freedom of practice. It was not limited to the health problems of the elderly; it covered everyone. Now the Province is in bitter turmoil and tension, and everyone is the loser.

The genius of American democracy has always been its ability to adjust to and to cope with changing social and economic needs with minimum disruption to our traditions.

The Anderson amendment is in our best traditions of constructive accommodation to changing needs.

By covering the heaviest costs of hospital and nursing-home care, the Anderson amendment will make it possible for private insurance companies to provide all kinds of complementary health-insurance programs at reasonable cost. Far from competing with private enterprise in the insurance field, I am convinced that the amendment will be its best stimulator.

It will, for one thing, make it less expensive for insurance companies to provide health coverage for younger people, by avoiding the necessity of having to weigh the premiums of the young sufficiently to cover the higher costs of the elderly.

In addition, the amendment contains an option feature which would permit elderly persons holding private policies to have the choice of having payments for the benefits used made to the private carrier, if it is eligible.

In short, Mr. President, the Anderson amendment is the best antidote to socialized medicine; and I earnestly hope the Senate will approve it.

Mr. ANDERSON. Mr. President, I yield 13 minutes to the distinguished majority leader [Mr. MANSFIELD].

The PRESIDING OFFICER. The Senator from Montana is recognized for 13 minutes.

Mr. MANSFIELD. Mr. President, the debate on the health-care and hospitalization amendment has been going on now, with time out for other business, since July 2. During that time, and during the many months and years leading up to this important vote, both supporters and opponents of this basic extension of social security for the elderly have exhausted their arguments on the measure.

Out of the wealth of testimony and debate, several basic facts which should now be beyond dispute have emerged.

First, it has been shown that a strong need exists for some plan of comprehensive medical care for the elderly—one which will provide adequate, economical medical care, while preserving the dignity of the individual. The proof of this lies in the fact that substitutes to the Anderson-Javits proposal have been offered by three Senators—the Senator from Connecticut [Mr. BUSH], the Senator from Kentucky [Mr. MORTON], and the Senator from Massachusetts [Mr. SALTONSTALL].

It has been shown that time is running against old age, to which, lest it be forgotten, all of us are headed. Americans live longer; yet they are being compelled to retire at a progressively earlier age. Out of these lengthening years of sharply reduced income, they must meet mounting medical expenses.

It has been shown that those most in need of health insurance are least likely to have it. Private insurance is either too costly, or older citizens are considered poor risks and are rejected by the insurance companies.

It has been shown that purely private insurance plans have not been able to do the job. Despite intensive efforts by private companies to reach these people, only about half of the Nation's 17 million elderly persons have some form of medical insurance, and many of those who are covered are inadequately covered.

Finally, it has been shown that the existing legislation of Federal-State cooperation in this field is inadequate. Only 24 States, or less than half, are now participating in the Kerr-Mills program, after nearly 2 years of operation; and of those, only 4 receive the major amount of the funds already allocated.

In short, Mr. President, it has been shown that the time has come for the Congress to act, and to act vigorously. We must act as a matter of common decency to end the neglect and degradation of millions of senior citizens who have given the best years of their lives to help make this a land of plenty.

The urgent need for a solution to the problem of these citizens has become a mandate for action on our part. As I have pointed out in earlier remarks, the needs of the elderly do not wait. And neither should we. The long and often heated discussions on the merits of this issue have served a useful purpose. Now let us put an end to talk, and substitute for words, deeds—deeds which will speak with great eloquence about the dignity and the rights of the aged.

Fortunately, the way toward final action has been made easier by the compromise amendment now before us. Let me point out that there is more involved here than a simple compromise for the sake of compromise. On the contrary, the proposed legislation which is before us today is vastly improved because of this compromise.

It derogates from the contribution of no other Senator to point out the deep understanding and the persistence with which the distinguished Senator from New Mexico [Mr. ANDERSON] has led the fight for this legislation. By the same token, it does not derogate from his leadership to note the great contributions which have been made to the perfection of the legislation by several distinguished Senators from both sides of the aisle. All of them have given to the solution of this problem deep concern, compassion, wisdom, and great practicality. And they have come up with a highly workable plan which can be accepted in good conscience by any Senator here today.

This measure combines the best features of several plans which have been advanced as solutions of this serious problem. At the heart of the proposed amendment is a system of social security financing which is designed to cover nearly 15 million of the more than 17 million elderly in the Nation today. It is clearly the simplest, most economical alternative for reaching in a program of this kind such a large number of people.

The remainder of the elderly, those not encompassed by social security, are not left out. At the initiative of the distinguished Senator from New York [Mr. JAVITS], provision is made for these people, so that health insurance is uniform for all of the Nation's elderly.

Careful pains have been taken to meet the honest reservations and fears of certain interested groups. As the title states, this measure does not permit any Federal supervision or control over the practice of medicine. It prohibits any Federal control over the selection, tenure, or compensation of any officer or employee of any hospital, nursing facility, or home health agency. It does not permit Federal control over the operation of any such institution. And it leaves to the individual complete choice of qualified hospital or nursing facility.

Despite these obvious safeguards, there are those who continue to decry as "welfare statism" and "socialism" the use of social security machinery to collect and dispense the bulk of the funds necessary to make the hospitalization and health-care insurance system work. With all due respect to these critics, I suggest that they reexamine their definition of "welfare" and take another look at the legislation dealing with this subject which now is on the books. Money paid into the social security fund, and the money proposed to be collected in support of the proposed health insurance for the elderly, is money destined to be returned to the individual with a minimum of strings attached. It is not charity. The individual has earned it. It is his by right. Once the proposed health insurance plan matures the individual will be secure in the dignity that any benefits he receives will have been earned.

This is in contrast to the MAA plan now on the books. Under this plan, support from the Federal Government, no matter how much the individual may merit it, is nothing more than a handout and a costly drain on the Federal Treasury. It is not distributed evenly to those who need it throughout the Nation. Often an elderly person who still has a few personal assets cannot qualify for these MAA welfare payments until such assets are exhausted.

Self-respect, a measure of security against the cost of ill health, is important to us. Should it be any less important to those who have given much during their productive years? Must we go on, in effect, insisting that older citizens beg for hospital care, as many of them now do?

Opponents of this measure raise the argument of fiscal responsibility in Federal expenditures. At the same time, they press for a continuation or extension of the present Kerr-Mills law. But what can be more fiscally irresponsible than to reject the use of the collecting

and disbursing machinery of a system which has proven its value to older citizens and its fiscal soundness over a period of nearly 30 years?

Finally, opponents fall back upon the timeworn argument that the freedom of the individual will be infringed if the Federal Government is involved. Ask any citizen over 65 whether he has lost his freedom because he gets a monthly social security retirement check which he has earned and paid for through years of labor. His answer will be a proper response for those who now argue against this legislation on these grounds. One may well ask: Whose freedom and for what? The truth is that this is the same argument which has been used throughout our history to oppose the type of social progress which is embodied in this legislation and which is essential to the survival of freedom in this Nation.

How can a do-nothing philosophy be justified on the grounds of preserving freedom when the freedom of millions of elderly Americans to enjoy peace of mind and decent care at a time of need is infringed? What freedom is preserved when citizens cannot grow old with a measure of dignity and self-respect in this, the world's most materially blessed Nation?

Mr. President, 26 Senators from both parties have joined in sponsorship of today's amendment. I want to say again that this amendment embodies a sound, sensible plan which can be—and should be—supported in good conscience by any Senator here who recognizes that a serious problem exists in the care of older citizens and that a solution to it is necessary. Legitimate objections have been met and adequate safeguards have been written into it. A failure to act on our part can properly be interpreted as an evading of a clear responsibility. Millions of Americans will measure the depth and sincerity of the professed concern over the plight of the elderly by this vote. Let us neither disappoint them nor our consciences; let us not look for an out, let us, instead, face up to the responsibilities entailed in this motion to table the Anderson-Javits proposal and vote it down. If this is done, we can then get on to the business at hand and, on the clear-cut proposal of health care for our aged, vote it up or down.

Few votes during this session of Congress will be as crucial as this one in affecting the quality of American life.

A number of Senators and members of the press have said that the question of health care for the aged, if not resolved in this session, will be a great issue in the fall elections.

I say it is already a great issue. It is a great issue with millions of older persons who face the prospect of the recurring illnesses of age without the means to pay for the hospital care they need. It is a great issue with millions of younger Americans, who bear the responsibility of caring for their parents during those periods of illness. It is a great issue with all those who are concerned to see our contributory social security system made adequate to our people's needs.

So it is already a great issue. In closing, I commend those members of both parties who stand ready to resolve it now, and resolve it one way or the other.

I hope we can do it by voting down the tabling motion to be offered; and, if we are successful in that endeavor, then face up to this matter on its merits and vote our consciences accordingly.

Mr. ANDERSON. Mr. President, I yield 5 minutes to the able Senator from Kentucky [Mr. COOPER], who has been a great leader in the field of public welfare.

The PRESIDING OFFICER (Mr. HICKEY in the chair). The Senator from Kentucky is recognized for 5 minutes.

Mr. COOPER. Mr. President, Members of the Senate, as one of the five Republicans who joined in introducing the Anderson-Javits health care amendment, I wish to say that the amendments to it, proposed by us, and accepted by the Senator from New Mexico [Mr. ANDERSON] did not represent an accommodation or a compromise.

Under the leadership of the senior Senator from New York [Mr. JAVITS] who played the primary roll, we considered at length and then proposed to Senator ANDERSON amendments which we thought would strengthen the original bill offered by him. As I have said, the chief proposals were developed through the leadership of the Senator from New York [Mr. JAVITS]. But in our conferences, other Senators suggested changes which were adopted, and the Senator from New Mexico [Mr. ANDERSON], in his wisdom and judgment, himself proposed changes. The process was an effort to strengthen the bill, and the bill has been strengthened.

The amendments made of the original Anderson proposal a base to which private insurance plans can be joined, if one wants to use the option, to provide greater services and benefits for those who would be included in the coverage of the measure.

I remember that when I first came to the Senate in 1947, the issue of medical care, provided through the social security system, was being debated in the Congress, although no bill came to a vote. In the years that have passed, the subject has been before us many times and in different forms.

Much historical and statistical information has been adduced in the debate by the Senator from New Mexico [Mr. ANDERSON], the Senator from New York [Mr. JAVITS], the Senator from California [Mr. KUCHEL], and other Senators who favor the measure, and by those who oppose it. I think particularly of information provided by the Senator from Nebraska [Mr. CURTIS] and the Senator from Oklahoma [Mr. KERR].

Whatever may be one's position on the Anderson-Javits amendment, the debate has established certain facts which are incontrovertible. The first fact is that there are millions of people in this country today who are over 65, and millions who will become 65 years of age, who do not have, and will not have, the financial resources to provide for themselves the same kind of medical care—even minimum care—that others of their more fortunate fellow citizens will enjoy.

I do not have to draw on statistics to know that statement to be true, and none of us does. As I said earlier today, I know this from experience as a local official. I know this to be true, from experience, traveling through my State as a Member of the Senate. I have been in the homes of friends and neighbors, and I know from my own experience, observation, and knowledge that there are many persons in my State and throughout the country who do not have the resources to secure the minimum of care that they need.

All of us know that a person who has ample financial resources can go into a hospital and stay as long as needed. His neighbor, a person next door without funds, will certainly secure good treatment, but will have to leave the hospital at the earliest possible date to make a place for someone else.

A second fact the debate establishes is that the Congress will not authorize a system financed by appropriations from general revenues which would provide the extent of care the Anderson-Javits plan offers. I point to the fact that during this debate, within the last 10 days, two plans to be financed by the appropriation of general revenues have been overwhelmingly rejected.

In 1960 the Senator from New York [Mr. JAVITS] and others of us introduced a bill which would have provided comprehensive care, financed chiefly from general revenues. It was defeated.

In 1954, when I was serving as a member of the Committee on Labor and Public Welfare, President Eisenhower sent to the Congress a bill which would have provided limited Federal reinsurance of private insurance plans, for those over 65 years of age. It was defeated in the House of Representatives. We could not even get a vote on it in the Senate. So I am led to the conclusion that the Congress will not support a plan based upon financing by appropriations from the Treasury.

It has been said that the Kerr-Mills program will do the job. I do not derogate its value, but it would take massive annual appropriations from Federal revenues to provide comprehensive aid under the Kerr-Mills program.

Further, while many applaud the idea, the States, because of lack of funds, must subject applicants to a means test. But, not only indigent persons, but persons in better financial circumstances cannot bear the heavy cost of hospital care.

The Kerr-Mills program, valuable as it is, seems to me to say, "When you are old, when you are sick, when you are 'broke,' then you may have a chance for medical care." The plan we propose would give workers assurance that when they become 65 years of age, a part of their hospital costs would be covered by health insurance under the social security system.

The VICE PRESIDENT. The time of the Senator from Kentucky has expired.

Mr. COOPER. Will the Senator yield me 2 more minutes?

Mr. ANDERSON. I yield 2 minutes to the Senator from Kentucky.

The VICE PRESIDENT. The Senator from Kentucky is recognized for 2 additional minutes.

Mr. COOPER. It would provide also, with humanity, help today to some 17½ million people already 65 years of age and older.

I believe the basic opposition to the Anderson-Javits plan is that it is based upon the social security system. People say, "It would be compulsory."

But, as I have said before, the same argument could be applied to the social security system today, and to all the benefits it provides those covered under it.

Each of us must vote in the light of our intellectual processes, the facts, and upon conscience. Like others in this body, I have considered for many years and debated in my mind the best method to provide health care. In 1960, I voted against the social security approach. But because of the reasons I have given today, I have come to the conclusion it is the only way we can provide for the health care of millions of our people. I do not want to vote against providing at least minimum health benefits for millions of people who will become sick or injured, who will suffer and who will not be able to obtain the care available to their more fortunate fellow citizens. We face a human issue today.

The VICE PRESIDENT. The time of the Senator from Kentucky has again expired.

The Senator from Illinois has 31 minutes remaining, and the Senator from New Mexico has 20 minutes remaining.

Mr. DIRKSEN. Mr. President, I yield 3 minutes to the distinguished Senator from Iowa [Mr. MILLER].

The VICE PRESIDENT. The Senator from Iowa is recognized for 3 minutes.

Mr. MILLER. Mr. President, I have sat through much of the debate on the Anderson-Javits amendments, which substantially represent President Kennedy's medicare proposal. I want to commend my distinguished colleague the able Senator from Nebraska [Mr. CURTIS] for his thoroughly prepared speech against the amendments. My remarks made in this Chamber last Wednesday fully outline my reasons for calling the amendments an "unfair prescription" for the medicare problem, but I should like to answer the points which have been made by those who argue in favor of the amendments.

First. They say that the coverage now would be made universal, because all people over 65, whether under social security or not, would be covered. This is not true. No one under 65 would be covered. And, as I pointed out last Wednesday, I think we should be far more concerned about coverage for those under 65 who suffer from catastrophic illness or disease than for those over 65 who are able to pay their own bills.

Second. They ask, What are the alternatives? One alternative is to exclude those who can afford to pay their bills. I suggested an "economic income" test along the lines of the amount of earned income which now reduces or excludes a person from social security benefits. Another alternative would be to cover all catastrophic situations, regardless of age, when the person cannot afford to pay his medical care bills.

Third. They say that the Kerr-Mills program will not do the job. I do not think anyone claims that the Kerr-Mills program is the complete answer. But I do think it should be given a fair and reasonable trial period, and then we can intelligently legislate to cover the needs which it does not meet.

Finally they have absolutely no argument against the fact that the social security system, which they would use to finance this program, is already in a precarious condition—with over $300 billion in costs of benefits for the present social security program being passed on to our future generations.

I cannot believe that a majority of our senior citizens who can afford to pay their bills want to have a "free ride" at the expense of future generations of Americans.

The amendments are unfair in their coverage and unfair to the future generations of America. I hope they will be tabled.

The VICE PRESIDENT. The time of the Senator from Iowa has expired.

Mr. ANDERSON. Mr. President, I yield 2 minutes to the Senator from Maine [Mr. MUSKIE].

The VICE PRESIDENT. The Senator from Maine is recognized for 2 minutes.

Mr. MUSKIE. Mr. President, I should like to ask the distinguished Senator from New Mexico if he will consider accepting a modification of the language of the pending amendments.

On page 17 of the amendments there is a definition of "skilled nursing facility" which reads in part as follows:

> The term "skilled nursing facility" means (except for purposes of section 1704(c)(2)) an institution (or a distinct part of an institution) which is affiliated or under common control with a hospital having an agreement in effect under section 1710.

In States like mine it seems to me this definition would work a hardship on some of our nursing homes, as we call them in my State. In Maine we have approximately 192 nursing homes, only 1 of which is "affiliated" within the meaning of this definition. Therefore, I suggest language to modify this provision of the amendments. The Senator from New Mexico has a copy of the language, which I should like to read into the RECORD. It would be included, if accepted by the distinguished Senator, on page 23 of the amendments, between lines 11 and 12.

The VICE PRESIDENT. The time of the Senator from Maine has expired.

Mr. ANDERSON. Mr. President, I yield 2 more minutes to the Senator from Maine.

The VICE PRESIDENT. The Senator from Maine is recognized for 2 additional minutes.

Mr. MUSKIE. The language would read:

> ADDITIONAL SKILLED NURSING FACILITIES
>
> (h) The Secretary shall, after consultation with associations of nursing homes, the American Hospital Association, the Joint Commission of Accreditation of Hospitals, and other appropriate professional organizations, make a full and complete study of the best ways of increasing the availability of skilled nursing facility care for beneficiaries under this title under conditions assuring good quality of care; and, on the basis of such study, he may make a determination that additional nursing facilities in which such conditions assuring good quality of care exists constitute skilled nursing facilities under section 1706(b) if they also meet the requirements of subsection (b) (other than the requirement of affiliation and other than the requirement that a hospital utilization review plan be made applicable), and if the Secretary shall find that such action will not create an actuarial imbalance in the Federal health insurance trust fund. The Secretary shall promptly report to the Congress from time to time and in any even by July 1, 1963, the results of the study under this subsection and any action taken as a result thereof.

The purpose of the language, Mr. President, is to make it possible for nursing homes which do not presently meet the high standards of care required by the pending amendments to work toward those standards and to achieve eligibility whether or not they are able to meet the test of affiliation with an established hospital.

Would the Senator be willing to consider accepting this modification?

Mr. ANDERSON. Mr. President, the American Hospital Association expressed interest in nursing homes. We tried to meet that interest and to raise standards of nursing homes in the proposal. The language the Senator has read is completely satisfactory. Therefore, I modify my amendments accordingly.

Mr. MUSKIE. I thank the Senator.

The VICE PRESIDENT. The amendments are modified accordingly.

Does either the Senator from New Mexico [Mr. ANDERSON] or the Senator from Illinois [Mr. DIRKSEN] desire to yield further time?

Mr. ANDERSON. Mr. President, I yield 3 minutes to the able Senator from Tennessee [Mr. GORE].

Mr. GORE. Mr. President, we approach final decision on an acute problem. It has been said that the problems of people are never solved, and that as one is solved others arise. This is one problem I am proud we have. It is said that the problem will grow greater. I hope it will. We have the problem partly because people live longer. We have the problem partly because of the greater benefits which a person can receive in medical care and in hospitalization, and in part because of the change in our social life by which it is not possible for the majority of our people to lay up sufficient for the traditional rainy day.

In seeking a solution of the problem, the Congress in its wisdom is turning increasingly to an approach of a social security system of financing of dispensation of benefits of administration. A method of financing such as that proposed that is broadly based, has been proved sound for more than two decades.

Of course, a payroll tax is in essence an assessment upon our national economy. But I think that is preferable in

the instance of benefits so widely to be enjoyed. Therefore, I believe it is the soundest way. I am confident it is the most effective way.

The problem, which I am proud we have, is an acute one. It is said that it will become more acute. Therefore, we must not only seek to solve the problem by sound financial methods, but also we need to find an effective means of relieving the acuteness of the problem.

The VICE PRESIDENT. The time of the Senator has expired.

Mr. DIRKSEN. Mr. President, I yield 3 minutes to the distinguished Senator from Louisiana.

The VICE PRESIDENT. The Senator from Louisiana is recognized for 3 minutes.

Mr. LONG of Louisiana. Mr. President, I yield to no Senator in my desire to care for the needs of the aged, the disabled, and the underprivileged in general. That is not the issue before us now. We are asked to vote on an amendment which would require that we pay the medical bill of everyone over the age of 65 whether he needed such care or not. We are asked to adopt an amendment which would tax the poorest people in our country on the same basis as that on which we tax the wealthiest. We are asked to vote one of the most regressive taxes we could find. It is a tax that would operate like a hidden sales tax. It would hit hardest at the poor, in order to finance medical care for all the people, whether they need such care or not.

My mother's cook and yard boy would be asked to pay my mother's medical bill, although she neither asks, expects, or demands it. Frankly, I think she would feel that the proposal was unsound. When the medical bills of everyone who might seek medical care under the measure, whether he needed such care or not, are added, we find the cost of medical care increased by 50 percent.

In Louisiana we have found that when we provide such services at State expense, patients stay in hospitals 50 percent longer than they would remain otherwise. People would be taking their mothers and fathers to hospitals to vacation in the hospital while they, themselves, took their families on vacations elsewhere in the summertime. Such a result has occurred in some States under the Kerr-Mills Act. The proposed legislation would fill the waiting rooms and corridors of hospitals with people who do not belong in hospitals. Instead of saying, "Doctor, may I go home," many people would say, "Doctor, must I go home?" By the time we are through considering the bill, we shall have 10 more amendments, so that the measure would apply to the medical needs of everyone. A deduction of 10 percent of payrolls would be required to start with. By the time we shall have finished with the measure, I guarantee that the cost will be increased by at least 50 percent.

Why is the cost of Blue Cross increasing so much? People say, "I am paying for this insurance. I might as well get as much benefit from it as I can."

There would be a payroll tax of 15 percent by 1970, which, on top of the 10 percent social security tax, would represent one-quarter of the income of the people. In addition, the people would be required to pay for national defense, foreign aid, and everything else. Think about it. If all taxes, State and Federal, were included in the deductions from the payroll, they would exceed 50 percent of a man's salary by 1970, should we start this kind of program.

Let us look after those who cannot afford to pay for their own medical care. Let those who can afford to pay for it decide how much medical care they wish to buy.

Mr. ANDERSON. Mr. President, I yield 4 minutes to the distinguished Senator from California.

The VICE PRESIDENT. The Senator from New Mexico yields 4 minutes to the Senator from California.

Mr. KUCHEL. Mr. President, through the proposed amendment we would deal with a grave problem which confronts the great majority of Americans who are over 65 years of age. We would not deal only with the problems which confront paupers. We would not deal only with the problems which conffont indigents. We would not deal only with the problems of those who are near indigents. We would deal instead, with all Americans over the age of 65 for whom the hazards and fears of catastrophic illnesses grow day by day. We would deal with that problem in an honorable way.

Senators on both the Democratic and Republican sides of the aisle have together fashioned this amendment in order to bring to all American people over the age of 65, whether they are under social security or not, some modest amount of protection against the unbelievably high cost of hospitalization.

Mr. President, as a Democrat, you are proud of your party. As a Republican, I am equally proud of mine. The proposal now before the Senate does not wear a partisan label. This measure is a bipartisan attempt on the part of Senators in both parties to solve a great and growing problem before the American people. Hospital costs have increased fivefold in 20 years. So too has our elderly population increased until it consists today of almost 10 percent of our population.

Yesterday I alluded to Blue Cross. Last year Blue Cross paid out $375 million in benefits to elderly people, and it took in from elderly people by way of premiums $200 million.

What is the answer to the high costs of private insurance health care for the aged? The answer must be that either the premiums are to be raised on our senior citizens or the premiums are to be raised on all, including those under 65 in order for private companies to pay the higher costs of the benefits which are now being paid for the care of the elderly.

We have in the Anderson-Javits amendment an opportunity for all citizens to absorb part of this risk on a pay-as-you-go basis during their working years. At the same time through our freedom-of-choice option we would invite—indeed, implore—private insurance companies in America to participate in the program and help in meeting the health care needs of those over 65. We would create a separate health insurance trust fund so that the moneys allocated into that fund in the Treasury would be sequestered for that purpose alone.

A few moments ago I listened to my able friend from New York [Mr. JAVITS]. I agree with him that our proposal offers the best, most efficient, and most conservative means by which to solve the health care problems of our senior ctiizens on a pay-as-you-go basis.

Mr. President, I am proud of the patron saint of the Republican Party. What did Abraham Lincoln say? On one occasion he said:

> The legitimate object of government is to do for a community of people whatever they need to have done, but cannot do at all, or cannot do so well for themselves in their separate and individual capacities.

The elderly people in America have a problem which they cannot solve for themselves without this typically American approach. Let the Senate stand up and be counted in favor of this amendment and against the motion to table.

Mr. ANDERSON. Mr. President, I have yielded time to the Republican whip. I now yield the remainder of the time on this side to the Democratic whip, the Senator from Minnesota [Mr. HUMPHREY].

The VICE PRESIDENT. The Senator from Minnesota is recognized for 9 minutes.

Mr. HUMPHREY. Mr. President, I know of no issue that has ever been before Congress which has been more fully and thoroughly discussed than the so-called Anderson amendments, and the methods and means of financing health care for the aged.

It is said with reference to the motion to table that the motion should be adopted because, first, the Committee on Finance has not acted upon the proposal; or, second, because we have inadequate information with respect to the proposal. Of course, there are other reasons which are advanced, such as the one that this is public policy which will do injustice to private insurance companies and to individuals and to the medical profession.

First of all, the fact that the amendment has not been acted upon by the Committee on Finance does not mean that it has not been discussed or studied.

Mr. President, this is the most studied and discussed proposal that has ever been before the Senate in recent years. Hearings were held on it in the Committee on Finance in 1960. That proposal was almost identical to the one that is before us now. The previous administration presented all sorts of proposals based on voluntary insurance programs, some of the principles of those reports being incorporated in the proposal before us in the form of the Javits amendment to the Anderson proposal.

In 1959 the Eisenhower administration submitted comprehensive reports to the other body, which reports were made public and available to every Member of Congress and to every citizen. They were comprehensive reports on the prob-

lem of the care for the aging, and medical and hospital care for the aging.

In 1960 hearings were held in both bodies.

In 1961 the White House Conference on the Aging issued volumes of reports on the matter of financing health and hospital costs of our elderly citizens.

I see in the Chamber the Senator from Michigan [Mr. McNamara], who is the chairman of the Special Subcommittee on the Aging, which held hearings on this subject all over the Nation. Those hearings had to do with assistance to elderly citizens, particularly with respect to hospitalization and medical care.

The same thing can be said with respect to 1962. The Department of Health, Education, and Welfare has issued detailed reports on the subject of health care for the aged.

My point is that if we need more study on an issue like this, we stand accused of being slow learners. We have had studies and studies made and have had information and information laid before us.

That does not mean that after the studies were made all of us necessarily agreed upon the means and methods of taking care of the problem.

First of all, what are the dimensions of the problem? First of all the number of the aging in our society is increasing every year in terms of the percentage of the population. Second, the costs of hospital care have gone up considerably year after year. Third, the cost of medical and hospital assistance in terms of relief for the needy is a tremendous burden upon the cities and counties and States at the present time. What is more, public assistance medicine has downgraded medicine and hospital care rather than upgraded them.

Some time ago our Nation made a decision with respect to what we are going to do with reference to persons who are aged 65 and over, in terms of social insurance. The great depression compelled us to face the issue: What do we do when people arrive at that point in their life where their opportunity for employment is less, where their incidence to disease increases, and where their social problems become magnified?

In the great depression we had to make up our minds as to whether we would have a continuance of the dole, whether we would ask citizens to submit to a poverty test or a means test; or whether we would adopt a program of social insurance.

If my recollection is correct, it was in the fall—August, I believe—of 1935 that this Nation by vote in this Congress determined that we would use the social insurance principle, the social security system of financing a program for old-age and survivor's insurance.

No responsible citizen in this land would reverse that decision.

We made up our minds that we would give that assistance and that relief as a matter of earned rights, rather than as a dole, or only after a person had submitted to a poverty or means test. These are the rights which people earn in their productive years. The same question is before us now.

With respect to the matter of disability, for example, we set up a disability trust fund. Now we seek to set up a health care trust fund.

What is more, we now have in the bill, through the cooperation of our friends on the Republican side, an option provision under which private insurance and the Blue Cross system can be used as a means of administration. I commend those who have offered that particular proposal.

Now we arrive at the point of determining whether or not a citizen age 65 and over who is in need of hospital care will have his need for that care determined on the basis of a means or poverty test or whether it will be determined on the principle of social insurance, so that the person may receive hospital and nursing home care under the sound financing principle which we have already set up.

It seems to me that there is but one decision that can be made by self-respecting people. I remind Senators that the present relief and assistance programs give little relief and assistance to most of the people who need it. The present systems require people literally to demean themselves, to surrender their property, their earning capacity, even, before they can receive the medical or hospital care which is necessary for a decent citizen to have.

The program before us provides for the storing up in the productive years of money in an insurance fund, so that it can be used in the twilight years of a person's life to give health care and hospital and nursing home care and diagnostic services and home nursing services. Every Senator knows, as the Senator from Kentucky has said, that this great need will increase rather than decrease.

I appeal to my colleagues in the Senate to look at this, not on the basis that a person who is poor enough can get some care. Of course, in a nation with a Judeo-Christian culture, we will not let any of our people go without care. However, I ask my colleagues in the Senate, what will we do with the sick people who are in the twilight of their life, who have given the best years of their life to their family and country and home and Nation? Will we ask them to demean themselves and sign a poverty oath before they can receive the modern hospitalization which is available to them?

Is this plan financially sound? The answer is "Yes."

Is this plan a heavy tax burden upon the people? The answer is "No."

If the same amount were provided under any other plan, it would cost much more than this proposal. This is a plan for self-respecting people who will get the benefits. They will get the benefits that they will pay for. What is more, the people who will get the benefits want to pay for them. They are not asking for a free ride.

I have heard the argument made that some people will get hospital care who do not need it. Well, Mr. President, there have been people who have been involved in automobile accidents who did not need the insurance, but they got it as a right, because they have paid for it. What we propose is a system of universal social insurance for health needs, so that they are available if they are needed. There is no compulsion to it.

Some people send their children to private schools or parochial schools; but I am happy to say that in America we have the policy of public education. Whether one sends his children to private or to public schools, he pays for the public schools.

Mr. President, the motion to table the proposed amendment is said to arise from two noble sentiments. One is that the amendment has not been acted upon by the Committee on Finance and that action by the Senate at this time would be improper. I would like to point out to Senators who may be laboring under this misunderstanding that the Committee on Finance did in fact consider the proposal in the course of its consideration of the Social Security Amendments of 1960. And if the Senators across the aisle need further assurances let me remind them that in 1950 an amendment to the social security amendments of that year, sponsored by Senator Knowland, was passed by this body with the help of Senators across the aisle without having been even considered by the Committee on Finance. His amendment, accepted by the conference committee on that legislation, changed the unemployment compensation laws; but the Committee on Finance did not consider any changes in the unemployment compensation law in that Congress.

The only other allegation offered in support of the motion to table the proposed amendment is that Senators are presumed to be unprepared to vote because they do not have sufficient information to vote intelligently. Mr. President, I can recall no other issue that has been more intensively studied and widely discussed than the amendment that is now before us. I cannot believe that there is a Senator who is not thoroughly familiar with the facts and the issues. Our constituents, who themselves are extremely well informed about the proposal cannot help but see through this rationalization and recognize it for what it is: an excuse for letting this critically needed legislation die.

Mr. President, during the long and intensive study and discussion that has been devoted over a period of several years to the problem of paying for health care in old age, it has been clearly established that the problem is serious indeed, and that it is not going to be solved without Government taking an important role in helping to finance these costs. The need for a Government role in solving this problem was recognized by the enactment of the 1960 legislation providing Federal Government support for programs of medical assistance for the aged.

We are not therefore trying to decide here whether the Government is going to help the aged find a way to pay their hospital bills. The only question before us, Mr. President, is how this highly desirable objective is to be accomplished: What should be the fundamental approach helping older people pay for ex-

pensive hospital care? And costs are up.

We have a choice between two directions in which we can go. And it is this choice that constitutes the single issue that is before us. It is the choice between social insurance and public assistance.

As a nation, we first faced up to the problem of old-age poverty when the great depression of the thirties wakened us to its magnitude and severity. We were forced to realize that in our modern urban civilization people too old to work commonly had little or nothing to live on, and that help was needed if they were not, quite literally, to starve.

Plainly something had to be done. Basically, then, as now, there were two ways we could go, and the choice between them represented a far-reaching decision of national policy. One possible course was to consign our aged permanently to the public dole—to require them to exhaust their savings and, when they reached a sufficient degree of poverty to pass the means test, to apply for public charity. This approach, waiting for poverty to become a fact and then seeking to treat it, would have meant accepting for all time a vast army of the aged living on a dole—all reduced to a common level of poverty.

To our great credit, we did not choose that road. We chose the alternative—a system of social insurance, under which people while working, and their employers, would contribute to funds from which modest but assured payments would be made to them when they were no longer working so that few of them should ever reach a state of destitution. There are practically no Americans today who would reverse the choice if they could.

The same basic reasons for preferring the contributory social insurance approach over the public assistance means-test approach apply with equal force to the problem of protecting the elderly against their high health costs. Under public assistance, eligibility for medical assistance is conditioned upon meeting a "humiliating test of poverty." In many States, the applicant's savings must be virtually exhausted, and even the children's financial situation must undergo a similar test before the parents can get help. Under the social insurance approach the elderly would receive health insurance protection as an earned right; the only test would be that of having worked sufficiently long in covered employment and self-employment to become insured.

State medical care programs throughout the country are uneven and offer uncertain benefits. About half the States have no program of medical assistance for the aged and most of those having one provide only meager help. Under the social insurance—Anderson amendment—proposal, uniform benefits of certain value would be guaranteed to the elderly throughout the Nation by Federal law.

I might add that many medical assistance relief programs deny the applicant the freedom to choose his own doctor or the hospital which he and his doctor feel is best. This means that continuity of care—and therefore quality of care—is often lost under the assistance programs. Under the social insurance—the Anderson amendment—proposal, the freedom to choose hospital and doctor would be guaranteed by law.

Mr. President, nobody is proposing that the medical assistance legislation that was enacted in 1960 should be abandoned. That legislation opened the way for much-needed improvements in the provision for the payment for medical care by the public assistance programs of the various States. But we must realize that only the very poorest will be protected under this legislation even if at some future time it should become effective. Enactment of the amendment is necessary so that the vast majority of the now self-sufficient people in the aged population will have protection against the economic hardships of a costly illness that so often force them, after a lifetime of independence, to seek the aid of children or of public charity.

I repeat, Mr. President, the assertion being made in various quarters that there is really no problem among the elderly as to hospital care is simply without foundation.

It may give us all a better idea of the problem the aged face because of illness or fear of illness if we look at the facts in a few actual cases. I have here some summaries made from letters that have been received by the President and the Department of Health, Education, and Welfare. In these summaries, I have carefully removed any identifying information so as not to subject these people to embarrassment. The originals of these letters are in my office and available for inspection by any of my colleagues.

I ask unanimous consent to have printed at this point in my remarks a statement showing a number of illustrative cases summarized briefly from letters in my office.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

NO INSURANCE FOR AGED HUSBAND

The case: This woman went to work when her husband suffered a heart attack in 1952 and was forced to stop working. He is 77 years old and is receiving social security benefits of $54 a month. She was ready to retire about a year and a half ago but found that she would be unable to get health insurance for her husband after she left her employment because he was too old. She kept working hoping to find some company that might insure him. She was going to retire this February—she would have drawn social security benefits of $85 a month—but her husband suffered a severe stroke with paralysis and was hospitalized for 70 days. Her insurance paid part of the cost, but she had to pay $957. She was forced to put him in a rest home for which she pays $325 a month, and also buys his medicine and pay his doctor bills.

She says, "I don't make only a little more than that take-home pay. I give them all I earn. No food bought yet or utilities * * * I work hard all day and give it all to a rest home because we could never get medical for people like him. I'll be done working in August 1963. What can I do with him to take decent care of him? All my savings are gone. I got a home paid for. I'll have to end up when I retire next year selling it for to give him proper care. And the sad part is, I can't afford to pay a therapist to work on him. And rest homes don't have them. To see him try to talk and can't just breaks my heart. He was such a good man."

Effect of health insurance proposal: If the proposed health insurance plan had been in effect, her husband's hospital costs for his 70-day stay would have been covered in full except for the deductible of $90. After his hospital stay of 70 days, he would have been eligible for 160 days of care in a skilled nursing facility providing physical and speech therapy. He would also have been eligible for 240 home health visits which also could include the services for a physical therapist.

ONE MORE ILLNESS WILL DEPLETE ALL RESOURCES

The case: Through their own efforts this 67-year-old cabinetmaker and his 66-year-old wife have established a small custom shop.

Last spring the wife was a victim of arsenic poisoning. Then in the fall she broke her ankle. The 8 days in the hospital and doctors' bills totaled some $890. She now requires drug prescriptions for high blood pressure.

The husband writes, "Almost 15 years ago I obtained a GI loan. We burn the mortgage in September. * * * The signing of a poverty oath, which is what it amounts to with the California [medical assistance for the aged] bill, is not only degrading but well might undermine the integrity of otherwise honest persons. Or, if you're a bum, you're a success. * * * We beg you to continue in your efforts to have this passed in this session. One serious illness could wipe us out."

Effect of proposed health insurance: Payment would have been made for the entire 8 days of the wife's hospitalization except for a deductible amount of $80.

CANNOT GET ADEQUATE PRIVATE INSURANCE AND SAVINGS WIPED OUT BY COST OF ILLNESS

The case: This aged couple carried Blue Cross. The husband receives social security benefits of $68 a month, and the wife works as an outdoors saleslady. "We carried it for quite a few years and then our premium began to go up and our benefits down, until our premium was more than doubled and our benefits reduced to $3 per day for a room and nothing else." She contacted the insurance commissioner, and was informed that Blue Cross was a private business and not subject to Government control. Recently she heard that Blue Cross was offering a slightly better policy for aged persons, but discovered that it was available only to people who could meet certain physical requirements. She also contacted the Prudential Insurance Co., but was told that people over 65 were being insured only if they were in perfect health.

Last year, the husband was hospitalized twice and the total bill came to about $2,000. "Have you any idea how long it took us to save this $2,000 and how hard we worked and made sacrifices? We are now in a position where we can't save anything, we are lucky to be able to make ends meet every month.

"Being ill isn't too hard to take when one is wealthy, but when one sick spell can practically wipe out one's life savings, that's quite a blow."

Effect of health insurance proposal: The husband's hospital costs for up to 90 days an illness would have been paid except for a $90 deductible.

REFUSES TO GIVE UP HOUSE TO GET PUBLIC ASSISTANCE

The case: The father-in-law of this 29-year-old man has exhausted his savings of a lifetime as a machinist in paying for his

health care. His uncancelable private hospitalization insurance policy was withdrawn. The son-in-law writes, "Because he has clung to his last security of any kind—title to his small house—he is not entitled to county medical aid, so he suffers, eating aspirins to ward off pain, awaiting death."

Effect of health insurance proposal: Protection against the cost of hospital services would be provided without subjecting people to a means test.

UNABLE TO PAY FOR INSURANCE

The case: This 66-year-old woman has worked more than 25 years as a nurse's aid, charwoman, and cook. Her husband has been ill for 37 of the 45 years of their married life, but she managed to get their child through high school and keep their family going. About 2 years ago she had two hospital stays and operations costing $700.55 and $400.80, which she paid. Her health has broken. She receives social security benefits of $60 a month, and works when she is able. She has been forced to quit paying on her insurance. They own a four-room home or cabin, but she says its sale would not bring enough to pay a hospital bill for either herself or her husband.

Effect of health insurance proposal: Under the administration's proposal, she would have protection against the cost of hospital care, very likely much greater than that provided under the insurance she was forced to drop. As she says, with health insurance provided under social security, people can live some way.

UNABLE TO PAY FOR INSURANCE

The case: This retired couple, living on social security and a small pension, was compelled to drop even a limited health insurance policy when the monthly premium for each one was jumped from $5.10 to $7.20, a rise of more than $25 per year.

Effect of health insurance proposal: Under the social security approach, contributions would be made during the working years, and basic health insurance benefits would be provided during the retirement years without any further contributions required. The couple could probably have afforded to carry a Blue Shield policy (costing perhaps $5 a month) that would cover physician services.

FAIL TO GET NEEDED CARE BECAUSE OF FINANCIAL CIRCUMSTANCES

The case: This elderly couple, he is aged 83 and she is 89, moved from Michigan to Florida to be with their son and his family. She receives a teacher's pension (less Blue Cross) of $86.70 a month, and the total security benefit for herself and her husband is $60 a month.

He has been ailing for many years and his wife had been taking care of him. In January of this year she injured her back in an accident and since the daughter-in-law could not care for both it became necessary to place him in a convalescent home. About 2 weeks later, he fell out of bed and broke his hip, necessitating his transfer to a general hospital where he was given treatment for both bladder trouble and the broken hip. An orthopedic doctor was paid $75 for traction, but the couple could not afford the cost of having pins inserted in his hip.

His stay in the hospital was for 1 month, the maximum period covered by their Blue Cross policy. Then he was transferred back to the lower cost convalescent home where he previously had fallen from his bed. As a precaution, Mr. C. was strapped to the bed this time.

Effect of health insurance proposal: Under the health insurance proposal, Mr. C. could have had his hospital costs paid for as long as necessary up to 90 days. The total cost to them for his hospital stay whether 1 month, or 3 months, would have been $90, the amount of the deductible. With basic protection against the cost of hospital care, they could concentrate their private insurance on the cost of other services, including physicians' services.

Payment could also have been made for skilled nursing facility for up to 180 days, and 240 home health visits per year.

RETIRED FARMER LOST "NEST EGG" BECAUSE OF COST OF ILLNESS

The case: This man is aged 84 and his wife is 86. They receive social security benefits of $60 a month. He and his wife worked hard on the farm in Iowa until 1950. Thinking they had saved enough to "slow up," they moved to Arkansas and bought a small acreage. "But then our troubles began," he writes. His wife fell and broke her hip. A year later she fell and broke her other hip and a leg. She had diabetes and arthritis and due to gangrene had to have her leg amputated.

He says, "It sums up we now have $6,000 against our home. We have no hospital insurance. * * * The result our little nest egg is gone."

Effect of health insurance proposal: His wife's hospital costs except for a $90 deductible, would have been covered and the couple would have insurance against future hospital, nursing facility, and home health services.

FACES LONG ILLNESS WITH NO MONEY

The case: Recently this 77-year-old Californian was hospitalized for 6 days. The hospital bill was about $500, and the doctor bill $325.

He writes, "My wife died 10 years ago after many years of sickness and I spent the money of many years earnings and savings along with the savings and earnings of the immediate family. Now at 77 I am facing a possible long illness. I still remember the threats made to me at ——— hospital in ——— that if hospital payments were not made promptly that the next time I came to visit my wife I'll find her in the corridor. I have been living a nightmare ever since. That was exactly what happened as I state in this letter."

Effect of health insurance proposal: This 77-year-old man would have protection against the cost of inpatient hospital services for up to 90 days of each hospital stay, except for a deductible of $90 for the first 9 days.

In addition, many of his other medical needs could be met through the provisions for payment for skilled nursing facility services after transfer from the hospital, and for up to 240 home health visits each calendar year.

CHILDREN MUST SELL THEIR HOME TO PAY AGED WOMAN'S MEDICAL EXPENSES

The case: This 72-year-old woman has been hospitalized because of cancer. She had her first cancer operation in 1938, and has been unable to obtain insurance coverage since then. Altogether she has undergone three major cancer operations.

The daughter and son-in-law state: "We let her sign herself on county welfare help. They moved her from ——— hospital to the ——— County infirmary, in ——— recently. The treatment she received there has been reported and is a matter of record. Needless to say we had her returned to ——— hospital. Why? Because we care. She is a dear old mother."

Since this woman is without resources, her daughter and son-in-law have had to pay for all expenses from their weekly paycheck. This has exhausted their finances and they must now sell their house in order to meet further medical expenses.

Effect of health insurance proposal: Payment would be made for hospital services for up to 90 days, subject to a $90 deductible. Thereafter, if appropriate, this 72-year-old woman could be transferred from the hospital to a skilled nursing facility. Payment would then be made for care for up to 120 days of skilled nursing facility services.

Mr. HUMPHREY. Mr. President, I hope that every Senator will bear in mind when he votes on this amendment that what is being proposed is a program of health insurance for the elderly that would be financed out of contributions made prior to retirement—when people can afford to pay them. Aside from the fact that the proposed program would be financed through social security and the fact that benefits would be limited to the elderly, what is being proposed is much the same as a Blue Cross plan.

The Blue Cross approach that the amendment follows has been proved to be a successful form of protection against health costs. It not only meets the most burdensome health costs people face, but also is designed to fit in with the other kinds of health insurance people ordinarily want. The Blue Cross-type benefit plan that is proposed would provide only basic protection, to which the elderly will want to add by buying health insurance against surgical costs, physicians' fees, and other health costs. And private insurance will benefit from this arrangement just as private insurance has benefited from the provision of basic cash benefit protection under social security.

Enactment of the amendment will scarcely have any effect on the medical profession—except to the extent that any hospitalization insurance plan permits the physician to prescribe expensive hospital care without the fear that his patient may be reduced to poverty because of it. Doctor bills are not even covered under the proposal. So far as hospitals are concerned, enactment of the amendment will mean that they no longer will need to overcharge younger patients or go without making needed improvements in their facilities in order to make up the deficit caused by older patients who cannot pay their own way. These advantages would be unmixed blessings for there is nothing in the amendment that would injure or conflict in any way with the practice of medicine or hospital practices. Decisions about health care would be left where they belong—squarely in the hands of the health professions—just as they are today.

Certainly, no one who has conscientiously studied the question can fail but be impressed by the vast wealth of information available on the subject and its accessibility. In 1959, the Eisenhower administration presented the House Committee on Ways and Means with one of a number of comprehensive reports on the problem the elderly have in paying their health bills. This report included a summary and analysis of the characteristics of the aged, factors influencing hospital and medical costs, methods of financing hospital care for the aged and methods of providing hospitalization and nursing home benefits through social security. Then came the wealth of testimony produced at the hearings on the Forand bill and the committee's report on the bill that recommended the 1960 medical assistance for the aged legislation. Later in 1960,

the Committee on Finance heard testimony on the problems the elderly face in financing their health costs and various proposals to solve these problems. That committee reported out what was to become the medical assistance for the aged; but the excellent minority reports from the committee show clearly the careful consideration given to this problem by the committee.

The 1961 White House Conference on Aging contributed more than 7,000 pages of information on the problem as it exists in the States.

Last year, the other body held extensive hearings on the predecessor of the amendment that is before us—testimony that covers more than 2,200 printed pages. More recently, the Department of Health, Education, and Welfare has published an up-to-date report on "The Health Care of the Aged—Background Facts Relating to the Financial Problem."

Of course, the excellent work carried on by the Special Committee on Aging, under the direction of the able senior Senator from Michigan [Mr. McNamara] and its predecessor, is well known to all of us. The committee has held very extensive hearings and submitted many reports which contain many pages more of information on the problem of health care in old age and related subjects.

The proposed amendment is the product of intensive study and research that has been carried out over a period of years. It has been designed to provide real and concrete help to relieve a problem which has been proved to be so serious as to require Government action. The specifications of the proposal are the product of hundreds of hours of discussion with individuals and organizations with widely varying interests and skills over a period of many years. We have behind us the experience of almost 2 years of failures with medical assistance for the aged—a program that at its best can do nothing to prevent dependency on public charity. All that remains to be decided is the basic issue of whether we are going to sit idly by and permit the elderly people of this, the richest nation on earth, to live under the threat that they will be impoverished by illness and reduced to charity or whether we are going to put the weight of this legislative body behind a measure that would make it possible for the millions of elderly people to live with the assurance that they will live on in independence and self-respect even if expensive illness strikes.

I have heard the appeals of Senators who argue that we should take no action on this measure. We all know that a vote to table the amendment is a vote to destroy the only practical answer to a problem that presses for a solution. After so many years of discussion and debate on this proposal I cannot believe that there is any Senator who is not fully prepared to reach a decision now. The American people have read the numberless newspaper and magazine articles on the proposal, they have listened to the debates, and they have made their decision after a full exposure to the facts. The American people have a right to expect no less from their representatives in the Congress.

Mr. President, I hope the motion to table will be rejected, and that the Anderson-Javits amendments will be agreed to.

Mr. DIRKSEN. Mr. President, how stands the time?

The VICE PRESIDENT. The Senator from Illinois has 25 minutes remaining.

How much time does the Senator yield himself?

Mr. DIRKSEN. I yield myself all of the remaining time.

The VICE PRESIDENT. The Senator from Illinois yields himself the remainder of his time.

Mr. DIRKSEN. Mr. President, I feel certain that every Member of the Senate has the same human quality that makes him interested in a program for the aged. As a boy of 5, I saw a father languish for 3 long years as a victim of apoplexy. As a boy of 5, I saw a mother languish for a long time as a coronary victim. So let no one declaim all the human virtues being on one side or the other, because we are all interested in this problem.

The whole question is one of approch. It is for that reason that I contend that the motion to table, which will be made in 25 minutes, should prevail. I assign some reasons. First, with respect to Kerr-Mills, what kind of effort has been made to sell that act? If the former Secretary of Health, Education, and Welfare has been half as diligent in bringing the Kerr-Mills Act to the attention of the country as Orville Freeman was in bringing an agricultural program to the attention of the country, not only from Washington but through his field force, this would be a far different story.

There is a medicare program. I am astonished that the administration leaders have been so careful never to mention the Kerr-Mills Act, which went on the books in the fall of 1960.

The second reason I assign why the amendments should be tabled is that not a single critic has proposed to amend the Kerr-Mills Act with respect to the so-called pauper's oath or needs clause.

Where is the amendment from the critics which would take that out?

I have an amendment on my desk; and before too long I expect to offer it. But I am no critic of the Kerr-Mills Act.

Why does not someone trot out an amendment, if there is dissatisfaction with the means test and the need clause? It has not been done. The administration has failed to sell the Kerr-Mills Act. I have looked for literature; I have been unable to find it. I receive tons of printed matter, in all colors and illustrated. It is on the whole subject of social security. But try to find a piece of literature, which is the responsibility of HEW, to make manifest to the eligible citizens of the country what they are entitled to under the 1960 law. It is not available. If the administration were interested, this would have been provided long before now.

I assign another reason. There has been an inadequate study of the whole subject. The Actuary for HEW appeared before the House Committee on Ways and Means. He found that the benefits would exceed the income. What did the Secretary do? He had to raise the base ante from $5,000 to $5,200. But look at the record and see the last word of Mr. Robert J. Myers, the Actuary of the Department of Health, Education, and Welfare, which the distinguished Senator from Oklahoma [Mr. Kerr] placed in the Record yesterday.

Next year and the following year the base for taxation purposes will have to be increased. Is that the way to legislate?

Mr. President, how do you think they got the basis for it? By interviews with 5,000 elderly people whom they asked to try to remember what their recent hospital costs were. What a way to establish basic data for a program of such vast dimensions as that, having such a permanent effect upon the whole destiny of America.

In addition thereto, they brought down from New York a man named Lewis Reitz, who, on the basis of 13 million insurance claims from 583 organizations, told the committee of the House that the cost would be twice what HEW had estimated for this purpose. The administration had no facts or no data with which to refute that statement.

Mr. Reitz said that in the initial year this program would cost not $1.1 billion; it would cost $2.5 billion. He said that by 1983 it would cost $5.4 billion.

When Mr. Cohen, the architect of so many of these programs, appeared before the Committee on Finance for the confirmation of his nomination in 1961, what did he say? He said the cost would go up from 5 to 10 percent indefinitely. That was in answer to a question by the distinguished Senator from Nebraska [Mr. Curtis], who quizzed Mr. Cohen at the time his nomination was under consideration. But Mr. Cohen went further. He said that, of course, he was not figuring on a bigger base now; but in the interrogation, he envisioned not the $5,200 provided in this proposal; he envisioned a $9,000 base on which to attach the tax.

The whole story is in the record of the hearings.

Talk about costs. What a tremendous program this will be.

Another reason has been emphasized. The nonneedy are included. Senators are included. Unless I cannot read the English language, every Senator and every Representative when he reaches the age of 65 will be entitled to these benefits. Do we want to go back home and say to the young workers, "Well, I voted myself a benefit. If you are 20 years old, and if you live long enough, you will pay social security taxes for 45 years, and I am going to be the beneficiary." I do not think I want to say that to them. I will carry my own load if I can.

What will be the general impact? We will have to obtain that information, I submit, from other sources which have had some experience. What was the experience in Great Britain? I observed

in a dispatch in 1961 that 600 doctors left Great Britain every year for the preceding 5 years, while 500,000 persons were on hospital waiting lists.

Hospital construction in Great Britain is deplorable. Only one new hospital had been built since 1948, a period of 13 years. That is according to a statement by D. S. Lees, a doctor of philosophy of the University of North Staffordshire.

The cost of Great Britain's medical program in 1950 was $1.3 billion; in 1961, it was $2.5 billion.

Mr. President, that information may be found in the Reader's Digest for October 1961. It is all there, set forth in great detail.

Mr. President, this proposal is a toe in the door. Let us seek to prove it. Go back sometime and read the Wagner-Murray-Dingell bill of 1943. I observe a knowing look on the face of the distinguished Senator from Virginia [Mr. BYRD]. He was a Member of the Senate at that time. He knows full well what that bill provided. Every insured individual and every dependent would be entitled to benefits. That was section 901. The bill also provided a National Advisory Council of 16 to be selected by the Surgeon General of the United States. It has been said that the Advisory Council would be new. It is 19 years old. It was included in one of those bewhiskered proposals when I was a Member of the body at the other end of the Capitol.

What else did the Murray-Wagner-Dingell bill provide? Physicians were to be selected from qualified lists and were to be paid on the basis of a fee schedule. That was what was contained in the Wagner-Murray-Dingell bill.

What else? A provision was included for a single trust fund. That proposal has been sugared and made to appear as something new.

And what else? Why, a provision for a single trust fund. This proposal has been sugared, and it is made to appear that this is something new. But that was in the Wagner-Murray-Dingell bill 19 years ago, and it is nothing new. So one can go back and can find for himself what the ultimate goal is; and the Wagner-Murray-Dingell bill also provided for recompense for dental services, and so forth.

This situation reminds me of a story about the rector of an English church who was preaching to his congregation about all the glories of heaven—ambrosia, nectar, and everything else on which one would subsist, including some substantial viands. When he got through, one of his parishioners said to him, "Parson, what good will that do me, without teeth?"

The rector replied, "Under social security, teeth will be provided."

Mr. President, this is just a beginning, believe me.

When Dr. Cohen was questioned by Senator CURTIS, in the Finance Committee, he said he was looking to a 50 percent increase in the benefits.

Walter Reuther addressed the Citizens Council on May 24, here in Washington; and in his keynote address he said:

> We are trying to make a beginning.

He also said:

> If King-Anderson is approved, we should expand the benefits.

And he said:

> We should include the $2.5 billion out of general appropriations.

And, Mr. President, during the 2 months that have passed since then, that provision has been included in the Anderson proposal which is before us.

What else did Walter Reuther say? He said:

> We should eliminate the deductibles.

And, Mr. President, last night the Senator from Oregon, distinguished and brilliant Senator that he is, offered a proposal to eliminate the deductibles; but for the moment, at least, that has been withdrawn. So we got it almost as soon on the rebound as it was uttered downtown in the form of a keynote speech at a convention.

And this measure has been sugared with the Javits amendment. Let us see what happens here. You see, Mr. President, before a private carrier can accept an option or an election on the part of an individual, the carrier must qualify. How will it qualify? By being licensed in every State and the District of Columbia and by doing 1 percent of the business, or by being licensed in a limited number of States and doing 10 percent of the business. Well, let us see. One of the finest insurance companies in Illinois is the Country Life, and it does one-tenth of 1 percent of the claims business in that State. So it would be disqualified under the provisions in regard to the election.

Furthermore, I am advised by an institute downtown which is identified with the insurance business that only 14 insurance companies in the United States would be able to qualify under the language carried in this bill. That is an amazing thing, believe me. So, Mr. President, is that an option? Is it something wonderful and worthwhile?

Mr. JAVITS. Mr. President, will the Senator from Illinois yield?

Mr. DIRKSEN. Mr. President, this is the only time I have on this bill; but I yield to my friend.

Mr. JAVITS. I should like to make a correction. If the Senator from Illinois will refer to my amendment, he will find that it concerns group plans which are qualified, written by any company, as well as those companies and organizations which are tax exempt. They are fully qualified. The 10-percent figure is incorrect; it is 5 percent. And I am informed that there are at least 200 insurance companies, if not more, that will qualify under that option. I just make that as a statement of fact.

Mr. DIRKSEN. Very well. The first item my friend referred to was nonprofit companies which are exempt under the internal revenue law. The last item he mentioned are those which could qualify for group hospitalization only. That is what this bill says; and if I am in error, I ask to be corrected. But I got my information from authentic sources; and they said 14 companies in the United States can qualify.

Mr. President, what kind of a discrimination is this on the part of this Government? A company that could not qualify probably would find that its customers would say, "Our company did not qualify with the Federal Government, so there must be something wrong with the company." Mr. President, this would begin to wash out all the competition in the insurance-company business. Would that be a fair way for the Government of the United States to treat a great industry which has done so much already for the aged people?

So you see, Mr. President, that is not much of a lure, as provided in the bill.

It is said the social security principle is freely accepted. Compulsory medicine is one thing, Mr. President. Social security is another. When one qualifies under social security, the payments are taken out of one's paycheck, whether he likes it or not. The payments are posted on the check, and one can see what is deducted. He does not have to do a thing or move a muscle; all he has to do is live, in order to get the benefits; and when age 65 comes, the benefits will be there, and the Government will have no control.

But what about this plan? The hospitals have to be qualified. The individual has to request the services. There have to be certifications for specialists, and that sort of thing; and there is a physical control in compulsory medicine that has no relationship to a social security principle in connection with getting a job in a factory and getting a paycheck at the end of the week. The deduction is nicely spelled out. One does not have to do a thing except be alive at age 65; and from then on it will be automatic, too.

Now, then, Mr. President, much has been said, at one time or another, about Blue Cross. Let us see what Blue Cross has to say about this. Here is a release issued just this week by Blue Cross, which has its headquarters in Chicago. It says:

> Just how this would work out—

Meaning the compromise—

> is not clearly defined, but at best it seems that Blue Cross would serve largely as a conduit for money and instructions from the Department of Health, Education, and Welfare to the providers of the services.

And it also says:

> It is unfortunate that this and other provisions of the compromise plan have been advanced without the thorough examination warranted by so complex a subject.

Blue Cross has dealt with 5 million aged persons, and that is its evaluation of this compromise.

What else does it say? It says:

> Based on extensive experience in covering more than 5 million aged persons and long-standing relations with the Nation's hospitals in every State, the plans feel that the Government assistance to the aged should be related in amount to income levels.

And one need not be needy. Even every Member of the U.S. Senate, including the present speaker, would be covered—because I am old enough now, Mr. President. So I would have the benefits of this plan; and I could return home and could see some of the young men there come to my door and "throw

it back at me", by saying, "I will be slaving in a factory, and they will be taking the payments out of my paychecks, but you will be the beneficiary by the accident of life, just because you are still alive."

Mr. President, what a business.

The release from Blue Cross also states:

Our estimate is that the income from the revenues provided in the amendment proposed in the Senate is not sufficient—

Blue Cross has had long experience, and Blue Cross says:

The income is not sufficient to cover the benefits described. Furthermore, it is doubtful that some of the benefits could be produced by providers of services because of shortages of skills and facilities in many areas.

Today the distinguished Senator from Vermont [Mr. AIKEN] spoke on this floor, and said that out of 135 nursing homes in his State, only 2 would qualify under this bill.

Mr. President, now I have concluded; but I have to pay my respects to my distinguished friend and associate, the Senator from California [Mr. KUCHEL], because in the brief and eloquent address he made he referred to Lincoln, the patron saint of our party, and used a quotation which has always been a favorite of mine:

The legitimate object of government is to do for a community of people whatever they need to have done, but cannot do at all, or cannot so well do for themselves, in their separate and individual capacities.

Mr. Lincoln, if you could listen, that is what we are trying to do—at least, some of us—on the floor of the Senate this afternoon. We are trying to do that and leave it in the hands of the people and of the States, so that it can be done by cooperative effort on the part of both, exactly as we exemplified it in the Kerr-Mills Act, so that we could preserve the posture of America and still get the job done.

One other thing, Mr. President. I took a committee to Europe in 1948. I was an eye victim. You remember it very well. They said, "Do not go. Your eyesight is in danger." I said, "I will go, in spite of it," and I did. My doctor, a great specialist at the Wilmer Clinic in Baltimore, said, "If you are determined to go, then I have to find someone to take care of you over there." He found for me the very greatest eye surgeon in Europe, Dr. Thiel. He took care of me. In very short order we became great friends. I said to him, "My friend, back home they want me to get everything new in the field of ophthalmology and eye surgery." This great surgeon, who had operated on the crown heads of Europe, laughed and said, "to take back to your country? Your country is so far ahead of anything in Europe that there is no comparison."

There is a tribute to American medicine. The longevity of our people, now over 70 years on average, is a tribute to American medicine and to the scheme we have followed all this time.

Are we now going to blanket all people over 65, needy and unneedy, into the whole scheme and put into effect in our country a permanent program that will have the same effect upon our people that has taken place in other countries?

When Bismarck finally put it on Germany, his boss, the Kaiser, said, "This is a difficult situation." But Bismarck knew how to bring them into the orbit of government, and said, "This is the best way to do it."

Mr. President, while doing the job, let us serve the gift of freedom. Was it not Pitt who said, "The plea of necessity is almost invariably the first infringement of freedom?"

We can do the job. Let us do it under the Kerr-Mills Act.

Mr. President, for my country—for my country, I repeat—I hope that this proposal will be laid on the table.

Mr. LAUSCHE subsequently said:

Mr. President, I ask unanimous consent that a statement which I made on August 23, 1960, on the floor of the Senate setting forth my reasons for supporting the medicare bill be included in the RECORD preceding the taking of the vote.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

STATEMENT BY SENATOR LAUSCHE

Since 1945, in discussing social security laws, numerous have been the times when I have declared my concept of what ought to be done with respect to the Government providing social security. In effect, I have repeatedly stated I did not subscribe to the philosophy of giving doles and subsidies, but I believed in a system which was actuarially sound, operated in a businesslike manner under which payments were to be made out of a fund which was built up through joint contributions by employers and employees.

That philosophy has been with me, I would say, for at least 15 years. I believe a fund created in that manner in all probability will be prudently managed, since it places a joint responsibility on the employer and the employee, and in all probability it will be based upon a sound actuarial foundation and will be conducted with businesslike operations.

My belief is that the elderly people of our Nation are in need of this type of service. I think not only of the indigent but also of those who through prudence and thrift have accumulated a modest estate.

It is a rather dominant and frightening prospect for an elderly person to find, in the twilight days of life, that whatever he has accumulated through prudence is to be dissipated as a result of the huge costs which come in caring for one's self, especially during an illness in the mature years of one's life. I have in mind specific instances when people have told me, for instance, "I have assembled enough to have a modest home. I am proud of my home. I do not wish to see it dissipated, but I cannot see my way clear to save it if I have to carry these inordinate medical expenses."

The costs of living for the aged, especially those to fight disease, have become extraordinarily large. I need not discuss that, because it is generally understood that medical expenses, including drug costs and nursing services, are beyond the ability of the ordinary person to carry.

On that foundation, it is my judgment that the program of providing medical service cannot be avoided.

To reiterate and to summarize, it is my firm conviction that the funds out of which payments should be made for the social security approach should be accumulated through current contributions jointly made by employers and employees or earmarked taxes.

Mr. CHURCH subsequently said: Mr. President, I ask unanimous consent that a statement giving my reasons for the vote that I cast a few moments ago may appear in the RECORD at a place preceding the vote itself.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

STATEMENT BY SENATOR CHURCH

During the 6 years I have been here in the Senate, nothing has been more upsetting to me than the many accounts I have received from elderly people in Idaho concerning the problems they face in obtaining adequate medical care. Some of these reports come from people receiving old-age assistance, but most have come from elderly residents living on a modest retirement income. These are proud people, who cherish their independence, and who resent having to ask for relief. Typically, they are people who receive regular retirement income from social security, which they feel they have earned through their own contributions during their working years. Oftentimes, this retirement income is supplemented by a little interest or dividends from the savings they have invested over the years.

These people are confronted today with a very special problem. They have discovered that, during the past 20 years, the cost of hospitalization and nursing home care has increased out of all proportion to other costs they must meet. All of us are aware of this, regardless of age or circumstance. Even those with ample incomes have found it necessary to protect themselves against these spiraling costs by taking out insurance policies for medical care and hospitalization, so that the risk of serious illness and the costs which now attend it, can be spread out over the whole group which is insured. Today, we are told that over three-quarters of our families are covered by these private health insurance policies, which should be proof enough that insurance represents the most workable answer to the problem of meeting the rising cost of modern hospital care.

Unfortunately, private health insurance has not proved a workable answer for the elderly. After the age of 65, too many policies turn out to be nonrenewable; or the rates go up sharply, while the coverage benefits go down. Since 60 percent of those over 65 have cash incomes of less than $1,000 a year, their problem of securing adequate coverage at rates within reach, has become increasingly acute.

Considerations of this kind forced the Congress to address itself to the subject of medical care for the aging in the summer of 1960. Our hurried deliberations at that time—squeezed between the national party conventions and the Presidential election—resulted in the enactment of the Kerr-Mills bill. This bill, which had the blessing of the American Medical Association, recognized the need for extending Federal aid to the various States, in order to enlarge upon their respective programs of medical care for the aged. I voted for the bill, because it furnished some measure of relief for many thousands of elderly people who desperately needed better medical care. But I hoped then, as I do now, that the "relief" approach, based upon a "means" test, financed by the Federal taxpayers generally, yet administered under differing eligibility requirements as determined by each separate State, would not become the permanent pattern for the future. For in the long run, this pattern not only departs from the insurance approach which we have thus far

found to be so satisfactory, but also potentially will entail the highest administrative costs, eventually will impose the largest bureaucracy, and ultimately will lead to the very system the doctors fear the most—"socialized medicine." It is to avoid these dangers, through the substitution of a "pay-as-you-go" insurance-type program under social security, that I shall vote in favor of the pending amendment, or against a motion to lay it on the table.

After the adoption of the Kerr-Mills bill, it became the principal responsibility of the Senate's Select Committee on the Problems of the Aging to investigate the need for a more satisfactory medical care program. I was privileged to serve on this committee and to conduct hearings in Idaho at Pocatello and Boise. These hearings revealed that, during the past decade, Idaho's number of senior citizens had increased by a third, now comprising a total of 58,258 persons over 65. Although almost all of the doctors who appeared at the Idaho hearings, as well as the administrators of the present program, testified in favor of retaining the "means" test approach, a sizable number of older people took exception, asserting that the present program in Idaho is neither adequate nor desirable, that it leads to abuse by some who really do not need the help, while it fails to reach many others who are too proud to ask for charity.

The evidence accumulated by the Select Committee in its hearings across the Nation as a whole, indicates that the Kerr-Mills approach is failing to furnish us with an adequate solution; that only 19 States have taken advantage of its provisions for the "medically needy," that the programs' reliance on annual congressional appropriations makes many States reluctant to commit themselves to a medical plan with an uncertain supply of funds; and that some States continue to defer action in the expectation that Congress will soon pass a more satisfactory program.

The pending amendment of the distinguished Senator from New Mexico [Mr. ANDERSON], as now modified, opens the door to a more sensible approach to the problem of medical care for the aging. It would provide for a system of medical insurance that is self-financing, uniformly applicable, and devoid of any "means" test, while protecting the legitimate interests of private insurance companies, medical institutions, and physicians.

The most significant single feature of the pending amendment is its utilization of the Social Security System as a financing mechanism. Unlike existing law, which pays for medical care with handouts from general tax revenues, this program will pay for itself through an increase of one-half of 1 percent in the total social security tax paid on wages by employers and employees. Thus, medical expenses which tend to cluster in the latter years of life will be met, just like retirement allowances, by payments made in advance during healthy, working years.

Although 90 percent of our people will ultimately be covered by social security, it is true that special provision needs to be made for those who will never become eligible for its retirement benefits. The pending amendment would permit such people, otherwise eligible for medical care under existing law, to remain so. No one's entitlement for medical care under any existing program would be diminished, but medical care would be extended to millions of elderly people, not now covered by any existing program, who are receiving their ordinary retirement benefits under social security.

The proposal has been further modified to permit any individual under social security, approaching retirement age, to decide between continuing his private medical insurance protection, with a choice of benefits tailored to his individual needs, or to let his insurance lapse and accept the coverage provided by the regular statutory program. If he chooses, under an approved plan, to continue his private insurance protection in force, social security would reimburse his insurance company in the amount provided under the statutory program for benefits received, while he would remain entitled to whatever extra benefits his policy might confer.

Many voices have been raised in opposition to the pending amendment. I do not question the sincerity of the people who oppose it, though I have found their arguments unconvincing. They have variously charged that this proposal will destroy the private medical insurance companies; that it will turn the Nation's physicians, whose fees are not covered by it, into lackeys of the Federal Government; that it will even make the Secretary of Health, Education, and Welfare a czar of medicine, ruling over the health needs of the people.

But private medical insurance companies will still have complete responsibility for the insurance needs of citizens below the age of 65, and beyond that until death, if the individual so chooses. Furthermore, the challenge of providing the private insurance subscriber with the best service, so as to keep him on the rolls after the age of 65, should make for better insurance protection for all, and is likely, therefore, to generate an increase in the business of the private carriers. Lastly, it will be possible for Blue Cross, and other similar private organizations, to participate heavily in the administration of the social security health program, thus minimizing the growth of the public administrative agencies in the various States which are now beginning to mushroom under the impetus of existing law.

This amendment will not alter the established relationships between physicians and patients or between patients and medical institutions. The patient will continue to choose freely his doctor and hospital. Since doctors' fees, as such, are not included, the program constitutes the least possible threat to the continuing independence of the medical profession.

The argument has often been voiced that approval of this proposal means the adoption of a compulsory medical care program, whereas the Kerr-Mills bill represents a voluntary program. But this objection makes no sense at all. If the compulsion consists of the tax, how can it be more compulsory to levy the tax upon those who will receive the benefits, than to levy the tax generally upon all of the people, many of whom will not? The cost of either system is defrayed by taxation, but the social security tax limits the burden to those who will receive the benefits.

If, on the other hand, the compulsion is thought to consist of having to accept the benefits provided, then the objection rests upon a misapprehension of the facts, for anyone eligible for these benefits under social security is free to refuse them, making such other arrangements for his care as he may desire. From either standpoint, then, the compulsory argument is a baseless one.

If we fail to adopt an insurance-type program for financing adequate medical care for the aging, and thus make permanent the relief-type approach sanctioned by existing law, the time will come when we shall have committed ourselves, beyond recall, to a steadily expanding system that will eventually lead to socialized medicine. Remember that the Kerr-Mills approach, based upon revenues derived from general taxation and involving not only prescribed medicines, hospitalization, and nursing home care, but also doctors' fees and such other broader coverage as each State may decide, contains all of the essential characteristics of a socialized system. Let no one be fooled that the "means" test protects against this eventuality. For it already varies greatly from State to State, and inevitably, as time passes, general coverage will go up, as the "means" requirements go down. After a time, the test will become a mockery, even as the pauper's oath already has become a mockery in our veterans' hospitals. And the very thing that the doctors fear the most will come to pass. The American Medical Association, which gave the doctors such poor guidance years ago in connection with private medical insurance, has once again failed to grasp the real issue at stake.

As compared to the alternative program already commenced, the pending amendment involves the least possibility of our establishing a system of socialized medicine in this country. It is a unique American proposal, which uses the insurance method to solve the real and unresolved problem of providing adequate medical care for the aging. It does so in a manner which preserves the prerogatives of both the patient and his healers, while assuring our elderly people that they shall be able to live out their natural lives with the greatest strength of body and peace of mind that modern medical science and enlightened social policy can provide.

Mr. KERR. Mr. President, I move to lay on the table the amendments offered by the Senator from New Mexico [Mr. ANDERSON], the Senator from New York [Mr. JAVITS], and other sponsors, the pending question.

The VICE PRESIDENT. The question is on the motion of the Senator from Oklahoma.

Mr. KERR. Mr. President, I ask for the yeas and nays.

The yeas and nays were ordered.

The VICE PRESIDENT. The question is on the motion of the Senator from Oklahoma. The yeas and nays have been ordered, and the clerk will call the roll.

The Chief Clerk called the roll.

The result was announced—yeas 52, nays 48, as follows:

[No. 121 Leg.]

YEAS—52

Aiken	Fong	Prouty
Allott	Fulbright	Randolph
Beall	Goldwater	Robertson
Bennett	Hayden	Russell
Boggs	Hickenlooper	Saltonstall
Bottum	Hill	Scott
Bush	Holland	Smathers
Butler	Hruska	Smith, Maine
Byrd, Va.	Jordan	Sparkman
Capehart	Kerr	Stennis
Carlson	Long, La.	Talmadge
Cotton	McClellan	Thurmond
Curtis	Miller	Tower
Dirksen	Monroney	Wiley
Dworshak	Morton	Williams, Del.
Eastland	Mundt	Young, N. Dak.
Ellender	Murphy	
Ervin	Pearson	

NAYS—48

Anderson	Gruening	McCarthy
Bartlett	Hart	McGee
Bible	Hartke	McNamara
Burdick	Hickey	Metcalf
Byrd, W. Va.	Humphrey	Morse
Cannon	Jackson	Moss
Carroll	Javits	Muskie
Case	Johnston	Neuberger
Chavez	Keating	Pastore
Church	Kefauver	Pell
Clark	Kuchel	Proxmire
Cooper	Lausche	Smith, Mass.
Dodd	Long, Mo.	Symington
Douglas	Long, Hawaii	Williams, N.J.
Engle	Magnuson	Yarborough
Gore	Mansfield	Young, Ohio

So Mr. KERR's motion to lay on the table the amendments offered by Mr. ANDERSON for himself and other Senators was agreed to.

Mr. DIRKSEN. Mr. President, I move to reconsider the vote by which the Anderson-Javits amendments were tabled.

Mr. KERR. Mr. President, I move to lay that motion on the table.

The VICE PRESIDENT. The question is on agreeing to the motion to lay on the table the motion to reconsider.

The motion to lay on the table was agreed to.

Mr. RANDOLPH subsequently said:

Mr. President, I have voted to table the Anderson-Javits amendment to H.R. 10606 because I am convinced that this important general welfare measure, including the extension of the vital program of aid to dependent children of unemployed parents, will suffer either demise or intolerable delay in the other body if sent there by the Senate with the controversial health-care-for-the-aged amendment included. This would be a tragic condition to impose on 12,500 West Virginia families of unemployed fathers having dependent children in the homes. It is a situation which must be avoided not only for the sake of approximately 45,000 West Virginians, but, also, for thousands of dependent children and their unemployed parents in at least 14 other States having aid to dependent children of the unemployed programs.

This position on my part was a most difficult one to take because I have been and continue to be an advocate of health care for our senior citizens based on the social security principle. I would vote for the Anderson-Javits amendment on its merit as a separate bill or if attached to a measure which, if defeated or delayed in the other body, would not result in the hardships that would be inflicted by the death of or extended inaction on H.R. 10606.

Mr. President, perhaps there is no public opinion agency or influence in the United States more dedicated to health care for the aged than is the Committee on Political Education, AFL–CIO, otherwise known as COPE.

The fact is that it was COPE's political memo No. 15–62 of July 16, 1962, which convinced me of my prior evaluations of the probable status of H.R. 10606 in the other body if the Anderson-Javits amendment should be attached to the measure by the Senate. COPE bulletin No. 15–62 virtually confirms my belief that if we wish to kill extension of aid to dependent children of unemployed parents and bottle up the other worthy provisions of H.R. 10606, all that is necessary to be done is to add to it the Anderson-Javits amendment. I quote as follows from the COPE bulletin:

The Senate votes this week on a compromise health care plan tacked on as an amendment to a general welfare reform bill. Even overwhelming success in the Senate—and at this point a close vote is predicted—would leave health care a rough path to cut through the legislative jungle.

Approval in the Senate would send the bill to the House Rules Committee, chaired by reactionary HOWARD SMITH, Democrat, of Virginia, who could roost on the bill till doomsday. If SMITH bottles it up, House Members could file a discharge petition to get it out of committee, but that requires support of two-thirds of the Members. Even then, the bill would only be starting its travels, and there just isn't time to go the full route.

That is just one of the honest journalistic appraisals of the poor chances H.R. 10606 would have in the other body during this final session of the 87th Congress with an Anderson-Javits type amendment attached.

But, Mr. President, some competent observers—and I share their views—believe that the House Ways and Means Committee, which has primary jurisdiction over this type of legislation and which, in fact, originated H.R. 10606, will never permit the measure to be referred to the House Rules Committee for a rule on whether or not it could go to a House-Senate conference. Thus, as the COPE bulletin seems to admit, the whole bill will lie dormant in the other body—not the so-called medicare amendment alone.

If there is one among us who says or believes this could not happen, let him or her remember the unhappy fate of the 1962 supplemental appropriations measure which the House Appropriations Committee would not claim from the Speaker's desk after it had been amended by this body. That measure, which included among its important items $85 million in small business loan funds, died a most unnatural death because the House Appropriations Committee would neither act on it nor have it moved to the House Rules Committee as a prerequisite to being ordered to conference. It is my opinion that H.R. 10606, with a revenue amendment such as the Anderson-Javits proposal attached without the blessing of the House Ways and Means Committee, doubtless would die either on the Speaker's desk for want of authority to be moved elsewhere or within the Rules Committee of the other body. Thus, ADCU extension and other worthy provisions of H.R. 10606 would be inordinately delayed or thoroughly buried, along with the health care for the aged amendment.

On the other hand, Mr. President, without the controversial Anderson-Javits amendment attached, H.R. 10606 is apparently a noncontroversial bill—and a vitally important one to hundreds of thousands of West Virginians and citizens—mostly children of other States in families of unemployed parents and in foster homes.

At this point in my remarks, I request indulgence while I quote from a letter received July 12 from a West Virginia constituent who resides in the little mountaintop community of Victor, Fayette County:

DEAR SIR: I am writing you to let you know how I feel about the ADC program.

Sir, I am an ex-coal miner and 46 years old and can't get a job. And I am willing to work at anything. I have six children and the oldest is 14 years old. There are four of them in school.

I have been out of work 3 or 4 years. I have worked 20 years in the coal mines, but when they converted to the new method of mining coal they did not need me any more. Since I am past 40 years old, no one else will hire me.

What am I supposed to do? I am willing to work. I am too old to get a job and too young to get a pension. I also can't get relief because I am able to work. What will become of my family?

The children will have to go to school. They don't have the clothes or the money for lunches.

The ADC program was what kept my children in school last winter and kept us from starving. If they cut it off what will become of us?

Mr. President, I need not read further from the constituent's letter. It is typical of an increasing number of equally pathetic communications being received from desperate parents and other aroused citizens.

The writer of the letter from which I quoted is one of 12,500 unemployed fathers of dependent children in the State of West Virginia whose benefits under the program of aid to dependent children of unemployed parents ceased as of midnight June 30, 1962.

West Virginia newspapers of Tuesday morning, July 10, 1962, published the following Associated Press dispatch from Charleston:

Governor Barron issued a statement Monday deploring the forced layoff of thousands of jobless West Virginians who had been employed on public works projects.

Barron, who is hospitalized at Elkins for a physical checkup, released the statement through his office here.

Employment on the State's primary public works program, aid to dependent children of the unemployed (ADCU), was halted pending action by Congress to extend Federal participation. More than 12,000 West Virginians were affected by the suspension.

Barron said: "I am deeply concerned over the unavoidable layoff of those of our people who have been providing for their families through the ADCU program. The plight of the jobless fathers affected by these unfortunate developments disturbs me more than I can say."

Barron said his office is making every effort to speed up congressional approval of legislation to renew the Federal-State program. The Federal Government provided 70 percent of the operating funds for the program.

The Governor remarked: "When the way has been cleared by Congress to make money again available to go with State matching funds, those on the ADCU rolls in West Virginia will be returned to their jobs immediately."

These conditions are the consequence of the failure of this body to act to afford the other body an opportunity to act on our amendments to H.R. 10606 before the temporary aid to dependent children of the unemployed program expired.

Mr. President, H.R. 10606, passed by the House in mid-March, was reported to the Senate by the Finance Committee on June 14 in ample time to be considered and passed by this body before the June 30 expiration date of the temporary aid to dependent children of the unemployed program. And it was made the pending business in time to be passed before June 30.

But H.R. 10606 was held up and selected—in what I consider to have been a tragic mistake of legislative procedure—as the measure on which the

health care for the aged issue would be contested. Thus, a noncontroversial program for the benefit of needy persons is caught in a stalemate and suffering already is occurring while an effort is made to bring another needed program—health care for senior citizens—into being over a route which any realistic legislator must know will not be accepted in the other body during the life of the 87th Congress.

The decision I have made and the vote I have recorded represents the personal responsibility of a Senator. I have been under the heaviest of pressures not to vote to table. But I am not interested in making an empty gesture to our senior citizens when I feel so convinced that there will be no action in the other body this year on the subject that is not generated by the House Ways and Means Committee on its own measure. I am acting in what I construe to be the best interests of the State I represent and the thousands of citizens who need the benefits of a law—not the suffering that comes from stalemate.

It is my view and my deep conviction that it is not proper for the ADCU program and other worthy public assistance provisions of H.R. 10606 and their intended beneficiaries to be made victims of what certainly would be lengthy controversy in this Congress over the so-called medicare issue.

I earnestly desire that health care be provided our aged citizens as much as does any Member. But let us stop making gestures which complicate the problems of many citizens and do not actually solve the problems of any.

Mr. President, I reached the personal determination that I would not be a party to compounding the mistake which has been made in using H.R. 10606 as the vehicle for creating further conflict over both principle and jurisdiction.

Consistent with my longtime espousal of the principle of providing health care for the aged under the social security system, I permitted my name to be listed among the cosponsors of the pending Anderson-Javits amendment. But that was back in June. I did not have any misgiving about being associated with the principles of the amendment, but I did have grave misgiving about the amendment being offered to H.R. 10606. I regret that I did not protest more strongly and that I did not refuse to cosponsor the amendment to this particular measure.

When efforts to work out earlier unanimous-consent agreements failed and the first one agreed to on July 5 was for today on the motion to table the Anderson-Javits amendment, I had the personal feeling that the provisions of H.R. 10606 for extension of the ADCU program and others of real merit were being seriously jeopardized—that the whole bill would face indefinite delays if not total inaction in the other body.

Events of the past 2 weeks—both here and in West Virginia and in other States—have served to confirm my earlier apprehension that the so-called medicare debate would be protracted and that distress would be complicated and compounded among the people forced by circumstances to rely on aid to dependent children of the unemployed parents program payments.

Without any forewarning and without affording the States any opportunity whatsoever to plan for the impact of a cessation of the aid to the dependent children of the unemployed parents program, the Senate has created an impasse in West Virginia and some other States and the victims are innocent people whose only source of funds suddenly dried up on July 1, 1962. Many citizens who had anticipated their aid to the dependent children of the unemployed parents payments on July 1 now, 17 days later, are still without money to pay their rents or to buy groceries and other necessities. In our State it has become necessary for officials to ask landlords in some instances to delay evictions in the hope that Congress will act soon to get aid to the dependent children of the unemployed parents going again.

West Virginia funds are inadequate to meet the costs of the $1.5 million a month aid to the dependent children of the unemployed parents program without jeopardizing the State's ability to match its share of the costs of all regular public assistance programs. In the absence of a law extending the aid to the dependent children of the unemployed parents program we cannot expect State officials of West Virginia or any other State to operate on hypothecation.

And in the absence of any indication whatsoever of when or if the other body might take action on an amended version of H.R. 10606, the States which operate aid to the dependent children of the unemployed parents programs are in difficulty and the former aid to the dependent children of the unemployed parents benefit recipients are made innocent victims.

On July 10, 1962, I discussed these problems with the chief sponsor of the pending amendment, Senator ANDERSON, of New Mexico. And on July 11 he introduced S. 3521 for himself, the two Senators from West Virginia, the senior Senator from Illinois [Mr. DOUGLAS], and the senior Senator from New York [Mr. JAVITS]. It is a bill to amend the Social Security Act and related provisions to extend for 2 months—to August 31, 1962—the aid to the dependent children of the unemployed parents program and certain other temporary public assistance plans.

I believe it was sponsored in good faith. Its purpose was to afford the Congress an opportunity to extend the aid to the dependent children of the unemployed parents program and others on a temporary 60-day emergency basis, retroactive to July 1, 1962, while the regular legislation (H.R. 10606) continues through the legislative processes. This simple extender could ease much distress—temporarily, at least. But it continues to languish in the Senate Finance Committee.

Passage of this temporary bill (S. 3521), however, would not be retroactive in West Virginia as to needed benefits on work-welfare programs because the projects were stopped on June 30 and there would be no resumption of payments to unemployed parents of dependent children until the programs are again active.

Mr. President, in the light of events and conditions which I have described and because it is my personal conviction that H.R. 10606 would be in jeopardy if it reaches the other body with the Anderson-Javits amendment attached, I voted reluctantly to table that amendment.

I did so in order to endeavor to help expedite action in this body and the other, and in conference on H.R. 10606—the general welfare reform measure. Its provisions extending aid to dependent children of the unemployed parents and other vital public asistance benefits must be made public law as speedily as possible.

I will renew my support for the principle of health care for the aged under social security if it is presented in a separate bill or as an amendment to a measure less urgent than is H.R. 10606. The health care for the aged issue can be faced another day on another bill other than H.R. 10606. If this is done I will be for it, but I will still doubt that there will be action in the other body on a health care for the aged plan under the social security system that does not originate in the House Ways and Means Committee.

Mr. President, I am fully cognizant that many of my friends and supporters, as well as administration leaders, will misunderstand my vote. It is my hope, however, that they will at some future time more accurately gage my action as being in the national interest and for the welfare of West Virginians.

Mr. DWORSHAK. Mr. President, I voted to table the Anderson-Javits amendment to the public welfare bill because I am opposed to placing a medicare program under the social security system. Those who sponsored this proposal at this time without adequate committee hearings invited opposition and defeat of efforts to bypass the committee which would have jurisdiction under normal procedure.

Mr. President, the Kerr-Mills medicare plan, approved 2 years ago, is being sabotaged by many States which have failed to take advantage of Federal assistance in caring for the elderly citizens who require medical attention and who are unable to provide it themselves. In Idaho the Kerr-Mills program is working satisfactorily, according to reports from the State and the Governor, and I can see no justifiable reason for making a change at this time.

I ask unanimous consent to have printed at this point in my remarks an editorial entitled, "Kerr-Mills Bill—Why Not Try It?" published July 2, 1962, in the Post-Register at Idaho Falls, Idaho.

There being no objection, the editorial was ordered to be printed in the RECORD, as follows:

KERR-MILLS BILL—WHY NOT TRY IT?

The Associated Taxpayers of Idaho recently deplored the jettisoning of an existing joint Federal-State medical program for the aged if the King-Anderson bill is passed by Congress.

The point is well taken. The Kerr-Mills bill has been adopted by Idaho and other

States in an effort to meet the real problem of high medical expenses with which many elderly people simply cannot cope. But the Kerr-Mills program has hardly been given an opportunity to operate before the medicare protagonists want to scrap it.

There is some talk of continuing the Kerr-Mills measure as a supplement. But there is growing concern that it would be discarded once King-Anderson is approved.

Max Yost, executive manager of the taxpayers organization of the State, noted this week that the Kerr-Mills program has not had an adequate trial period, that available statistics are inadequate to prove the program should either be retained or scrapped or modified.

Yost pointed out an extraordinary paradox in the thinking of compulsory medical care tied to social security:

"Opponents of the social security approach argue that Kerr-Mills has not had a sufficient trial; administration spokesmen object to it as costly, particularly to the States, but they would keep it in operation.

"If retention rather than abandonment of the Kerr-Mills proposal comes about when a social security supported bill passes, it would make the King-Anderson bill the most costly, overall, of all the pending proposals. It would require a social security tax increase; it would keep Kerr-Mills as a supplemental program, and require continued participation by Idaho. And, by virtue of the limited benefits provided, would require beneficiaries in many instances to bear a significant proportion of medical care costs."

King-Anderson proponents should be called upon to explain specially why the Kerr-Mills bill will not meet the problem, why they are so anxious to junk it before an adequate test.

PUBLIC WELFARE AMENDMENTS OF 1962

The Senate resumed the consideration of the bill (H.R. 10606) to extend and improve the public assistance and child welfare services programs of the Social Security Act, and for other purposes.

Mr. LONG of Louisiana. Mr. President, I call up my amendment 6–20–62—A.

The LEGISLATIVE CLERK. At the end of the bill it is proposed to add the following:

COVERAGE OF POLICEMEN IN LOUISIANA UNDER TITLE II OF THE SOCIAL SECURITY ACT

SEC. 203. Section 218(p) of the Social Security Act is amended by inserting "(1)" immediately after "(p)," and by adding at the end thereof the following new paragraph:

"(2) The agreement with the State of Louisiana may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), be modified pursuant to subsection (c)(4) to apply to service performed by employees of such State or any political subdivision thereof in any policeman's position covered by a retirement system in effect on or after the date of enactment of this subsection, but only upon compliance with the requirements of subsection (d)(3). For the purposes of the preceding sentence, a retirement system which covers positions of policemen and other positions shall, if the State of Louisiana so desires, be deemed to be a separate retirement system with respect to the positions of such policemen."

Amend the table of contents by inserting at the end of the matter describing the contents of title II of the bill the following:

"Sec. 203. Coverage of policemen in Louisiana under title II of the Social Security Act."

The VICE PRESIDENT. The question is on agreeing to the amendment of the Senator from Louisiana.

Mr. LONG of Louisiana. Mr. President, the amendment would merely permit the policemen of Louisiana to elect, if they choose to do so, to come under the social security system. There is much precedent in other States for such action. I believe the Senator in charge

of the bill is willing to accept the amendment.

Mr. KERR. Mr. President, as I understand the amendment of the Senator from Louisiana, it would provide the same opportunity to the policemen of Louisiana which has been made available in other States from time to time.

Mr. LONG of Louisiana. Mr. President, I ask unanimous consent to have printed at this point in the RECORD a brief explanation of the amendment.

There being no objection, the explanation was ordered to be printed in the RECORD, as follows:

BRIEF EXPLANATION OF AMENDMENT PERMITTING THE EXTENSION OF SOCIAL SECURITY COVERAGE UNDER TITLE II OF THE SOCIAL SECURITY ACT TO POLICEMEN IN THE STATE OF LOUISIANA

The Social Security Amendments of 1954, which made old-age and survivors insurance coverage available to most employees under State or local retirement systems, continued the exclusion of policemen and firemen. Since 1954 the Social Security Act has been amended at various times to permit specified States to extend social security coverage to policemen and firemen who are under State or local retirement systems, until at present 17 States may provide such coverage. The proposed amendment would permit Louisiana to cover policemen on the same basis permitted in the 17 States now named in the law. The amendment would not apply to firemen in Louisiana; they would continue to be excluded under the Federal law.

Under the proposed amendment the State of Louisiana could modify its coverage agreement with the Secretary of the Department of Health, Education, and Welfare to extend social security coverage, under the established referendum procedure, to policemen employed by the State, or to those employed by other political subdivisions—cities, parishes, etc.—of the State. Under this referendum procedure, coverage may be extended to the retirement system group involved only if the majority of those eligible to vote indicate in a secret referendum that they desire coverage. Upon a favorable vote, all members of the group in positions covered by the State or local system could be covered under social security, including persons who are ineligible to become participating members of the system. Where policemen are in a retirement system with other classes of employees they may, at the option of the State, hold a separate referendum and be covered as a separate group.

Mr. KERR. Mr. President, I urge the adoption of the amendment.

The VICE PRESIDENT. The question is on agreeing to the amendment of the Senator from Louisiana.

The amendment was agreed to.

The VICE PRESIDENT. The bill is open to further amendment.

Mr. CLARK. Mr. President, I call up my amendment 7–13–62—B.

The VICE PRESIDENT. The amendment of the Senator from Pennsylvania will be stated.

The LEGISLATIVE CLERK. At the appropriate place in the bill it is proposed to insert the following new section:

SEC. — . (a) Subsection (c) of section 211 or the Social Security Act is amended (1) by striking out "or" at the end of paragraph (4), (2) by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; or", and (3) by adding after paragraph (5) the following new paragraph:

"(6) The performance of service by an individual during the period for which an exemption approved under section 1402(h) of the Internal Revenue Code of 1954 is in effect."

(b) Subsection (c) of section 1402 of the Internal Revenue Code of 1954 is amended (1) by striking out "or" at the end of paragraph (5) and inserting in lieu thereof "; or ", and (3) by adding after paragraph (5) the following new paragraph:

"(6) the performance of service by an individual during the period for which an exemption approved under section 1402(h) is in effect."

(c) Section 1402 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new subsection:

"(h) MEMBERS OR ADHERENTS OF CERTAIN RELIGIOUS FAITHS.—

"(1) EXEMPTION.—Any individual who is a member or adherent of a recognized religious faith whose established tenets or teachings are such that he cannot in good conscience without violating his faith accept the benefits of insurance, such as those provided by the insurance system established by title II of the Social Security Act, may so certify in an application filed with the Secretary of Health, Education, and Welfare (in such form and manner as may be prescribed by regulations made under this chapter) requesting exemption from such title II insurance extended to service performed by him in his trade or business. Upon findings by the Secretary that such applications was made in good faith and that the members of such religious faith make adequate provision for elderly members of the faith to prevent them from becoming public wards in their old age, the application shall be approved and the individual exempted from coverage in the old-age and survivors insurance program.

"(2) EFFECTIVE PERIOD OF EXEMPTION.—An exemption pursuant to this subsection shall be effective for the taxable year in which it is approved and all succeeding taxable years, except that no such exemption shall be effective for any taxable year which ends before the date of enactment of this subsection."

The VICE PRESIDENT. The question is on agreeing to the amendment of the Senator from Pennsylvania.

Mr. CLARK. Mr. President, a parliamentary inquiry.

The VICE PRESIDENT. The Senator will state it.

Mr. CLARK. Is the Senate operating on limited time?

The VICE PRESIDENT. Under the agreement, 30 minutes is allotted to each side.

Mr. CLARK. Mr. President, I yield myself 5 minutes.

The VICE PRESIDENT. The Senator from Pennsylvania is recognized for 5 minutes.

Mr. CLARK. Mr. President, the sponsors of the amendment are a group of Senators not usually found together in sponsoring legislation. They include, in addition to myself, the able Senator from Arizona [Mr. GOLDWATER] and the able Senators from Ohio [Mr. LAUSCHE and Mr. YOUNG].

The purpose of the amendment is to right what we consider an injustice, in terms of civil liberties, to a very small group of people, the Amish sect, of whom a number reside in my Commonwealth. The amendment would give certain members of the Amish faith and others, if any, with similar religious scruples against receiving social security benefits, an optional exemption from the social security laws under stated conditions.

The amendment would permit those who, because of their religious belief, have been in opposition to all insurance benefits, including social security benefits, to file an application for exemption with the Secretary of HEW certifying the basis of their objection to old-age and survivors insurance.

If the Secretary finds that the application was filed in good faith and that the religious faith in question makes adequate provision for its elderly members to prevent them from becoming public wards in their old age, he will approve the application for exemption.

The U.S. Government should not remain in the unenviable position of having to enforce social security laws against Amish citizens in violation of their religion. The Byler case was a case in point. In April of 1961 three horses belonging to Valentine Y. Byler, of New Wilmington, Pa., were seized and sold by the Internal Revenue Service to meet Mr. Byler's unpaid social security self-employment tax. Mr. Byler, a farmer, is an adherent of the Amish faith, which teaches its members to avoid insurance in any form. He therefore declined to pay his social security tax in the years 1956–59, although he quite properly reported the tax on his returns for those years. The Commissioner of Internal Revenue subsequently indicated his agency had no choice but to enforce collection of Mr. Byler's tax, which amounted with interest to $308.96. Present law, the Commissioner explained, does not permit to laymen any exception from the social security tax obligation because of religious conviction.

Members of the clergy are presently given optional coverage under social security, and conscientious objectors can obtain exemptions from the selective service laws.

My amendment has been revised to meet most of the significant administrative objections of prior proposals. In its present form there is every reason to believe that it will apply only to a few hundred Amish farmers, since virtually no other group would qualify under the limitations contained in the amendment. The Internal Revenue Service advises that its Philadelphia, Pittsburgh, and Cleveland offices have only 595 Amish social security delinquent accounts open at this time.

I point out that in order to obtain the exemption, the religious faith must oppose all forms of insurance benefits, other than liability insurance required by law. As far as is known only the old order Amish have such beliefs that all insurance benefits are against the word of God.

The insurance coverage must amount to an actual violation of religious faith, not just an inconvenience or a preference for another form of protection.

The amendment is limited in scope to the self-employed. Virtually all Amish are in this category. The administrative problems which would exist if

the exemption applied to all employees are avoided.

The Secretary just find that the members of the religious faith "make adequate provision for elderly members of the faith to prevent them from becoming public wards in their old age." The Amish maintain a fund for the needy of the Amish faith and care for their elder members quite satisfactorily.

The amendment would not affect very many people. It is not a "foot in the door" amendment for a large number of religious sects. It is merely the extension of justice and fairness to a group of honest and conscientious people who believe in all sincerity that it is wrong to accept insurance benefits.

The bill would remove all benefits of the social security law for persons of the Amish faith who chose to apply for exemption and whose applications for exemption were approved.

It would not cost the taxpayer any money. It is only an act of simple justice. I urge the sponsor and the Senator in charge of the bill to accept the amendment.

Mr. LAUSCHE. Mr. President, will the Senator yield?

Mr. CLARK. I am happy to yield to the distinguished Senator from Ohio as much time as he desires.

Mr. LAUSCHE. Mr. President, I am a joint sponsor of the amendment with the senior and junior Senators from Pennsylvania [Mr. CLARK and Mr. SCOTT], the junior Senator from Arizona [Mr. GOLDWATER], and my colleague from Ohio [Mr. YOUNG].

Several months ago the Amish people of Pennsylvania and Ohio—and I believe some of New York—together with the Senators from Pennsylvania [Mr. CLARK and Mr. SCOTT] and I met in the office of the Internal Revenue Commissioner, Mr. Caplin. In attendance at that meeting were probably 100 Amish citizens. They asked for the meeting, hoping that there might be worked out a plan under which there would be allowed to them the full enjoyment of their religious beliefs. They proceeded to point out that under their religious teachings, instilled in them from their infancy to adulthood, the principle: "Take care of your own. Take care of your sick and your incapacitated and your aged. That is your responsibility under moral law."

In that meeting these Amish people, with great simplicity and no pretence or falsehood, pointed out that they had abided by the teachings of their church. They pointed out that they refused to accept the benefits of social security; that even though in some instances they had been compelled to pay the premiums, they still would not accept the benefits. In the discussion, the Internal Revenue Commissioner, to justify the position taken by himself, said, "I recognize your plight. I recognize the strength of the argument you make. But I want you to understand that under my oath I am compelled to abide by the law. My oath was to the effect that I would uphold the Constitution of the United States and enforce the laws that come within my dominion in this department."

That was a beautiful statement: "I stand on my oath."

One of these long-bearded bishops of the Amish church got up and said, "Mr. Commissioner, you must abide by the oath of your office. I must abide by the teachings of my church, and I contemplate doing that."

I wish that all Senators had been at that meeting.

One cannot very well answer that argument, when he knows that it is one of the deeply and anciently established principles of the Amish people. I know that in Ohio there are some citizens who feel that the Amish are backward, that they do not send their children to school beyond the sixth grade, and that their schools are principally operated by the Amish themselves.

However, let us remember that they have asked for no doles, that they have asked for no Government support. They are asking only to be left alone so that they can work on their farms and take care of their families and take care of their aged and their incapacitated.

The VICE PRESIDENT. The time of the Senator has expired.

Mr. CLARK. I yield 2 additional minutes to the Senator from Ohio.

Mr. LAUSCHE. One of these Amish bishops described how the revenue collector came to his farm to demand the payment of the unpaid premiums. It is a rather amusing incident. The Federal agent came down to the farm, and he saw the Amish man plowing with a swayback horse. He decided that he would not take the horse that was attached to the plow. Down in the pasture he saw a horse that looked much better in strength. He went down to grab the good-looking horse, but he could not catch it. So the Federal agent went up into the barn and got a bucket of oats, and ran all over the field trying to attract the horse, but he could not catch it. I point that out merely to show how deeply they abide by the teachings of their church. They say, "We will not be compelled by law into the breaking of our teachings."

It is on that basis that they have asked the Senator from Pennsylvania and the Senate to modify the social security law to permit them to become exempt if they apply for exemption. I believe the law ought to be changed. It will strengthen the social security law if their plea is granted. These people are not pretenders. They are genuine in their belief. They have not adopted their religion to escape this obligation with respect to social security. It has been with them from their youth. I urge my colleagues in the Senate to support the amendment.

Mr. GOLDWATER. Mr. President, I am sure that every Senator is aware of the civic and religious virtues of those sterling Americans, our good neighbors of the Amish faith. Though few in number, they are a shining example of all the qualities that make both for good citizenship and spiritual distinction. Industrious, thrifty, self-reliant, and self-supporting in the sphere of material things, they are also firm and sincere in their religious convictions.

Despite the pressures and temptations of the surrounding world, they adhere faithfully to their tradition and to the tenets of their creed, seeking neither aid nor favor from outside their own community. When any of their people are stricken by disaster or suffer hardship as the result of the inescapable exigencies of human existence, they provide the necessary aid and remedies by their own efforts and from their own resources.

Mr. President, it is my conviction that the social and economic structure of our country would be far stronger and healthier if more of us emulated their sturdy virtues. The prosperity and self-reliance of the Amish people are a living demonstration that the principles on which our Nation was established by the Founding Fathers are still viable, that they continue to be an appropriate guide for the conduct of our domestic national affairs despite the drastic changes which have since occurred both here at home and throughout the world.

That is why, Mr. President, I feel so strongly that we must avoid, as far as possible, doing anything which would destroy or even weaken the existence of this exemplary community. That is the reason I cosponsored the pending amendment.

Mr. President, it is my understanding that as part of their religious doctrines, the Amish people are forbidden to purchase or participate in any form of insurance. This appears to be a perfectly logical corollary of their belief in self-help and mutual aid, a belief they fully carry out in their daily lives.

As far as they are concerned, the social security system is simply another form of insurance and hence, participation in it constitutes for them, a violation of their religious principles. As a result, we have recently witnessed several cases of refusal to pay social security taxes by members of the Amish community in consequence of which part of their property has been forcibly seized by the Federal Government. In at least one instance, the property consisted of several horses, the seizure of which made it virtually impossible for their owner to continue to earn his living as a farmer.

In this connection I should like to call to your attention that in the ethical codes of some of our major Western religions, and generally in the conscience of civilized mankind, it is regarded as a breach of morality to deprive a delinquent debtor of the tools of his trade, of the instruments which he must have in order to earn his livelihood. And, Mr. President, if I am not mistaken, laws in many of the States contain provisions against such seizures. It is a matter of deep regret indeed to see our Federal laws requiring us to act in so uncivilized a manner.

Mr. President, the spectacle of an Amish farmer being penalized for his refusal to disobey his religious principles and go against the promptings of his conscience reveals a strange and unjust paradox in our Federal laws. Mr. Presi-

dent, when the country is engaged in or threatened by war, we have never hesitated to impose almost universal conscription of adult males for military service. The conscription laws are based on the well-nigh unchallenged premise that in times of danger to the Nation's survival, every person has an unequivocal obligation to serve his country even at the risk of life itself.

But for many years we have recognized that even this primary and overriding obligation should not be imposed when to do so would compel an individual to disobey the genuine dictates of his own conscience. For the benefit of such conscientious objectors we have enacted laws exempting them from military service.

Mr. President, is it equitable to relieve an individual, on grounds of religion or conscience, from fulfilling the highest duty which a citizen owes to his country, while simultaneously denying a similar privilege to those who, on the same grounds, feel compelled to disobey the infinitely lesser obligation of paying certain taxes, but at the same time rejecting any benefits such taxes make available to them?

Mr. President, I simply cannot believe that the American public, if this matter were brought to its attention, would hesitate a moment in giving its overwhelming support to equality of treatment in these two situations. I am equally confident that if the pending amendment becomes law, it will have the wholehearted approval not only of our people but of civilized opinion everywhere.

The PRESIDING OFFICER (Mr. HUMPHREY in the chair). The question is on agreeing to the amendment of the Senator from Pennsylvania [Mr. CLARK].

The amendment was agreed to.

Mr. KERR. Mr. President, do I correctly understand that the amendment of the Senator from Pennsylvania has been agreed to?

The PRESIDING OFFICER. The Senator from Oklahoma is correct.

Mr. CLARK. Mr. President, I move that the Senate reconsider the vote by which the amendment was agreed to.

Mr. KERR. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. HARTKE. Mr. President, I offer the amendment which I send to the desk. I ask unanimous consent that the reading of the amendment be dispensed with but that the text of the amendment be printed in the RECORD.

The PRESIDING OFFICER. Without objection, the reading of the amendment will be dispensed with, and the amendment will be printed in the RECORD.

The amendment is as follows:

On page 93, line 15, insert "(if provided in or after the third month before the month in which the recipient makes application for aid)" before "medical care".

On page 94, line 12, insert "(if provided in or after the third month before the month in which the recipient makes application for assistance)" after "care and services".

On page 100, between lines 15 and 16, insert the following:

"STARTING DATE FOR PUBLIC ASSISTANCE IN FORM OF MEDICAL OR REMEDIAL CARE

"SEC. 156. (a) (1) So much of section 6(a) of the Social Security Act as precedes paragraph (1) thereof is amended by inserting '(if provided in or after the third month before the month in which the recipient makes application for assistance)' before 'medical care'.

"(2) So much of section 6(b) of such Act as precedes paragraph (1) thereof is amended by inserting '(if provided in or after the third month before the month in which the recipient makes application for assistance)' after 'care and services'.

"(b) So much of section 406(b) of such Act as precedes clause (1) thereof is amended by inserting '(if provided in or after the third month before the month in which the recipient makes application for aid)" before 'medical care'.

"(c) Section 1006 of such Act is amended by inserting '(if provided in or after the third month before the month in which the recipient makes application for aid)' before 'medical care'.

"(d) Section 1405 of such Act is amended by inserting '(if provided in or after the third month before the month in which the recipient makes application for aid)' before 'medical care'.

"(e) The amendments made by this subsection shall apply in the case of applications filed after September 30, 1962, under a State plan approved under title I, IV, X, or XIV of the Social Security Act."

Mr. HARTKE. Mr. President, this is a technical amendment. At present, if an individual applies for medical attention before the board meets, then during the period from the time the attention is given him by his physician until the time when the board meets, the physician is not allowed to be paid, under present law, in certain States.

The amendment would rectify that situation and permit a doctor to be paid at the time the service is rendered, rather than after the time the welfare board acts.

I understand there is no objection to the amendment.

Mr. KERR. Mr. President, I have no objection.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Indiana.

The amendment was agreed to.

The PRESIDING OFFICER. Are there further amendments?

Mr. MILLER. Mr. President, the distinguished Senator from New York [Mr. JAVITS] asked that he be notified before the third reading of the bill, so that he might possibly offer an amendment.

I suggest the absence of a quorum.

Mr. SMATHERS. Mr. President, the distinguished Senator from New York also notified me that he might desire to have an amendment considered, and asked that a quorum call be placed prior to the third reading of the bill.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MILLER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JAVITS. Madam President, I send to the desk an amendment which is offered by me, on behalf of myself and my colleague [Mr. KEATING].

The PRESIDING OFFICER (Mrs. NEUBERGER in the chair). The amendment will be read.

The amendment was read, as follows:

On page 92, in line 19, insert "(a)" after "Sec. 1604."

On page 93, between lines 11 and 12, insert the following:

"(b) Any State which is dissatisfied with the Secretary's action under subsection (a) or under 1603(c) may appeal to the United States district court for the district in which the capital of such State is located by filing with such court a notice of appeal. The jurisdiction of the court shall attach upon the filing of such notice. A copy of the notice of appeal shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary shall thereupon file in the court the record of the proceedings on which he based his action. The action of the Secretary shall be reviewed by the court (on the record) in accordance with the provisions of the Administrative Procedure Act."

On page 100, between lines 15 and 16, insert the following:

"HEARING ON AND JUDICIAL REVIEW OF FEDERAL ACTION CONCERNING STATE PUBLIC ASSISTANCE PLANS

"SEC. 156. (a) Section 4 of the Social Security Act is amended by inserting '(a)' after 'Sec. 4.', and by adding at the end of such section the following new subsection:

"'(b) Any State which is dissatisfied with the Secretary's action under subsection (a) or under section 3(c) may appeal to the United States district court of appeals for the district in which the capital of such State is located by filing with such court a notice of appeal. The jurisdiction of the court shall attach upon the filing of such notice. A copy of the notice of appeal shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary shall thereupon file in the court the record of the proceedings on which he based his action. The action of the Secretary shall be reviewed by the court (on the record) in accordance with the provisions of the Administrative Procedure Act.'

"(b) Section 404 of such Act is amended by adding at the end thereof the following new subsection:

"'(c) Any State which is dissatisfied with the Secretary's action under subsection (a) or under section 403(c) may appeal to the United States district court for the district in which the capital of such State is located by filing with such court a notice of appeal. The jurisdiction of the court shall attach upon the filing of such notice. A copy of the notice of appeal shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer desginated by him for that purpose. The Secretary shall thereupon file in the court the record of the proceedings on which he based his action. The action of the Secretary shall be reviewed by the court (on the record) in accordance with the provisions of the Administrative Procedure Act.'

"(c) Section 1004 of such Act is amended by inserting '(a)' after 'Sec. 1004.', and by adding at the end of such section the following new subsection:

"'(b) Any State which is dissatisfied with the Secretary's action under subsection (a) or under section 1003(c) may appeal to the United States district court for the district in which the capital of such State is located by filing with such court a notice of appeal. The jurisdiction of the court shall attach upon the filing of such notice. A copy of the notice of appeal shall be forthwith trans-

mitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary shall thereupon file in the court the record of the proceedings on which he based his action. The action of the Secretary shall be reviewed by the court (on the record) in accordance with the provisions of the Administrative Procedure Act.'

"(d) Section 1404 of such Act is amended by inserting '(a)' after 'Sec. 1404.', and by adding at the end of such section the following new subsection:

"'(b) Any State which is dissatisfied with the Secretary's action under subsection (a) or under section 1403(c) may appeal to the United States district court for the district in which the capital of such State is located by filing with such court a notice of appeal. The jurisdiction of the court shall attach upon the filing of such notice. A copy of the notice of appeal shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary shall thereupon file in the court the record of the proceedings on which he based his action. The action of the Secretary shall be reviewed by the court (on the record) in accordance with the provisions of the Administrative Procedure Act.'"

And make appropriate changes in the table of contents.

Mr. JAVITS. Madam President, this is a judicial-review amendment. The purpose is to bring about a review in the courts of the United States of any determination made by the Secretary which relates to withholding money from any State under the four benefit sections or provisions of the bill, as to its public welfare phases.

The State of New York, which my colleague [Mr. KEATING] and I have the honor to represent, feel very keenly about this matter; and during the hearings before the Finance Committee a statement was submitted by Myles B. Amend, on behalf of the New York State Board of Social Welfare; and in the statement we find the following:

First, provision for court review of proposed deductions or penalties where construction of law is involved, as recommended by the New York Temporary State Commission To Study Federally Aided Welfare Programs (1951–53), and more recently by the Temporary State Commission on Coordination of State Activities (1961).

That was submitted as one of the things which would ease the burden of the situation on the States.

Madam President, let us understand that the Secretary has absolute plenary power over the States in regard to these payments, which are a critically important element in connection with the States' own welfare programs; and I invite attention to section 1604 of the bill, on page 92, beginning in line 19, as follows:

SEC. 1604. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

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

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

It goes on to say that the Secretary may notify the State and may stop the payments under the plan.

There is a deep feeling by the State of New York and by other States that this is an arbitrary and plenary power which would be vested exclusively, and without any review of any character, in the Secretary of Health, Education, and Welfare.

This is not the only situation in which judicial review is desirable, Madam President. Judicial review is also the rule in connection with a number of other programs in which the Federal Government aids the States. For example, in aid to the States for hospital construction, under the Hill-Burton Act, there is judicial review if the Surgeon General refuses to approve a State application and if the State feels that refusal is contrary to the law. The same is true in connection with the matching grants for library services; and judicial review is also provided for in connection with agreements concluded by the Secretary of Labor under the so-called distressed-area program which we passed not very long ago; and such review is also provided for in the case of certain phases of unemployment compensation under the relationships between the United States and the States; and such review is also provided for in connection with vocational education and vocational rehabilitation, where there is sharing of the programs with the States; and such review is also provided for in connection with water pollution control.

It seems to me we should be encouraging the States to take more responsibility, and that we should give, within the confines of the law, an opportunity for the expression of the State's initiative in connection with the development of its own plan, to entitle it to aid under the Federal plans provided by this bill, and that we should not give the Secretary of Health, Education, and Welfare this absolute, arbitrary power.

I have discussed this amendment with the distinguished floor manager of the bill, who I think certainly would be sympathetic toward the idea of not vesting such untrammeled, autocratic power in any Government official; and I understand the feeling of the Senator from Oklahoma; namely, that he desires to have the bill go to the other body with the minimum possible number of amendments, or, if possible, without any amendment, or, at least, certainly without an amendment which might engender controversy. I appreciate that feeling on his part. But I should like to ask him to realize that this suggestion is not a pet idea of mine, but is really a deeply felt and widely entertained view, not only in New York, speaking through its Commissioner of Welfare, but also among a body of people who have a deep feeling on this subject and who work with it all the time; and this feeling is shared by other States, as shown by the position taken at the conferences of welfare officials.

So I shall appreciate it very much if something can be placed in the RECORD at this stage to indicate how we think such a situation could be resolved, when a State honestly feels that it lacks freedom of initiative and action within the confines of the law and believes it is not absolutely restricted to whatever the Secretary of Health, Education, and Welfare may determine he wants the State to do in connection with any changes in its plan. So I shall deeply appreciate it if the distinguished floor manager of the bill will express his position on this subject.

Mr. KERR. Madam President, I am glad to discuss this matter with the Senator from New York. As I told him, I hope the Senate will pass the bill without amendment, or at least without any controversial amendment, so that the bill as passed by the Senate may be accepted by the House, without requiring a conference, in order to expedite congressional action on the bill, because it contains so many provisions which I believe of great significance and value to all the States in the Union. It was for that reason that I requested that the Senator from New York not urge adoption of the amendment.

I can understand the concern by the administrators of these programs within the States in regard to the attitude of the Secretary of Health, Education, and Welfare; and many instances have arisen under the laws in the past, in which administrators of one of more States have requested the Congress to provide relief when there was controversy between the States and the Administrator with reference to the interpretation or administration of the program.

I am sure the Senator from New York remembers that in 1950 Congress authorized payment under the Pennsylvania and Missouri laws for the blind; and in 1951, an amendment submitted by Senator Jenner, of Indiana, authorized disclosure of certain information which was in dispute in Indiana; and in 1961, Congress authorized action with respect to unsuitable homes, in connection with a situation which had arisen in Louisiana, Mississippi, Michigan, and so forth, by providing for a moratorium on Federal action, under a ruling by Secretary Flemming.

With reference to misunderstandings or controversies that arise, it is my hope that action would first be sought in the Congress. In the event that relief could not be obtained through legislation, where a case was made out to be worthy, then I think it would be well to give serious consideration to the enactment of legislation providing a judicial review with reference to the interpretation of the laws of the Congress.

As one member of the Finance Committee, I would be glad at any time to request the committee to have hearings with reference to any matter that was of concern to him or other members of the committee, in the hope that we might explore the possibility of obtaining, either administratively or by legislation, such relief as would be indicated by situations which were meritorious and worthy.

As of this time, however, without further deliberation by the committee and further study of the problem, it would seem to me that we would not be justified in setting up a system of judicial review of decisions and actions of the administrator of the program.

Mr. JAVITS. The Senator has opened the window for me, and I would like, if I might, to get the problem in focus for the purpose of this discussion. The Senator knows as well as I do that I would not press such an amendment in the face of the Senator's objection, nor could I expect the Senate to approve it. That is quite proper. The Senator is in charge of the bill, and it is not the kind of amendment that I should press for.

The Senator is in charge of the bill on the floor, and although he cannot bind the committee, what he would say about it would have great effect. May I ask the Senator this question? We are talking about States. If a State, through its Senator, requested, as a matter of legislative oversight by the Finance Committee, a review of a decision by the Department of Health, Education, and Welfare of a particular determination which it felt was unjust, would the Senator have the right to assure his State that there was a real assurance that it would get the review—at least, that it would get a hearing before a proper committee of the Senate to review what a State—not an individual Senator—felt was an unfair determination by the Secretary?

Mr. KERR. So far as I am concerned, I would urge to the Finance Committee such a response to a request the Senator has indicated he might attempt. The Senator from Delaware [Mr. WILLIAMS] is the ranking Republican member of the committee. I shall be glad to have him say if he does not agree with me in the firm belief that, without the slightest difficulty or delay, such a hearing would be accorded by the Finance Committee.

Mr. WILLIAMS of Delaware. Madam President, if the Senator will yield, I am glad to join the Senator from Oklahoma in giving the assurance to the Senator from New York that the committee would give consideration to it.

Mr. JAVITS. I am grateful to my colleagues.

Unless the Senator from Oklahoma wishes to use any of his time, I am prepared to withdraw the amendment, on the basis of the colloquy which the Senator has accorded to me.

The PRESIDING OFFICER. The amendment is withdrawn.

The bill is open to further amendment.

If there be no further amendment to be proposed, the question is on the third reading of the bill——

Mr. MANSFIELD. Madam President, it is with deep personal interest in the Nation's welfare programs that I speak today, for I represent a State in which some of its important work centers are today suffering from mass unemployment at rates ranging up to 12 percent and more. The historic provisions of this year's amendments to the welfare laws dealing with retraining and rehabilitation are so timely, not only for their humanitarian purposes, but for the effectiveness with which they will come to grips with many aspects of unemployment at the root of the problem.

This year's amendments to the Nation's public welfare programs embody an exciting new principle which is at once humanitarian and practical. Ever since the first administration of Franklin Roosevelt, Congress has sought to legislate reforms which would, in the words of the statute now on the books, give social security to those whose future was anything but sure and bright, without impairing the sense of independence or of initiative of our citizens.

The social security and welfare programs of the New Deal are among the greatest legacies of a great reform President. It is not a criticism of them, or of him, but rather a credit to their success that the President and the Congress seek now, more than 25 years after the passage of the Social Security Act, to expand the purpose of our welfare programs so as to return as many Americans as possible to active roles in society, and to lengthen their productive years. A view which holds that recipients of welfare aid must, by destiny, be forever recipients of welfare aid, is essentially pessimistic, and essentially static. The view which holds that men seek to be productive, and give up their dependence only when the circumstances of society destroy all opportunities, is essentially optimistic, for it holds that those circumstances can be removed, and those opportunities restored. That is the view I hold.

Madam President, H.R. 10606 authorizes the President's request for retraining and rehabilitation programs as a part of the minimum standard services of welfare programs in which the Federal Government participates. The Department of HEW's estimate of the cost of these new services for the next fiscal year is $40.8 million. In addition, this legislation maintains the 1961 increase of $1 in Federal assistance to the aged, the blind, and the disabled, and adds another $4 increase effective October 1, 1962, bringing the Federal share of social security payments on the maximum monthly average up to $70 per recipient. The child welfare program, now set at $25 million a year, is increased by $5 million for next year, and then graduated by annual $5 million increases up to $50 million a year for 1969 and thereafter.

Madam President, as a Democrat who takes pride in our party's record of progressive reform thinking, and as an American impressed with the bipartisan faith in the value and future of this country's welfare programs, and as a Senator from Montana intimately acquainted with the heartbreaking effects of mass unemployment in the mines and lumber mills of the Northwest, I take pride in voting for this legislation, for it truly represents an investment in the future productivity of million of Americans.

Mr. JAVITS. Madam President, will the Senator yield me 2 minutes on the bill?

Mr. MANSFIELD. I yield to the Senator from New York.

Mr. JAVITS. The Senator from New Mexico [Mr. ANDERSON], who does not happen to be on the floor at the present time, and I fought what I considered to be a very good fight. I congratulate our gallant opponent, the Senator from Oklahoma [Mr. KERR], on his victory in respect to the amendments.

It is my deep conviction, and I would not be true to myself if I did not say so, that the Senator from New Mexico and I and our other colleagues have arrived at a truly balanced plan which can operate within the concept of the American private enterprise tradition and yet under social security financing.

I feel its adoption is inevitable. Nothing which has occurred has convinced me or the country that the manifest need, for which there is a national responsibility, has been met.

For myself, I will willingly and happily engage in this struggle, for it will continue, with the Senator from New Mexico, in the hope that we may do better on another day. It is my deep conviction that that day will not be too long distant.

I thank the Senator for yielding to me.

The PRESIDING OFFICER. The bill is open to further amendment.

Mr. WILEY. Madam President, I call up my amendment identified as "7-11-62—A."

The PRESIDING OFFICER. The amendment offered by the Senator from Wisconsin will be stated.

The CHIEF CLERK. It is proposed to insert the following at the proper place:

USE OF PAYMENTS FOR BENEFIT OF CHILD

SEC. 107. (a) Section 405 of the Social Security Act is amended to read as follows:

"USE OF PAYMENTS FOR BENEFIT OF CHILD

"SEC. 405. Whenever the State agency has reason to believe that any payments of aid to families with dependent children made with respect to a child are not being or may not be used in the best interests of the child, the State agency may provide for such counseling and guidance services with respect to the use of such payments and the management of other funds by the relative receiving such payments as it deems advisable in order to assure use of such payments in the best interests of such child, and may provide for advising such relative that continued failure to so use such payments will result in substitution therefor of protective payments as provided under section 406(b)(2), or in seeking appointment of a guardian or legal representative as provided in section 1111, or in other action authorized under State law which is deemed necessary to protect the interests of such child; and any such action taken by the State agency pursuant to such State law, other than denial of such payments with respect to such child while in the home of such relative, shall not serve as a basis for withholding funds from such State under section 404 and shall not prevent such payments with respect to such child from being considered aid to families with dependent children."

Mr. WILEY. Madam President, this is an amendment that I have been requested to present in the interest of the children themselves. In many instances funds which have been made available for a child have been misappropriated or misused by the parents.

I understand the committee had a similar amendment before it, and rejected it. However, it appeared to me that this was a matter of public policy, and those who have asked me to present

this amendment feel just that way. So I have offered the amendment.

I have spoken to the chairman of the committee. I would like to have him take the amendment to conference, if there is a conference, so that it can be considered by the conferees.

Mr. KERR. Madam President, I appreciate very much the attitude of the Senator from Wisconsin in offering this amendment. His purpose is a laudable one—to provide additional safeguards that the money being provided for aid to dependent children will be more certainly spent for their needs.

However, the bill has section 108 in it, which is new legislation, and which provides a number of safeguards which have for their purpose the achievement of the same objective which is in the mind of the distingiushed Senator from Wisconsin.

However, an identical amendment was before the Finance Committee. The Secretary of the Department of Health, Education, and Welfare, the distinguished Mr. Ribicoff, made it very plain that in his judgment the protective payments provision in section 108 is a specific answer to the problem envisioned by this amendment, and that section 108 has essential safeguards and fair play provisions.

After full hearings, with many witnesses heard both for and against this amendment, the Finance Committee took adverse action.

Therefore, Madam President, I have no choice. I urge my good friend to withdraw the amendment, or else I shall be forced to ask that it be rejected.

Mr. WILEY. Madam President, in view of the statement made by the distinguished Senator, which in itself is an assurance that there is adequate authority in the bill to protect not only the public interest, but also the interest of the child for whom the funds are to be provided, I shall not insist on a vote on the amendment. I withdraw the amendment.

Mr. KERR. I thank the Senator. I say to him further that if the language contained in section 108 in the bill proves to be inadequate to meet the problem to which the Senator has referred and to which his amendment is addressed, I shall join him in seeking to find a more effective way to do exactly what he has in mind for these children.

Mr. WILEY. I thank the Senator.

The PRESIDING OFFICER. The amendment has been withdrawn.

AID TO DEPENDENT CHILDREN OF UNEMPLOYED PARENTS

Mr. BYRD of West Virginia. Mr. President, with each passing day we are becoming more aware of the pressing need for enactment of H.R. 10606, because it affects a number of welfare programs which expired on June 30. I am particularly concerned with one of these expired programs—that which authorizes Federal participation in State programs of aid to dependent children in cases where the parent, who is the family wage earner, is unemployed.

Prior to enactment of Public Law 87–31 last year, aid to dependent children funds could go only to children who were deprived of parental support or care by reason of the death, continued absence from home, or the physical or mental incapacity of a parent. Public Law 87–31 authorized the States to set up temporary programs during the period May 1, 1961, to June 30, 1962, extending ADC payments to children in need because of the unemployment of a parent.

A total of 15 States—including my own State of West Virginia—responded to the authorization granted by Congress and put into effect programs of aid to dependent children for children of unemployed parents. Many more States would have adopted such programs, no doubt, if the period of Federal participation had been longer than 14 months.

As to the results of the program, I can only speak for the State of West Virginia. But in the short period that the law was in effect it produced highly successful and praiseworthy results. It has provided support, and the respect that goes with useful employment, to more than 15,000 West Virginia recipients comprising more than 52,000 persons.

In my State, payments received under the aid to dependent children of the unemployed is not looked upon as a dole. Under West Virginia regulations governing ADCU, the recipient husband and father is obliged to work on approved public works projects. Thus, the recipient earns every penny that is paid to him.

The need for the ADCU program in West Virginia is especially critical, for we are still faced with the problem of long-term unemployment. Prospects for job opportunities in private industry, while gradually improving, do not, at this time, hold out sufficient hope for a substantial reduction in unemployment. Thus, the public works jobs available to ADCU recipients are not only a means of providing employment to many persons, but of providing useful services to the State, to counties, and to municipalities.

The ADCU program in West Virginia has been singularly successful in inspiring new hope and aspirations in the hearts of many persons in my State. It has made the unemployed father feel like a breadwinner again, and it has been a cohesive force for renewed family strength.

The ADCU program has been good for West Virginia in many respects. It has been the vital force behind Gov. W. W. Barron's statewide cleanup campaign, and it has also been responsible for many improvements in our State parks and forests, for tourists and in-state vacationers. The program has also made possible the accessibility of heretofore unapproachable areas of scenic beauty to all who wish to see more of the grandeur of West Virginia's hills. In effect, this work will encourage tourism in the State, and thus eventually provide new employment opportunities in the private sector.

There is another provision of H.R. 10606 which ties in with the extension of the ADCU program. This is the provision authorizing Federal participation in community work and training programs for ADC recipients 18 years old and over. These work and training programs for able-bodied adults are highly desirable in offering such persons an opportunity to render service to the community which offers them assistance, as well as to develop or acquire new working skills.

A committee amendment adopted on the floor of the Senate on July 3, would make the community work and training provisions of the bill effective retroactively to July 1, 1961. This amendment would do more than allow payment to those States—like West Virginia—which utilized community work and training programs in the past in the same manner as the bill authorizes for the future.

Mr. President, H.R. 10606 should not be delayed any longer. Its passage is extremely important to many people in West Virginia who have come to know a better life because they were not forced to sit in idleness, and were given a chance to engage in productive work.

The PRESIDING OFFICER. The bill is open to further amendment. If there be no amendment to be proposed, the question is on the engrossment of the amendments and the third reading of the bill.

The amendments were ordered to be engrossed and the bill to be read a third time.

The bill (H.R. 10606) was read the third time, and passed.

Mr. MANSFIELD. Madam President, I move to reconsider the vote by which the bill was passed.

Mr. KERR. Madam President, I move to lay that motion on the table.

The PRESIDING OFFICER. The question is on agreeing to the motion to lay on the table the motion to reconsider.

The motion to lay on the table was agreed to.

Mr. KERR. Madam President, I move that the Senate insist upon its amendments, request a conference with the House of Representatives thereon, and that the Presiding Officer appoint the conferees on the part of the Senate.

The motion was agreed to; and the Presiding Officer appointed Mr. BYRD of Virginia, Mr. KERR, Mr. LONG of Louisiana, Mr. WILLIAMS of Delaware, and Mr. CARLSON conferees on the part of the Senate.

Mr. PROXMIRE. Madam President, I ask unanimous consent that H.R. 10606, the welfare bill, be printed as passed, with the Senate amendments numbered.

The PRESIDING OFFICER. Without objection, it is so ordered.

87TH CONGRESS
2D SESSION

S. 3565

IN THE SENATE OF THE UNITED STATES

JULY 25, 1962

Mr. ANDERSON (for himself and Mr. JAVITS) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide for payment for hospital services, skilled nursing facility services, and home health services furnished to aged beneficiaries under the old-age, survivors, and disability insurance program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Insurance Benefits Act of 1962".

TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF CONTENTS—Continued

FINDINGS AND DECLARATION OF PURPOSE

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

(b) The purposes of this Act are (1) to provide aged

individuals entitled to benefits under the old-age, survivors, and disability insurance system or the railroad retirement system with basic protection against the costs of inpatient hospital services, and to provide, in addition, as an alternative to inpatient hospital care, protection against the costs of certain skilled nursing facility services, home health services, and outpatient hospital diagnostic services; to utilize social insurance for financing the protection so provided; to encourage, and make it possible for, such individuals to purchase protection against other health costs by providing in such basic social insurance protection a set of benefits which can easily be supplemented by a State, private insurance, or other methods; to assure adequate and prompt payment on behalf of these individuals to the providers of these services; and to do these things in a manner consistent with the dignity and self-respect of each individual, without interfering in any way with the free choice of physicians or other health personnel or facilities by the individual, and without the exercise of any Federal supervision or control over the practice of medicine by any doctor or over the manner in which medical services are provided by any hospital; and (2) to provide such basic protection, financed from general revenues,

to those persons who are now age 65 or over or who will reach age 65 within the next several years and who are not eligible for benefits under the old-age, survivors, and disability insurance or railroad retirement systems.

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

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

TITLE I—HEALTH INSURANCE BENEFITS FOR THE AGED

BENEFITS

SEC. 101. The Social Security Act is amended by adding after title XVI the following new title:

"TITLE XVII—HEALTH INSURANCE BENEFITS FOR THE AGED

PROHIBITION AGAINST INTERFERENCE

"SEC. 1701. (a) Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any hospital, skilled nursing facility, or home health agency; or to exercise any supervision or control over the administration or operation of any such hospital, facility, or agency.

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

"FREE CHOICE BY PATIENT

"SEC. 1702. Any individual entitled to have payment made under this title for services furnished him may obtain inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services from any provider of services with which an agreement is in effect under this title and which undertakes to provide him such services.

"DESCRIPTION OF SERVICES

"SEC. 1703. For purposes of this title—

"Inpatient Hospital Services

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

"(1) bed and board (subject, however, to the limitations in section 1709(c) and (d) on the amount which is payable with respect to certain accommodations),

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

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

excluding, however—

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

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

"Skilled Nursing Facility Services

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

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

"(2) bed and board in connection with the furnishing of such nursing care (subject, however, to the limitations in section 1709 (c) and (d) on the amount which is payable with respect to certain accommodations),

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

"(4) medical social services,

"(5) drugs, biologicals, supplies, appliances, and equipment which are furnished for use in such skilled nursing facility,

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

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

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

"Home Health Services

"(c) The term 'home health services' means the following items and services, which are furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and pe-

riodically reviewed by a physician, which items and services are provided in a place of residence used as such individual's home—

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

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

"(3) medical social services,

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

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

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

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

"Outpatient Hospital Diagnostic Services

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

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

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

excluding, however—

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

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

"Drugs and Biologicals

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

cals (or of the hospital with which the skilled nursing facility furnishing such drugs or biologicals is affiliated or is under common control).

"Arrangements for Certain Services

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

"DEDUCTIBLE; DURATION OF SERVICES

"Deductible

"SEC. 1704. (a) (1) Payment for inpatient hospital services furnished an individual during any benefit period shall be reduced by a deduction equal to $20, or if greater, $10 multiplied by the number of days, not exceeding nine, for which he received such services in such period.

"(2) Payment for outpatient hospital diagnostic services furnished an individual during any thirty-day period shall be reduced by a deduction equal to $20. For purposes of the preceding sentence, a thirty-day period for any individual is a period of thirty consecutive days beginning with

the first day (not included in a previous such period) on which he is entitled to benefits under this title and on which outpatient hospital diagnostic services are furnished him.

"Duration of Services

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

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

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

Payment under this title for inpatient hospital services or skilled nursing facility services furnished an individual during a benefit period may also not be made for any such services after one hundred and fifty units of services have been furnished to him in such period; and, for purposes of this sentence—

"(3) a 'unit of service' shall be equal to one day of inpatient hospital services or two days of skilled nursing facility services, and

"(4) there shall not be counted any inpatient hospital services furnished in a benefit period for any days

in excess of ninety days or any skilled nursing facility services furnished in a benefit period for any days in excess of one hundred and eighty.

For purposes of the preceding provisions of this subsection, inpatient hospital services or skilled nursing facility services shall be counted only if payment is or would, except for this subsection and except for the failure to comply with the procedural and other requirements of or under section 1709 (a) (1), be made with respect to such services under this title. Payment under this title for home health services furnished an individual during a calendar year may not be made for any such services after such services have been furnished him during two hundred and forty visits in such year.

"Benefit Period

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

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

"(2) ending with the ninetieth day thereafter on

each of which he is neither an inpatient in a hospital nor an inpatient in a skilled nursing facility (whether or not such ninety days are consecutive), but only if such ninety days occur within a period of not more than one hundred and eighty consecutive days.

"Day

"(d) For the purposes of this section, a 'day' on or for which inpatient hospital services or skilled nursing facility services are furnished shall have the meaning customarily assigned to it by the hospital or skilled nursing facility furnishing such services, but in no event shall it be less than twenty-four hours (except the day on which such individual is admitted to, or discharged from, such hospital or such skilled nursing facility).

"ENTITLEMENT TO BENEFITS

"SEC. 1705. (a) Every individual who—

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

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

shall be entitled to health insurance benefits for each month for which he is entitled to such benefits under section 202, beginning with the first month after December 1963 with respect to which he meets the conditions specified in paragraphs (1) and (2). Notwithstanding the preceding provi-

sions of this subsection, no payments may be made under this title for inpatient hospital services, outpatient hospital diagnostic services, or home health services furnished an individual prior to January 1, 1964, or for skilled nursing facility services furnished him prior to July 1, 1964.

"(b) For the purposes of this section—

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

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

"DEFINITIONS OF PROVIDERS OF SERVICES

"SEC. 1706. For purposes of this title—

"Hospital

"(a) The term 'hospital' (except for purposes of sec-

tion 1704(c)(2), section 1709(f), paragraph (6) of this subsection, and so much of section 1703(b) as precedes paragraph (1) thereof) means an institution which—

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

"(2) maintains clinical records on all patients,

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

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

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

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

"(7) meets such other of the requirements pre-

scribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals, as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services by or in the institution.

For purposes of section 1704 (c) (2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of section 1709 (f) (including determination of whether an individual received inpatient hospital services for purposes of such section 1709 (f)), and so much of section 1703 (b) as precedes paragraph (1) thereof, such term includes any institution which meets the requirements of paragraphs (1), (2), (4), and (6) of this subsection. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of section 1704 (c) (2), include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients.

"Skilled Nursing Facility

"(b) The term 'skilled nursing facility' means (except for purposes of section 1704 (c) (2)) an institution (or a distinct part of an institution) which is affiliated or under common control with a hospital having an agreement in effect under section 1710 and which—

"(1) is primarily engaged in providing to inpa-

tients (A) skilled nursing care and related services for patients who require planned medical or nursing care or (B) rehabilitation services,

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

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

"(4) maintains clinical records on all patients,

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

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

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

of such State responsible for licensing institutions of this nature, as meeting standards established for such licensing; and

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

except that such term shall not (other than for purposes of section 1704(c)(2)) include any institution which is primarily for the care and treatment of tuberculosis or mentally ill patients. For purposes of section 1704(c)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.

"Home Health Agency

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

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

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

"(3) has policies, established by a group of professional personnel (associated with the agency), including one or more physicians and one or more regis-

tered professional nurses, to govern the service (referred to in paragraph (2)) which it provides,

"(4) maintains clinical records on all patients,

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

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

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

"Physician

"(d) The term 'physician' means an individual (including a physician within the meaning of section 1101(a)(7)) legally authorized to practice surgery or medicine by the State in which he performs the functions referred to in this title.

"Utilization Review

"(e) A utilization review plan of a hospital shall be deemed sufficient if it is applicable to services furnished by

the institution to individuals entitled to benefits under this title and if it provides—

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

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

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

"(4) for prompt notification to the institution, the individual, and his attending physician of any finding (after opportunity for consultation to such attending physician) by the physician members of such committee

or group that any further stay therein is not medically necessary.

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

"Provider of Services

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

"Skilled Nursing Facilities Affiliated or Under Common Control With Hospitals

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

"(1) the facility will be operated under standards, with respect to—

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

"(B) a system of clinical records, and

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

which are developed jointly by or are agreed to by the two institutions;

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

"(3) the utilization review plan of the hospital will be extended to include review of admissions to, duration of stays in, and the professional services furnished in the skilled nursing facility and including review of such individual cases (and at such intervals) as may be specified in this title or in regulations thereunder, and with notice to the facility, the individual, and his attending physician in case of a finding (after opportunity for consultation to such attending physician) that fur-

ther skilled nursing facility services are not medically necessary.

"States and United States

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

"Additional Skilled Nursing Facilities

"(i) The Secretary shall, after consultation with associations of nursing homes, the American Hospital Association, the Joint Commission on Accreditation of Hospitals, and other appropriate professional organizations, make a full and complete study of the best ways of increasing the availability of skilled nursing facility care for beneficiaries under this title under conditions assuring good quality of care; and, on the basis of such study, he may make a determination that additional nursing facilities in which such conditions assuring good quality of care exist constitute skilled nursing facilities under section 1706(b) if they also meet the requirements of subsection (b) (other than the requirement of affiliation and other than the requirement that a hospital utilization review plan be made applicable) and if the Secretary shall find that such action will not create an actuarial imbalance in the Federal Health Insurance Trust Fund. The Secretary shall promptly report to the Congress from time to time and in any event by July 1, 1963, the results of the study under this subsection and any action taken as a result thereof.

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

"SEC. 1707. In carrying out his functions, relating to determination of conditions of participation by providers of services, under section 1706(a)(7), section 1706(b)(8), or section 1706(c)(6), the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1712, appropriate State agencies, and recognized national listing or accrediting bodies. Such conditions prescribed under any of such sections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide (subject to the limitation provided in section 1706(a)(7)) higher requirements for such State than for other States.

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

"SEC. 1708. (a) The Secretary may, pursuant to agreement, utilize the services of State health agencies or other appropriate State agencies for the purposes of (1) determining whether an institution is a hospital or skilled nursing facility, or whether an agency is a home health agency, or (2) providing consultative services to institutions or agencies to assist them (A) to qualify as hospitals, skilled nursing

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

"(b) (1) An institution shall be deemed to meet the conditions of participation under section 1706(a) (except paragraph (5) thereof) if such institution is accredited as a hospital by the Joint Commission on the Accreditation of

Hospitals. If such Commission hereafter requires a utilization review plan, or imposes another requirement which serves substantially the same purpose, as a condition for accreditation of a hospital, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1706(a)(5).

"(2) If the Secretary finds that accreditation of an institution by a national accreditation body, other than the Joint Commission on the Accreditation of Hospitals, provides reasonable assurance that any or all of the conditions of section 1706 (a), (b), or (c), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution as meeting the condition or conditions with respect to which he made such finding.

"CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

"Requirement of Requests and Certifications

"SEC. 1709. (a) Except as provided in subsection (f), payment for services furnished an individual may be made only to eligible providers of services and only if—

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

such person or persons as the Secretary may by regulation prescribe;

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

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

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

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

"(D) in the case of home health services, such services are or were required because the individual

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

"(3) with respect to inpatient hospital services or skilled nursing facility services furnished such individual after the twenty-first day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1710(e) (based on a finding that timely utilization review of long-stay cases is not being made in such hospital or facility);

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

the hospital or skilled nursing facility, as the case may be, received notice of such finding.

"'Determination of Costs of Services

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

"Amount of Payment for More Expensive Services

"(c) (1) In case the bed and board furnished as part of inpatient hospital services or skilled nursing facility services is in accommodations more expensive than two-, three-, or four-bed accommodations and the use of such more expen-

sive accommodations rather than such two-, three-, or four-bed accommodations was not at the request of the patient, payment with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such two-, three-, or four-bed accommodations unless the more expensive accommodations were required for medical reasons.

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

"Amount of Payment Where Less Expensive Services Furnished

"(d) In case the bed and board furnished as part of inpatient hospital services or skilled nursing facility services in accommodations other than, but not more expensive than, two–, three–, or four-bed accommodations and the use of such other accommodations rather than two–, three–, or four-bed accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with

the purposes of this title, the amount of the payment with respect to such services under this title shall be the reasonable cost of such services minus the difference beween the charge customarily made by the hospital or skilled nursing facility for such services in two-, three-, or four-bed accommodations and the charge customarily made by it for such services in the accommodations furnished.

"No Payments to Federal Providers of Services

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

"Payment for Emergency Inpatient Hospital Services

"(f) Payments shall also be made to any hospital for inpatient hospital services or outpatient hospital diagnostic services furnished, by the hospital or under arrangements (as defined in section 1703(f)) with it, to an individual entitled to health insurance benefits under this title even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services

and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payment shall be made only in amounts determined as provided in subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1710(a).

"Payment for Services Prior to Notification of Noneligibility

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

"AGREEMENTS WITH PROVIDERS OF SERVICES

"SEC. 1710. (a) Any provider of services shall be eligible for payments under this title if it files with the Secretary an agreement not to charge any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1709(g)), and to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, except that such provider of services may charge such individual or other person the amount of any deduction imposed pursuant to section 1704(a) with respect to such services (not in excess of the amount customarily charged for such services by such provider) and, where the provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider may also charge such individual or other person for such more expensive items or services but not more than the difference between the amount customarily charged by it for the items or services furnished at such

request and the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

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

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

"(2) by the Secretary at such time and upon such notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined, and has given such provider notification thereof, (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider no longer substantially meets the applicable provisions of section 1706, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has

refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information.

Any termination shall be applicable—

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

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

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

"(c) Nothing in this title shall preclude any provider of services or any group or groups of such providers from being represented by an individual, association, or organization authorized by such provider or providers of services to act on their behalf in negotiating with respect to their participa-

tion under this title and the terms, methods, and amounts of payments for services to be provided thereunder.

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

"(e) If the Secretary finds that timely review in accordance with section 1706(e) of long-stay cases in a hospital or skilled nursing facility is not being made with reasonable regularity, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or skilled nursing facility after a date specified by him, no payment shall be made for inpatient hospital services or skilled nursing facility services after the twenty-first day of a continuous period of such services. Such decision may be made only after such notice to the hospital, or (in the case of a skilled nursing facility) to the hospital and the facility, and to the public as may be prescribed by regulations, and its effectiveness shall be rescinded when the Secretary finds that the reason therefor has been removed and there is reasonable assurance that it will not recur.

"PAYMENT TO PROVIDERS OF SERVICES

"SEC. 1711. The Secretary shall periodically determine the amount which should be paid to each provider of services under this title with respect to the services furnished by it, and the provider shall be paid, at such time or times as the Secretary believes appropriate and prior to audit or settlement by the General Accounting Office, from the Federal Health Insurance Trust Fund the amounts so determined; except that such amounts may be reduced or increased, as the case may be, by any sum by which the Secretary finds that the amount paid to such provider of services for any prior period was greater or less than the amount which should have been paid to it for such period.

"HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

"SEC. 1712. For the purpose of advising the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, there is hereby created a Health Insurance Benefits Advisory Council which shall consist of fourteen persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as Chairman. Not less than four of the appointed members shall be persons who are outstanding in the fields pertaining to hospitals and

health activities. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, three at the end of the first year, four at the end of the second year, three at the end of the third year, and four at the end of the fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms. The Secretary may, at the request of the Council, appoint such special advisory or technical committees as may be useful in carrying out its functions. Appointed members of the Advisory Council and members of its advisory or technical committees, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such a committee or committees, shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section

5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of four or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.

"REVIEW OF DETERMINATIONS

"SEC. 1713. Any individual dissatisfied with any determination made by the Secretary that he is not entitled to health insurance benefits under this title or that he is not entitled to have payment made under this title with respect to any class of services furnished him, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205 (b) with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205 (g).

"OVERPAYMENTS TO INDIVIDUALS

"SEC. 1714. (a) Any payment under this title to any provider of services with respect to inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services, furnished any individual shall be regarded as a payment to such individual.

"(b) Where—

"(1) more than the correct amount is paid under this title to a provider of services for services furnished

an individual and the Secretary determines that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services, or

"(2) any payment has been made under section 1709(g) to a provider of services for services furnished an individual,

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

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

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

"(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1709(g)) for services furnished to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience.

"(d) No certifying or disbursing officer shall be held

liable for any amount certified or paid by him to any provider of services where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

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

"SEC. 1715. (a) The Secretary is authorized to enter into an agreement with any organization, which has been designated by any group of providers of services, or by an association of such providers on behalf of its members, to receive payments under section 1711 on behalf of such providers, providing for the determination by such organization (subject to such review by the Secretary as may be provided for in the agreement) of the amount of payments required pursuant to this title to be made to such providers, and for making such payments. The Secretary shall not enter into an agreement with any organization under this section unless he finds it consistent with effective and efficient administration of this title.

"(b) To the extent that the Secretary finds that performance of any of the following functions by an organization with which he has entered into an agreement under subsection (a) will be advantageous and will promote the

efficient administration of this title, he may also include in the agreement provision that the organization shall (with respect to providers of services which are to receive payments through the organization)—

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

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

"(3) assist in the application of safeguards against unnecessary utilization of services furnished by providers to individuals entitled to have payment made under section 1711;

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

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

and proper for carrying out the functions covered by the agreement.

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

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

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

"(2) by the Secretary at such time and upon such notice to the organization, and to the providers which have designated it for purposes of this section, as may be provided in regulations, but only if he finds, after reasonable notice and opportunity for hearing to the

organization, that (A) the organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the organization is disadvantageous or is inconsistent with efficient administration of this title.

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

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

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

"OPTION TO BENEFICIARIES TO CONTINUE PRIVATE HEALTH INSURANCE PROTECTION

"SEC. 1716. (a) In lieu of payments to a provider of services under an agreement under this title, payments may be made to an eligible carrier under an approved plan with respect to services, for which payment would otherwise be made under the preceding provisions of this title (hereinafter in this section referred to as 'reimbursable health services'), which are furnished by such provider of services to any individual entitled to health insurance benefits under this title if such individual elects to have payment for such services made to such carrier.

"(b) (1) An individual may make an election under subsection (a) with respect to the approved plan of an eligible carrier only if he was covered by an approved plan of such carrier (or an affiliate thereof) continuously during whichever of the following periods is applicable—

"(A) if the month in which such individual becomes entitled to health insurance benefits under this title is any month in 1964 or January, February, or March of 1965, the ninety-day period ending with the close of the month before such month, or

"(B) if the month in which he becomes so entitled is April 1965 or a subsequent month, the period beginning January 1, 1965, and ending with the close of the

month before the month in which he becomes so entitled or, if shorter (i) in the case of a plan meeting the requirements of clause (A), (B), (C), or (D) of subsection (c) (5), the one-year period ending with such close of such month, or (ii) in the case of a plan meeting the requirements of clause (E) of such subsection, the two-year period ending with such close of such month.

"(2) An individual may make an election under subsection (a) in such manner and within such period as the Secretary may prescribe, but in no event more than three months after the month in which such individual becomes entitled to health insurance benefits under this title; and an individual shall be permitted only one such election. An election so made may be revoked at such time or times and in such manner as may be so prescribed, and shall be effective at the end of the ninety-day period following such revocation or, if later, the end of the benefit period (as defined in section 1704 (c)), if any, of the individual during which such revocation is made or, if a benefit period begins during such ninety-day period, the end of such benefit period.

"(c) To be approved for purposes of this section with respect to an individual, a plan must—

"(1) be an insurance policy or contract, medical or hospital service agreement, membership or subscrip-

tion contract, or similar arrangement provided by a carrier for the purpose of providing or paying for some medical or other type of remedial care;

"(2) with respect to the period before an individual becomes entitled to health insurance benefits under this title, include provision of, or payment for the cost of—

"(A) inpatient hospital services, with no greater deductible and limitations than are applicable in the case of inpatient hospital services which constitute reimbursable health services, or

"(B) in the case of a plan meeting the requirements of clause (A), (B), (C), or (D) of paragraph (5), inpatient hospital services to the extent provided in subparagraph (A), but without application of the deductible under section 1704(a)(1) and with a limitation of forty-five days on the duration of such services;

"(3) with respect to the period during which an individual is entitled to health insurance benefits under this title, include provision of, or payment to providers of services for the cost of—

"(A) all reimbursable health services, or

"(B) in the case of a plan meeting the requirements of clause (A), (B), (C), or (D) of para-

graph (5), such reimbursable health services, but without application of the deductible under section 1704(a)(1) and with a limitation of forty-five days on the duration of inpatient hospital services;

"(4) include provision of, or payment for part or all of the cost of, some additional medical or other type of remedial care not included as reimbursable health services; and

"(5) (A) be a group plan, or a continuation of a group plan which is available to individuals on conversion of a group plan after their separation from the group, or (B) be issued by a corporation, association, or other organization which is exempt from income tax under section 501(c) of the Internal Revenue Code of 1954, or (C) be a prepayment group practice plan, or (D) be a plan which the Secretary determines, on the basis of available data, is likely to result in a ratio of acquisition costs to payments with respect to the cost of medical or any other type of remedial care which is not greater than the ratio of such costs to such payments in the case of most of the group plans approved under this section, or (E) in the case of a plan which does not come within clause (A), (B), (C), or (D), be issued by a corporation, association, or other organization which (i) is licensed in the fifty States and the District of

Columbia to issue insurance covering all or any part of the cost of medical or any other type of remedial care and, in the most recent year for which data are available, has made payments with respect to the cost of such care aggregating at least 1 per centum of all such payments in the fifty States and the District of Columbia, or (ii) is determined by the Secretary to be national in scope, or (iii) is licensed to issue insurance covering part or all of the cost of such care in the State with respect to which it requests eligibility hereunder and, in the most recent year for which data are available, has made payments with respect to the cost of such care aggregating at least 5 per centum of such payments in such State.

For purposes of paragraph (5)—

"(6) a 'group plan' issued in any State is a plan which meets the requirements established by the law of such State for such plans or, in the case of a plan in a State in which there is no State law establishing requirements for such plans, which—

"(A) is issued to employers for their employees, or to unions for their members, or to other associations for their members who are bound together by a single, mutual interest other than insurance; and

"(B) covers at least ten persons in the group;

"(7) the 'acquisition costs' of a plan are costs directly related to the sale of coverage under such plan to individuals, including costs such as costs of advertising, commissions and salaries of agents, and salaries and other expenses of field staff directly involved in the sale of coverage under the plan.

"(d) A carrier shall be eligible for purposes of this section if it—

"(1) is a corporation or other nongovernmental organization which is lawfully engaged in issuing plans described in subsection (c) (1) in the State with respect to which it requests eligibility under this section;

"(2) agrees that any information provided in connection with any approved plan will be accurate and complete;

"(3) agrees, in the case of any individual who has made an election under this section with respect to an approved plan and who revokes such election (including termination of such coverage by such individual or the carrier), to continue to make payments under such plan with respect to him until his revocation is effective (or would be effective if such termination were considered a revocation) as provided in subsection (b) (2);

"(4) agrees to provide the Secretary, on request, such reports as may reasonably be necessary to enable

him to determine the amounts due, under any plan with respect to which an election has been made under this section, on account of reimbursable health services and the administrative expenses of the carrier in connection therewith, and agrees to permit the Secretary to determine the accuracy of such reports;

"(5) agrees to make payments for reimbursable health services to providers of services, or to provide reimbursable health services, with respect to individuals who have made an election under this section in the same amounts, under the same conditions, and subject to the same limitations as are applicable in the case of such services for which payments are made under the preceding sections of this title; and

"(6) agrees not to impose any fees, premiums, or other charges with respect to reimbursable health services for individuals entitled to health insurance benefits under this title.

"(e) If a plan ceases to be approved under this section or a carrier ceases to be an eligible carrier or ceases to do business, any individual who has made an election under this section and is covered by such plan or by a plan of such carrier shall be deemed to have revoked his election under this section and such revocation shall, notwithstanding subsection (b) (2), be effective immediately upon such cessa-

tion; except that the limitations applicable under such plan shall apply with respect to the benefit period (as defined in section 1704(c)), if any, of such individual existing at the time of such cessation.

"(f) (1) An eligible carrier shall be paid from time to time amounts equal to the payments made or the cost of services provided by it for reimbursable health services under approved plans with respect to individuals who have made an election under this section and, in addition, such amounts as the Secretary finds to be the administrative costs of such carrier which are reasonably necessary to the provision of or payment for the cost of reimbursable health services for such individuals under an approved plan, except that such additional amounts for any year may not be more than 50 per centum greater than the comparable part of the cost of administration of this title.

"(2) In the case of a plan to which subparagraph (B) of subsection (c) (3) is applicable, the limitations and conditions of payment for reimbursable health services under the preceding sections of this title shall be modified in accordance with such subparagraphs; and for such purposes the maximum units of reimbursable health services (within the meaning of section 1704(b)) for which payment will be made under this title shall be one hundred and five units.

"REGULATIONS

"SEC. 1717. When used in this title, the term 'regulations' means, unless the context otherwise requires, regulations prescribed by the Secretary.

"APPLICATION OF CERTAIN PROVISIONS OF TITLE II

"SEC. 1718. The provisions of sections 206, 208, and 216(j), and of subsections (a), (d), (e), (f), and (h) of section 205 shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

"DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

"SEC. 1719. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made."

FEDERAL HEALTH INSURANCE TRUST FUND

SEC. 102. (a) Section 201 of the Social Security Act is amended by redesignating subsections (c), (d), (e), (f), (g), and (h) as subsections (d), (e), (f), (g), (h), and (i), respectively, and by adding after subsection (b) the following new subsection:

"(c) There is hereby created on the books of the Treasury of the United States a trust fund to be known as

the 'Federal Health Insurance Trust Fund'. The Federal Health Insurance Trust Fund shall consist of such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Health Insurance Trust Fund for the fiscal year ending June 30, 1963, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

"(1) (A) 0.18 of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1962, and before January 1, 1964, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

"(B) 0.68 of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1963, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages

established and maintained by such Secretary in accordance with such reports; and

"(2) (A) 0.135 of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1962, and before January 1, 1964, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns; and

"(B) 0.51 of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1963, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns."

(b) The first sentence of the subsection of such section 201 herein redesignated as subsection (d) is amended by striking out "and the Federal Disability Insurance Trust Fund" and inserting in lieu thereof ", the Federal Disability Insurance Trust Fund, and the Federal Health Insurance Trust Fund".

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

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

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

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

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

(A) by striking out "Trust Funds" wherever that

appears and inserting in lieu thereof "Trust Funds (except the Federal Health Insurance Trust Fund)";

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

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

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

INCREASE IN EARNINGS BASE

Definition of Wages

SEC. 103. (a) (1) Paragraph (3) of section 209(a) of the Social Security Act is amended by inserting "and prior to 1963" after "1958".

(2) Such section 209(a) is further amended by adding at the end thereof the following new paragraph:

"(4) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $5,200 with respect to employment has been paid to an indi-

vidual during any calendar year after 1962, is paid to such individual during such calendar year;".

Definition of Self-employment Income

(b) (1) Subparagraph (C) of section 211 (b) (1) of such Act is amended by inserting "and prior to 1963" after "1958"; and by striking out "; or" and inserting in lieu thereof "; and".

(2) Such section 211 (b) (1) is further amended by adding at the end thereof the following new subparagraph:

"(D) For any taxable year ending after 1962, (i) $5,200, minus (ii) the amount of wages paid to such individual during the taxable year; or".

Definitions of Quarter and Quarter of Coverage

(c) (1) Clause (ii) of section 213 (a) (2) of such Act is amended by striking out "1958" and inserting in lieu thereof "1958 and before 1963, or $5,200 in the case of a calendar year after 1962".

(2) Clause (iii) of section 213 (a) (2) of such Act is amended by striking out "1958" and inserting in lieu thereof "1958 and before 1963, or $5,200 in the case of a taxable year ending after 1962".

Table for Determining Primary Insurance Amount

(d) (1) The table in section 215 (a) of such Act is

amended by striking out all the figures in columns II, III, IV, and V beginning with the line which reads

"101.50	102.30	315	319	109	254.00"

and down through the line which reads

		"399	400	127	254.00"

and inserting in lieu thereof the following:

"101.50	102.30	315	319	109	255.20
102.40	103.20	320	323	110	258.40
103.30	104.20	324	328	111	262.40
104.30	105.10	329	333	112	266.40
105.20	106.00	334	337	113	268.00
106.10	107.00	338	342	114	268.00
107.10	107.90	343	347	115	268.00
108.00	108.50	348	351	116	268.00
		352	356	117	268.00
		357	361	118	268.00
		362	365	119	268.00
		366	370	120	268.00
		371	375	121	268.00
		376	379	122	268.00
		380	384	123	268.00
		385	389	124	268.00
		390	393	125	268.00
		394	398	126	268.00
		399	403	127	268.00
		404	407	128	268.00
		408	412	129	268.00
		413	417	130	268.00
		418	421	131	268.00
		422	426	132	268.00
		427	431	133	268.00
		432	433	134	268.00".

(2) The amendment made by paragraph (1) shall be applicable with respect to monthly insurance benefits under title II of such Act for months after December 1962 and with respect to lump-sum death payments in the case of deaths after December 1962.

Average Monthly Wage

(e) Paragraph (1) of section 215(e) of such Act is amended by striking out "and the excess over $4,800 in the case of any calendar year after 1958" and inserting in lieu thereof "the excess over $4,800 in the case of any calendar

year after 1958 and before 1963, and the excess over $5,200 in the case of a calendar year after 1962".

TECHNICAL AMENDMENTS

Suspension in Case of Aliens

SEC. 104. (a) Subsection (t) of section 202 of such Act is amended by adding at the end thereof the following new paragraph:

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

Persons Convicted of Subversive Activities

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

Advisory Council on Social Security Financing

(c) (1) Subsection (a) of section 116 of the Social Security Amendments of 1956 is amended by striking out "and of the Federal Disability Insurance Trust Fund" and

inserting in lieu thereof ", of the Federal Disability Insurance Trust Fund, and of the Federal Health Insurance Trust Fund". Such subsection is further amended by inserting before the period at the end thereof "and the health insurance benefits program".

(2) Subsection (d) of such section is amended by striking out "and the Federal Disability Insurance Trust Fund" and inserting in lieu thereof ", the Federal Disability Insurance Trust Fund, and the Federal Health Insurance Trust Fund".

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

TITLE II—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1954

CHANGES IN TAX SCHEDULES

Self-Employment Income Tax

SEC. 201. (a) Section 1401 of the Internal Revenue Code of 1954 (relating to the rate of tax on self-employment income) is amended to read as follows:

"SEC. 1401. RATE OF TAX.

"In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows—

"(1) in the case of any taxable year beginning after December 31, 1962, and before January 1, 1964, the tax shall be equal to 5.4 percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1963, and before January 1, 1966, the tax shall be equal to 5.8 percent of the amount of the self-employment income for such taxable year;

"(3) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1968, the tax shall be equal to 6.6 percent of the amount of the self-employment income for such taxable year; and

"(4) in the case of any taxable year beginning after December 31, 1967, the tax shall be equal to 7.3 percent of the amount of the self-employment income for such taxable year."

Tax on Employees

(b) Section 3101 of such Code (relating to rate of tax on employees under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3101. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121 (a)) received by him with respect to employment (as defined in section 3121 (b))—

"(1) with respect to wages received during the calendar year 1963, the rate shall be $3\frac{5}{8}$ percent;

"(2) with respect to wages received during the calendar years 1964 and 1965, the rate shall be $3\frac{7}{8}$ percent;

"(3) with respect to wages received during the calendar years 1966 and 1967, the rate shall be $4\frac{3}{8}$ percent; and

"(4) with respect to wages received after December 31, 1967, the rate shall be $4\frac{7}{8}$ percent."

Tax on Employers

(c) Section 3111 of such Code (relating to rate of tax

on employers under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3111. RATE OF TAX.

"In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121 (a)) paid by him with respect to employment (as defined in section 3121 (b))—

"(1) with respect to wages paid during the calendar year 1963, the rate shall be $3\frac{5}{8}$ percent;

"(2) with respect to wages paid during the calendar years 1964 and 1965, the rate shall be $3\frac{7}{8}$ percent;

"(3) with respect to wages paid during the calendar years 1966 and 1967, the rate shall be $4\frac{3}{8}$ percent; and

"(4) with respect to wages paid after December 31, 1967, the rate shall be $4\frac{7}{8}$ percent."

Effective Dates

(d) The amendment made by subsection (a) shall apply with respect to taxable years beginning after December 31, 1962. The amendments made by subsections (b) and (c) shall apply with respect to remuneration paid after December 31, 1962.

INCREASE IN TAX BASE

Definition of Self-Employment Income

SEC. 202. (a) (1) Subparagraph (C) of section 1402 (b) (1) of the Internal Revenue Code of 1954 is amended by adding "and before 1963" after "1958"; and by striking out "or" and inserting in lieu thereof "and".

(2) Such section 1402 (b) (1) is further amended by adding at the end thereof the following new subparagraph:

"(D) for any taxable year ending after 1962, (i) $5,200, minus (ii) the amount of the wages paid to such individual during the taxable year; or".

Definition of Wages

(b) Section 3121 (a) (1) of such Code is amended by striking out "$4,800" wherever it appears and inserting in lieu thereof "$5,200".

Federal Service

(c) Section 3122 of such Code is amended by striking out "$4,800" and inserting in lieu thereof "$5,200".

Returns in the Case of Governmental Employees in Guam and American Samoa

(d) Section 3125 of such Code is amended by striking out "$4,800" wherever it appears and inserting in lieu thereof "$5,200".

Special Refunds of Employment Taxes

(e) (1) Section 6413 (c) (1) of such Code is amended—

(A) by inserting "and prior to the calendar year 1963" after "the calendar year 1958";

(B) by inserting "or (C) during any calendar year after the calendar year 1962, the wages received by him during such year exceed $5,200," after "exceed $4,800,"; and

(C) by inserting before the period at the end thereof "and before 1963, or which exceeds the tax with respect to the first $5,200 of such wages received in such calendar year after 1962".

(2) Section 6413 (c) (2) (A) of such Code is amended by striking out "or $4,800 for any calendar year after 1958" and inserting in lieu thereof "$4,800 for the calendar year 1959, 1960, 1961, or 1962, or $5,200 for any calendar year after 1962".

Effective Date

(f) The amendments made by subsections (b), (c), and (d) shall be applicable with respect to remuneration paid after 1962.

TECHNICAL AMENDMENT

SEC. 203. Section 3121 (l) (6) of the Internal Revenue Code of 1954 is amended by striking out "and the Federal Disability Insurance Trust Fund," and inserting in lieu thereof ", the Federal Disability Insurance Trust Fund, and the Federal Health Insurance Trust Fund,". The amendment made by this section shall be effective January 1, 1963.

TITLE III—RAILROAD RETIREMENT AMENDMENTS

HEALTH INSURANCE BENEFITS FOR THE AGED UNDER THE RAILROAD RETIREMENT ACT

SEC. 301. (a) The Railroad Retirement Act of 1937 is amended by adding after section 20 of such Act the following new section:

"Health Insurance Benefits for the Aged

"SEC. 21. (a) For the purposes of this section, and subject to the conditions hereinafter provided, the Board shall have the same authority to determine the rights of individuals described in subsection (b) of this section to have payments made on their behalf for health insurance benefits consisting of inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services within the meaning of title XVII of the Social Security Act as the Secretary of Health, Education, and Welfare has under such title XVII with respect to

individuals to whom such title applies. The rights of individuals described in subsection (b) of this section to have payment made on their behalf for the services referred to in the next preceding sentence shall be the same as those of individuals to whom title XVII of the Social Security Act applies and this section shall be administered by the Board as if the provisions of such title XVII were applicable, references to the Secretary of Health, Education, and Welfare were to the Board, references to the Federal Social Insurance Trust Fund were to the Railroad Retirement Account, references to the United States or a State included Canada or a subdivision thereof, and the provisions of sections 1707 and 1712 of such title XVII were not included in such title. For purposes of section 11, a determination with respect to the rights of an individual under this section shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

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

"(A) has attained age sixty-five and

"(B) (i) is entitled to an annuity, or (ii) would be entitled to an annuity had he ceased compensated service and, in the case of a spouse, had such spouse's husband or wife ceased compensated service, or (iii) had been awarded a pension under section 6, or (iv)

bears a relationship to an employee which, by reason of section 3 (e), has been, or would be, taken into account in calculating the amount of an annuity of such employee or his survivor,

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

"(c) No individual shall be entitled to have payment made for the same services, which are provided for in this section, under both this section and title XVII of the Social Security Act, and no individual shall be entitled to have payment made under both this section and such title XVII for more than ninety days of inpatient hospital services or more than one hundred and eighty days of skilled nursing

facility services or more than one hundred and fifty units of such services during any benefit period, or more than two hundred and forty visits in any calendar year in which home health services are furnished. In any case in which an individual would, but for the preceding sentence, be entitled to have payment for such services made under both this section and such title XVII, payment for such services to which such individual is entitled shall be made in accordance with the procedures established pursuant to the next succeeding sentence, upon certification by the Board or by the Secretary of Health, Education, and Welfare. It shall be the duty of the Board and such Secretary with respect to such cases jointly to establish procedures designed to minimize duplications of requests for payment for services and determinations and to assign administrative functions between them so as to promote the greatest facility, efficiency, and consistency of administration of this section and title XVII of the Social Security Act; and, subject to the provisions of this subsection to assure that the rights of individuals under this section or title XVII of the Social Security Act shall not be impaired or diminished by reason of the administration of this section and title XVII of the Social Security Act. The procedures so established may be included in regulations issued by the Board and by the Secretary of Health, Education, and Welfare to implement this section and such title XVII, respectively.

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

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

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

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

(b) Section (1) (q) of such Act is amended by striking out "1961" and inserting in lieu thereof "1962".

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

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

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

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

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

"(iii) At the close of the fiscal year ending June 30, 1963, and each fiscal year thereafter, the Board and the Secretary of Health, Education, and Welfare shall determine the amount, if any, which, if added to or subtracted from the Federal Health Insurance Trust Fund would place such fund in the same position in which it would have been if service as an employee after December 31, 1936, had been included in the term 'employment' as defined in the Social Security Act and in the Federal Employment Contributions Act. Such determina-

tion shall be made no later than June 15 following the close of the fiscal year. If such amount is to be added to the Federal Health Insurance Trust Fund the Board shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Retirement Account to the Federal Health Insurance Trust Fund; if such amount is to be subtracted from the Federal Health Insurance Trust Fund the Secretary of Health, Education, and Welfare shall, within ten days after the determination, certify such amount to the Secretary of the Treasury for transfer from the Federal Health Insurance Trust Fund to the Retirement Account. The amount so certified shall further include interest (at the rate determined under subparagraph (B) for the fiscal year under consideration) payable from the close of such fiscal year until the date of certification.";

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

(E) by amending the subparagraph redesignated

as subparagraph (C) by subparagraph (A) of this paragraph to read as follows:

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

(2) The amendments made by paragraph (1) of this subsection shall be effective January 1, 1963. Such amendments and the amendments made by section 202(a) shall not be construed to increase or diminish the sums to be transferred, under the provisions of section 5(k)(2) of the

Railroad Retirement Act before their amendment by paragraph (1) of this subsection, between the Railroad Retirement Account and the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund.

AMENDMENTS TO RAILROAD RETIREMENT TAX ACT

Tax on Employees

SEC. 302. (a) Section 3201 of the Railroad Retirement Tax Act is amended by striking out ": *Provided*" and inserting in lieu thereof the following: ". With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3101 of the Federal Insurance Contributions Act are increased with respect to wages by section 201(b) of the Act which amended the Social Security Act by adding title XVII the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3101 are so increased with respect to wages: *Provided*".

Tax on Employee Representatives

(b) Section 3211 of the Railroad Retirement Tax Act is amended by striking ": *Provided*" and inserting in lieu thereof the following: ". With respect to compensation paid

for services rendered after the date with respect to which the rates of taxes imposed by section 3101 of the Federal Insurance Contributions Act are increased with respect to wages by section 201 (b) of the Act which amended the Social Security Act by adding title XVII the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by twice the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3101 are so increased with respect to wages: *Provided*".

Tax on Employers

(c) Section 3221 of the Railroad Retirement Tax Act is amended by inserting after "$400" the first time it appears the following: ". With respect to compensation paid for services rendered after the date with respect to which the rates of taxes imposed by section 3111 of the Federal Insurance Contributions Act are increased with respect to wages by section 201 (c) of the Act which amended the Social Security Act by adding title XVII the rates of tax imposed by this section shall be increased, with respect only to compensation paid for services rendered before January 1, 1965, by the number of percentage points (including fractional points) that the rates of taxes imposed by such section 3111 are so increased with respect to wages".

TITLE IV—HEALTH INSURANCE BENEFITS FOR PRESENTLY UNINSURED INDIVIDUALS

COVERAGE PROVISIONS

SEC. 401. Anyone who—

(1) has attained the age of 65,

(2) (A) attained such age before 1967, or (B) has not less than 3 quarters of coverage (as defined in title II of the Social Security Act or section 5(l) of the Railroad Retirement Act of 1937), whenever acquired, for each calendar year elapsing after 1964 and before the year in which he attained such age,

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

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

shall (subject to the limitations in this part) be deemed, solely for purposes of section 1705 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month

in which he meets the requirements of this subsection and ending with the month in which he dies or, if earlier, the month before the month in which he becomes entitled to monthly insurance benefits under such section 202 or meets the requirements set forth in subparagraph (B) of section 21 (b) of the Railroad Retirement Act of 1937.

LIMITATIONS

SEC. 402. (a) The provisions of section 401 shall apply only in the case of an individual who—

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

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

(b) The provisions of section 401 shall not apply to any individual who—

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

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

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

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

PAYMENTS TO TRUST FUND

SEC. 403. There are hereby authorized to be appropriated to the Federal Health Insurance Trust Fund (established by section 201 of the Social Security Act) from time to time such sums as the Secretary deems necessary, on account of—

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

(b) the additional administrative expenses resulting therefrom, and

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

in order to place such Trust Fund in the same position in which it would have been if sections 401 and 402 of this Act had not been enacted.

TITLE V—MISCELLANEOUS PROVISIONS

STUDIES AND RECOMMENDATIONS

SEC. 241. The Secretary of Health, Education, and Welfare shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to (1) the adequacy of existing facilities for health care for purposes of the program established by this Act; (2) methods for encouraging the further development of efficient and

economical forms of health care which are a constructive alternative to inpatient hospital care; (3) the feasibility of providing additional types of health insurance benefits within the financial resources provided by this Act; and (4) the effects of the deductibles and use of the option upon beneficiaries, hospitals, and the financing of the program.

87TH CONGRESS
2D SESSION

S. 3565

A BILL

To provide for payment for hospital services, skilled nursing facility services, and home health services furnished to aged beneficiaries under the old-age, survivors, and disability insurance program, and for other purposes.

By Mr. ANDERSON and Mr. JAVITS

JULY 25, 1962
Read twice and referred to the Committee on Finance

HEALTH INSURANCE BENEFITS ACT, 1962

Mr. ANDERSON. Mr. President, in the days preceding the vote last Tuesday to table the so-called Anderson amendment to H.R. 10606, the welfare bill, a number of changes were made in the amendment as originally introduced on June 29. This amendment, you will recall, would have established a health insurance program for some 17½ million Americans age 65 and over.

The senior Senator from New York [Mr. JAVITS] proposed a final major modification in his original amendment to the so-called Anderson amendment, and his modifying amendment, which I accepted, was not printed. Additionally, the junior Senator from Colorado [Mr. CARROLL], the senior Senator from Michigan [Mr. MCNAMARA], and the junior Senator from Maine [Mr. MUSKIE] proposed modifying language which was accepted; and I made two technical changes in the amendment.

Since the welfare bill is no longer Senate business, it is impossible under the rules of this body to order printed the so-called Anderson amendment in the form in which it was before us on July 17. I am, therefore, introducing today a bill which is the final form taken by the health care for the aged amendment to H.R. 10606. I do this so that Senators and other interested persons will have available the exact language which was the subject of the vote last week.

I have not asked the 25 cosponsors, including 5 Members from the other side of the aisle, to join in introducing this bill or the 22 other Senators who voted against tabling to join in sponsoring the bill I introduce today. The reason for this is that I am taking this step simply as a way to have this proposal printed. Their support for the social security approach to the problem of health care for the aged is already a matter of record.

Mr. President, I send my bill to the desk and ask that it be referred to the proper committee.

The PRESIDENT pro tempore. The bill will be received and appropriately referred.

The bill (S. 3565) to provide for payment for hospital services, skilled nursing facility services, and home health services furnished to aged beneficiaries under the old-age survivors, and disability insurance program, and for other purposes, introduced by Mr. ANDERSON, was received, read twice by its title, and referred to the Committee on Finance.

Mr. JAVITS subsequently said: Mr. President, the Senator from New Mexico [Mr. ANDERSON] today introduced a bill which represented what the Senate voted on in respect to the so-called health-care-for-the-aging bill. I have just talked with him and it is agreeable with him if I ask unanimous consent to be made a cosponsor of the bill. Accordingly, I ask unanimous consent that I be made a cosponsor of the bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE TASK FORCE

HEALTH CARE TASK FORCE

Mr. JAVITS. Mr. President, the problem of health care for the aging will continue to come before the Congress until a practical solution is provided. With the percentage of the aging in our population continuing to grow and costs for medical care continuing to rise while their retirement and other incomes remain relatively static, it is obvious that assistance must be forthcoming if these millions of Americans are to get the health care they need.

Many questions were raised in the Senate debate on the Anderson-Javits bill last July, and I have therefore invited a health care task force composed of some of the best minds in our country on this problem to go into the question of the best way to provide health care for our senior citizens. This task force will, it is expected, bring in a report and recommendations seasonably so that we may have the benefit of their thinking early in the next Congress.

I ask unanimous consent to print in the RECORD the text of my announcement made in New York, September 12; the statement by former Secretary of Health, Education, and Welfare, Arthur S. Flemming; and the news stories which appeared in the New York Times and the New York Herald Tribune, September 13.

There being no objection, the announcement, statement, and articles were ordered to be printed in the RECORD, as follows:

SENATOR JAVITS ANNOUNCES FORMATION OF MEDICARE TASK FORCE

Senator JACOB K. JAVITS today announced the formation of a task force on health care for the aging to conduct a full-scale study of the Anderson-Javits health care bill in preparation for the 1963 drive for enactment.

The task force is comprised of a group of outstanding health care experts, including two former Secretaries of Health, Education, and Welfare, Marion B. Folsom and Dr. Arthur Flemming.

Senator JAVITS said the task force will analyze the major objections raised by opponents of the Anderson-Javits bill this year when it was defeated in the Senate by only four votes. He said the task force will seek to determine if the plan is practical and workable, and will recommend any changes it may deem necessary to improve it.

"This task force is nonpolitical and representative of all interested and qualified groups," Senator JAVITS said. "These distinguished leaders have taken on an important job, and I believe their findings will be of enormous benefit to the next Congress. Their investigation will get underway now so that their report can be made known to the public and Congress early in 1963, before Congress is asked again to act on a health care for the aging bill."

Research staffs will be made available for the study by the University of Oregon development fund and New York University Law School. The study will be financed by individual benefactors.

Mr. Folsom is now director of Eastman Kodak Co.; Dr. Flemming is president of University of Oregon. Other members of the task force are: Dr. Dickinson W. Richards, emeritus professor of medicine, College of Physicians and Surgeons, Columbia University; Winslow Carlton, New York health consultant; Thomas Tierney, executive vice president, Colorado Hospital Service (Blue Cross), Denver, Colo.; Dr. Vernon W. Lippard, dean of Yale Medical School; Dr. Arthur Larson, Duke University, former Director of USIA; Russell A. Nelson, director, Johns Hopkins Hospital; John C. Leslie, vice president, Pan American Airways, and chairman, Committee on Aging, Community Service Society of New York; Dr. James Dixon, president, Antioch College, Ohio; Dr. Russell Lee, Palo Alto Clinic, California; and Hubert Yount, vice president, Liberty Mutual Insurance Co., Boston, Mass.

Senator JAVITS said the task force will investigate and report on such matters as:

1. Financing the program: Is the social security system the best way?

2. The private sector option: How practical is it? Are its terms workable? Are provisions for eligibility of vendors of health care, and of insurance carriers, sound?

3. Benefits: Are services provided by the bill deliverable?

4. Cost estimates: How valid?

Senator JAVITS said the task force will also study the growth capabilities of the present Kerr-Mills Act as related to health care requirements of the aging.

STATEMENT BY DR. ARTHUR FLEMMING

I am delighted to respond to the request of Senator JAVITS to participate in the work of the health care task force which he has taken the initiative in bringing together. As a result of my experiences as Secretary of Health, Education, and Welfare I am convinced there is a genuine need for the development of a positive program to assist the aged in protecting themselves in advance against the economic hazards of illness.

I feel that the establishment of this task force by Senator JAVITS reflects his continuing determination to provide the leadership in this area that will substitute action for talk. I look forward to working with the distinguished group of experts that have responded affirmatively to his invitation. I sincerely hope that we may be able to come up with findings and recommendations which will be of real help to the next Congress when it once again faces this very important issue.

[From the New York Times, Sept. 13, 1962]

AGED-CARE STUDY SET UP BY JAVITS—12 EXPERTS ON HEALTH TO MAKE INDEPENDENT SURVEY

Senator JACOB K. JAVITS announced yesterday that 12 prominent health authorities would make an independent study of the best way to provide medical care for the aged.

He said the study would start with an analysis of objections that killed the Anderson-Javits bill in the Senate, 52 to 48, in July.

Senator JAVITS, who is standing for reelection this year, stressed that the study, to be privately financed through contributions, would be nonpolitical and that members of the task force would have "no strings" on them in their work.

The New York Republican said, however, that he hopes the study, after assessing the practicability of the Anderson-Javits approach, might be able to recommend changes that would improve it and make it more understanble and acceptable to the public.

SPONSORS NOT BOUND

He said he had advised Senator CLINTON P. ANDERSON, Democrat, of New Mexico, that

he was taking the lead in setting up the health care task force, but he stressed that none of the sponsors would necessarily be bound by its recommendations.

Two former Secretaries of Health, Education, and Welfare are on the task force. They are Marion B. Folsom, now a director of the Eastman Kodak Co., and Arthur S. Flemming, president of the University of Oregon. Both served in the Eisenhower administration.

Other members, all of whom serve without pay, are:

Dr. Dickinson W. Richards, professor of medicine emeritus at Columbia's College of Physicians and Surgeons; Winslow Carlton, New York health consultant; Thomas Tierney, executive vice president of the Colorado Hospital Service (Blue Cross); Dr. Vernon W. Lippard, dean of the Yale Medical School.

Also, Dr. Arthur Larson of Duke University, former consultant to President Eisenhower; Russell A. Nelson, director of the Johns Hopkins Hospital; John C. Leslie, vice president of Pan American Airways and chairman of the Committee on Aging of the Community Service Society in New York.

Also, Dr. James Dixon, president of Antioch College; Dr. Russell Lee of the Palo Alto Clinic in California, and Hubert Yount, vice president of the Liberty Mutual Insurance Co. of Boston.

While disclaiming politics, Senator JAVITS stands to benefit from his role in setting up the health care task force. The move serves to again identify him at the outset of his campaign with an issue upon which the Democrats hope to win votes nationally in the congressional election.

Amendments to the administration's medical care bill, proposed by Mr. JAVITS and a small band of other Republicans, helped make the losing Senate vote closer, but 31 of the 52 negative votes were Republican.

Mr. JAVITS announced plans for the study at a news conference at the Hotel Pierre.

[From the New York Herald Tribune, Sept. 13, 1961]

MEDICARE: WHAT'S BEST?

(By John Molleson)

Senator JACOB K. JAVITS announced yesterday the formation of a 12-member committee of prominent citizens to make recommendations on health care for the aged.

The Senator said he was convinced the public had not been fully informed on the issue of medical care for the aging, and that this could have contributed to the defeat a few weeks ago of the Anderson-Javits medicare bill. The bill lost in the Senate by only four votes.

Mr. JAVITS described the committee as nonpolitical and representative of all interested and qualified groups. He said it would report to the public and Congress early next year on whether the Anderson-Javits proposals were sound, or if some other approach should be tried.

Included among the 12 are two former Secretaries of Health, Education, and Welfare—Marion B. Folsom, now director of the Eastman Kodak Co., and Dr. Arthur Flemming, president of the University of Oregon.

The Senator said the group will report on such matters as:

Is the social security system the best way to finance the program?

How practical is the private sector option, for private insurance companies and nonprofit health organizations to be included in the Government plan?

Are the services provided by the bill "deliverable"?

Are its cost estimates valid?

The study will be privately financed and is expected to cost less than $100,000, Mr. JAVITS said. Research staffs will be made available by the University of Oregon Development Fund and the New York University Law School. The members of the force will serve without compensation.

In addition to the former Secretaries, the committee includes:

Dr. Dickinson W. Richards, emeritus professor of medicine, College of Physicians and Surgeons, Columbia University.

Winslow Carlon, New York health consultant.

Thomas Tierney, executive vice president of the Colorado Blue Cross.

Dr. Vernon W. Lipprd, dean of the Yale Medical School.

Dr. Arthur Larson, of Duke University, former director of the USIA.

Russell A. Nelson, director of Johns Hopkins Hospital.

John C. Leslie, vice president of Pan American Airways and chairman of the Committee on Aging of the Community Service Society of New York.

Dr. James Dixon, president of Antioch College, Ohio.

Dr. Russell Lee, Palo Alto Clinic, Calif.

Hubert Yount, vice president of the Liberty Mutual Insurance Co., Boston.

HEALTH CARE TASK FORCE

A NATIONAL PROGRAM FOR FINANCING HEALTH CARE OF THE AGED

Guiding Principles for Complementary Public and Private Action

A Report to the American Public from the

NATIONAL COMMITTEE ON HEALTH CARE OF THE AGED

November 1963

Contents

NATIONAL COMMITTEE ON HEALTH CARE OF THE AGED

ARTHUR S. FLEMMING, *Chairman*
President, University of Oregon

RUSSELL NELSON, M.D.
Vice-Chairman
President, Johns Hopkins Hospital

JAMES DIXON, M.D.
President, Antioch College

MARION B. FOLSOM
Director and former Treasurer
Eastman Kodak Company

ARTHUR LARSON, PH. D.
Director, World Rule of
Law Center
Duke University

RUSSEL V. LEE, M.D.
Founder, Palo Alto Clinic

JOHN C. LESLIE
Chairman, Committe on Aging,
Community Service Society of
New York

WINSLOW CARLTON
Secretary of the Board
Chairman, Group Health
Insurance, Inc.

VERNON W. LIPPARD, M.D.
Dean, Yale Medical School

DICKINSON W. RICHARDS, M.D.
Lambert Professor of
Medicine Emeritus,
College of Physicians & Surgeons
Columbia University

THOMAS M. TIERNEY
Director, Colorado
Hospital Service

HUBERT W. YOUNT
Former Executive Vice-President,
Liberty Mutual
Insurance Companies

HOWARD L. BOST, PH.D., *Study Director*

PROFESSOR HENRY H. FOSTER, JR., *Legal Consultant*

FOREWORD

This report is the result of a year's study of the problem of financing health care of the aged made by an independent, ad hoc committee composed of individuals of widely varying backgrounds of experience and responsibility. The work was motivated by recognition of the seriousness of the problem in our nation and the need for an over-all national policy for its solution.

Formation of the Committee was suggested by Senator Jacob K. Javits, of New York, in the summer of 1962. Following debate on the Senate floor of the Anderson-Javits proposals for a Federal program of health insurance for the aged in July of that year, the Senator was impressed by the need for a fresh and independent review of the issue. He made it clear to the Committee, and repeated in a public statement announcing the Committee's formation, that the Committee was in no way responsible to him nor would he be bound by the Committee's recommendations. This has been in all respects an independent and non-partisan effort.

The Committee met in ten full-day sessions to frame this report. Policy aspects rather than specific details of programs and proposals have been the focus of the Committee's work. Members have accommodated their individual opinions on matters of detail in order to achieve consensus on the major issues. Throughout its deliberations, the Committee has made particular efforts to see the problem as a whole and to keep its various parts in perspective, evaluating separate measures in the context of their effect upon over-all results.

The main thesis of the conclusions reached is that the need of our aged population for health insurance is such that actions are required in both the private and public sectors of the nation, that the success of action in each of these sectors depends upon effective action being taken in the other, and that national policy providing for a dual, synchronized approach is required. For attaining this solution, the Committee has formulated guiding principles which are presented in this report.

The Committee has not engaged in research involving fact-finding but has depended and drawn upon the extensive body of data available from studies and reports of governmental and non-governmental organizations, in all instances seeking and utilizing the most recent information available.

We wish to express special appreciation for the resourceful, painstaking and patient work of Dr. Howard L. Bost, study director. We are grateful for the advice of Professor Henry H. Foster, Jr. of New York University Law School on legal questions, Charles C. Slay for editorial assistance, and to the many individuals consulted on various aspects of our study.

THE COMMITTEE

HEALTH CARE TASK FORCE

I

The Problem

The development of sound, effective provision for the health care of the aged population is one of the most important and urgent matters of unfinished business before our nation.

This unfinished business requires attention because it vitally affects so many individuals and bears so directly upon their well-being. Almost 18 million people in our nation are age 65 or over, and the number is increasing rapidly, by nearly 1,000 each day. In 1950, there were 12-1/4 million, by 1970 there will be 20 million, and by 1980, almost 25 million. The period we are living in is not only one in which the number of aged is rising and in which this age group is becoming an increasing proportion of the nation's population, it is also a period in which medical science is advancing at an accelerating pace and is contributing increasingly to human well-being. Health care is becoming a more essential and larger component in the American standard of living. This is particularly true for older people as a group, whose health problems are more numerous and more severe than those of younger people. These basic and continuing trends make health care of the aged a matter of increasing importance in our nation.

Attention is urgently required because the impact of health care cost is a major threat to the independence and dignity of elderly people. Difficulty in meeting health expenses and fears that costs of needed care will eat away or exhaust resources and lead to dependency, are widespread and common in our aged population. This is a product of the harsh reality that old age is typically a period of life in which health expenses are high and income is low.

Studies by the Department of Health, Education, and Welfare indicate that the per capita costs of personal health services for those age 65 and over are running about 2-1/2 times as high as for the rest of the population. Excluding services financed by public funds, the health care expenses of the aged are still more than twice as high as those of persons under 65 years of age. In 1961, the costs were estimated to be $226 per aged person as compared to $103 for other persons.

As would be expected because most of the aged do not have earnings from employment, income levels in the aged population are relatively low. Reports issued by the Bureau of the Census show that of the aged persons who live alone, almost half had money incomes of $1,000 or less in 1960 and three-fourth had less than $2,000 a year. Among families in the nation where the head is 65 or over, the median annual income in 1960 was $2,897; in comparison it was $5,905 for other families which, however, are

larger in terms of numbers of persons per family. But for two-person families, which account for almost three out of four older families, median annual income was $2,530 where the head was age 65 or over as compared with $5,314 where the head of the family was younger.

The median value of the liquid assets held by spending units headed by aged persons was but $1,000 in 1960, according to studies conducted by the University of Michigan. Equity in their home is the most common form of non-liquid assets which the aged have accumulated during their lifetimes and this type of asset usually accounts for the major part of their net worth. It should be recognized that the equity aged persons have in their homes ordinarily does not represent an appropriate resource for meeting illness expenses.

Traditionally, funds provided by the immediate family or other relatives of aged persons have contributed importantly to meeting illness costs. The changing pattern of American society, the growing urbanization and mobility of the population, the not infrequent doubling-up of generations who are aged, and many other factors which are part of modern living, are reducing the extent to which the family can be looked to and relied upon for security in old age.

A further factor intensifying the problem for the aged is that health services continue to become more expensive. As measured by the Consumer Price Index of the Bureau of Labor Statistics, medical care prices have been rising more consistently and much faster than the cost of living. While the price index for all items by June, 1963 had gone up 27 percent over-all since 1950, the rise in the prices for medical care items had been 59 percent. Hospital daily rates had increased 139 percent in this period.

The disadvantaged position of the aged, resulting from the combination of their higher health care expenses and lesser ability to meet them, has been extensively documented by many studies and reports by both governmental agencies and private organizations. There is general agreement that a problem does exist which our nation must solve. It is a national problem and a human problem of major proportions and one that is clearly within the nation's capacity to solve.

But the development of sound, effective provision is a matter of unfinished business. Although provision for health care of aged persons on public relief rolls has long been established and continues to be improved, and although in recent years we have begun providing through the Kerr-Mills program for the health care of the medically indigent aged (those who require public aid to meet their health care costs), these measures are confined to dealing with dependency after it has occurred. These measures do not encourage or strengthen the efforts of the aged to avoid dependency. For the millions of aged persons who have not sought relief but are exposed to the risk of health costs they cannot meet, these existing measures do nothing

to improve the chances that they will be able to retain their independence. Public relief programs do not reduce the disadvantage of these millions of aged persons in coping with illness costs nor ease the special risk they face of losing their self-sufficiency and being reduced to a level of indigency by the impact of health costs.

Moreover, it is important to recognize that dependency frequently contributes to deterioration of health in the declining years of life. The downward spiral often begins with an episode of acute illness which destroys the aged person's financial independence; this state of dependency, in turn, inhibits rehabilitation and creates a chronic condition that both robs the individual of a life worth living and burdens his family or the community with a high cost of care.

The existing need lies in developing sound, effective provisions for improved protection of aged individuals against the loss of their independence, of their pride and self-sufficiency as a result of health care costs. In threatening the status of the individual, his security and his dignity, the economic hazard of health care of the aged constitutes one of the great unsolved problems of the nation. The development of protection against this threat, provisions to enable individuals in old age to manage health care and sickness costs without humiliation and sacrifice of self-respect, is a challenge befitting this nation and its concern for the individual. Our way of life, our social, political and economic system, instills in our people a high value upon the independence of the individual in his private affairs and an equally strong stigma upon becoming dependent and losing self-sufficiency in dealing with personal matters. An individual's health and his health care is a personal matter. The problem and the challenge present in the circumstances surrounding health care of the aged call for the nation to proceed in a way that respects the values held by the individuals who comprise our aged population and that carries out the precept of regard for the individual, his independence and dignity, for which we stand as a people and as a nation.

The requirement imposed by the problem as here defined is provision within the nation for needed protection of the aged against the impact of health care costs. The facts and the character of the problem point squarely to the conclusion that what is needed is development and extension of health insurance to cover the high risk to which aged persons are exposed.

Insurance is appropriate and effective as a method of dealing with health care costs because these costs tend to be unpredictable and beyond the control of the individual as to the time or the amount in which cost is incurred. Health care expenses, moreover, are spread unevenly among individuals and the amount of expenditure required tends to fluctuate sharply from time to time. For these reasons, health care is distinct from other items entering into the cost of living such as food, rent and clothing. Spending required by a family or individual for these latter items can be managed

and controlled as to the timing and amount of expenditure and consequently the expense involved can be predicted and budgeted; this is not generally the case with respect to illness expenses. The need for and advantages of insurance against medical and hospital bills is borne out by personal experience of most people. It is attested to by the widespread acceptance of health insurance by the American people.

For aged persons, the importance of having protection against their health care costs is seen to be even greater than it is for those who are younger, because the aged are more likely than the rest of the population to be sick, to be sick for prolonged periods, and to require more expensive services, particularly hospitalization. Findings in 1960 of the National Health Survey of the United States Public Health Service show that almost 4 out of 5 aged persons in the noninstitutional population have one or more chronic health problems. One out of seven elderly persons is completely limited in activity by chronic conditions. On the average, aged people are sick in bed over two and a half times as many days per year as younger people. The aged require hospitalization more often than persons under age 65 and the length of their stay in the hospital per admission is twice as long on the average. For one out of ten hospitalized aged persons, the length of stay is 30 days or longer. The hospital bill alone for the average length of stay of an aged person usually amounts to more than $500, according to the President's Council on the Aging.

On the basis of the condition of their health and of their proneness to illness, it is apparent that older people are especially subject to the economic hazards of illness. Without insurance, the shock-loss produced by a siege of major illness, particularly illness requiring hospitalization, could be expected to have a serious effect on the financial security of many if not most aged persons. Repeated episodes of illness or necessity for long-term care are potentially crushing in their financial impact.

These elements of the situation of the aged, high vulnerability to loss, in the face of characteristically slender margins of income and liquid assets to meet losses, with maintenance of independence at stake, present a problem that can best be met by extension to aged persons of health insurance coverage.

While this conclusion points the direction that should be taken in meeting the problem confronting the nation, it leaves unresolved the character and design of actions that will be required to accomplish adequate health insurance coverage of the aged. Agreement as to the objective does not suffice, since in the American economic and social system either private or public actions or both are available to accomplish social objectives. Consequently, a basic question is that of the respective responsibilities of private and public effort which will constitute sound and effective provision for achieving the needed health insurance coverage among aged persons.

Private health insurance, in its dramatic growth and success in reaching the great majority of the nation's population, has not only established its basic role in the nation but also has demonstrated that it has both significant potentialities and limitations. It is apparent that private health insurance has encountered greater difficulties in extending coverage among aged persons than in the case of the rest of the population and that it has not been as effective in protecting them against the economic hazard of illness.

According to information from the private insurers and reported by the Department of Health, Education, and Welfare, slightly over half of the noninstitutional aged population in 1961 had some hospital insurance as compared to three out of four persons in the general population. Less than half of the aged had any surgical protection whereas among the general population this protection is almost as extensive as hospital insurance. While insurance against other health costs, such as out-of-hospital care, nursing and drugs, is held by only a small part of the younger population, it is even more limited for the aged. Data from the 1959 National Health Survey indicate that among those in the aged population with family income under $2,000 a year, more than two out of three aged persons had no health insurance whatever. This is the group most subject to being reduced to partial or total dependency by illness costs. Also it is significant that among persons having insurance the proportion of the hospital costs met by insurance has been found to be lower for the aged than for the rest of the population. Findings of the National Health Survey of 1958-60 indicate that the percentage of hospitalized persons with insurance for whom their insurance paid less than half of the hospital bill was more than twice as high for the aged as for younger persons.

It is reliably estimated that while insurance is now paying upwards of one third of the personal health expenses of the younger part of the population, insurance is meeting only between 10 and 15 percent of the costs incurred by persons age 65 and over. In sum, it is evident that the effectiveness attained by private insurance in meeting the impact of health costs is far less for elderly people than for those who are younger.

The major factors that have impeded successful development of private health insurance for our older population and that restrict its ability to solve the problem of health care of the aged are believed to be quite clear and unmistakable. They are, moreover, highly pertinent to the conclusion that is reached about what further actions should be taken in the nation to meet the problem.

One basic factor is the cost of health protection for aged persons. For most types of health care, with the notable exception of dental care, the utilization of services and, consequently, costs of services are markedly higher for the aged than for younger persons. The differential is greater with respect to hospitalization expenses. The National Health Survey during 1958-60 found that on the average, aged persons were hospitalized more

than two and a half times as many days as those who were younger. Because of such differentials, provision of the same level of benefits to elderly people as to those who are younger involves a large increase in cost of protection. This means that the price charged to the aged must be far higher than that charged to others for the same level of benefits. To reduce the price of insurance for the aged ,their protection must be curtailed by benefit restrictions, or the insurance plan must cover the loss resulting from the higher cost of protection. If a "community rate" is charged the aged, the loss resulting must be met by higher premiums charged to younger persons than would otherwise be necessary.

Another basic factor is the level of income for aged persons. In two ways, both of which are of fundamental significance, this factor makes more formidable the difficulty for private insurance in meeting the need of the aged for health care protection. The characteristic aspects of the financial situation of aged persons, relatively low and fixed income, slender and irretrievable reserves, mean that a high level of protection against the economic hazards of illness is required to meet the needs of this population group. The amount of costs which can be met at the time of illness is much lower for the aged than for those in general population. Accordingly, it is necessary for health insurance to cover a much larger proportion of health care costs in the case of the aged. The importance of a high level of protection for aged persons is accentuated by the fact that costs are encountered more frequently and in larger amounts than by younger persons and by the greater tendency for health care costs to be progressive and accelerative for the aged because of chronic conditions and long-term illnesses.

In addition to increasing the level of protection required, the factor of low income has the further and more obvious implication of restricted ability of the aged to afford private health insurance. The net result of this is that the amount which must be charged for insurance designed to prevent unmanageable costs at the time of illness exceeds the ability of aged persons, particularly those most needing protection, to pay the required premiums. In other words, private insurance providing the needed level of protection is priced out of the market which must be served for the attainment of solution of the problem of health care of the aged.

The impasse which exists to widespread development of private insurance meeting the protection needs of the aged population is apparent from even the roughest analysis of the elements of the difficulty presented. Based on Census Bureau data previously cited in annual terms, the median family income of two-person aged families was $211 a month in 1960. In comparison with this, average private expenditures for personal health services in 1960 amounted $35.83 per month for two aged persons, on the basis of estimates by the Department of Health, Education, and Welfare. While some portion of these costs should be met out of pocket, the conclusion from these data is nevertheless inescapable that the monthly premium which must

be charged for insurance covering a major portion of health care costs would of necessity have to be very high in relation to what the aged population can afford. To the extent that provision is required for the expense of providing insurance, for adverse selection and for other cost elements which must be covered by the premiums charged, the difficulty is intensified.

Several other factors of significance have affected unfavorably the performance of private insurance in developing protection for the aged comparable to the rest of the population. Whereas the enrollment of groups of employees, often with the employer making a contribution to lower or cover the cost for employees, has been the chief means of achieving coverage under health insurance in the rest of the population, these significant advantages have not been extensively available in bringing coverage to the aged population. Individual enrollment has proved to be much more expensive and less effective than group enrollment.

It is important to recognize, however, that most of the non-profit voluntary health insurance plans have traditionally permitted individuals upon leaving an employed group to convert to a direct-pay policy. Insurance companies are rapidly following suit. Moreover, marked improvements are being made in enrollment techniques and in underwriting methods which reduce expenses of selling and administration, broaden the pooling of risks and reduce selectivity and restrictions in providing coverage to aged persons. With all of these advances, however, the factors of high use of care and relatively low ability to finance protection during retirement, which characterize the aged, remain as basic obstacles. The need to defray the cost of protection during retirement by making advance provision for it during the individual's working years has been recognized by private insurance in the development of paid-up-at-retirement policies, but coverage attained under these policies is very limited in extent and has not become a significant element in the over-all picture.

It must be recognized that the future will bring changes affecting the difficulty confronting private health insurance in meeting the needs of the aged population. Continued expansion of the potentialities of medical science can be expected to add to life expectancy but, in preserving life, will increase both the need for and the use of health care by the aged population. Continuation of the shift in the pattern of health problems in the nation, with chronic health conditions becoming increasingly important as the cause of morbidity and mortality, may be expected to bring greater concentration of the need for extensive health care in the years of life after age 65. Consequently, the proportion of the nation's health services required by the aged would become greater, and the differential between the aged and the rest of the population with respect to utilization of health services would be accentuated.

Persons most knowledgeable about medical care costs expect that the cost of care will continue to rise at a more rapid rate than the cost of

living because of the same factors that have operated in the past. The national effort devoted to medical research is producing remarkable scientific advances but the application of these often means more complex and expensive health services, requiring additional and more specialized personnel, equipment and facilities which add to the cost of care and increase the economic hazard of illness. These factors point not only to increased need on the part of the aged population for protection against health care costs in the future, but also to rising cost of the protection that is needed.

On the other hand, the economic position of people reaching age 65 in the future may be expected to be better than those currently aged. Rising income during their productive years and larger amounts of personal savings will mean that at the time of retirement individuals will tend to have larger financial reserves. Greater life expectancy and the long-term trend to declining participation in employment after age 65, however, point to a lengthening of the period during which savings and post-retirement income must support the individual if he is to retain his independence in old age.

The outlook for changes in the level of income of aged persons in the future is a factor of crucial significance to the prospects for development of private insurance which will meet the need for protection against health care costs. Social insurance benefits, which constitute the primary source of income for the aged who are not employed, can be expected to increase in the future due to higher wages upon which benefits are based, even if there are no increases in the level of benefits under the program. Under the present social security program, the maximum monthly benefits of $127 for a retired insured person, $105 for a widow and $190 for a couple, will be attained or approached in many instances, although reductions because of early retirement and low earnings in base years will hold average payments down to a level substantially under the maximum amounts. Moreover, an increasing proportion of the aged population will be eligible for benefits under this program. From close to 75 percent in 1961, the proportion of the aged eligible for social security is expected to rise to 85 percent by 1970, and to 90 by 1980.

Private pension plans, as a source of supplementary old age benefits, can also be expected to be of growing importance in the future. Coverage under such plans has expanded rapidly since 1950. According to studies of the Social Security Administration, 37 percent of the private labor force was covered under private pension plans in 1959. The private plan benefits for retirees with 30 years of service were found to fall within a range of roughly 20 to 35 percent of their average earnings. It must be recognized, however, that because of changes in jobs and other factors, the number of persons who ultimately will be able to qualify for benefits will be far less than the number who are at some time employed by firms having pension plans. Moreover, those who qualify often will not have sufficient service to receive benefits at levels potentially offered by the plans.

Giving full recognition to increased benefit that can reasonably be anticipated under public and private retirement programs, it is nevertheless apparent that the income levels from this source for persons becoming aged in the future will be low, even in comparison with present day standards and costs of living. In view of the long-term trend of declining labor market participation of the aged, it is not reasonable to expect earnings from employment to more than maintain relative importance. Nor is it reasonable to expect that income from other sources for persons aged 65 and over will increase sufficiently in the future to alter materially the income picture for the aged population. Consequently, the difficulty of elderly people in financing from their income during old age the cost of needed protection against health care costs is seen to be a continuing factor of major importance as a limitation on the potentiality of private insurance in providing protection for the aged population.

In summary, the conclusion reached by the Committee is that insurance against the economic hazard of illness is essential to a sound solution of the problem of health care of the aged. Although a start has been made, there is not effective coverage of the aged today. Moreover, in view of the difficulties of extending protection to the aged population, the Committee sees no prospect that private insurance can alone provide a satisfactory solution. The nation is confronted with a continuing problem, calling for long-term provision — a solution that will meet the needs of this generation and will keep the next generation from being faced with the problem that now confronts us.

HEALTH CARE TASK FORCE

II

Proposed Solution: A Dual Public-Private Health Insurance Program

The central purpose of an American solution to the problem of financing the health care of present and future generations of the aged must be to encourage and protect the independence and dignity of the individual. In its basic approach to this problem, our nation must aim at preventing dependency as a concomitant of the deterioration of health in the declining years of life.

This requires a shift in public policy from placing major reliance upon charity and welfare assistance measures to placing emphasis upon the development within the nation of health insurance for the aged. Public assistance programs present the prospect of great increases in requirements for public funds without accomplishing the objective of preserving the independence of elderly people or of reducing the economic hazard of illness as a threat to their independence. By their nature, such programs, including the Kerr-Mills program, deal with dependency after it occurs; health insurance, by reducing the cost which must be met at the time of illness to a level that is manageable, can prevent dependency and encourage self-reliance.

Clearly, the solution required in America today and for the future lies in actions which will achieve the health insurance coverage called for by the risk of illness in old age.

To accomplish the necessary development of health insurance for the aged, the Committee proposes a dual public-private program, consisting of separate and distinct plans in the respective sectors of the economy. These plans are equally essential and should be complementary. Together they should provide balanced and effective basic protection covering roughly two-thirds of the aggregate health care costs incurred by the aged, leaving the remaining costs to be met by the individual on an "out-of-pocket" basis or through supplementary private insurance.

The public plan, in the Committee's view, should utilize the principle of contributory social insurance to cover all persons 65 years of age and over, with payments collected during the working years of all employed and self-employed persons. The most appropriate area of protection to be provided by the public plan is institutional care, which is the most frequent cause of financial shock-loss to the aged. The extent of this protection under the proposed plan would represent approximately one third of the aggregate health care costs of the aged.

Another third of these costs, the Committee believes, should be the

subject of special private insurance covering the largest non-institutional costs that occur most frequently among the aged. Special efforts are called for in order to bring the cost of such basic, complementary private coverage within reach of most of the aged, to whom the most economical and efficient forms of insurance are not ordinarily available. The Committee sees a need for Congressional action to permit insurance organizations to join together in concerted efforts to provide low-cost protection on a mass-enrollment basis.

These components of the proposed dual program for the aged are both mutually reinforcing and mutually dependent. The Committee urges that one aspect not be considered out of the context of the other; rather, they should be considered together. To this end, the Committee recommends the establishment of a National Council on Health Care of the Aged, which would keep both the public and private components of the program under continuing review.

Under the proposed program, the health services that are to be financed will be obtained and rendered within the American system of medical care, the same system which serves the general population of the nation. The financing of health care costs by the program will be supportive of the patient-physician relationship requisite for good medical care. The program will strengthen the economic base supporting the operation and improvement of the health care establishment throughout the nation, helping to stimulate expansion of needed health care resources to serve all groups.

To provide guidelines for developing health insurance for the aged under broad national policy, the Committee has formulated a number of principles. These are set forth below and are discussed in the sections of the report which follow. We believe that through combined public and private action embodying these principles, a solution to the problem of financing the health care of the aged will be attainable in a way that is compatible with, and in fact will strengthen and reinforce American traditions and values.

Guiding Principles for Public Insurance

1. A long-range public plan should be established, based on the principle of contributory insurance and calling for all employed and self-employed persons to participate during their working years, so that upon reaching age 65 all will have the protection provided under the plan without further payment.
2. The long-range public plan should be self-financed by a separately designated payroll tax, collected as a part of the Social Security tax and equally shared by employees and their employers (or paid by the self-employed), with the benefit level under the plan tied to the proceeds from this source.

Contributions should be placed in a special trust fund committed to provide stipulated benefits after age 65 to those under the plan.

3. The extent of health insurance protection provided by the public plan should be designed to offset substantially the abnormal burden resulting from greater use and higher cost of health services required in old age, so as to give the aged a fair chance of maintaining their independence and providing for themselves.
4. The public plan should be designed to encourage and facilitate coverage of the aged under private health insurance for additional protection. It is essential that health insurance coverage provided under the public and private plans be complementary and that the roles of the public and private sectors in providing protection be mutually reinforcing.
5. The benefit structure of the public insurance plan should be focused upon health services, the cost of which tends to have the greatest and sharpest impact, rather than upon services involving routine costs or costs which tend to fall in a less concentrated fashion.
6. The public insurance plan for the aged should fit into the current system of health facilities and medical care in the nation, with maximum free choice among providers of services, and it should contribute to the improvement and expansion of needed health resources in the communities of the nation.
7. A fundamental long-range objective of the public insurance plan for the aged should be progressive improvement in the quality of the services financed through the plan.
8. Responsibility for the administration of the public insurance plan for the aged should be assigned to the Secretary of Health, Education, and Welfare, with the assistance of an Advisory Council on Health Insurance for the Aged. In administering the plan, the Secretary should be authorized to contract for services of voluntary organizations and required to invite proposals from such organizations for consideration. Direct administration of benefits should be undertaken by the Federal agency only if proposals from voluntary agencies are not adequate.

Guiding Principles of Complementary Private Insurance

1. As a corollary action to the establishment in the public sector of a plan for the aged limited to basic institutional services,

national policy should assign to private insurance the complementary role of establishing protection to cover other health care requirements of aged persons.

2. Private health insurance should concentrate primarily on covering the major clusters of expense for physician care and other non-institutional services, so that, together with the institutional care covered by the public plan, the aged will have a well-balanced package of basic protection.
3. Basic complementary protection under private insurance should be made available to all persons in the aged population without disqualifications, reductions in benefits, or increases in premiums because of advanced age or condition of health.
4. Private insurance organizations should devote intensive efforts to extending basic complementary protection to the aged population, with concentration on developing marketing methods designed to produce high volume, low-cost mass coverage.
5. Congress should take action which would make it possible for insurance companies and non-profit health plans to join in concerted nation-wide efforts to extend to the aged population basic protection, complementary to that established under the public insurance plan for the aged.
6. To increase the proportion of the aged covered in the future under complementary protection, private insurance organizations should develop methods for prepaying during the years of active employment the cost of health insurance in old age. Employed groups also should be encouraged to continue retirees under group insurance plans.

National Advisory Council

A National Advisory Council on Health Insurance for the Aged should be created and charged with advising the Secretary in administering the public insurance plan for the aged and with making periodic reports to the Congress through the President on the status, in both the private and public sectors, of implementation of national policy for health care of the aged.

III

Guiding Principles for the Long-Range Program

A. Public Insurance

1. A long-range public plan should be established, based on the principle of contributory insurance and calling for all employed and self-employed persons to participate during their working years, so that upon reaching age 65 all will have the protection provided under the plan without further payment.

DISCUSSION

The Committee believes that the contributory principle is of fundamental importance to the soundness of the long-range public plan that serves as part of a dual public-private program for the aged. Although special provisions will be needed during the transitional period following its initiation, a basic feature of the on-going plan should be that the individual bears, during his working years, a part of the cost of the protection which he and his spouse would have for the remainder of their lives after reaching age 65. Requirement of contribution on the part of the individual as called for is not an unusual feature. In fact, most people are accustomed to paying toward the cost of their insurance and retirement benefits under existing programs of various types.

"Contributory" as used here is also intended by the Committee to mean that each payment which is collected from the individual for the public insurance plan should be clearly visible to him and should be separately identified both as to the amount that he is paying and as to the purpose for which he is paying it. This will make understanding and awareness of the individual's participation in the plan much clearer than if his payments were rolled in with general taxes he may pay — thereby becoming lost in the total, making it impossible for him to know how much he is paying toward the plan and, indeed, leaving it unclear and uncertain whether or not he is in fact participating in its cost. Making known to the individual the amount he is contributing toward the plan is in line with common practice under private insurance arrangements and under the Federal Old Age, Survivors and Disability Insurance program.

The principle set forth by the Committee also calls for the individual's and his employer's contributions under the long-range public plan to be made before retirement, with the entire cost to the individual being spread over his working lifetime. This is sound for the individual because he is better able to assume and bear his share of the cost while he is employed before he becomes aged. It is sound for the employer because his share can

be treated as a cost of doing business. The same point applies here as applies to old age retirement or pension plans, where systematic contributions by employees and employers, extending throughout the period of employment, are well established and widely recognized as being the best way of meeting the costs of providing benefits after retirement.

Under a system where individuals make regular and definite contributions during their productive years so that protection without further payment will be theirs at retirement age, it is important that all employed and self-employed persons be included in the system. The reason for this is that it cannot be determined at the time a person first enters employment, for example, at age 25, whether or not, 40 years later when he reaches age 65, he will have the financial resources that would enable him to get along for the remainder of his life without the protection that will be provided under the public insurance plan. The principle here, therefore, calls for a contributory plan in which all employed persons participate. Without this feature, a contributory public program would lose effectiveness as a component of sound and realistic national policy for solving the problem of health care that confronts people when they become aged. The factors of reduced income and increased need for health care in old age make it predictable that for most all those currently employed, the protection offered under the plan will serve in good stead when they become aged. Hindsight, to determine those who might have been excluded from participating during their productive years, is clearly not feasible. The problem of providing for retirement calls for foresight and the prudent and effective course is for all to participate during their working years.

A further element of this principle calls for the protection under the public plan to be provided when the individual reaches age 65, whether or not he has in fact retired. This is to avoid an incentive for people to retire solely for the reason of obtaining the protection afforded by the plan. It reflects the Committee's view that it is socially and economically desirable for individuals to continue active employment beyond age 65, if they are able and want to do so. A further consideration is that after age 65, employment is often intermittent or partial. It would be neither desirable nor feasible to make adjustments, or stops and starts, in the health protection of aged persons based on gradations and other changes occurring from time to time in their participation in employment.

Attainment of age 65 is believed by the Committee to be the appropriate point for use in defining age for purposes of eligibility since this line of demarcation is one beyond which health care costs normally rise significantly and is the age in common usage under existing pension and insurance plans. Furthermore, the fixing of a definite age at which individuals become eligible has the added advantage of providing a further element of certainty upon which the planning of individuals, employers, and others concerned can be firmly based.

These elements of the stated principle impart to the plan its fundamental character as a public insurance program under which an individual becomes entitled to defined protection when he becomes aged on the basis of a right arising from his prior contributions to the plan. Consequently, in the years before his retirement and throughout old age, he can know that he will have the protection offered by the public insurance plan and that this will not be affected by where he lives or by what his circumstances may be or may become during his retirement years.

This will provide a solid footing upon which the individual can stand in planning and managing his own affairs both before and after he becomes aged. It will constitute a foundation for personal initiative, strengthening the position of the individual in his effort to attain and preserve his independence, and adding to the effectiveness of the plan in the prevention of dependency.

The character of the plan called for by the Committee would be such that no stigma would attach to the receipt of benefits under it in the event of illness. In contrast to the welfare or relief approach, the public insurance plan would involve no "means test". Obtaining the benefits of the plan would not represent an acknowledgement of personal deficiency or involve the humiliation and shock of accepting and conceding to others that one's status has fallen to that of dependency. Instead, a public insurance plan of the character prescribed would preserve the self-respect of aged persons who obtain the benefits it provides. Rather than representing public charity or being regarded as a "hand-out", the protection and services provided under the plan would be in the nature of an "earned right" and the general attitude characterizing the plan would be that it is one under which an individual helps "pay his own way." Even for those who get a "bargain" under the plan, those whose contributions are much less than the value of their benefits, the difference in attitude engendered is one of fundamental social and political significance. In designing the public part of a long-range program for health care of aged in our nation, these attributes are highly important in making it the kind of program that we should have in America.

2. **The long-range public plan should be self-financed by a separately designated payroll tax, collected as a part of the Social Security tax and equally shared by employees and their employers (or paid by the self-employed), with the benefit level under the plan tied to the proceeds from this source. Contributions should be placed in a special trust fund committed to provide stipulated benefits after age 65 to those under the plan.**

DISCUSSION

The Committee believes that the best safeguard for the continuing stability and integrity of the long-range public plan lies in making the plan

self-financing, linking benefit levels in a clear and direct manner to the level of a separate tax levy supporting the plan and paid by those who will benefit under it. Not only does this approach offer protection against unwarranted expansion under the guise of "something for nothing", perhaps motivated by paternalistic or political considerations, but also it affords protection against the perennial pressures for expansion and contraction of Congressional appropriations which would jeopardize the continuity or consistency if not the fidelity of the protection provided by the plan.

Consistent with these considerations, a specially designated payroll tax devoted to the support of a special trust fund upon which the plan is dependent for its on-going financial support is called for by the principle. The special purpose and character of the trust fund should be made explicit in the name given to it. The management of this trust fund and the collection of the payroll tax should be in the pattern which has proved to be efficient and successful under the Federal Old Age, Survivors, and Disability Insurance program.

In view of the long-term character of a public old age health insurance plan, the level of payroll tax assessed for the support should be established from the outset on a basis consistent with actuarial projections of requirements for fully financing the stipulated benefits and the necessary cost of administration. Provision should also be made for periodic re-examination for the purpose of determining changes in the tax rate and wage base that might be required to maintain the plan on a sound actuarial basis. These measures will contribute to public recognition of the cost, specifically the level of contributions required from employees and employers, entailed by the plan. In ensuring such recognition and awareness, lies the best long-run assurance for prudent development and operation of the plan.

In launching the plan, it is important that provision be made for necessary initial balances in the special trust fund. This should be accomplished in a manner consistent with the integrity of the self-financing character of the long-range plan. The alternative by which this could be achieved are 1) setting the effective date for starting contributions to the plan in advance of the effective date for provision of benefits, with the interval being determined by the requirement for accumulation of money in the trust fund; or 2) providing for a repayable advance from the Treasury to the trust fund, with the tax schedule designed to provide a margin for such repayment. The second alternative would permit the benefits under the plan to be provided at an earlier date, and in view of the pressing need of the aged for protection against illness costs, this alternative merits consideration. However, in view of uncertainties about the volume of claims in the initial period of operation, the first alternative represents the preferable course if the delay in reaching a decision to establish the plan is not unduly prolonged.

3. **The extent of health insurance protection provided by the public plan should be designed to offset substantially the abnormal burden resulting from greater use and higher cost of health services required in old age, so as to give the aged a fair chance of maintaining their independence and providing for themselves.**

DISCUSSION

In the context of the aggregate cost of all the health care required by the aged population, the question of what proportion should be brought within the scope of a long-range public insurance plan is fundamental to the planning of the program and to the philosophy guiding its future course. This question is at the root of the uncertainties on the part of many about where the decision to establish a program would ultimately lead. Similarly, it underlies the concern on the part of some that an initial step, irrespective of justification, might constitute an "opening wedge" leaving no logical stopping point. This question, and the concerns arising from it, deserve and require answering.

The principle stated above is believed by the Committee to provide reasonable and feasible criteria for guiding national policy in setting appropriate boundaries for the role of the public insurance plan providing health protection for the aged. Acceptance of this principle means that the public insurance plan should cover a part of the health care required by the aged but should not encompass the entire problem. The part deemed to be within the proper scope of the plan is delimited, as a matter of principle, to that proportion which in the over-all will offset substantially the greater burden of health care costs falling on the aged population, in comparison with the rest of the population. Thus, the purpose and function of the public insurance plan is to narrow the problem facing the aged to dimensions that make the residual of the problem manageable by the aged themselves. This will give those in the aged population a fair chance of maintaining their independence by providing for their own needs through private insurance and their individual resource, as people under 65 years of age must do.

Establishment of a public insurance plan for health care of the aged in accordance with this principle will retain an important role for personal intiative on the part of individuals in meeting their health needs after retirement. Also, it will retain a major role for private health insurance in providing protection needed by aged persons. Public assistance programs, particularly the Kerr-Mills programs for the medically indigent aged, will continue to be needed for supplementation where insurance coverages are inadequate and personal resources insufficient to cover costs of necessary health care. In this capacity, however, rather than being used as the basic approach for dealing with the consequences of the abnormally high cost of health care for the aged as a group, public assistance will have the function

of dealing with exceptional individual situations involving special hardship, which is the function which assistance programs and methods are appropriately designed to perform. With the public insurance plan in combination with private insurance providing protection to prevent dependency as a common occurrence among aged persons as result of illness cost, frequency of resort to assistance would be greatly diminished, and administrative costs, case investigations and the amount of public welfare expenditures required by the aged would decline substantially.

4. **The public plan should be designed to encourage and facilitate coverage of the aged under private health insurance for additional protection. It is essential that health insurance coverage provided under the public and private plans be complementary and that the roles of the public and private sectors in providing protection be mutually reinforcing.**

DISCUSSION

The concept of a dual approach involving both the public and private sectors of our nation in providing the protection needed by the aged carries important implications for the formulation of the public insurance plan. The provisions of the legislation dealing with the public plan will, in fact, largely determine the role which private health insurance will have. It will determine whether these roles are competitive and conflicting or are compatible and mutually reinforcing.

The above principle, in calling for complementary roles for public and private insurance plans, reflects the firm belief of the Committee that there will be a continuing need for both approaches and that by making use of the efforts and special advantages available through each of these, a more effective and viable solution to the over-all problem is attainable. This is in opposition to the view that the structuring of a dual approach is a matter of minor significance, tacitly assuming transition to an exclusive public program providing for total health care of the aged. The projection of long-term complementary roles for public and private insurance, implementing the principle, is also in contrast to the approach of pitting the public and private insurance plans in a contest for survival in which one or the other becomes the victim of adverse selection of risks.

Application of the principle would involve achieving compatibility of the benefit structure under the public plan with the additional protection by private health insurance, so that duplication would be avoided and pyramiding of coverages would not occur to produce a bonus to the user of services resulting from an excess of benefit payments over the costs he incurred. Also the principle implies that the public insurance plan would be designed so that additional protection under private insurance would be logical and attractive and could be cleanly fitted to comprise balanced protection with-

out gaps and inconsistencies and avoiding incentives for faulty use of health services.

The result that is achieved in meeting the total problem by this complementary dual approach clearly will be contingent upon the effectiveness of both the public and private actions. Thus, designing the public plan for the aged so as to facilitate additional coverage of health risks under private insurance is seen to contribute to the national objective. In this perspective, it becomes apparent that simplicity in the design of the benefit structure of the public insurance plan is desirable. An assortment of benefit alternatives and options involving co-insurance features, duration of services covered, and variable deductibles would produce variations if not uncertainties and unevenness in the effectiveness of the program. The resultant complexities would tend not only to create confusion among the aged with respect to the public plan, but would affect understanding and acceptance on their part of the need for coverage under private health insurance for additional protection. Moreover, complexities in the public plan would complicate the integration with private insurance and create administrative difficulties adding to cost.

The matter of whether or not a deductible provision should be included in the public plan has a particular bearing on the development of additional protection under private insurance. There are practical limits to the amount of deductibles which can be included in health insurance for aged persons without serious loss in the effectiveness and attractiveness of the protection available. To the extent that deductible amounts are incorporated in the public plan, the latitude available for inclusion of deductible features in complementary private health insurance is correspondingly reduced. Viewing the composite picture of health services required by aged persons and, in that context, the combined effects achieved by public and private insurance, rather than looking at the various components separately, gives rise to the question of where the latitude for requiring out-of-pocket payment by the patient can be utilized most appropriately and effectively. The question is especially pertinent where the use of services under the public plan is necessarily accompanied by use of other services that either are covered under complementary private insurance or remain to be borne by the patient at the time of illness. Although the effect of deductibles on the utilization of services is a controversial and unsettled point, there is no dispute about the reduction in the number of claims when deductibles apply to services the cost of which is less than the deductible amount. Many health services are of this nature and in designing protection to cover them, the availability of maximum latitude to private insurance for inclusion of deductible provisions can facilitate the development and provision of insurance at lower rates and on a more attractive basis than otherwise. The deductible should be reserved for this use.

It is important in the planning of complementary public and private

insurance that each plan should take the other into account. The patterns of use of the various types of health services are interrelated. Considerations of continuity throughout various phases and levels of care, requisite to its effectiveness, must be recognized in the designing of protection. The complexity of the determinants of utilization and of avoiding improper use of services, and many other pertinent factors, all make the conclusion inescapable that the success of efforts to deal with one segment of health care depends to a significant degree upon the success of other efforts in dealing with the other segments. This is seen to be the ultimate reality of the matter however segmentation is made, whether along the lines of types of services, of the nature or cause of illness, of levels of costs, or in other ways.

For example, the success as well as the cost of insurance for in-patient hospital services are influenced to an important extent by the effectiveness of other insurance in covering other services such as preventive measures, diagnostic services, ambulant patient services in clinics and physicians' offices, nursing home care, home care and rehabilitation services.

Thus, the inherent characteristics of health care make the principle of having public and private insurance plans complementary and mutually reinforcing a matter of fundamental importance to national policy on health care of the aged.

5. The benefit structure of the public insurance plan should be focused upon health services, the cost of which tends to have the greatest and sharpest impact, rather than upon services involving routine costs or costs which tend to fall in a less concentrated fashion.

DISCUSSION

The rationale underlying this principle is that the public insurance plan and the contributions financing it will be most effective in preventing dependency of aged persons if the benefits bear on the contingencies which are most likely to cause aged persons to lose their independence and to become dependent upon other persons, charity or welfare measures.

Although this principle might conceivably be implemented in other ways, the Committee believes that the best course is to devote the resources of the public insurance plan essentially to meeting the cost of in-patient hospital service and skilled nursing home care. Hospital and nursing home care, more than other health services, frequently imposes a great financial burden on aged persons. Doctor bills, diagnostic services, and drug costs, for example, are more likely than hospital bills to be spread over time. The proposed concentration on institutional services would mean that the public insurance protection comes to bear in connection with episodes of hospitalized illness and of long term care, which, in fact, characteristically present

the problem of major and catastrophic health costs. Moreover, it is with respect to hospital care that the greatest difference exists between the cost of health services for the aged as compared with person under 65 years old.

In defining the institutional services to be covered by the public insurance plan, there are numerous substantive aspects to be dealt with. In doing so, it is important that recognition be given not only to the special characteristics of the need for in-patient care among aged persons, but also to ways of dealing with this need which will minimize costs and make more efficient use of limited health resources, consistent with medical judgments as to the services and level of care required. The appropriate objective here is that the benefit structure of the plan should permit and encourage a rational pattern of use of in-patient care.

The need for inpatient care most often will require admission to general or special short-term hospitals. Admission to these institutions should be covered under the plan for any type of condition which the particular institution accepts for treatment, with benefits covering the hospital services rendered. In recognition of the special characteristics of the health problems of aged persons, the maximum length of stay covered under the public plan for the aged should be at least as great as, if not greater than, benefit levels commonly prevailing under health insurance among younger persons in the population. Although the duration of hospital benefits varies widely under private group health insurance plans, several studies indicate that the average maximum duration is within the range of 70 to 90 days. In 1961-62, the Bureau of Labor Statistics found that the number of hospital days covered at full rate was 70 days or over in more than half of 91 selected collectively bargained plans studied; and in 1962, the most common hospital benefit provided by Blue Cross Plans was 70 full benefit days, according to a survey by the Department of Health, Education, and Welfare.

Limitations in the benefit structure on the duration of services to be covered, however, cannot be looked to as a device for achieving proper utilization of institutional care. Provision should be made for review of utilization by medical staff committees of the institutions as are recommended by national medical and hospital organizations. Experience indicates that a medical review committee in each institution can be an effective influence in dealing with problems of faulty use of service.

The need of aged persons for admission to hospitals and, more frequently, the length of stay in the hospitals, can be reduced in many instances by appropriate use of skilled nursing home facilities to provide in-patient care. From this, substantial advantages are gained in terms of lower costs and reductions in capital and personnel requirements. The advantages obtained affect not only the program for aged persons but the entire health care system of the nation. Moreover, in many instances, appropriate use of skilled nursing facilities instead of the general hospital can provide care

better to the needs of individual patients, particularly greater emphasis upon rehabilitation. Achievement of the objective of having the right patient in the right level of care at the right time calls for close and effective working relationships between hospitals and skilled nursing homes, to accomplish appropriate and timely interchange of patients and to assure proper follow-up in the nursing institution of regimens for patients who otherwise would be retained in the hospital. Collaborative arrangements between hospitals and skilled nursing homes need encouragement and the plan should provide for this.

Accordingly, the plan should call for the progressive development of affiliations of skilled nursing homes with general hospitals at the local community level. These affiliations will provide continuous medical staff supervision, access to management skills in general hospitals and long-term improvements in quality of care. Moreover, these will contribute to the development of effective utilization review plans and to ensuring that skilled nursing facilities are differentiated in character and in use from custodial homes. The benefit structure of the plan should cover in-patient care in skilled nursing homes for patients who are transferred from a hospital, with exceptions made to this only where it is found, upon review and determination in advance by qualified hospital medical staff members, that admission to the hospital can be avoided by direct admission to the skilled nursing home.

The benefit structure of the plan should incorporate a further element of institutional services which in some instances would serve as an alternative way of meeting economically and effectively the needs of aged persons for in-patient hospital and nursing home care, and, more frequently, would serve to reduce the duration of their stay in such institutions. Specifically, it should cover skilled nursing services under the supervision of a hospital and related hospital services extended from the institution, which are rendered to the patient in his home or other place of residence. Likewise, hospital services, such as physical therapy and social service, should be covered when extended from the hospital to the patient in a skilled nursing home which is without such services. Although at the outset of the plan, these home health care services would not be widely available for use in lieu of in-patient hospital or skilled nursing home care, it can be expected that provision for these under the plan will stimulate their development. Alignment of these services with community hospitals, we believe, will accelerate and widen their availability beyond that otherwise likely to occur; and, at the same time, it will avoid duplication in staffing and minimize the need for personnel in short supply, such as nurses, physical therapists and medical social workers.

It is significant to point out that all of the elements of institutional services for which coverage is proposed under the benefit structure of the public insurance plan for the aged in-patient hospital services, skilled nursing home

care as well as nursing and hospital services extended to the patient's home — would be provided upon the direction of the patient's physician and, as a condition for coverage under the plan, would require his order to initiate their provision. Consequently, all services for which coverage is proposed would be supportive of the physician's care of the patient and would be under his medical control.

In the context of the dual public-private program for health care of the aged, assigning to the public plan the role of providing basic protection against the cost of institutional services means that the provision of basic protection for physician care and other major components of total health services is assigned to the private sector and is to be dealt with through private health insurance or by the individual directly. Since these services, at least physicians' services, would necessarily be required in conjunction with the services covered under the public plan, and since the individual would remain responsible for financing them, there would exist in all instances an important element of responsibility on the part of the individual to provide for his needs. Consequently, deductible or co-insurance features in the public plan would not be required to assure that the individual remains responsible for paying a part of the cost of the health care he obtains. This has the further desirable effect of making the benefit structure under the public plan relatively simple, thereby facilitating the development of complementary protection for physician care, diagnostic and other services through private insurance.

A further aspect of this approach is that the proposed benefit structure would entail dealing with far fewer providers of services under the public insurance plan than would be the case with most other formulations of benefit structure. The magnitude of administrative functions in obtaining information, making benefit payments, and in the general operation of the public plan, would be much reduced from that which would be entailed if the plan covered such services as physician care or drugs, or if the benefits were of a nature requiring for their administration direct contact with and submissions from all individual beneficiaries.

It is significant, also, that a public plan focusing on institutional services would avoid the difficulties that might be anticipated from government dealing on an extensive basis with professional fees. Moreover, focusing on institutional services serves to place the plan at a desirable distance from the patient-physician relationship and from the dangers of and resistance to intrusions into areas of delicate personal affairs. It is not only appropriate but advantageous that in the allocations of functions between the public and private sectors, the function of providing protection against the cost of physicians' services should be handled by private health insurance on a voluntary basis rather than under the public insurance plan.

A further consideration supporting the application of the principle in the manner proposed is that the public insurance plan, in dealing with the

cost of institutional services, would be functioning in an area where there are well established precedents and practices and where the administrative functions lend themselves to techniques of standardization and centralization within an area. As has been widely demonstrated, application of such techniques under hospital insurance operations leaves wide latitude for local variations in the substantive content and provision of institutional services and latitude for progressive modifications in institutional services programs. These conditions do not generally apply in the area of non-institutional services. Coverage under insurance of medical and dental professional services in broad scope, of preventive services, drugs and other services outside institutions, is in many respects in a developmental phase. Insurance for these services is characterized by a need for experimentation, for emergence of new patterns, and for the accumulation of experience. Moreover, the area of non-institutional services contains a substantial component of services which are involved in routine health care, or are incidental in character or amount, thereby making this area appropriately subject to techniques of private health insurance such as major medical coverage. For these reasons, the assignment to the private rather than the public plan the function of developing and dealing with protection against costs for non-institutional services is deemed to be especially appropriate.

In summary, it is believed that a benefit structure under the public insurance plan for the aged along the lines proposed will capitalize on the particular capacities and strengths of both the public and private sectors of the nation and will contribute to the accomplishment and stability of the long-range dual public-private program.

The proposed apportionment of responsibilities between the public and private sectors would leave the largest segment of health care, in terms of proportions of aggregate expenditures for health care of the aged, the continuing responsibility of the individual and open to coverage under private health insurance on a voluntary basis. At the same time, the proposed division would substantially accomplish the philosophical objective set forth in principle number three, that of offsetting the differential in the burden borne by the aged as a group, in comparison with the rest of the population, in meeting health care costs.

6. The public insurance plan for the aged should fit into the current system of health facilities and medical care in the nation, with maximum free choice among providers of services, and it should contribute to the improvement and expansion of needed health resources in the communities of the nation.

DISCUSSION

The basic concept underlying this principle is that the system of facil-

ities and personnel serving the general population, specifically the currently existing system of medical care in America, should also serve the aged population. This concept has several attributes and implications which are of fundamental significance.

A central implication is that the operation of the public plan should involve purchase of, rather than provision of, the health services which are covered. This means that instead of setting up a system to produce the services that are covered by benefit provision, the insurance plan should buy these services, utilizing the basic system of medical care in the nation and leaving the selection of where care is to be obtained to the free choice of the individual seeking the care. This approach of purchasing services, is in sharp contrast to that which has been followed in many other instances in establishing governmental health programs, for example, by the federal government in providing health care to veterans, by state governments in providing for care of persons with mental illness and tuberculosis, and not infrequently by local government in providing medical care for indigent persons. Similarly the approach called for by this principle is in contrast to the creation of a national health service for aged persons, having responsibility and authority for providing services by means of operating health facilities and employing personnel to render the care directly to beneficiaries.

The approach called for by the principle would keep the provision of health services for the aged in the main stream of the medical care of the total population. It would not split off health facilities and personnel to serve aged persons from those serving the total community. Nor would it set up separate patterns for obtaining or for delivering health care; rather, it would avoid duplicating facilities and services at the community level. The insurance plan, embodying this approach, would, in fact, strengthen the basic community structure of health care resources by purchasing and providing adequate payment for services obtained through this basic structure.

A further significant advantage of this approach lies in the fact that for the aged population it offers the widest possible availability of the services covered by the program. For the nation as a whole, it minimizes, through common use of health care resources by aged and non-aged persons, requirements for expensive resources which are in short supply.

In essence, the principle reflects the fundamental belief of the Committee that the American health service establishment should be preserved, strengthened and used for the aged along with persons under age 65, that the institutional services for aged covered by the public insurance plan will best be provided and will improve most rapidly in an open system, characterized by local autonomy of operation and control of health care institutions and by free choice of the individual in obtaining care. Accordingly, legislation for the public plan should prohibit interference in the operation of private agencies providing services to beneficiaries under the plan.

In the long run, the best hope for the future of health care of the aged population in our nation lies in maintaining and strengthening the delivery of services to the aged within the main stream of medical care for the total population, and by developing adequate insurance coverage among aged persons, assuring that they are not disadvantaged in sharing with others in the advances being made throughout the nation in the quality and availability of health care.

The establishment of a public insurance plan for hospital and nursing home care of the aged, paralleled by expanding private health insurance covering other services, can be expected to increase the utilization of health services. The aged will obtain needed health care which otherwise would not have been sought or provided. While this will bring a more equitable distribution of health services in relation to the health needs among the age groups in the population, it will also bring a need for more health facilities and personnel.

The need for expansion and upgrading of health care resources, both personnel and facilities, is a concern affecting the health care of the total population, not alone the care of the aged. With population increasing, and the demand for health services rising even more rapidly, and with the growing complexity of modern medical care requiring a broadening array of skills and facilities, the pressure on the capacity of existing health care resources to deliver needed services is outstripping the additions being made to that capacity. Moreover, shifts in the allocation of health resources and direction of their expansion are required to meet changing patterns of community needs, such as the growing needs for long-term care and rehabilitation services.

However, the Committee does not believe that the public insurance plan is the appropriate mechanism for action to increase the national supply of physicians, nurses, and other health workers and to meet the shortages of facilities. Although bearing importantly on improvements in the health care of the aged, such action to be most effective must be specially designed and addressed to the particular problems in expanding health manpower and facilities.

Nevertheless, the public insurance plan can make an important contribution by improving the ability of the aged to pay for health care. Health facilities and resources do not come into being or remain available unless there is the necessary financing to pay for services and cover the cost of operation. Just as lack of such support depresses the scope and standards of services which an institution is able to provide and impedes its ability to keep pace with the expanding potentials of modern medical care, adequate financing for services has the effect of stimulating expansion and improvement of services. Similarly, in areas where the prospect of insufficient financial support for operation is retarding expansion of needed facilities, adequate payment for the services covered by the program will accelerate

the establishment of additional facilities, thus leading to improvement in the distribution and availability of health care facilities in the nation.

This factor is of such import that, as a matter of principle, the public insurance plan should provide for payment of the full cost of rendering the services covered by its benefit structure. Depreciation of the physical plant and equipment of health care institutions should be included as a proper element of these costs and recognition should be given to a continuing need for modernization.

7. A fundamental long-range objective of the public insurance plan for the aged should be progressive improvement in the quality of the services financed through the plan.

DISCUSSION

In the legislation establishing the plan, provisions for standards for institutional services are deemed to be essential. Grounds for this lie in safeguarding the public interest in the use under the plan both of funds and facilities. Moreover, the need for program standards is compelling as a matter of mercy and concern for the aged persons who will require health care covered by the plan. Also it is important as a means of giving effective encouragement and support to the continuous efforts of voluntary professional organizations and official agencies to maintain and raise standards for health care, efforts which are of great value to all groups in the population of the nation.

Accordingly, legislation establishing the plan should set forth high goals for the quality of the care that is to be purchased under the plan. The goal for quality of institutional services should be in line with standards developed by voluntary accrediting agencies. The goal should provide for these standards to be extended as may be required to assure that all the services for which the plan makes payment are under proper professional medical and nursing supervision. Legislative provisions establishing such goals should be accompanied by further provisions setting out the general manner by which they are to be accomplished. Specifically, provision should be made for the goals to be reached by a series of steps. These should be designed to allow reasonable and necessary time for institutions to meet high standards where they cannot be attained immediately. Also, criteria should be prescribed for the methods to be employed in the application of program standards, requiring that methods utilized serve purposes beyond administrative determinations. Particularly, they should be designed to foster efforts by institutions to achieve progressive improvement and to encourage cooperative measures on local, regional or state levels which may help in making higher standards attainable.

It seems essential, however, that substantial latitude be provided for administrative implementation of legislative provisions dealing with standards. Close contact and rapport with the health field, as well as careful, competent judgment will be essential on a continuing basis for effective implementation. For this reason, the legislation should provide that exercise of administrative discretion require prior advice of the National Advisory Council on Health Insurance for the Aged, (see Section III C for discussion of the Council), particularly upon matters such as the definition and phasing of the steps by which goals are translated into standards to be required under the plan and upon the methods of applying program standards and determining that they are met.

The propasal for legislative provisions relating to standards is based upon several underlying considerations, specifically, the established approaches to standard setting in the health field, some special considerations pertaining to standards for skilled nursing facilities, and the problem which exists in accommodating to unevenness throughout the nation in the level of standards prevailing at the time the plan is started. These considerations merit elaboration.

At the outset, recognition must be given to the fact that hospital and nursing home licensure provisions, valuable as they are, tend to concentrate on factors relating to the adequacy and safety of physical facilities and would not suffice to meet the concern for patient care services under the public insurance plan. Moreover, it must be recognized that in the field of institutional health care, voluntary professional accrediting agencies have been primarily responsible for the development of standards.

There is good reason to believe that voluntary agencies can be expected in the future, as they have in the past, to perform most effectively the function of standard setting. An important long-range consideration in this connection is the need for continuing review and modification of standards to keep pace with changing requirements as medical science and technology advance. The advantages of a greater degree of independence and flexibility obtained in voluntary channels, as well as the desirability of avoiding undue concentration of authority and attendant potential rigidities, are considerations pointing conclusively to the use of standards developed by voluntary professional agencies as a basis for quality standards applied under the public insurance plan for the aged.

Making clear in legislation the intent that standards formulated by voluntary professional accrediting agencies be utilized would serve to provide for evolutionary development of program standards and would also help to keep services rendered under the plan within the framework of the prevailing system of personal health services in the nation, facilitating the integration of care for the aged with that made available to other population groups.

In proceeding from this general approach to a more specific level, it should be recognized that with respect to hosiptal care, standard setting by a voluntary professional agency, the Joint Commission on Hospital Accreditation, is well established, generally accepted, and notably successful. With respect to nursing home care, however, no comparable pattern of standard setting has as yet been developed and widely applied. But this may be expected to emerge within the foreseeable future.In anticipation of such development, the approach to standards in legislation establishing the plan should be in the same pattern for care in nursing facilities as for hospital care but with provision of necessary administrative discretion for selecting the point of reference for program standards.

It is deemed highly important that the legislative basis for standards for nursing home care under the plan should clearly establish the intent to exclude custodial care where skilled nursing care is not required by, and provided to, the patient. In the absence of a clear position on this point, it can be anticipated that program resources intended for health care would be diverted to other purposes. Furthermore, emphasis would be lost that is required for the development of adequate facilities and institutional services for long-term illness, and rehabilitation, which not only are the weakest links in our existing system of health care but are of critical pertinence to the health needs of our aged population.

This important consideration, along with the objective under the plan of meeting needs of the aged for in-patient care to the extent medically appropriate through provision for skilled nursing home services, provides strong grounds for including the attainment of effective functional relationship between skilled nursing homes and hospitals as an element of the goals set forth in the basic legislation for the plan. Progressive development of affiliations to achieve this goal is deemed to be important not only in facilitating timely transfer of patients but is seen to have significant bearing upon the improvement of the quality of care for aged patients under the plan. By bringing the skilled nursing facility increasingly under the influence of the hospital, it can be expected that the capabilities of skilled nursing facilities in providing post-hospital care would be enhanced and that continuity of care would be promoted. Thus the care of patients would be improved and the extent to which skilled nursing home facilities are utilized in lieu of more expensive hospital care would be increased.

The aspect which far more than any other is seen to present difficulty in formulating a constructive yet feasible approach to standards under the plan is that of accommodating to the present uneven level of institutional care. In terms of both qualitative and quantitative factors, such unevenness exists within, as well as among the various areas of the nation. There is relatively little difficulty in reaching the conclusion, as an abstract proposition, that there should be quality standards in a public program for health care; moreover, the device of utilizing standards is widely espoused and generally

accepted as an appropriate and effective means of stimulating and ensuring progress in health care. Similarly, there would likely be relatively few reservations about the desirability of achieving optimal functional relationships between the hospital and the nursing home. Nevertheless, a seeming dilemma arises in reconciling the clear desirability of standards with the reality that the immediate effect of stipulating such standards when the plan is established would exclude a segment of existing health care resources. This problem is most serious when no alternative source of care to that which would be sub-standard and excluded is presently available in a local area. Reducing the level of standards to be achieved under the plan to avoid this effect is no answer to the dilemma. It would mean stipulating standards which are at or below the lowest existing level of quality, thereby sacrificing the objective of raising the quality of care and, in fact, would be tantamount to having no program standards at all.

It is in recognition of this inherent problem that the principle calls for adoption of high standards as goals, with the provision that their achievement should be accomplished through progressive steps over sufficient time to allow qualitative and quantitative improvement in institutional care, thereby minimizing the problem of exclusion of resources. The proposed approach injects the factor of time as the means for resolving the dilemma.

In addition to bridging the unevenness in standards prevailing at the present time in various areas, this approach could immediately influence the development of new facilities and programs for which a "moratorium" in achieving desirable standards would not be deemed appropriate. This effect would be most significant in connection with skilled nursing facility services. Only a fraction of the facilities and services required to meet needs for long-term illness are now in existence; a large portion of the need for such care in the period ahead must be met through development of new facilities and programs. The proposed approach would have the effect of discouraging proliferation of sub-standard nursing facilities and services and would tend to point the planning and development of new facilities and their institutional program to the provision of services of acceptable quality.

For the implementation of the proposed approach to standards under the plan, it is appropriate, indeed necessary, that a significant degree of administrative latitude be provided. Such latitude would be needed to carry out legislative intent that program standards be based upon and keep pace with those formulated by voluntary professional groups. Even more, it would be needed to determine the steps, the timing and the methods by which the goals are to be translated and applied to services rendered by institutions existing at the outset of the plan. Latitude for administrative determination, however, should be within clearly prescribed limits and guided by general criteria set forth in the basic legislation.

Recognition and weighing of the many complex considerations bearing on the implementation of legislative provisions as proposed would require

widely informed and broadly based judgements. The exercise of administrative discretion within the latitude provided and also the acceptance of administrative judgements would be greatly benefited if such judgements were based upon and suported by recommendations of a broadly representative body. For this reason, the Advisory Council on Health Insurance for the Aged should have, among other statutory duties, responsibility for formulating recommendations to guide administrative policies with respect to program standards within the latitude provided by legislation. In all aspects of its work on standards, the Council should make the fullest possible use of the specialized knowledge and experience of State agencies.

In summary, this proposal is designed to provide a framework within which feasible and effective steps would be forthcoming toward desirable goals, which would be appropriately established and geared to keep pace with changing conditions and developments in the health field. The progressive improvement achieved in the quality of services financed by the plan for health care of the aged would contribute importantly to the elimination of sub-standard institutional health care not alone for the aged but for all groups in the nation.

8. Responsibility for the administration of the public insurance plan for the aged should be assigned to the Secretary of Health, Education, and Welfare, with the assistance of an Advisory Council on Health Insurance for the Aged. In administering the plan, the Secretary should be authorized to contract for services of voluntary organizations and required to invite proposals from such organizations for consideration. Direct administration of benefits should be undertaken by the Federal Agency only if proposals from voluntary agencies are not adequate.

DISCUSSION

This principle calls for unified responsibility, requisite for sound and efficient administration of the plan, to be assigned to the Secretary of Health, Education, and Welfare. Also included in the principle are two additional elements which are deemed highly important in view of the nature of the program and the complexities surrounding health care and its utilization.

With the services covered under the program being provided through the same health facilities that serve other population groups, there is special need for, as well as significant advantages to be derived from, appropriate participation from the health and health-related fields in the formulation of administrative policies for carrying out the plan. For this reason, the principle calls for the plan to be administered with assistance from an Advisory Council on Health Insurance for the Aged (see Section III C for discussion of the Council).

Consistent with the principle of keeping the provision of health services of the aged in the mainstream of community services, the basic legislation establishing the plan should expressly authorize the designation of voluntary organizations as agents for the administration of benefits. Moreover, it should be made mandatory that planning for the operation of the plan in the various areas of the nation should include exploration and compilation of information on possibilities for utilizing existing organizations that are currently engaged in providing or administering insurance benefits for institutional services. Specifically, it should be mandatory that proposals from such organizations be invited and evaluated. The criteria for such evaluation should be developed with the advice of the Advisory Council on Health Insurance for the Aged. Where it is found that the function of administering or providing benefits in an area can be adequately performed by an experienced and competent voluntary organization interested in assuming the function and that the cost to the plan would be reasonable in relation to the cost of direct administration, it should be expected that the organization would be utilized on a contractual basis mutually satisfactory to the parties.

By utilizing existing voluntary mechanisms in the many areas where they are highly developed, we believe the best results will be obtained. The process of review and settlement of bills for institutional care is a complex and technical function, requiring not only agreements but working relationships involving continual contact with the institutions rendering the services. No agency of government has the number of experienced and competent personnel to handle the volume of this work entailed by the projected plan. Not only would acquisition of the necessary staff require considerable expense and time, but development of such staff would represent a duplication of administrative resources which exist within one or more voluntary organizations in most areas of the nation, resources which have the capacity and competence to provide efficiently the services required in the operation of the plan.

Furthermore, in many instances voluntary organizations possessing this capability to perform services have well-established and effective relationships with providers of services which in all likelihood could not be duplicated under direct administration by the public plan of its payment to institutions. These relationships would contribute significantly to the acceptance and smooth functioning of the plan. Moreover, the utilization of existing channels would tend to consolidate the handling of payments for care rendered to the aged population with that for other population groups covered under voluntary insurance. This would permit efficiencies leading to advantages for all groups. Moreover, it would mean economies through reduced billing and other administrative costs on the part of community institutions rendering services under the plan.

With respect to the operational function of eligibility determination and certification, it is clear that direct public administration is indicated. Within

the Department of Health, Education, and Welfare, the Bureau of Old-Age and Survivors Insurance has a nation-wide network of field offices and representatives. The utilization of this existing organization would provide the most efficient means of determining eligibility and maintaining information on the status of eligible beneficiaries as they move from place to place throughout the nation. The existing field offices would provide accessible centers for supplying information to beneficiaries. The staff of this agency is experienced and competent in the performance of these functions. The high degree of efficiency attained by the Bureau in its operation, and its demonstrated ability in providing assistance and service to aged beneficiaries and others concerned, would be highly advantageous to the plan.

With respect to the administration of standards of care under the plan, state agencies should be utilized where they are willing and able to assume responsibility for the determination of compliance. It is implied that payment be made under the plan to the states to cover the full cost of the services rendered. Administrative planning and policy for seeking and utilizing assistance and services from the states, should be developed with the advice of the Advisory Council on Health Insurance for the Aged.

III

Guiding Principles for the Long-Range Program

B. Private Insurance

1. As a corollary action to the establishment in the public sector of a plan for the aged limited to basic institutional services, national policy should assign to private insurance the complementary role of establishing protection to cover other health care requirements of aged persons.

DISCUSSION

National policy for the solution of the problem of health care of the aged must extend its concern beyond the establishment of a public insurance program. Sensible, effective solution of the problem requires actions in both the public and private sectors and requires that these be mutually reinforcing. The principle here calls for assignment of a role to private insurance which is complementary to, but distinct from that which is undertaken in the public sector. Both of these aspects of the role of private insurance are of significance and merit amplification.

The conclusion that responsibility for providing protection to the aged against costs of health services should be divided and defined in a manner that leaves private insurance distinct from public insurance, is in contrast to the alternative of intermixing responsibilities, as under a public subsidy of private insurance. Clear demarcation of the role of private insurance will make the dual approach a more stable one and will lead to a more dynamic and effective development of the capacities of private insurance than would fusing or mixing responsibilities.

It is important, however, that distinctness of roles does not mean that sight is lost of the objective that the separate components, public and private insurance, fit together to provide aged persons with a total package of protection that is well balanced and adequate.

Accordingly, national policy must take into account the full dimension of the problem of health care of the aged and the total picture of the health services required; specifically, it must be designed to lead to development of needed protection for health services not covered by the public plan to coincide with that provided by the public plan. Only through development of this coverage can serious deficiencies be avoided, under which some aspect of prevention, diagnosis or treatment suffers serious neglect that could warp the utilization of services and compromise the objective of providing for good health care.

In sum, basic protection against the cost of non-institutional services is just as essential as the coverage of institutional services in the over-all national health program for the aged. Consistent with the principles advanced by the Committee for delimiting the responsibilities assigned to the public sector, the principle here calls for explicit and simultaneous assignment of responsibility to the private sector of the essential function of providing complementary protection covering non-institutional care, to balance and round out health insurance for the aged population. Distinctness of responsibilities would be achieved under the proposal by looking, on the one hand, to public insurance for basic coverage of institutional services for the aged and, on the other, to private insurance for coverage of physician care, diagnostic services, nursing care and other costs against which protection is needed.

The projected role of private insurance in meeting the problem is not subordinate, fringe, or supporting; rather, it is basic and central. Fulfillment of this role is essential not alone to avoid improper use by the aged of institutional services covered under public insurance, but to accomplish the solution of the problem of health care of the aged. The fact that physician's care constitutes the foundation and fundamental requisite for preventing, diagnosing, and treating health problems, makes it doubly true that complementary protection in the private sector would be a basic and pivotal element in solving the problem.

Confining the scope of the public insurance plan for the aged to basic institutional services as proposed would in fact leave a broad spectrum of health services, representing about two-thirds of the total cost of health care, to be financed either through private insurance or by the aged on an out-of-pocket basis. A wide field would thus be open for the application of private insurance. This extends beyond the various aspects of physician services rendered in hospital, clinic, office, or home to encompass other services such as diagnostic procedures, nursing, dentistry, drugs and appliances.

In the provision of protection to the aged population it is highly important that flexibility be preserved for experimentation and innovation. This is essential for continuing development of the protection provided to the aged and for adaptation to changes in health needs and medical practice. The rapid advance of medical science and technology brings continuous changes in the patterns and components of health care. These affect not only the availablility and utilization of various elements of health service but also standards of care and concepts of need. The assignment of responsibility to the private sector as proposed would capitalize upon the ability of private insurance to make adjustments and shifts in emphasis in keeping pace with the evolving circumstances of health care.

Moreover, the assignment of the broad area to the private sector affords, in the opinion of the Committee, ample opportunity for exercise of individ-

ual choice and initiative. The omission of options in the public portion of the total program does not ,therefore, preclude a large degree of latitude for the individual in determining for himself the extent of protection which he will have.

2. **Private health insurance should concentrate primarily on covering the major clusters of expense for physician care and other non-institutional services, so that, together with the institutional care covered by the public plan, the aged will have a well-balanced package of basic protection.**

DISCUSSION

Within the broad spectrum of services and costs remaining outside the public plan, private complementary protection for the aged should be designed so that ordinarily the individual is spared the cost of catastrophic illness and is left with costs that he can manage.

To minimize the occurrence of dependency among aged persons as a result of expenses encountered in obtaining health care, health insurance provided under the dual public-private program must give protection against the large, concentrated expenses that occur most frequently. This, the public plan would do in the area of institutional services. The Committee believes that, correspondingly, the complementary private insurance should place primary emphasis on covering the major clusters of expense for other health services.

One of these clusters can be sharply defined in terms of services to be covered, namely, surgery and other physician care rendered in the hospital or skilled nursing home. Such medical-surgical coverage is, next to hospitalization, the most common form of health insurance in the nation (although medical services is nursing homes are rarely included), and it is clearly a natural component of basic private protection because it directly complements the hospitalization benefits of the public plan.

Attention must also be given to designing the benefits provided by the combined public-private program so as to avoid as far as possible a skewing of the demand for health care services. A leading example of the costly use of health care resources brought about by the terms of health insurance coverage is the hospitalization of patients for diagnostic tests that could be adequately given on an ambulatory basis. The same thing may happen in the case of minor surgical procedures if only in-patient surgery is covered. The Committee believes therefore, that the basic complementary coverage under private insurance should include benefits for diagnostic procedures and surgery for patients who are not hospitalized.

The costs for other care by physicians and for nursing, drugs, medical supplies, and prosthetic devices of various kinds accumulate to large proportions in many illnesses of the aged. Frequently, such costs follow a period of hospitalization; in other cases, no hospitalization is involved. The contingency of concentration of such costs cannot satisfactorily be defined in terms of services, diagnoses or the locus of care but only as clusters or accumulations of expense accruing over a time period. Private insurance has developed "major medical" insurance provisions which deal with such occurrences, and the Committee recommends that there be a major medical component in the complementary basic private plan. This would call for a deductible amount of expense before benefits were payable, a ceiling on the total amount of benefits that would be paid, and probably a co-insurance factor requiring the beneficiary to pay a part of the covered costs, most commonly 20%.

In designing complementary basic protection for the aged, the benefit level established under private insurance for the aged must be relatively high to accomplish the purpose underlying the principle advanced by the Committee. It must be recognized that the limits on the ability of the aged to meet uninsured costs tends to be narrow. In addition to having characteristically low incomes, other factors, such as the tendency for income to be of a fixed character without prospect of future improvements in financial situation to ease the burden of indebtedness incurred to bridge a period of financial stringency, the tendencies for depletion of reserves to be irretrievable, and for health care costs to be progressive and accelerative for chronic conditions and long-term illness, all have the effect of reducing the ability of the aged to absorb the impact of costs at the time services are required. If liquidation of assets which produce the income they look to for meeting living costs or sacrifice of equity in their homes is required to meet the impact of illness costs, the objective of maintaining independence is not served.

These and related considerations lead the Committee to conclude that basic complementary protection established for the aged by private insurance should be designed to cover roughly one-third of the aggregate amount of health care costs incurred by the aged. This proportion is approximately equal to that which would be covered under the public insurance plan as proposed by the Committee.

There would remain, outside the scope of basic protection provided by the dual public-private health insurance program, roughly another third of total costs to be met either by the individual at the time of receiving services or by adidtional protection which he might obtain under private insurance. By placing emphasis upon basic protection, covering large, concentrated expenses that occur most frequently, as called for by the guiding principles advanced by the Committee, the residual third of costs would in substantial part consist of routine and low-cost items, the cost of which would tend to be relatively widely distributed and manageable by the aged. This residual

third of total health care costs, which includes amounts not covered because of deductible and co-insurance provisions in complementary basic insurance, would leave a major element of individual responsibility for financing services at the time they are received.

It is important that the area of costs above the roughly two-thirds, covered by basic protection under the public-private health insurance program, should remain open for the development of additional protection under private insurance. In this area, it is particularly desirable that additional insurance coverage be designed to minimize impediments of cost and thereby encourage individuals to place their health problems under medical treatment at an earlier rather than a later point and to maintain continuity and follow-up of medical management of their health problems. This is especially pertinent to coverage of physician visits for aged persons since frequently their health problems are of a chronic and progressive character and their financial circumstances would incline them to delay incurring expense as long as possible. Additional protection which is supportive of effective patient-physician relationships would help to avoid health loss and to reduce needs for costly services and facilities.

However, some of the costs in the area outside the basic protection of the public-private health insurance program for the aged would not be insurable, and some, it would be undesirable to cover. It should be recognized also that the need for custodial and domiciliary care, involving provisions for housing and personal services for aged persons, is a serious and growing problem in the nation as a consequence of the prolongation of life and increasing inability of families in the circumstances of urban life to provide for these needs. Although no attempt has been made to define outer limits for the development and application of private health insurance, the Committee believes that the lack of definitions and standards of practice as a basis for determining appropriate responsibilities with respect to financing custodial care of aged persons is a need urgently requiring joint attention of public and private health and welfare agencies.

3. Basic complementary protection under private insurance should be made available to all persons in the aged population without disqualifications, reductions in benefits, or increases in premiums because of advanced age or condition of health.

DISCUSSION

This principle is intended to give emphasis to a point of fundamental importance to the effectiveness of the private sector in contributing to solution of the problem of health care of the aged. Although a variety of methods may be utilized by private insurance in enrolling aged persons,

sight must not be lost of the significance of availability of basic complementary protection to all without restrictions.

The implementation of this principle requires broad pooling of risks as a basic feature in the provision of private insurance coverage to aged persons. The essential attributes of the type of risk-spreading involved in making protection available to all without restriction are well established in the private sector under "group" insurance.

For example, customarily under group health insurance the level of protection established is made available to all, on common terms, and without medical examination or other screening for the purpose of excluding or treating differentially individuals to whom higher risk attaches. Rather than placing emphasis on selecting out of the group only those risks which are deemed good or acceptable, emphasis is on obtaining maximum participation and extending protection to as many members of the group as possible.

Moreover, under group insurance, the concern of the insurer in the on-going operation of the plan is not focused on the utilization of health services by individual members of the group, even where benefits required by an individual are consistently on the high side; rather, the concern of the insurer focuses on the utilization experience of the group as a whole, and upon the adequacy of aggregate premiums received from the group in relation to the total benefits required by all covered individuals in the group.

The need for applying these characteristics to the coverage of the individuals making up the aged population is apparent, if indeed not compelling. Restrictions on the eligibility of individuals for insurance protection and other procedures for selection of risks, using medical examinations or statements as to health conditions for the purpose of disqualifying those individuals most likely to require health services, are seen to be inconsistent with the projected assignment to the private sector of responsibility for meeting a basic part of the problem of health care of the aged population. Similarly, cancellation or reduction of protection on individuals who encounter unusually high, or continuing, or repeated requirements for services is inconsistent with the objective in view.

These considerations are especially pertinent in dealing with protection of aged persons, not only because a large proportion have accumulated health impairments, but also because, sooner or later, almost all such individuals, as their age increases, will come to be poor health risks and, consequently, would be subject to restrictions on elegibility for protection, or to disqualifications based on an insurer's selection of risks, or even to cancellation of protection when they need it most.

The avoidance of restrictions on elegibility of aged persons for basic

complementary protection is closely related to, in fact intertwined with, two major variables, namely, the level of enrollment and the rates charged for protection. For example, with low enrollment it could be expected, as a result of adverse selection, that those covered would tend to be aged individuals representing poorer than average risks; hence, the pooling of risks under the protection would tend to be a pooling of poor risks. Consequently, either high rates, prohibitive for many aged persons, would have to be charged for the protection or restrictions would have to be introduced to exclude poor risks, in order to keep the cost of protection within reach of those for whom it is intended. The spiral effect produced by the relationship of these variables holds in both directions: if true mass enrollment can be achieved, covering the great majority of the aged under basic complementary protection provided by private insurance, there will result an automatic averaging of risk. Under these circumstances, both individual underwriting or the screening of applicants and the rates charged for protection can be minimized. Moreover, both lower cost of protection and absence of restrictions on eligibility would in turn tend to make possible a higher level of enrollment.

This is not to say, of course, that aged persons could be permitted complete latitude to obtain and drop their coverage at will; reinstatements of lapsed policy holders will have to be subject to reasonable restrictions, but new applicants can be accepted as is done under group insurance so that none will be excluded on the basis of condition of health or advanced age.

The essential point which it is important to recognize is that absence of restrictions on eligibility of aged persons for protection, low cost to the aged of such protection, and high level of enrollment in the aged population are factors which are tied together, are mutually dependent and are reinforcing. The presence of these factors, in combination, is seen by the Committee to be essential to the validity of a plan of action in the private sector under which private insurance is to play a basic role in meeting the problem of health care of the aged.

4. Private insurance organizations should devote intensive efforts to extending basic complementary protection to the aged population, with concentration on developing marketing methods designed to produce high volume, low-cost mass coverage.

DISCUSSION

Coverage of a great majority of the aged for basic complementary protection under private insurance is a matter of fundamental importance to the success of the program proposed by the Committee. For private insur-

ance to fulfill a role coordinate with that of the public insurance plan for basic institutional services, thus rounding out and achieving balance in the total provision for the health care of the aged, obviously requires enrollment of a high proportion of the aged population.

There are several factors which would point to successful accomplishment of this by private insurance. The establishment of public insurance covering basic institutional services would be of great significance in attaining broad participation under private insurance offering other services. Relieved of the responsibility for covering the heavy burden of expensive hospital and related institutional care, private insurance could then provide effective protection for aged persons at substantially reduced premium charges. Basic complementary protection of the character previously discussed (see Principle 2 for Private Insurance) could be provided in most areas of the country for a premium level of an order of magnitude of $2 to $3 a week under conditions of high-volume, low-cost provision of insurance coverage.

The attractiveness of participation in such insurance would be enhanced by the fact that it would offer better protection at far lower cost than ever before possible. With purchase of the complementary protection which could be made available by private insurance, a relatively high level of security against illness costs would be attained. For the children and other relatives of aged persons, adequate protection for the aged individuals in their families would for the first time, in most instances, become a feasible and attainable objective. The response to this opportunity could be expected to contribute importantly to the expansion of enrollment.

Since private insurance would constitute a basic rather than a supplementary element of health protection for aged individuals, the effect would more likely be to stimulate interest in closing the gap in protection, making it comprehensive, than to diminish interest in having private insurance. The health consciousness of the aged, due to their vulnerability to, and experience with health care costs, could be expected to accentuate response to the availability of well designed private health insurance, complementary to protection under the public insurance plan. Moreover, the fact that an increasing number of those reaching old age in the future will have been accustomed to carrying private health insurance may be expected to add to their recognition of the need for the protection and their willingness to purchase it.

Another factor of importance, particularly at the outset, would be the release of substantially all of the estimated $475 to $525 million in purchasing power now spent annually for hospital insurance coverage for the aged. This would become available for reallocation at the time the proposed public insurance plan covering basic institutional services becomes effective. Consequently, a sizable, immediate market for complementary private insurance would be created, giving impetus to the rapid development of a substantial volume of coverage.

As a result of these and related factors, private insurance for the aged would be on a new plateau upon which the potentialities for achieving broad participation in the aged population would be greatly enhanced.

Expanding private insurance coverage among the present and future aged nevertheless presents a special problem and should be dealt with as such. The difficulties to be overcome in extending complementary protection under private health insurance to a high proportion of the aged population should not be minimized. Factors such as the wide dispersion and relatively limited mobility and comparative isolation of many elderly people make for difficulty in disseminating information and establishing contacts for purposes of enrollment. Major problems are encountered in communication, in the use of material, correspondence, and other means for interpreting protection available, and for securing the understanding and acceptance required in the enrollment process. The past experience of both nonprofit and other health insurance organizations in their efforts to enroll aged persons points up these and related problems.

With the aged scattered throughout the population in individual or small family units, only a mass approach can achieve the lowest cost and universal availability. Both of these objectives must be achieved if private insurance is to discharge its responsibility in the dual public-private program projected by the Committee.

In the absence of special measures, experience shows that enrolling individuals and administering their coverage ordinarily involves outlays, operating costs and other expenses approaching the amount of benefit payments for the health services covered. As a result, the rates ordinarily charged for protection under policies provided on an individual basis must be approximately double the amount of the health care costs met by the insurance. Obviously, such costs in providing protection would seriously reduce the potentialities of private insurance to achieve broad participation among the aged. Consequently, improved methods of coverage and gains in efficiency through high volume operation are seen to be essential to reduce the cost of complementary basic protection for the aged under private insurance.

Concern that rates for this private, basic insurance be as low as possible is accentuated by data on the incomes of the aged. For those who are unable, or who fail to obtain private insurance for the complementary protection they require, public assistance or private charity would be necessary to meet health care costs incurred in excess of means. It is clear, however, that the proportion of the aged population becoming dependent upon welfare programs would be affected to an important extent by the level of rates charged under private insurance for complementary protection.

For these reasons, special measures are needed to maximize the efficiency of private insurance for the aged and to permit the lowest possible rates.

By capitalizing on the new and improved opportunity for expanding enrollment among the aged which would exist with adoption of national policy as projected, and through imaginative, intensive and concerted efforts of insurers organized for a nation-wide effort, a degree of recognition and acceptance under private insurance could be achieved that would establish such coverage as a commonplace necesity for aged persons in our nation.

5. **Congress should take action which would make it possible for insurance companies and non-profit health plans to join in concerted nation-wide efforts to extend to the aged population basic protection, complementary to that established under the public insurance plan for the aged.**

DISCUSSION

This principle calls for removal of impediments to the development and execution of a plan of action in the private sector which the Committee believes to be necessary for solution of the problem.

Formidable difficulties confront private insurance in completing basic protection of the aged on as extensive a scale as is required to meet the problem. The importance and urgency as well as the long term significance of successful accomplishment by private insurance of this assignment make special measures and efforts necessary. Specifically, a plan of action involving concerted efforts of insurers, on a broad front, through an organized approach, is seen by the Committee to be needed to make complementary basic protection available throughout the nation to all aged persons without regard to their health status, to achieve the level of participation in the aged population necessary to overcome adverse selection of risks, to disseminate information widely and efficiently so as to establish firmly public understanding and general acceptance of the protection, and to develop the large volume and standardization of operation needed for efficiency and provision of basic protection at low cost. In short, the character of the problem requires planning and large scale organized effort on a nation-wide basis in the private sector as well as in the public sector.

Legislation enacted by Congress establishing the public insurance plan for the aged should at the same time clear the way for and encourage development of nation-wide action in the private sector to provide basic protection complementary to that established under the public plan. The action by Congress should include 1) removal of legal obstacles to concerted activities on the part of private insurance organizations in formulating and carrying out an organized plan of action, 2) provision for official public endorsement for complementary basic protection offered under such

plans, and 3) exemption from State taxes on premiums paid for protection bearing such endorsement.

The basic legal obstacles standing in the way of organized concerted efforts by insurers in the private sector for accomplishing the purpose in view arise from anti-trust laws at the federal level or from anti-compact or anti-discrimination laws at the state level. The various essential elements of an effective organized plan — agreement among large numbers of private insurers as to a uniform basic coverage to be provided aged persons at a uniform rate, pooling of losses made necessary by acceptance of all applicants without underwriting selection, and expense provisions lower than regular insured business — all pose problems under these laws. The Committee is advised that insurance comes within the federal sphere as essentially interstate commerce. It is therefore within the power of the Congress to pass enabling legislation for the organization of concerted efforts on a broad scale in the private sector, permitting nation-wide approach to extension of complementary basic protection to the aged population.

It is pertinent to point out that there is impressive evidence of growing acceptance in the private sector of the need for voluntary insurance organizations to join forces to be most effective in reaching and enrolling the aged and in efficiently meeting their needs for health protection. The State 65 Plans which have been established within the last two and a half years in the states of Connecticut, Massachusetts, and New York provide not only precedent for, but substantial evidence of advantages obtainable from organized, concerted efforts in the private sector. But the full potentialities of this approach remain to be realized through development on a broader basis, and under conditions where premium rates could be much less than the amount charged under the demonstration programs, which could result from the division between the private and public sectors of responsibility for providing basic benefit coverage and from increased volume and greater efficiency attainable on a nation-wide basis.

It is important to point out also that organized undertakings to extend complementary basic protection to the aged population through joint efforts of private insurance organizations should not, and need not, mean foreclosing "elbow-room" for additional efforts, continued experimentation, and still further innovations in the private sector. In fact, such organized voluntary plans should be devised so as to provide a base to which additional benefit features could be attached, permitting local and individual variation and facilitating experimentation with new benefits. This will provide options which participants in a basic plan may purchase in order to extend their protection to the extent they choose to do so. It must be recognized that uniformity in the complementary basic protection has significant advantages in facilitating promotion and enrollment, and administrative efficiencies. But development in the private sector of large volume, standardized coverage of the aged for complementary basic protection

should leave clear the opportunity for participating insurance organizations to extend and go beyond the complementary basic protection by covering any and all additional services that it may be possible to include.

It is deemed important that participation of private insurance organizations in organized plans of the character visualized should be on a voluntary basis, so as to preserve appropriate leeway in the private sector against rigidities of an industry-wide structure. Moreover, to avoid loss of identity on the part of the various health insurance organizations in the private sector, many of which are non-profit in character, the enrollment of and issuance of protection to aged persons and the administration of the coverage provided could remain functions of the insurers participating in a plan, with pooling of risks being accomplished through a structure representing a combination of the participating insurers.

Action by Congress called for by the principle should make provision for official public endorsement of private insurance for aged persons under the approach permitted and encouraged by the legislation. It is desirable that this involve legal authorization for the use of a symbol signifying official public endorsement of a plan of complementary basic protection for aged persons meeting specified conditions and appropriate standards for such protection. This would not only give tangible public recognition and encouragement to efforts in the private sector pursuant to national policy but it would contribute to widespread understanding and rapid acceptance among the aged population of complementary basic protection under private insurance. Conditions required for approval of a plan should relate to appropriate organizational aspects of the consortium of insurers, provision of protection on a not for profit basis, limitations on expense provisions allowed for inclusion in premium rates, availability of the coverage to aged persons without underwriting selection, and provision of benefits which in character and extent constitutes complementary basic protection in line with national policy on health care of the aged. In the administrative application of these conditions, the advice of the National Advisory Council on Health Insurance for the Aged (see Section III C. for discussion of the Council) should be obtained. Recommendation by the Council would provide an appropriate basis for official public endorsement and authorization for use of a symbol as proposed.

To provide further encouragement and assistance to concerted efforts in the private sector to extend complementary protection to as many of the aged as possible, the legislative action by the Congress should exempt from state premium taxes the private insurance coverage for the aged bearing the symbol of public endorsement. This would, in effect, provide a discount to aged persons in obtaining the complementary protection provided under private insurance and would aid in making the rates charged for such protection as low as possible. Loss of revenue to the states from taxes on health insurance for the aged would be more than offset by reduction in state

public assistance costs by virtue of wider coverage of aged persons under insurance to meet health care expenses.

With passage of legislation as called for by the principle, the organization of efforts in the private sector along the lines envisioned might be effectively acomplished either on a national level or within each of the respective multi-state regions of the nation. The national level would seem to offer important advantages, particularly in terms of publicity and use of mass communication media to establish nationwide familiarity and acceptance of the voluntary plan for complementary protection for the aged. This could be particularly effective at the outset if tied to the launching of the public insurance program at the national level. However, through interregional coordination, nationwide efforts could be carried out in a manner that would capture many of these advantages.

Many possibilities exist with respect to arrangements for achieving comprehensive, concentrated efforts in the private sector for extending to the aged population of the nation the basic complementary health insurance coverage which is seen to be essential to the success of national policy to meet the problem of health care of the nation. The potentialities of such arrangements are deemed to be of such importance that legislative action is strongly urged to remove impediments to planning and development along the lines seen to be needed.

The Committee recognizes that the proposed plan of action for private insurance under this legislation goes well beyond any existing practice or mechanism developed by voluntary insurance in the United States to meet a special social need. Its most evident precedent is found in the State "65 Plans", which, as we have already remarked, have been established with the same end in view as that which prompts this national proposal. We can only repeat that in our opinion only large-scale, special, national efforts on the part of private insurance can deal effectively with the present and future needs of the aged for protection against the costs of health care, even with the public insurance plan, as we recommend, carrying a part of the responsibility for basic protection comparable to that assigned to private insurance.

6. To increase the proportion of the aged covered in the future under complementary protection, private insurance organizations should develop methods for prepaying during the years of active employment the cost of health insurance in old age. Employed groups also should be encouraged to continue retirees under group insurance plans.

DISCUSSION

The potential for coverage under private complementary protection

of persons retiring in the future can be greatly increased through the development of arrangements for advance payment prior to retirement.

In essence, this approach calls for the method of financing used by private pension plans to be applied to the provision of health insurance protection after retirement. Arrangements for "funding" the cost of such protection would serve to relieve the burden of paying for protection which otherwise must be borne during retirement, a period when income is reduced and health care expenses increase. The cost would be shifted to the productive period of life and spread over the span of the working years by setting aside funds when individuals are employed and are better able to make provision for the protection that will be needed.

With such arrangements, the complementary protection needed during retirement can be provided under private insurance to many who otherwise would not be able to bear the cost of adequate protection after they become aged. It is pertinent to point out that the level of outlay required to make advance provision for complementary health insurance protection after retirement would be small in comparison with that required to provide income benefits after retirement on the scale generally prevailing under private pension plans. If payments on such policies were fixed as percentages of pay, the amounts available at age 65 would be more in line with the cost of health services at that time.

In view of the potential advantages of advance funding for the cost of health protection — whether in conjunction with private pension plans, or as a feature attached to group health insurance plans, or as a separate program — the Committee believes that the cost of health protection after retirement should be financed in advance of retirement to an increasing extent in the future.

It is recognized that this development will require much ingenuity on the part of insuring organizations. Changes occurring over extended periods of time in such factors as the price level of health services and in the technology of medicine, pose challenges requiring imaginative approaches in developing provisions adaptable to changing conditions. But even where it is not possible to make future commitments in terms of services, provisions for advance finding will make funds available for purchase of protection needed after age 65. Hence, irrespective of changes in the conditions of health care, there are inherent advantages in advance provision before retirement to defraying the cost of needed protection after retirement.

Rapid development of arrangements under which this advantage becomes widely available is needed to broaden and strengthen the economic base for extending complementary protection to the aged population under private insurance. In the development of these arrangements and in their application, it is desirable not to restrict mobility of individuals, in terms of changes in jobs and places of residence, by the penalty of loss of accrued

"credits" toward insurance coverage in old age. Consideration should therefore be given to vesting such credits in the individual, so that they would accumulate over his working lifetime.

An important opportunity for covering under voluntary health insurance an increasing proportion of persons retiring in the future lies in attaching the coverage needed after retirement to the group plan under which persons are covered before retirement. To the retiree, this offers the advantages of remaining under group insurance. Even though continuation may be upon a modified basis with respect to benefits or the extent or amount of the insurance cost which he bears, the economies inherent in linking continued protection to the group insurance program are significant in relation to other alternatives available to him after retirement. If the protection after retirement is made available on a basis where the cost of complementary coverage for retirees is pooled with that for younger persons, a strong incentive is provided for persons who are retiring to continue their protection.

In view of the advantages, the growing trend to extend such coverage should be encouraged and accelerated. Arrangements should be broadened to include all employees reaching retirement age, irrespective of their length of service with the employer, and should provide continued protection for the spouse of the retiree. Moreover, arrangements for extending coverage should include reasonable safeguards against discontinuation of protection during the lifetime of retirees as a result of changes in the group insurance program which affect the basis on which the provision of protection rests.

III

Guiding Principles for the Long-Range Program

C. National Advisory Council

A National Advisory Council on Health Insurance for the Aged should be created and charged with advising the Secretary in administering the public insurance plan for the aged and with making periodic reports to the Congress through the President on the status, in both the private and public sectors, of implementation of national policy for health care of the aged.

DISCUSSION

This principle calls for a strong advisory council. It would have two basic assignments: 1) participating in the formulation of policies for administering the public plan; and 2) reviewing from the perspective of national policy and of the total problem, the entire field of health insurance for the aged, encompassing the dual public, private program.

Each of these assignments is seen to be highly important to successful accomplishment of the purposes of legislation on the subject of health care of the aged. It is believed that each of these assignments will best be carried out by charging a single council with both of them because of the nature of the two functions is such that each one will benefit and reinforce the effectiveness of the other.

Legislation establishing the National Advisory Council on Health Insurance for the Aged should specify that the Council should be broadly representative in its composition, with its members being appointed by the President for overlapping terms, and with selection of the chairman left to the members of the Council. To enable the Council to discharge properly its responsibilities, provision should be made for a small professional secretariat.

The Council should be charged with providing advice to the Secretary upon his request on policy matters in the planning and operation of the public insurance plan for the aged. Moreover, it should be charged with initiating at its discretion, recommendations to the Secretary on policy matters.

The Secretary shoud be required to consult regularly with the Council. Specifically, with respect to quality standards and utilization of voluntary organizations and official state agencies as discussed under Principles 7

and 8 for Public Insurance, it should be mandatory that the Secretary seek the advice and recommendations of the Council prior to the establishment or modification of policies on these matters.

In setting forth the responsibility of the Council for preparing and issuing periodic reports, it should be clearly stipulated that such reports should be based upon review and evaluation of the functioning of both private and public insurance for health services for the aged, with particular concern for inter-relation and coordination in developments and for aggregate effectiveness in serving the needs of the aged population. The periodic reports of the Council should include such recommendations as the Council may wish to make as to desirable actions to be taken in either the public or public sectors or in both. The perspective of the Council in reviewing and evaluating from time to time the current status in the nation of health insurance for the aged should be that of broad and long range objectives of national policy and should include recognition of changes and trends both in health care and in the health problems of aged persons.

The intent underlying these proposals is that the Council would not be a "window-dressing" but that it would have effective influence in the formulation of policies in the administration of the public plan. By being broadly representative in its membership and by having within its purview the total problem of health care of the aged, it is believed that the Council not only would contribute significantly to the success of the public insurance plan but beyond this would fulfill an important role in furthering cooperation and coordination between the private and public sectors of the nation in accomplishing the objectives of national policy.

Public Welfare Amendments of 1962 *and* Proposals for Health Insurance for the Aged

by WILBUR J. COHEN and ROBERT M. BALL*

THE Public Welfare Amendments of 1962, which became Public Law 87–543 with President Kennedy's signature on July 25, 1962, represent the most important changes in the public welfare provisions of the Social Security Act in that act's history. The amendments emphasize rehabilitation services and the training of staff, liberalize payments, and provide States with significant new tools for making welfare programs more effective.

The amendments, as passed, do not affect the program of old-age, survivors, and disability insurance. The major proposals of the Kennedy Administration for health insurance for the aged under social security were, however, offered, debated, and tabled by the Senate in the form of an amendment to the public welfare bill. The legislative history of the health insurance proposal is accordingly included in the last section of this article.

The most significant of the amendments to the public assistance titles are the following:

1. Seventy-five-percent Federal matching is provided for State expenditures for defined social services and training activities in the Federal-State public assistance programs.

2. Federal sharing in State assistance expenditures for the needy aged, the blind, and the disabled is increased. Federal sharing is also extended to expenditures to meet the need of the second parent when he is unemployed or incapacitated and is living in the home with needy children.

3. The provision for aiding the dependent children of unemployed parents is extended 5 years.

4. The provision for aid to certain children receiving foster-home care is made permanent; before October 1, 1964, such children may be receiving institutional care.

5. Protective payments in behalf of dependent children are authorized.

6. Provision is made for demonstration projects.

7. Funds are authorized for the use of the Secretary of Health, Education, and Welfare in providing for the training of personnel, directly or by arrangements with institutions.

The major changes in the child welfare provisions (title V, part 3, of the act) are listed below:

1. The amount authorized for annual appropriation is increased from $25 million to $30 million for the fiscal year 1962–63 and, in steps of $5 million, to $50 million for 1968–69 and thereafter.

2. Beginning July 1, 1963, State child welfare plans must provide for coordinating their services with the services provided for dependent children under title IV, and they must also show by that date that they are working toward making child welfare services available by July 1, 1975, to all children in the State who need them.

3. A portion of the Federal child welfare appropriations is to be earmarked for day-care services, effective for the fiscal year 1962–63 and thereafter.

4. Specific requirements with respect to day-care services provided under the State child welfare plans are added, effective July 1, 1963.

5. Grants to institutions of higher learning for special projects for training in the field of child welfare are authorized, beginning 1962–63.

6. The purposes for which grants to States may be used are clarified and broadened through a new definition of child welfare services.

Public Welfare Amendments of 1962

BACKGROUND AND LEGISLATIVE HISTORY

The Public Welfare Amendments of 1962 constitute the most comprehensive and constructive overhauling of Federal legislation relating to public assistance and child welfare services that Congress has ever made. Detailed study of the operation of existing law, its weaknesses, and desirable modifications preceded the development of the new public law.

After his election but before his inauguration,

* Mr. Cohen is the Assistant Secretary for Legislation of the Department of Health, Education, and Welfare; Mr. Ball is the Commissioner of Social Security.

Reprinted from the *Social Security Bulletin*, October 1962

President Kennedy established a task force on health and social security for the American people. This task force, which was chaired by Wilbur J. Cohen, reported to the President on January 10, 1961, and made a number of recommendations regarding public assistance and child welfare.

The recession situation of the early months of 1961 suggested the need for immediate action, and most of the provisions regarding public welfare recommended by the Administration were subsequently embodied in temporary legislation enacted that year, with most provisions scheduled to expire June 30, 1962.[1] This legislation provided for aid to dependent children of unemployed parents; for foster-family home care of certain children removed from their homes by a court because continuance in the home was contrary to their welfare; for modification and extension of the authority for training public welfare personnel; for an increase of $1 in the amount of assistance subject to Federal participation in the programs for the aged, the blind, and the disabled; for assistance to American citizens returned from foreign countries; and for modest increases in the maximums on Federal grants for public assistance purposes to Puerto Rico, the Virgin Islands, and Guam.

In his testimony before the Committee on Ways and Means of the House of Representatives on February 15, 1961, when the bill to amend the program of aid to dependent children was under consideration, Secretary Ribicoff assured the Committee of his intention to make a thorough study of the public welfare programs. He also said that he would return to the Committee in 1962 with whatever recommendations might evolve from this study.

Prelegislative Studies and Developments

On May 2, 1961, Secretary Ribicoff met with representatives of the National Association of Social Workers, discussing with them problems and needs in the welfare field and receiving from them an offer of cooperation and help in undertaking the studies that he had announced. On May 10 a somewhat expanded group, representing public welfare agencies, private welfare agencies, schools of social work, and others, was constituted as the Ad Hoc Committee on Public Welfare and held its first meeting. On May 14, in a speech to the National Conference on Social Welfare the Secretary described the limitations of existing welfare programs and his determination to make substantial improvements in the existing structure. On the same date, he announced that a separate study of possible adminstrative and program changes would be undertaken by George Wyman, an administrator who had had local, State, and Federal experience in public welfare, as well as experience in the private welfare field.

After the enactment on May 8, 1961, of Public Law 87–31, the question of work relief came sharply into focus, as Federal participation in assistance was being provided for the first time to a group of individuals (unemployed parents) who were, by definition, employable. By midsummer the much broader issue of arbitrary public welfare limitations reached a boiling point, generally characterized in the public press and elsewhere by the name "Newburgh," referring to the New York community in which a set of very restrictive regulations with respect to welfare recipients had been adopted.

On August 26 the Wyman report was submitted to the Secretary, and on September 6 the Ad Hoc Committee on Public Welfare submitted its report. (Grants for staff services for both studies were furnished by the Field Foundation.)

A number of other studies were also made available to the Secretary. One of these, *Public Welfare: Time for a Change*, was a report by Elizabeth Wickenden and Winifred Bell of the project on public services for families and children, sponsored by the New York School of Social Work of Columbia University. Materials on needed welfare legislation were also submitted by the National Social Welfare Assembly, and less formal studies and advice were received from numerous other groups representing diverse interests in the public welfare field. The reports of the Advisory Council on Public Assistance and of the Advisory Council on Child Welfare Services, both established under the 1958 amendments to the Social Security Act, had been made to Congress at the beginning of 1960 and were also available.

To analyze the wealth of material available to him, the Secretary appointed a task force in the Department, which in turn established 12 work groups, each dealing with a different aspect of the public welfare programs. The groups considered

---

[1] See the *Bulletin*, July 1961, pages 18–19, and September 1961, pages 8–9.

categories of public assistance, services in public assistance, child welfare services, project grants, levels of assistance, work relief, exemption of earned income of assistance recipients, various ways to promote the constructive use of assistance payments by recipients who have demonstrated their inability to handle money, residence requirements, training of public welfare personnel, medical care for recipients of aid to dependent children, and Federal financial participation in the public assistance programs. The task force and its work groups submitted a consolidated analysis of the available materials to the Secretary at the end of October.

Administrative Changes

Out of all these materials it was entirely natural that certain recommendations could be handled administratively and that others would require legislation. On December 6, 1961, the Secretary announced 10 administrative changes. They dealt with (1) location of deserting parents, (2) administrative actions to reduce and control fraud, (3) allowing children to conserve income for education and employment, (4) safeguarding the children in families of unmarried parents, (5) safeguarding children in families in which the father has deserted, (6) safeguarding children in hazardous home situations, (7) improving State staff training and development programs, (8) developing services to families, (9) encouraging States and localities to provide more effective family welfare services, and (10) coordinating family and community welfare services.

On January 29, 1962, the Secretary announced six additional administrative changes. They related to (1) eliminating unnecessary paperwork, (2) initiating more effective services for children and youth, (3) intensifying efforts to combat illegitimacy, (4) placing increased emphasis on research and demonstration to reduce dependency, (5) strengthening vocational rehabilitation services for disabled recipients of public assistance, and (6) planning more effective training of public welfare personnel. Another administrative change, announced on March 5, provides for Federal participation in payments to patients of mental institutions who are no longer actually in the institutions but have moved into nursing homes, boarding homes, or the homes of relatives.

President's Message

On February 1, 1962, President Kennedy sent to Congress a message concerning the public assistance and welfare programs in which he said:

> Public welfare, in short, must be more than a salvage operation, picking up the debris from the wreckage of human lives. Its emphasis must be directed increasingly toward prevention and rehabilitation—on reducing not only the long-range cost in budgetary terms but the long-range cost in human terms as well. Poverty weakens individuals and nations. Sounder public welfare policies will benefit the Nation, its economy, its morale, and most importantly, its people.

This was the first Presidential message ever to be devoted exclusively to public welfare.

House Action

On the same day that the President sent to Congress his public welfare message, the Administration's proposals for extending and improving the programs of public assistance and child welfare services under the Social Security Act were transmitted to Congress. The Administration bill (H. R. 10032) was introduced in the House by Representative Wilbur D. Mills, Chairman of the Committee on Ways and Means. The bill provided for—

1. Increased Federal participation in services designed to promote self-support and self-care and to strengthen family life and in expenditures for training of public welfare personnel.
2. Demonstration projects that States could undertake without having to meet all the conditions of the Federal act.
3. Progressive extension of child welfare services, with higher Federal authorizations.
4. Earmarking part of child welfare services funds for day-care services.
5. New authority for training child welfare personnel.
6. Community work and training projects, as part of the program of aid to families with dependent children.
7. As an incentive for recipients to accept employment, requiring the States to consider, in determining the amount of the assistance payment, all expenses reasonably attributable to work.
8. Protective payments when inability to manage money had been clearly demonstrated.
9. Counting, for Federal matching purposes, as a recipient of aid to families with dependent children

not only the single adult caring for the child but the husband or wife of that adult.

10. Extending the 1961 provision for aiding dependent children of unemployed parents, making permanent the 1961 provision for certain children receiving foster care, and temporarily broadening the latter provision to include children receiving care in private child-care institutions.

11. New training provisions for public welfare personnel.

12. Limiting to 1 year the maximum residence requirement that States can impose under Federal-State programs and increasing slightly the amount of Federal participation for States that abolish all residence requirements.

13. Permitting the States, on an optional basis, to combine their plans for the aged, the blind, and the disabled.

14. An advisory council on public welfare.

15. Extending the temporary $1 increase in assistance payments for the aged, the blind, and the disabled, made in 1961.

16. Making permanent the program for aiding Americans repatriated from abroad.

17. Removing the dollar limitations on Federal assistance payments to Puerto Rico, Guam, and the Virgin Islands.

18. Changing the name of the program from "aid to dependent children" to "aid to families with dependent children."

The proposals also included a number of technical amendments.

The Committee on Ways and Means held hearings on February 7, 9, and 13, at which Secretary Ribicoff and other witnesses from the Department of Health, Education, and Welfare and many public witnesses were heard. In executive sessions held March 1, 5, 6, and 7, the Committee agreed to a number of modifications in the bill. The Chairman then introduced a "clean bill," H. R. 10606, on March 8, which was ordered to be reported the same day.

The Administration's recommendations were changed in a number of respects, listed below.

1. The Secretary was authorized to provide services to those persons who have been or are likely to become recipients of public assistance only upon their request.

2. Authority for financial participation in the cost of services provided under contracts between the State agency and nonprofit private agencies was deleted.

3. Specific language was introduced to avoid any possible duplication of services of public welfare agencies and of vocational rehabilitation agencies.

4. A number of minor amendments to make more explicit provisions for day care and for community work and training programs were included.

5. A new section, 107 (a), which was to become perhaps the most controversial in the bill, was added. This section authorized a State agency, in the best interests of the child, to provide counseling and guidance and to advise the relative caring for the child that failure to use the payments for the child's benefit might result in any one of a number of specified actions or in any other action authorized by State law, other than denial of payments while a child is in the home, without State loss of Federal funds. The language used in the bill, "any other action authorized by State law," clearly authorized voucher payments (that is, direct payments to grocers, landlords, etc.) and any other type of restriction or control. Such authorization would have represented a substantial departure from the usual pattern of the relationship between the Federal Government and the States.

6. The limitation in the Administration proposal on the ratio of protective payments to all other payments was increased from 1/2 of 1 percent to 5 percent.

7. The provision for aid to the spouse of the relative with whom a child is living was narrowed slightly to apply when the relative is the child's parent and the child is eligible because of a parent's unemployment or incapacity.

8. The provisions for training of public welfare personnel were somewhat modified.

9. The provision for payments under the dependent children program for children receiving foster-home care was made permanent, and the expiration date for provision of aid to children of unemployed parents was extended to June 30, 1967. An expiration date of June 30, 1964, was placed on the provision for assistance to repatriated American citizens.

10. The section on residence provisions was deleted entirely.

11. The proposal to eliminate the dollar ceilings on grants to Puerto Rico, the Virgin Islands, and Guam was eliminated, but modest increases in these ceiling were made.

12. The public assistance formula or Federal participation in the programs for the blind, the aged, and the disabled was modified so that additional

Federal funds of somewhat more than $4 per recipient, in addition to those available under the temporary formula scheduled to expire June 30, would have become available on July 1, 1962.

13. The temporary exceptions that had been made for the programs of aid to the blind in Missouri and Pennsylvania since 1950 were made permanent, and the provisions for the optional combined State plan were modified so that, in States where aid to the blind is administered by a separate agency, these agencies could continue to administer the part of the program for the blind.

On March 13, the Rules Committee granted a rule providing for 4 hours of debate with a motion to recommit but no other amendments. Some of the minority members of the Ways and Means Committee attempted a motion to recommit, with instructions to delete the revised matching formula, when the bill was debated in the House on March 15. This motion was defeated by a voice vote. The House then went on to pass H.R. 10606 by a vote of 319 to 69.

Finance Committee Action

At the time that H. R. 10606 passed the House, the Senate Finance Committee was not able to take up the welfare bill immediately but held public hearings on May 14, 15, 16, and 17 and executive sessions on June 6 and 7. The Committee made a number of amendments in the bill.

1. It concluded that the requirement that a State provide minimum services prescribed by the Secretary in order to qualify for any Federal participation under a program was too drastic. It modified this requirement to provide that, if the State did not make the minimum prescribed services available, Federal participation in administrative costs would be reduced to 25 percent but that Federal participation in assistance payments would not be affected.

2. It adopted language clarifying the language in the House bill concerning the relationship between State public welfare agencies and State vocational rehabilitation agencies and stating more explicitly the circumstances under which services could be provided and reimbursement made.

3. It adopted the formula in the House bill for the $4 increase in payments to the aged, the blind, and the disabled but made the effective date October 1, 1962. The $1 increase that was scheduled to expire June 30, 1962, was extended through September 30, 1962.

4. It adopted an amendment to the section on protective payments, under which a State would be permitted to use such payments for those cases that, under the State's usual standards, would have their needs met in full even though the operation of some other feature, such as a statutory maximum, prevented all recipients of aid to families with dependent children from having needs met in full.

5. It eliminated section 107 (a) of the House bill, which would have permitted voucher payments and any other action authorized under State law.

6. It adopted an amendment exempting payments for work on community work and training programs under title IV from Federal income tax and withholding liability.

7. It deleted the provision in the House bill that would have expanded foster care under the dependent children program to include Federal participation in payments for otherwise eligible children who were placed in private child-care institutions.

8. It adopted the "Baldwin amendment" for a 1-year period ending June 30, 1963. This provision would authorize Federal participation in foster-care payments when the placement and supervision were the responsibility of another public agency (such as the probation department of a juvenile court), if the other agency had in effect an agreement with the welfare agency assuring that the objectives of title IV would be carried out.

9. It revised the training provisions to authorize, within the dollar limitations established by the House bill, a program of direct Federal training and grant activity and of scholarships and stipends for those persons who are preparing for employment in public welfare agencies. The existing provisions of law that would have been made permanent, within dollar limitations, by the House bill would thus have been repealed. Under the House bill, provisions for training would have been handled entirely through grants to the States.

10. It raised the dollar limit on grants for public assistance to Puerto Rico from the House figure of $9.8 million to $10.5 million and for the Virgin Islands from $330,000 to $400,000.

11. It adopted an amendment that would provide, in programs of aid to the blind, for exempting, in addition to present exempted amounts ($85 a month in earnings plus one-half the balance), other amounts of income or resources necessary to fulfill a State-approved rehabilitation plan for a blind indi-

vidual. The additional exemption would not be available for more than 1 year for one individual.

12. It adopted a clarifying amendment with respect to day care, indicating that families with ability to do so would be expected to pay reasonable fees for such care.

13. It restored Administration-proposed language, not included in the House bill, that would modify the existing authority for research and demonstration projects in child welfare to include grants to institutions of higher learning for special projects for training personnel for child welfare services.

14. It amended the House provision authorizing the Secretary to appoint advisory committees by limiting to 10 the number of such committees and to 15 the number of members in each committee.

Where appropriate, conforming changes were made in the combined title under which States could merge their programs for the aged, the blind, and the disabled. Some other, essentially technical amendments were made, and the bill was ordered reported to the Senate.

Senate Floor Action

H.R. 10606 was taken up by the Senate on July 3, with Senator Kerr managing the bill for the Senate Finance Committee. The Committee's amendments were adopted, as was an amendment presented by Senator Kerr for the Committee. This amendment provided that authority for Federal participation in payments for work on community work and training programs operated as a part of the program for dependent children would be retroactive to July 1, 1961, for States that had operated such programs. Certain requirements in the Committee bill would be waived until October 1, 1962. The Senate also adopted on that day an amendment by Senator Williams of New Jersey, providing an additional authorization under the child welfare services program of $750,000 a year for the day care of children of migrant agricultural workers.

In accordance with an announcement that had been made earlier, Senator Anderson on July 5 called up his amendment, which would have provided health insurance for aged persons. This amendment was sponsored by 21 Democrats and 5 Republicans. Most of the debate on the bill from July 5 to July 17, when the Anderson amendment was tabled by a 52-48 vote, was devoted to that amendment and to substitutes for and amendments to it. On July 9, a unanimous-consent agreement was adopted under which, beginning July 11, time for debate was controlled and equally divided between the proponents and opponents. The agreement provided that a vote on the motion to table the Anderson amendment was to occur at 3 o'clock on July 17. (Details on congressional consideration of the issue of health insurance for the aged are presented later in this article.)

During the debate on the Anderson amendment, the following additional amendments to the welfare bill itself were approved.

1. An amendment by Senator Saltonstall eliminating the reduction in Federal sharing in administrative costs required in the Finance Committee bill if States did not provide the minimum services prescribed by the Secretary. Under the Saltonstall amendment, beginning July 1, 1963, States would have to provide such minimum services in order to be eligible for 75-percent Federal participation in any of their services or training costs, but failure to provide the services would leave them with 50-percent matching in all administrative costs, as in the past.

2. An amendment by Senator Douglas permitting the States to exempt up to $25 of the earned income of old-age assistance recipients. The proposal was modified on the Senate floor and the figure raised to $50 and then approved.

3. An amendment by Senator McCarthy and others restoring language similar to that in the House-passed bill concerning Federal participation in payments for foster care under the dependent children program when the child was placed in a private child-care institution.

Two amendments were defeated during this period. One by Senator Moss would have prevented States from considering the ability of relatives to assist persons receiving aid to the blind. The other, also offered by Senator Moss, would have put a provision into the statute requiring that additional Federal funds going to the States because of the change in the formula for old-age assistance, aid to the blind, and aid to the permanently and totally disabled would have to be made available in full to the individual recipients. (The reports of both the Ways and Means Committee of the House of Representatives and the Senate Finance Committee included language making clear that this result was expected to occur and that the Committees believed it would occur.) The amendment was defeated on the basis of the technical problems involved.

After the tabling of the health insurance amendment on July 17, three additional amendments to the welfare bill were adopted and two were offered and withdrawn. The Senate adopted the following changes:

1. An amendment by Senator Hartke permitting Federal participation in payments made directly to suppliers of medical care when the services were rendered within the 3 months preceding the month of application for assistance.

2. An amendment by Senator Long of Louisiana, permitting policemen in that State to be covered under old-age, survivors, and disability insurance through the provisions for coverage available to policemen in certain other States.

3. An amendment by Senator Clark and others permitting adherents of certain religious groups to file a waiver of participation in the old-age, survivors, and disability insurance system if their teachings forbid acceptance of such benefits. (This amendment was concerned with members of the Amish group.)

One of the two amendments offered and then withdrawn was proposed by Senator Javits. It would have made explicit provision in the statute for judicial review of certain actions of the Secretary relating to State plans for their welfare programs. The other, proposed by Senator Wiley, would have reinstated section 107 (a) permitting voucher payments and other unspecified actions under State law.

The Senate approved the bill by a voice vote approximately an hour after the tabling of the Anderson amendment.

Conference Action

The conferees of the House and Senate met on July 18 and made the following significant changes in the Senate-passed bill:

1. The Williams amendment making separate provision for day care of children of migrant agricultural workers was eliminated.

2. The Senate Finance Committee amendment exempting payments under community work and training programs from liability for income tax and income-tax withholding was eliminated.

3. Section 107 (a) was restored, in a limited form; the House language permitting "any other action" (in the interest of the child) that might be authorized under State law was limited to advice that civil or criminal penalties might be imposed upon determination by a court of competent jurisdiction that the payment was not being used for the benefit of the child.

4. The Finance Committee limitation on the number of advisory committees that the Secretary might appoint and the number of members of each committee was eliminated, and a provision substituted that the Secretary should report annually to Congress on the number of advisory committees and their members and activities.

5. The provisions of the House and Senate bills concerning the training of public welfare personnel were included, with the same total dollar limitation set by each bill, and with the Secretary authorized to use a part of the appropriated funds for direct training activities and grants and the remainder to be allotted to States as provided in the House-passed bill.

6. The House version of the language on payment of foster care under the dependent children program when the child is in a private child-care institution was adopted with a beginning date of October 1, 1962, and a terminal date of September 30, 1964.

7. The ceilings on public assistance grants to Puerto Rico and the Virgin Islands were reduced to the House figures, $9.8 million and $330,000, respectively.

8. The Douglas amendment permitting exemption of earned income for recipients of old-age assistance was modified to permit the exclusion of the first $10 of earnings and up to one-half the remainder of the first $50.

9. The two amendments affecting the old-age, survivors, and disability insurance system—the one permitting coverage of policemen in Louisiana and the other permitting members of certain religious groups to withdraw from the system—were considered inappropriate for inclusion in a welfare bill and eliminated.

Final Action

The House of Representatives on July 19 approved the Conference Committee report by a vote of 357 to 34. Later the same day the bill was approved by a voice vote in the Senate and was thus cleared for the President.

On July 25, the President signed the bill, which then became Public Law 87–543. In a statement

concerning the new legislation the President said, in part:

> I have approved a bill which makes possible the most far-reaching revision of our Public Welfare program since it was enacted in 1935.
>
> This measure embodies a new approach—stressing services in addition to support, rehabilitation instead of relief, and training for useful work instead of prolonged dependency. This important legislation will assist our states and local public welfare agencies to redirect the incentives and services they offer to needy families and children and to aged and disabled people. Our objective is to prevent or reduce dependency and to encourage self-care and self-support—to maintain family life where it is adequate and to restore it where it is deficient.

IMPROVEMENT IN PUBLIC ASSISTANCE SERVICES

Beginning with the President's Welfare Message of February 1, 1962, the entire legislative history of Public Law 87–543 emphasizes the importance of the rehabilitative factor in the public assistance programs. The State-administered and State-supervised programs of public assistance provide income maintenance, medical care, and social services to the needy aged, the blind, the disabled, and families with dependent children. Services to applicants for and recipients of assistance provided by the staff of the welfare agency are an essential component of program administration.

Services and Other Administrative Costs

Costs of services provided under the public assistance programs have been shared equally by the Federal Government and the States. Effective September 1, 1962, Federal matching in certain services and in the cost of staff training is increased from 50 percent to 75 percent. Thus, the new law offers an incentive to the States to offer more rehabilitative services and to increase the number of skilled public welfare personnel to provide the services.

The Secretary of Health, Education, and Welfare is to prescribe the minimum services necessary to help applicants and recipients attain or retain capability for self-care or self-support or to help them maintain and strengthen family life. These services are to be provided under State plans for old-age assistance, aid to families with dependent children, aid to the blind, and aid to the permanently and totally disabled. Services are authorized in the program of medical assistance for the aged, with no minimum prescribed. The Secretary is also to specify additional services to applicants and recipients that prevent and reduce dependency, which would be entirely optional with the States.

The new law permits Federal participation in the cost of providing services not only to applicants for and recipients of assistance but also to those persons who request them and who, within periods defined by the Secretary, have been or are likely to become applicants and recipients. Effective July 1, 1963, a State that does not provide under its State plan for the prescribed minimum self-care or self-support services will receive Federal matching funds on only a 50–50 basis. This ratio applies to the cost of all services, training, and other administrative costs.

The new law specifies how the services are to be furnished. The staff of the State and local public assistance agency is authorized, as before, to provide services. In addition, services that cannot be economically or effectively provided by agency staff or are not otherwise reasonably available may be obtained by agreement with another State public agency, subject to limitations prescribed by the Secretary.

Services identified in the Vocational Rehabilitation Act as "vocational rehabilitation services" are not ordinarily to be provided by the public assistance agency staff but by the State vocational rehabilitation agency. The latter is the only agency that may furnish these services if it (1) has in effect a State plan to furnish such services to individuals needing them, inc uding recipients of public assistance, or (2) is not providing such services generally but is able and willing to provide them upon being reimbursed for their cost by the public assistance agency. Vocational rehabilitation services may not be obtained from any other public agency when the State vocational rehabilitation agency is able and willing to provide them.

Welfare Services for Each Child Under Dependent Children Program

To further improve and coordinate services to children, a provision is added to the requirements for the dependent children program, effective July 1, 1963. Each State plan must provide for the development of a program of welfare and related services for each child recipient, geared to the child's home conditions and special needs. The plan must

also provide for coordinating these programs with those developed in the child welfare services plan under title V to further promote the welfare of dependent children and their families.

Technical Amendments Emphasizing Rehabilitation and Other Services

The new law changes the name of title IV to "Grants to States for Aid and Services to Needy Families with Children" and makes the necessary conforming changes throughout this title. The emphasis on rehabilitation and other services is also identified in the purpose clause of each title, and there is authorization for such services not only to old-age assistance recipients but also to persons receiving medical assistance for the aged.

Community Work and Training Programs

Another change in title IV is designed to assist the States in encouraging the conservation of existing work skills and the development of new ones. Federal financial participation is authorized in State expenditures for aid to families with dependent children made in the form of payments for work performed by a relative aged 18 or older with whom a dependent child is living. For this financial sharing the State plan must include provisions that give reasonable assurance to the Secretary that certain conditions are being met. These conditions include appropriate standards for safety, health, and other working conditions.

Payment for work must be not less than the minimum rate established by State law and not less than the prevailing community rate for similar work. The work must serve a useful public purpose and not result in the displacement of regular workers, and it cannot be work that would otherwise be performed by employees of public or private agencies, institutions, or organizations. Except for emergency projects or those generally nonrecurring, it must be work not normally undertaken by the State or community.

A State carrying on work and training projects must take into consideration, in determining need, expenses reasonably attributable to work. There must be provision that the person assigned to a work project shall have an opportunity to seek employment and to secure appropriate training or retraining when it is available. Aid may not be denied when refusal to work is based on good cause.

The State plan must include a provision, similar to that in State plans for aid to children of unemployed parents, for entering into cooperative arrangements with the State public employment service so that the person may be returned to the labor force as quickly as possible. These arrangements would include provisions for registration and periodic re-registration for employment and also for maximum use of the placement services and other services and facilities of the employment offices.

In addition, the State plan must provide for entering into cooperative arrangements with the State vocational education agency and the State agencies responsible for adult education services and facilities for training or retraining in preparation for regular employment. So that the parent's absence at work will not affect the welfare of the child, there must be provisions for appropriate arrangements for the child's care and protection. The State plan must provide that no adjustment or recovery will be made for payments correctly made for work. The State may not include as an expenditure for Federal sharing the cost of making or acquiring materials or equipment in connection with a work program or the cost of its supervision.

The Secretary is to report the experience of the States in community work and training programs before January 1, 1967. The report will be sent to the President for transmission to Congress.

For States that, before the enactment of Public Law 87-543, carried on community work and training programs that met the plan requirements (with certain exceptions), the Federal Government shares in expenditures made from July 1, 1961, through September 30, 1962. After that date such programs must meet all the State plan requirements under the law.

Incentives for Employment

As one step towards the goal of rehabilitation, the new law requires that the State consider all expenses attributable to employment in determining the need of a recipient of public assistance; formerly such consideration was optional and not always provided. In addition, in their programs of aid to families with dependent children, the States may permit earned or other income to be set aside for the

dependent child's future identifiable needs, such as his education.

Use of Payments for Benefit of Child

When there is a question whether the money payment in aid to families with dependent children is being used for the child's benefit, the State agency may provide, to the relative caring for the child, counseling and guidance in the use of the payment and in the management of other funds. Upon continued failure to use the payment for the benefit of the child, the agency may advise the relative of the possibility of payment to another interested person or appointment of a guardian or legal representative, or that criminal or civil penalties, authorized by State law, may be imposed by a court of competent jurisdiction. These actions may be taken by a State agency without jeopardizing Federal financial participation or raising a question concerning the conformity of the State plan under title IV of the Social Security Act.

Another change relates to a 1961 amendment allowing the States time to amend their laws that require—contrary to a ruling of January 17, 1961, of the Department of Health, Education, and Welfare—aid to be denied because of conditions in the home in which the child is living. The new law permits States to deny aid if, pursuant to State statute, adequate care and assistance are otherwise provided the child.

Protective Payments Under Dependent Children Program

The definition of "aid to families with dependent children" in title IV is amended to include payments made to another person interested in or concerned with the welfare of the child and his relative. Standards for determining who is "interested or concerned" are to be prescribed by the Secretary.

A State plan under which protective payments are made must provide for the following procedures: (a) determination by the State agency that the relative caring for the child is unable to manage funds to the extent that making payments to him is contrary to the child's welfare; (b) making protective payments that, for the recipients involved, in addition to other income and resources, are sufficient to meet all their needs, according to State standards; (c) exerting special efforts to develop greater ability on the part of the relative to manage funds; (d) making periodic review to determine if serious mismanagement continues, stopping the protective payments if it does not, and seeking the appointment of a guardian or other legal representative if mismanagement is likely to continue; (e) furnishing aid in the form of foster-home care; and (f) giving the relative caring for a dependent child an opportunity for a fair hearing on any determination that he is unable to manage the payment.

The number of individuals for whom protective payments may be made in any month may not exceed 5 percent of other recipients under this program during the month.

The Secretary is to submit to the President for transmission to Congress before January 1, 1967, a report on the administration of the provision and on State experience in making protective payments, with recommendations for continuation or modification.

Aid for Both Parents of Dependent Child

The definition of "aid to families with dependent children" is amended to provide for Federal sharing in State expenditures for assistance given to a second parent. The parent must be living with the child, and the child's deprivation must be based on the incapacity or unemployment of a parent. This change in Federal law recognizes the need of the family when both parents are in the home and provides Federal financial participation to assist the States to meet need more adequately.

IMPROVEMENTS IN ADMINISTRATION

Several of the provisions of the new law were concerned with improving the administration of the public assistance programs.

Advisory Council on Public Welfare

The Secretary is directed to appoint a 12-member advisory council on public welfare in 1964 to review the administration of the programs of public assistance and child welfare services and to make recommendations for improvement. The council is also to review the public assistance programs especially in relation to old-age, survivors, and disability insurance and to the fiscal capacities of the States and

the Federal Government, as well as matters bearing on the amount and proportion of Federal and State shares in the public assistance and child welfare services programs.

The council members are to include persons representing employers and employees in equal numbers, State or Federal agencies concerned with the administration and financing of the public assistance and child welfare services programs, and nonprofit social welfare organizations; other persons with special qualifications; and members of the public. The council is to report its findings and recommendations to the Secretary by July 1, 1966.

The Secretary is directed to appoint succeeding advisory councils under similar conditions. He is authorized also to appoint advisory committees to assist him in carrying out his functions under the Social Security Act and report annually to Congress on the number of committees and their membership and activities.

Waiver of State Plan Requirements for Demonstration Projects

Congress recognized the need for the development of new methods and for experimentation to better meet the complex social and economic problems in the public assistance programs. Accordingly, it authorized the Secretary to waive any of the requirements for State plans in States that desire to carry on an experimental, pilot, or demonstration project likely to assist in promoting the objectives of the programs.

The cost of such projects is to be financed with the help of Federal funds. The law makes available not more than $2 million of the funds appropriated for payments to the States under the public assistance titles in any fiscal year up to July 1, 1967, to assist in paying any portion of the cost of these projects not otherwise subject to Federal participation.

Increase in Trained Welfare Personnel

The present authorization for training grants in title VII has been made permanent, and the Secretary has been given new authority. An appropriation of $3.5 million is authorized for the fiscal year 1962–63 and $5 million for each succeeding fiscal year. An amount to be determined by the Secretary, but not more than $1 million for 1962–63 and $2 million each year thereafter, is to be available to him to provide directly or through grants to or contracts with public or nonprofit institutions of higher learning with respect to personnel employed by or preparing for employment with public assistance agencies for (1) training, (2) establishment and maintenance of fellowships and traineeships, and (3) special short courses of study (to last not more than 1 year).

The Secretary will allot the remainder of the appropriated funds to the States for the training objectives of title VII. The allotments will be based on population; relative need for trained public welfare personnel, particularly personnel to provide self-support and self-care services; and financial need.

To the extent the Secretary finds it necessary, he may prescribe requirements for the repayment of the amount expended on fellowships or traineeships when an individual fails to work the specified amount of time in a public assistance program. He may also waive these requirements when they would be inequitable or contrary to the purposes of the assistance programs.

REVISION OF TEMPORARY PROVISIONS AND INCREASE IN FEDERAL SHARE OF PA EXPENDITURES

Dependent Children of Unemployed Parents or in Foster-Family Homes

In 1961, aid to families with dependent children was broadened to include dependent children of unemployed parents. It was also extended to include payments for foster-family care for certain children removed from their homes by judicial determination. Both provisions, scheduled to expire June 30, 1962, have been extended by the new law—the former to June 30, 1967, and the latter permanently.

Federal Share of Assistance Payments

In addition to extending the temporary increase of $1 in payments to the aged, the blind, and the disabled, effective October 1, 1961, through June 30, 1962, the new law increases Federal financial participation in these payments by an additional $4. The formula change, effective October 1, 1962, is accomplished by increasing the Federal share of

the assistance payment from 4/5 of the first $31, with an average maximum of $66, to 29/35 of $35, with an average maximum of $70. Since the Federal Government continues to share in the vendor payments for medical care, up to $15, for old-age assistance recipients, the average monthly maximum in old-age assistance in which it participates is now $70 plus $15 or $85.

Extension of Assistance to Repatriated American Citizens

In 1961, temporary assistance was authorized for American citizens and their dependents returned from foreign countries because of destitution, illness, war, or similar crisis. This authorization expired June 30, 1962; it is extended by the new law through June 30, 1964.

Refusal of Unemployed Parent To Accept Retraining

Where a State plan includes aid to families with dependent children because of the unemployment of a parent, denial of aid is now required if the unemployed parent refuses without good cause to undergo retraining.

Federal Payments for Foster Care in Child-Care Institutions

The Federal Government will continue to share in State expenditures for payments when a child recipient of aid to families with dependent children, following a court determination, is placed in foster care in a nonprofit child-care institution. Formerly Federal sharing was limited to payments for children receiving foster-family care. Payment with respect to a child in an institution is to be limited, as prescribed by the Secretary, to the items of cost covered in the care in a foster-family home. The amendment is effective for the period October 1, 1962, through September 30, 1964.

State Plans Not Meeting Income-and-Resources Requirements for Aid to the Blind

A temporary provision, first enacted in 1950, authorized Federal financial participation in certain State programs of aid to the blind that do not meet the requirements of the income-and-resources clause. This provision has been extended from time to time and was scheduled to expire in 1964. The new law makes it permanent.

COMBINED STATE PLANS FOR AGED, BLIND, AND DISABLED

Effective October 1, 1962, a new title (XVI) is added to the Social Security Act that gives the States the option, instead of having separate State plans for titles I, X, and XIV, of combining their programs of assistance for the aged, the blind, and the disabled and for medical assistance for the aged. A State filing a combined plan under the new title could not receive payments for the same period or future periods under titles I, X, and XIV.

The State plan requirements are, with few exceptions, unchanged. The necessary adaptations have been made, such as establishing income exemption for the aged and the blind and continuing the present limitation on residence requirements in medical assistance for the aged. States that administer aid to the blind through a separate agency may continue to do so under the new title.

Under title XVI the provision of separate and additional Federal funds for vendor payments for medical care for recipients of old-age assistance is extended to the blind and the disabled. The provision of medical care for 42 days in a medical institution because of a diagnosis of tuberculosis or psychosis, now limited to the aged, is also extended to the blind and the disabled.

MISCELLANEOUS AND TECHNICAL AMENDMENTS

To accompany the increase in the Federal share of expenditures for assistance among the States, the annual dollar limitations for Puerto Rico, the Virgin Islands, and Guam were raised to $9,800,000, $330,000, and $450,000, respectively.

Under the program of aid to families with dependent children, the relative with whom a dependent child is living is permitted to receive money payments or medical care to meet his needs in a month, whether the child is receiving aid in the form of money payment or medical care. Formerly he could receive aid only if aid to the child was in the form of a money payment.

The new law amends the provisions for the disregarding of income in aid to the blind. As in the

past the States must disregard the first $85 of earned income in a month, plus half the earned income in excess of $85 a month. Additional amounts of other income and resources are now to be disregarded for a maximum of 12 months if the recipient has an approved plan for self-support. The additional income and resources must be necessary for the fulfillment of this plan.

The provisions for foster care of dependent children, as enacted in 1961, required that the responsibility for placement and care of children determined by a court to be in need of foster care must be in the agency administering the program of aid to families with dependent children. For the 9 months October 1, 1962—June 30, 1963, responsibility for such children may be given to another public agency with which the welfare agency has an agreement. The agreement must include a provision for (1) developing a plan for each child (including periodic review of the necessity for the child to continue in foster care) to assure his proper care while he remains in foster care and (2) services to improve the conditions in the home from which he was removed or to make possible his placement in the home of another, specified relative. The agreement must also include other provisions necessary to accomplish the purpose of the program under the State plan.

All public assistance titles are amended to permit Federal matching in State expenditures for medical or remedial care furnished for as long as 3 months before the month of application.

The States are given the option, in determining need, of disregarding a certain amount of income earned by a recipient of old-age assistance. As of January 1, 1963, out of the first $50 per month of earned income, the State agency may disregard not more than the first $10 plus half the remainder.

CHILD WELFARE SERVICES

The new law contains, in substance, all the Administration's recommendations for expanding and improving child welfare services, as stated in President Kennedy's Welfare Message and embodied in the draft bill transmitted to the Speaker of the House by Secretary Ribicoff on February 1, 1962.

Extension of Child Welfare Services

Under the previous law, $25 million a year was authorized to be appropriated for grants to the States for child welfare services. The new law increases the authorization to $30 million for the fiscal year 1962–63, $35 million for 1963–64, $40 million each for 1964–65 and 1965–66, $45 million each for 1966–67 and 1967–68, and $50 million a year thereafter.

In the past the law has provided for grants to States for the use of cooperating State public welfare agencies in carrying out the State plan that they have developed jointly with the Secretary of Health, Education, and Welfare. The amendments require, effective July 1, 1963, that the State child welfare plan provide for coordinating its services with those under the State plan for dependent children, with a view to ensuring that dependent children and their families will receive welfare and related services that will be most effective in promoting their well-being.

State child welfare plans are also required, effective July 1, 1963, to make a satisfactory showing that the State is extending the program with a view to making available by July 1, 1975, to all children in need of them throughout the State, child welfare services provided by the staff of State and local public welfare agencies. The staff, to the extent feasible, is to be composed of trained child welfare personnel. In extending services, priority must be given to communities with the greatest need for such services, taking into consideration their relative financial need.

Day Care

Effective for fiscal years beginning after June 30, 1962, funds appropriated for child welfare services in excess of $25 million a year, up to a maximum of $10 million, are to be earmarked for day-care services (including the provision of day care) under the State child welfare services plan. Such care may be provided only in facilities (including private homes) licensed by the State or approved (as meeting established licensing standards) by the State agency that is responsible for licensing facilities of this type.

The earmarked funds are to be allotted among the States on the basis of the population under age 21 and the State's allotment percentage (which varies between 30 percent and 70 percent in accordance with the relative State per capita income); the minimum allotment is $10,000. The portion of its allotment that a State certifies it will not use may

be reallotted among States needing and able to use additional funds in providing day care under their State plan. The reallotment is to be based on need, the population under age 21, and the relative per capita income of the States needing such funds. The States are required to match all child welfare service funds allotted to them. Effective July 1, 1963, a State child welfare plan must meet four additional requirements:

1. It must provide for cooperative arrangements with the State health authority and the State agency primarily responsible for supervision of public schools to assure their maximum utilization in providing necessary health and education services for those children who are receiving day care.

2. It must set up a committee to advise the State public welfare agency on the general policy involved in furnishing day-care services under the State plan. The committee is to include representatives of other State agencies concerned with day care or related services and persons representing professional, civic, or other public or nonprofit private agencies, organizations, or groups concerned with the provision of day care.

3. It must establish such safeguards as may be necessary to assure provision of day care under the plan only when it is in the best interest of the child and the mother and only when it is determined, under criteria established by the State, that a need for such care exists. When the family is able to pay part or all of the costs of such care, the p'an is to provide for the payment of fees considered reasonable.

4. It must give priority, in determining the need for day care, to members of low-income or other groups in the population and to geographical areas with the greatest relative need for the extension of day care.

Definition of Child Welfare Services

The definition of child welfare services is clarified and somewhat broadened to read

> Public social services which supplement, or substitute for, parental care and supervision for the purpose of (1) preventing or remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children, (2) protecting and caring for homeless, dependent, or neglected children, (3) protecting and promoting the welfare of children of working mothers, and (4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible or, where needed, the provision of adequate care of children away from their homes in foster-family homes or day-care or other child-care facilities.

Training

Before the amendments, the law authorized grants for research or demonstration projects in the field of child welfare. The new law adds authorization for grants to public or other nonprofit institutions of higher learning for special projects for training child welfare personnel, including traineeships with such stipends and allowances as may be permitted by the Secretary.

COST OF AMENDMENTS

It is estimated that the Public Welfare Amendments of 1962 and the administrative actions taken in 1961 and 1962 by the Secretary of Health, Education, and Welfare will involve the expenditure in the fiscal year 1962–63 of nearly $300 million in addition to the amounts authorized by earlier law. Of these amounts, $97.9 million represents the cost of continuing the provisions for aid to families with dependent children in which need results from the unemployment of a parent, the foster-home care provisions, and the $1 increase in assistance payments in which Federal participation is available for the aged, the blind, and the disabled—all provisions enacted on a temporary basis in 1961.

The President, in the 1962–63 Budget, asked for a total of $190.1 million for this legislation (including the extensions of the temporary provisions). This figure covers the estimated amount of the increased Federal share of services and training costs, day-care costs, the inclusion in the recipient count of the second parent in needy families with dependent children, and the optional single program for the aged, the blind, and the disabled.

The President's Budget Message did not include the additional increase of more than $4 for each aged, blind, or disabled recipient of public assistance. This is the major item accounting for the higher cost of Public Law No. 87-543, as it was enacted.

Proposals for Health Insurance for the Aged

ADMINISTRATION PROPOSAL

On February 9, 1961, President Kennedy transmitted to Congress his recommendations relating to a health program. To help meet the problem of financing the high cost of illness in old age, the President recommended the addition of a health insurance program to the present old-age, survivors, and disability insurance system.

Under his proposal as transmitted, all persons aged 65 and over who are eligible for old-age, survivors, and disability insurance or railroad retirement benefits would be entitled to (1) up to 90 days of in-patient hospital services in a single spell of illness, subject to a deductible amount (to be paid by the patient) of $10 a day for up to 9 days, with a minimum of $20; (2) up to 180 days of skilled nursing-home services after discharge from a hospital; (3) hospital outpatient diagnostic services for all costs in excess of $20; and (4) visiting-nurse and related home-health services.

On February 13, a bill (H.R. 4222, the Health Insurance Benefits Act of 1961) proposing a program along the lines set forth by the President was introduced by Representative King of California. (A companion bill, S. 909, was introduced in the Senate by Senator Anderson.) The House bill was referred to the Committee on Ways and Means, which held public hearings from July 24 through August 4, 1961. There was no further congressional action in 1961 on health insurance for the aged.

In both his State of the Union Message of January 11, 1962, and his health message of February 27, President Kennedy renewed his 1961 request that the old-age, survivors, and disability provisions of the Social Security Act be amended to provide health insurance protection for the aged. On June 11, the House Ways and Means Committee went into executive session to consider the Administration's proposal for a health insurance program for the aged under the Social Security Act.

SENATE FLOOR DEBATE

Anderson Amendment

In the absence of action on the Administration's proposal by the House of Representatives or the Senate Committee on Finance, Senator Anderson, on June 29, 1962, presented to the Senate for himself, 20 other Democratic Senators, and 5 Republican Senators an amendment intended to be proposed to H.R. 10606, the public welfare bill. Although the amendment provided the same health insurance benefits that would have been provided under S. 909 (except that skilled nursing-home benefits would have been payable only for services furnished in facilities affiliated with a hospital), the proposed amendment made several significant modifications designed to meet various objections raised to certain provisions of S. 909.

These major modifications included provision for (a) the payment of health insurance benefits financed from general revenues for aged persons not eligible for monthly cash benefits under the old-age, survivors, and disability insurance or railroad retirement systems; (b) the use of approved private organizations, selected by hospitals or the other providers of services, in the administration of the program; and (c) an option under which beneficiaries could receive the health benefits through private insurance, group practice, and other voluntary plans, instead of through the Government.

Persons entitled to health insurance benefits.—One frequent criticism of S. 909 had been that it did not provide protection for the uninsured aged. The Anderson amendment would have provided for this uninsured group of 2½ million aged persons the same health benefits that would have been provided for those insured under old-age, survivors, and disability insurance and would have financed the protection for the uninsured from general revenues. Under the amendment, persons who reach age 65 before 1967 and who do not meet the regular insured-status requirements of the old-age, survivors, and disability insurance program would have been deemed insured for health insurance benefits only. The uninsured reaching age 65 after 1966 would have needed, to be deemed insured for health benefits, 3 quarters of coverage—with a minimum of 6—for each year elapsing after 1964 and before reaching age 65.

The special insured-status requirements for health insurance would therefore have "washed out" in 1970 for women and 1972 for men, since in those years the number of quarters that would have been required to qualify for health benefits would have been the same as the number required under present law for cash benefits under old-age, survi-

vors, and disability insurance. The effect of the special insured-status provision would have been to ensure for practically everyone aged 65 or over protection under the program, since most jobs are now covered by the Social Security Act.

Use of private organizations in administering the program.—The amendment would have considerably broadened the opportunity for use of private organizations in the administration of the program. Groups of "providers," or associations of providers on behalf of their members, would have been permitted to designate a private organization of their own choice to receive provider bills for services and to pay these bills. In addition, such organizations could have been authorized—to the extent the Secretary considered it advantageous—to perform related functions, such as auditing provider records and assisting in the application of utilization safeguards. The Government would have provided advances of funds to such organizations for purposes of benefit payments and as a working fund for administrative expenses.

During their testimony before the Committee on Ways and Means on H. R. 4222, representatives of the American Hospital Association recommended that the Government use the services of voluntary organizations, such as Blue Cross, to administer the health insurance program. The principal advantage hospitals and other providers of services saw in an arrangement of this sort was that the policies and procedures of the Federal program would be applied by the same private organizations that administer the existing health insurance programs from which providers now receive payments.

It was believed that the participation of Blue Cross plans and similar third-party organizations offered possible advantages that go beyond the benefits derived from their experience in dealing with various types of providers of services. Having such private organizations serve as intermediaries between the Government and the providers would have helped to reduce anxiety on the part of providers of service and certain segments of the public about possible Government intervention in hospital practices.

Private insurance option.—A basic premise of S. 909 was that private insurance would play the same important complementary role that it has played in old-age, survivors, and disability insurance—that is, health insurance under the Social Security Act would be a base on which a beneficiary could build private supplementary protection. Many persons expressed the conviction that the health insurance proposal should have allowed beneficiaries to have all their protection with private insurance companies and health benefits plans instead of having Government protection or to continue any private insurance protection they may have acquired before attaining age 65 without changing it into a policy designed as a supplement to the Government protection.

The amendment included a provision under which an individual who had an approved private health plan or policy in effect for a period before reaching reaching age 65—one furnishing at least all the benefits of the Government plan as well as some additional health benefits—could have an optional arrangement. He could, if he wished, have the Government reimburse the private organization with which he had the policy for the cost of the statutory benefits used. The carrier's administrative cost related to the payment of statutory benefits would have been included in the reimbursement.

The amendment would have required the beneficiary to make the election within 3 months after he became entitled to health insurance benefits. Only one such election would have been permitted, although a beneficiary could have later revoked his election if he desired.

To keep the administrative difficulties of dealing with private insurance carriers and health plans within reasonable limits the amendment also included criteria that private plans would have had to meet in order to qualify for handling the payments. Commercial nongroup carriers that are licensed in all 50 States and make at least 1 percent of all health insurance payments in the United States, or that were determined by the Secretary to be otherwise national in scope, would have qualified. A commercial nongroup carrier that could not meet these requirements would have qualified in a particular State if it did at least 5 percent of the health insurance business in that State. In addition, any other carrier that sells group health insurance would have qualified with respect to its group plans. Nonprofit plans would have been approved without regard to these requirements.

Additional modifications.—The Anderson amendment also modified or clarified certain provisions of S. 909 to give additional assurance that the Federal Government would not have exercised control over

providers of services. An amendment provided that hospitals accredited by the Joint Commission on the Accreditation of Hospitals (and many small hospitals are not ordinarily accredited) would have been conclusively presumed to meet all the statutory requirements for participation, save that for utilization review. In the event the Joint Commission adopted a requirement for utilization review, accredited hospitals would have been presumed to meet all the statutory conditions. In addition, the health and safety requirement was modified to permit the Secretary to prescribe further conditions only to the extent that these conditions were included in the requirements of the Joint Commission. Linking the conditions for participation to the requirements of the Joint Commission would have furnished assurance that providers would have been required to meet only professionally established conditions.

The provisions in S. 909 for a "hospital utilization committee" were replaced in the amendment by provisions for a "utilization review plan." A plan would have been required to provide for a review of admissions, length of stays, and the medical necessity for services furnished as well as the efficient use of services and facilities. The amendment specified that such review take place within 1 week following the twenty-first day of each period of continuous hospitalization and subsequently at such intervals as may have been specified in regulations. The utilization committee would also have been required to notify the attending physician of its findings and provide an opportunity for consultation between the commitee and the physician. The utilization review plan of a hospital would have been extended to include review of admissions and length of stays in a skilled nursing facility affiliated with the hospital.

The Joint Commission, which has been considering adding utilization review as an accreditation requirement, has not decided what form the requirements should take. The utilization review requirement in the amendment therefore provided that both hospital staff reviews and other types of physician review arrangements outside the hospital would have been acceptable for purposes of the proposed program.

In addition, the amendment included several technical changes to take into account suggestions made by various professional organizations. The definition of the terms "drugs" and "biologicals," for example, was expanded to include those drugs listed in *Accepted Dental Remedies* and those approved by a drug or pharmacy committee of the hospital furnishing such drugs. The provisions relating to the definition of a "skilled nursing facility" were also revised to include only such a facility affiliated or under common control with a hospital. This more restrictive requirement was added to provide greater assurance that payments would have been made only to those skilled nursing facilities that have adequate medical supervision.

Financing.—The proposed amendment would have provided for an increase in the social security contribution rates of ¼ of 1 percent for employers and for employees and 4/10 of 1 percent for the self-employed. (The latter rate would have been ⅜ of 1 percent under S. 909.) The taxable earnings base would have been increased from $4,800 to $5,200 ($5,000 under S.909) a year. A separate health insurance trust fund would have been established for the program; S.909 would have provided for one social insurance trust fund with separate accounts for old-age and survivors benefits, disability benefits, and health insurance benefits, respectively.

Alternative Proposals

On the floor of the Senate, three major alternatives to the health insurance program proposed in the Anderson amendment were debated. All the alternatives accepted the need for additional Federal action with respect to financing the health care costs of aged persons but proposed to meet this need either by providing Federal funds to States or by providing a cash supplement to monthly old-age and survivors insurance benefits to help meet the cost of private insurance premiums.

The Morton amendment.—Senator Morton proposed on July 5 an amendment under which States offering approved group insurance plans for the aged through private carriers would have received Federal reimbursement for the cost of the premiums paid on behalf of eligible aged persons. Anyone participating in the State program could have elected to receive either ordinary or catastrophic illness coverage. Group-practice, service, and indemnity-benefit private plans would all have been eligible to participate under State programs. It would have been necessary for State programs to receive the Secretary's approval.

General Federal revenues would have been used to reimburse the States for costs up to $125 a year per participant. States would have paid the administrative costs of the program, plus any premiums in excess of $125 per person. Individuals with a Federal income-tax liability would have paid up to $100 toward their own premiums; the exact amount would have been dependent upon the amount of the liability.

Senator Morton estimated the initial costs of his proposal at about $1.3 billion a year. Senator Anderson suggested that the cost of the Morton proposal could have run as high as $2 billion a year.

The Morton amendment was defeated by voice vote on July 6, 1962.

The Saltonstall amendment.—The amendment proposed by Senator Saltonstall on July 9, 1962, was essentially the same proposal as S. 937, the bill introduced on February 13, 1961, by Senator Javits for himself and eight other Republican Senators, including Senator Saltonstall. This amendment, like the Morton amendment, would not have used social security financing. It would have provided for a program of Federal matching grants to the States for health benefits for the aged, furnished under a State plan approved by the Secretary of Health, Education, and Welfare.

State plans would have been required to offer the aged individual a choice between three types of packages: (1) short-term illness benefits covering up to 21 days of hospital services, up to 63 days of skilled nursing-home services (with substitution for hospital days permitted at a ratio of 3 to 1), up to 12 physician visits, outpatient diagnostic services, and up to 24 days of home health services; (2) long-term illness benefits with 80-percent coinsurance and a "deductible" of $175 for a maximum of 120 days of hospital care, surgical services, skilled nursing-home services, home health services, and certain other services at the option of the State; and (3) private insurance benefits, consisting of payment of half the premiums for a private health insurance policy, with the maximum payment amounting to $60 a year.

The Federal matching would have ranged from 33⅓ percent to 66⅔ percent. An individual whose income exceeded $3,000 and a married couple with income of more than $4,500 would have been required to pay enrollment fees related to income.

The Saltonstall amendment was defeated by a vote of 50 to 34 on July 12, 1962.

The Bush amendment.—On July 9, Senator Bush proposed an amendment under which reimbursement from social security trust funds would have been made to aged beneficiaries of old-age, survivors, and disability insurance for premiums paid for voluntary insurance. Beneficiaries would have been reimbursed, up to $9 a month, for the cost of premiums paid for any guaranteed renewable health insurance. To finance the program, the employer-employee contribution rate for old-age and survivors insurance purposes would have been increased 0.5 percent and the self-employed contribution rate, 0.375 percent. At $108 a year for 12.2 million beneficiaries—the number Senator Bush estimated would take advantage of the program—costs would be $1.3 billion in the initial year.

The Bush amendment was defeated on July 13, 1962, by a vote of 74 to 5.

Changes in Anderson Amendment

During the course of debate on the Senate floor, several amendments to the Anderson amendment were proposed and either accepted by Senator Anderson or approved by a vote of the Senate.

On July 12, Senator Javits proposed an amendment designed to modify the provisions of the Anderson amendment relating to the beneficiaries' option to continue private health insurance protection. Under his proposal, an approved private plan could have provided, in place of the 90-day hospital benefit with a deductible, a 45-day hospital benefit with no deductible. Group insurance plans, prepayment group-practice plans, nonprofit plans, and plans having acquisition costs comparable to those of approved group plans would have been qualified to offer the option of either the 90-day hospital benefit or the 45-day hospital benefit. Other nongroup plans would have been permitted to offer only the 90-day hospital benefit. The amendment changed the period during which a person would be required to have been covered by the approved plan from the 5 years that would eventually have been required under the Anderson amendment to only 1 year in group and nonprofit plans and 2 years in commercial individual policies. Senator Anderson accepted Senator Javits' proposal and modified his amendment accordingly.

An amendment proposed by Senator Carroll contained a declaration of congressional intent that

enactment of a health insurance benefits program should not result in the loss of any benefits to which an individual may be entitled under a State medical care program. This amendment was approved by voice vote on July 13.

On July 16, a proposal by Senator McNamara to modify the "benefit period" provision of the Anderson amendment was accepted by Senator Anderson. A "benefit period" was defined as a period beginning with the first day covered services are furnished and ending with the ninetieth day thereafter (not necessarily consecutive) on each of which the beneficiary is not an in-patient in a hospital or skilled nursing facility.

On July 17, Senator Anderson also accepted a modification of his amendment proposed by Senator Muskie. Skilled nursing facilities that are not affiliated with a hospital would have been permitted to participate if the Secretary, on the basis of full and complete study, determined that they were equipped to provide good quality care and that their participation would not create an actuarial imbalance in the Federal health insurance trust fund.

On July 17, the Senate voted to table the proposed Anderson amendment. The vote was 52 to 48.

Major Legislative Documents in the Field of Social Security—Eighty-seventh Congress

PUBLIC LAW 87–31—AID TO DEPENDENT CHILDREN OF UNEMPLOYED PARENTS

President's Message—Program To Restore Momentum to the American Economy (H. Doc. No. 81), February 2, 1961.

H.R. 3865 introduced February 6, 1961.

Hearings on H.R. 3865 before the Committee on Ways and Means, House of Representatives, February 15, 16, and 17, 1961.

H.R. 4884 introduced February 27, 1961, reported February 27, 1961, and passed by the House of Representatives March 10, 1961.

Report of the Committee on Ways and Means, House of Representatives, on H.R. 4884 (Report No. 28), February 27, 1961.

House of Representatives debate on H.R. 4884, March 10, 1961, *Congressional Record* (Vol. 107, No. 43).

Report of the Senate Committee on Finance on H.R. 4884 (Report No. 165), April 14, 1961.

H.R. 4884 reported by the Senate Committee on Finance, April 14, 1961, and passed by the Senate, April 20, 1961.

Senate debate on H.R. 4884, April 20, 1961, *Congressional Record* (Vol. 107, No. 67).

Conference Report on H.R. 4884 (H. Rpt. No. 307), April 25, 1961.

House and Senate debate on Conference Report on H.R. 4884, April 26 and 27, *Congressional Record* (Vol. 107, Nos. 70 and 71).

Public Law 87–31, signed by President Kennedy, May 8, 1961.

PUBLIC LAW 87–64—SOCIAL SECURITY AMENDMENTS OF 1961

President's Message—Program To Restore Momentum to the American Economy (H. Doc. No. 81), February 2, 1961.

H.R. 4571 introduced February 20, 1961.

Executive Hearings on H.R. 4571 before the Committee on Ways and Means, House of Representatives, March 9, 13, 22, 24, and 27, 1961.

H.R. 6027 introduced March 29, 1961, reported April 7, 1961, and passed by the House of Representatives April 20, 1961.

Report of the Committee on Ways and Means, House of Representatives, on H.R. 6027 (Report No. 216) April 7, 1961.

House of Representatives debate on H.R. 6027, April 20, 1961, *Congressional Record* (Vol. 107, No. 67).

Hearings on H.R. 6027 before the Senate Committee on Finance, May 25 and 26, 1961.

Report of the Senate Committee on Finance on H.R. 6027 (Report No. 425), June 20, 1961.

H.R. 6027 reported by the Senate Committee on Finance June 20, 1961, and passed by the Senate June 26, 1961.

Senate debate on H.R. 6027, June 26, 1961, *Congressional Record* (Vol. 107, No. 106).

Conference Report on H.R. 6027 (H. Rpt. No. 611), June 28, 1961.

House and Senate debate on Conference Report on H.R. 6027, June 29, 1961, *Congressional Record* (Vol. 107, No. 109).

Public Law 87–64, signed by President Kennedy, June 30, 1961.

President's Statement, The White House, June 30, 1961.

PUBLIC LAW 87–543—PUBLIC WELFARE AMENDMENTS OF 1962

President's Message—Public Assistance and Welfare Program (H. Doc. 325), February 1, 1962.

H.R. 10032 introduced February 1, 1962.

Hearings on H.R. 10032 before the Committee on Ways and Means, House of Representatives, February 7, 9, and 13, 1962.

Report of the Ad Hoc Committee on Public Welfare (printed in House hearings on H.R. 10032, pages 65–106).

Report for the Secretary of Health, Education, and Welfare, by George Wyman (printed in House hearings on H.R. 10032, pages 107–157).

Administrative actions taken by Secretary Ribicoff (printed in House hearings on H.R. 10032, pages 158–164).

Report of the Advisory Council on Child Welfare Services (printed in House hearings on H.R. 10032, pages 221–278).

H.R. 10606 introduced March 8, 1962, reported March 10, 1962, and passed by the House, March 15, 1962.

Report of the Committee on Ways and Means, House of Representatives, on H.R. 10606 (Report No. 1414), March 10, 1962.

House of Representatives debate on H.R. 10606, March 16, 1962, *Congressional Record* (Vol. 108, No. 38).

Hearings on H.R. 10606 before the Senate Committee on Finance, May 14, 15, 16, and 17, 1962.

Report of the Senate Committee on Finance on H.R. 10606 (Report No. 1589), June 14, 1962.

H.R. 10606 reported by the Senate Committee on Finance, June 14, 1962, and passed by the Senate, July 17, 1962.

Senate debate on H.R. 10606, July 3–17, 1962, *Congressional Record* (Vol. 108, Nos. 112–121).

Conference Report on H.R. 10606 (H. Rpt. No. 2006), July 13, 1962.

House and Senate debate on Conference Report on H.R. 10606, July 19, 1962, *Congressional Record* (Vol. 108, No. 123).

Public Law 87–543, signed by President Kennedy, July 25, 1962.

President's Statement, The White House, July 26, 1962.

HEALTH INSURANCE FOR THE AGED

H.R. 4222 and S. 109, introduced February 13, 1961.

President's Health Message (H.Doc. No. 85), February 9, 1961.

Hearings on H.R. 4222 before the Committee on Ways and Means, House of Representatives, July 24, 26, 27, 28, and 31 and August 1, 2, 3, and 4, 1961.

Secretary Ribicoff's *Report on Health Insurance* (printed in House hearings on H.R. 4222, Vol. 1, pages 67–180).

Actuarial Cost Estimates for Health Insurance Benefits Bill, Actuarial Study No. 52, Social Security Administration (printed in House hearings on H.R. 4222, Vol. 1, pages 41–66).

President's Message—Health Program (H. Doc. No. 347), February 27, 1962.

Amendment to H.R. 10606 proposed by Senator Anderson (Amendment 6–29–62–A).

Senate debate on Anderson amendment to H.R. 10606, July 3–17, 1962, *Congressional Record* (Vol. 108, Nos. 112–121).

S. 3565 introduced July 25, 1962 (identical with amendment to H.R. 10606 tabled by Senate July 17, 1962).

the HEALTH CARE of the AGED

background facts relating to the financing problem

UNITED STATES DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

Social Security Administration
Division of Program Research

Washington : 1962

Foreword

When the Supreme Court of the United States sustained the constitutionality of the old-age insurance provisions of the Social Security Act, Mr. Justice Cardozo, in writing the opinion of the Court, said, "the hope behind this statute is to save men and women from the rigors of the poor house as well as from the haunting fear that such a lot awaits them when journey's end is near." Now, a quarter century later, that hope has been largely realized. The social security program, founded on sound principles and since strengthened, has indeed done a great deal to provide economic security in old age and to relieve the haunting fears of poverty.

For the vast majority of the aged, however, there remains a major obstacle to their peace of mind and for all too many to their security and independence. It is the high costs of ill health in old age and the inability of many of the aged to meet these costs. A nation that cherishes independence and self-reliance and that has undertaken to help maintain these values through a sound system of social security cannot afford to let catastrophic health costs stand in the way of old-age security. The considerations that led to the enactment of the social security program more than a quarter century ago now point unmistakably to the addition of health insurance for the aged to this program.

As life expectancy has increased, bringing with it increased medical burdens of old age, it has become clear that provision for basic health insurance must be made a part of the program of retirement protection in the Social Security Act. Seeing the plight of their parents, people are coming to realize that insurance protection against the costs of hospital care in old age, like insurance providing for basic retirement income, requires use of the social security method. Nongovernmental programs, of course, are an important way of supplementing old-age insurance, and public assistance is a necessary back-stop for those with special needs.

It is plain from the wealth of data set forth in this report that the aged as a group have much greater health care needs than younger people and that the costs of meeting these needs are much greater than the aged, with their limited resources, can possibly afford to pay. Their incomes are lower than those of younger persons. Likewise, health insurance for the aged is far more expensive than for younger

persons, and adequate health insurance is beyond the reach of most of the aged. Public assistance programs are least effective in the low income States, where need is most prevalent. Some people cannot undertake to meet the cost of the serious illnesses of their aged parents without themselves suffering hardship. Some cannot take on this burden without facing the painful decision to do less than they should in providing education for their children and meeting other basic family needs.

It is imperative that the aged have basic insurance protection against the cost of needed hospital care. Of all health costs faced by the aged, the cost of hospital care is the one most likely to be catastrophic. Insurance to cover the costs of such care cannot be financed solely out of the incomes of the aged themselves. Social security protection, financed by payments made during the working years, supplemented by private programs and backed up by the Federal-State public assistance provisions for medical care, is the only way to a truly effective solution of the problem.

We have in our social security system an effective mechanism for providing retirement income in old age. This same system enables us to finance health care for the aged. It is time we used it for this purpose. Without health insurance protection under social security, the promise of freedom from the fear of want in old age cannot be truly met.

ABRAHAM RIBICOFF,
Secretary of Health, Education, and Welfare.

Preface

Financing the health care of aged persons is now widely acknowledged to be a matter of social concern. Decisions as to how community responsibility in this area is to be met should rest on a full appraisal of needs and existing resources.

Within the past year there has become available new and current information relating to the health needs of the aged and the relative incomes of young and of older families. These data present the same general picture of greater medical need and more limited income and resources among the aged that emerged from earlier studies, which were summarized in the Reports submitted by this Department to the Committee on Ways and Means of the House of Representatives in April 1959 and July 1961. The new data fill in certain details as to how the aged manage and the nature of the problem for them and their children, that have not hitherto been available.

There has now been almost a year and a half of experience under the new program of medical assistance for the aged that was adopted in 1960. We are thus in a position to appraise what this program is accomplishing.

It has seemed useful and timely to bring together under one cover the most current information and background facts relating to the health care problems of the aged and the existing methods of meeting their medical care costs, including private health insurance and public programs.

An appendix to this report summarizes the many and varied proposals that have been made since the late 1930's for Federal legislation to provide health insurance for the aged, to stimulate the spread of voluntary health insurance or to support State medical care programs.

No one report can provide all the reference data that may be needed by those who are concerned with the formulation of detailed policy relating to so important and far-reaching a problem as the health care of the aged. This report attempts to present the more significant background facts in a form that will be useful to anyone who is seriously studying the problem and the issues it raises.

Ida C. Merriam,
Director, Division of Program Research.

Contents

TEXT TABLES—Continued

TEXT TABLES—Continued

SUMMARY

New developments in medicine and the better living conditions attendant upon our growing productivity now keep more and more people alive beyond the biblical span of three-score-and-ten. At the same time, there is a tendency to retire the worker from active employment at a progressively younger age—leaving him more years to get along on reduced income.

OASDI and related income-maintenance programs developed over the last quarter century assure continued basic self-support for most persons after they reach age 65. Years of prosperity and advancing wage levels bring to many persons in later life some security in owned homes and other savings accumulated during the working years. But for nearly all the burden of health costs casts a heavy shadow over the prospects of retirement.

Persons 65 and over now total over 17 million, and their number is growing faster than the rest of the population. Today out of every 11 persons, one has passed his 65th birthday. By 1980, the proportion may well be more than 1 out of 10 and the number 25 million. Because women tend to outlive men, the aged population includes a disproportionate share of widows. Indeed, the 65 and over group has almost as many widows as married men. Close to half of the widows are past 75. It is in the oldest age groups that illness costs become especially high, and it is usually the widows who have the least financial resources.

The majority of the aged maintain independent living arrangements: About 7 in 10 live alone or with a spouse or one other relative; little more than half a million in all live in institutions. While independent living brings its own satisfactions, it usually means living on a rather restricted budget, and often with no one at home to help out during illness.

Few at age 65 can count on continuing to earn their living for the remaining years of life. In mid-1961, fewer than 1 in 4 of those 65 and over had any income from employment, even counting wives whose husbands worked. Furthermore, most of those who worked were not working full-time, merely supplementing payments under a public program. More than 9 in 10 aged persons now receive income from some public program, whereas only 1 in 20 is still working and drawing no income from a public program.

Public programs obviously are limited in what they pay. On the average, the aged person has to get along on only half as much income as the younger person in a family of the same size. While the older person's total needs are less than those of the younger person, they are far from 50 percent less.

Today 9 out of 10 workers are accumulating credits towards retirement benefits under the OASDI program. Persons currently drawing benefits, or eligible to do so if they choose to retire, already number three-fourths of those 65 or older and eventually should include almost every one. (The few not included will for the most part come under one of the other public retirement and income-support programs.)

Although OASI benefits to retired workers have been rising, the current average monthly payment of $76, or even the current maximum of $125 for a retired worker or $187 for an aged couple, is not likely to make for comfortable living without additional resources, particularly when serious illness strikes.

Medical bills for the aged person come high, judged both in terms of the dollar total and in the light of his limited resources. Older persons pay out more for medical care than young persons, and these payments take a larger share of their small income—and the share would be even greater if all the elderly got and paid for the care they needed.

How much care do the aged need? Persons 65 and over are twice as likely as younger persons to suffer a chronic condition, and 6 times as likely to have one restricting or limiting activity. By age 75 every fourth person (not in an institution) is totally unable to carry on normal activity—work or keep house. The average old person is incapacitated 5 weeks of the year by illness or injury, with two of these weeks spent in bed.

Aged persons as a group see doctors and get medical attention more than younger persons, but many, particularly those with low income, go without care that could bring relief. From 40 to 50 percent of those who have arthritis and rheumatism, or hernias, or who have trouble seeing or hearing, for example, and one out of 7 with a heart condition, are not currently under medical care. It is the aged in families with low incomes who are more likely to have incapacities and illnesses, but it is those in families with high incomes who see the doctor more often.

Hospital care for anyone poses a special problem because of the large and usually unexpected bills, making it difficult to plan ahead of time. It is especially difficult for the aged. The aged person has a 1 in 6 chance of going to a hospital in a given year, somewhat higher odds than for the person under 65. Also, once he is admitted, the aged person can count on staying an average of two weeks, as opposed

to one week for younger patients. Thus, he can expect a hospital bill twice that of his younger fellow patient. What makes the situation still worse is that less of the older person's bill will be met by insurance.

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

Sometimes the aged person himself discontinues the protection he had before retirement, because he no longer has the advantage of the lower group rate and must pay more on an individual basis—and usually for less adequate benefits. In addition the share paid by the employer is often stopped altogether, leaving much higher premium costs at the time income is sharply cut.

No more than half the aged today have any protection against hospital costs—the most common form of health insurance. According to the National Health Survey, just about half the elderly patients discharged from a short-stay hospital had no part of the hospital bill paid by insurance. Such insurance as was available was more likely than not to cover only short stays. Insurance took care of as much as three-fourths of the bill for 6 out of 10 stays under a month, and fewer than 5 out of 10 lasting a month or more.

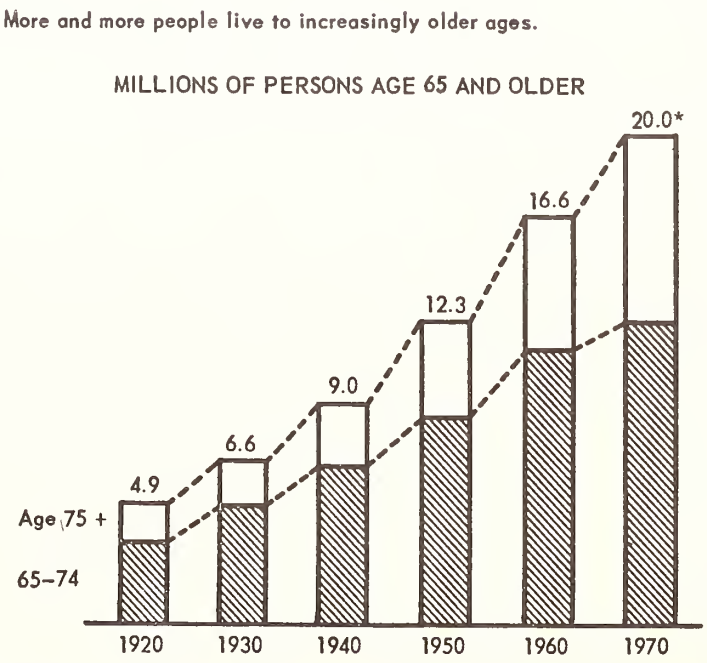
Although the average elderly patient leaves the hospital within two weeks, nearly 1 in 10 remains a month or longer. The longer his hospitalization lasts the more likely is the aged person to need help in paying for his care. Among OASI beneficiaries in a general hospital 3 out of 4 of those staying as long as 2 months, and 1 out of 2 of those hospitalized for shorter periods could not assume responsibility for all of their own medical costs.

The burden of paying for hospital care is even greater when one takes account of those who do not leave the hospital alive. Terminal illnesses often are especially expensive and those at the older ages, most likely to die, are least likely to have any insurance. Often they leave a legacy of debt with a heavy burden on surviving widows.

No one can foresee just when he will enter the hospital—although 9 out of 10 persons who reach age 65 are sure to go at least once in their remaining lifetime. But all the evidence indicates that the year one does have to go will be characterized by unusually high medical bills of all kinds. In 1957–1958, for example, hospital care costs, excluding those paid out of public funds, averaged $49 per person 65 or older.

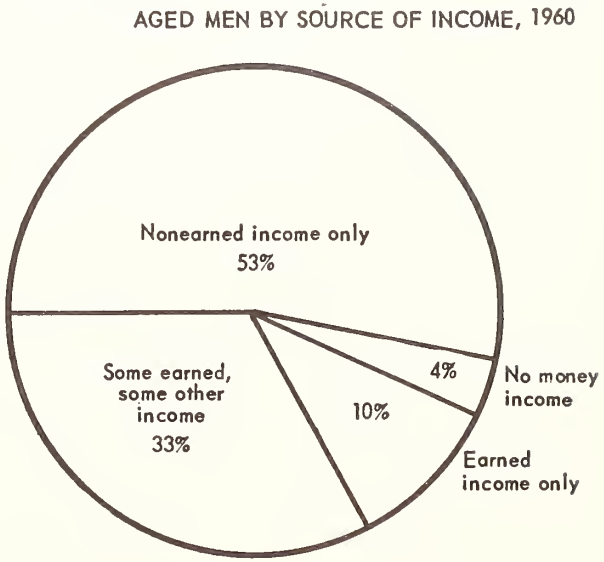
HEALTH PROBLEMS OF THE AGED

1. More and more people live to increasingly older ages.

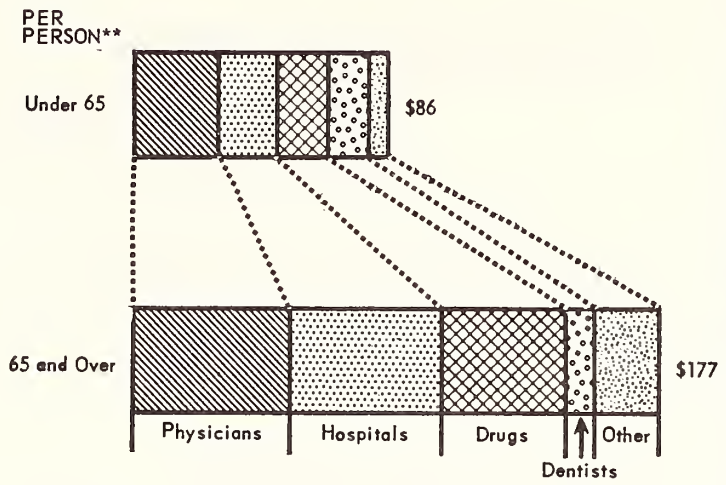


*Projected

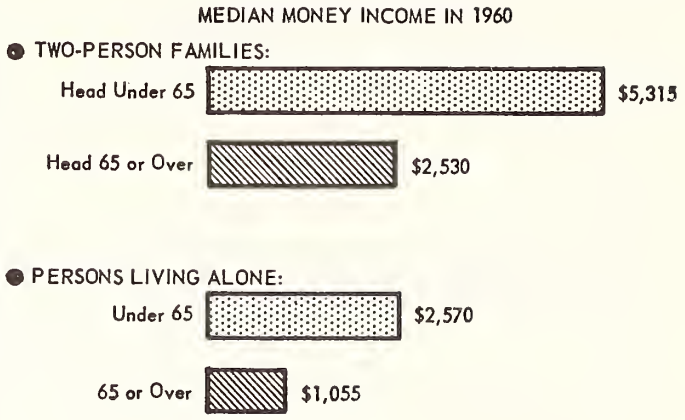
2. Few men over 65 are still working; most depend in part on public programs.



3. Average medical expenses in a year are at least twice as high in old age.



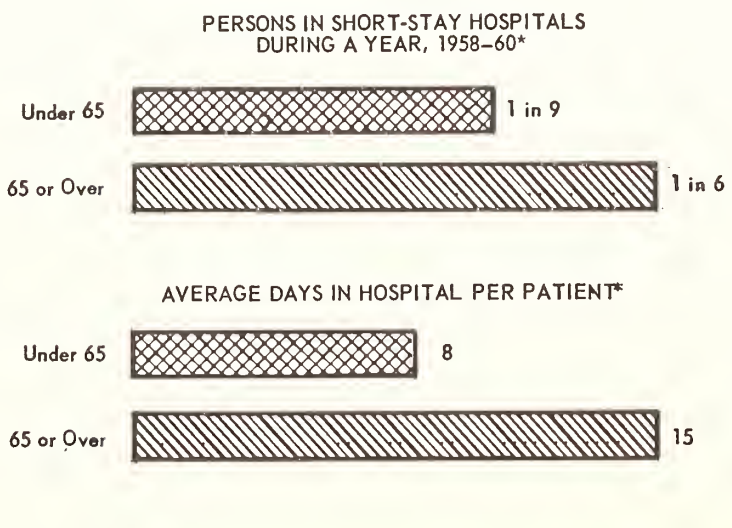
4. With most of them retired, income of the aged average much lower than the rest of the population.



**In 1957–58; excludes private expenditure for nursing home care and all care at public expense.

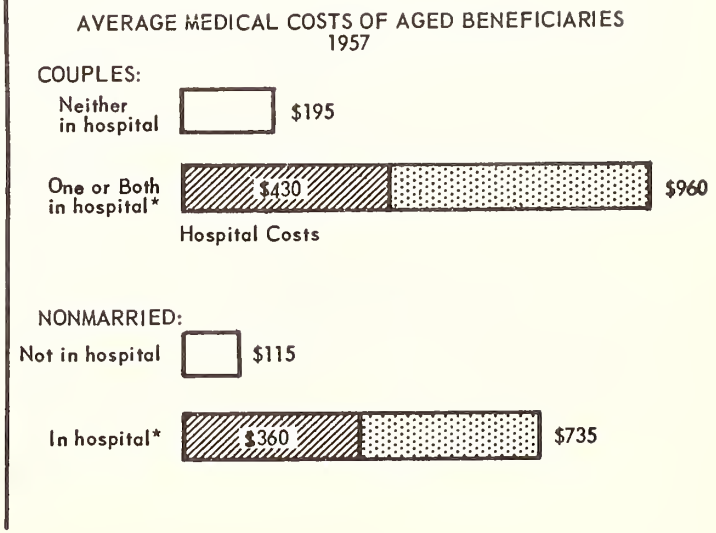
HEALTH PROBLEMS OF THE AGED

5. Old people go to the hospital more often and stay longer than younger persons.



*Adjusted to allow for decedents.

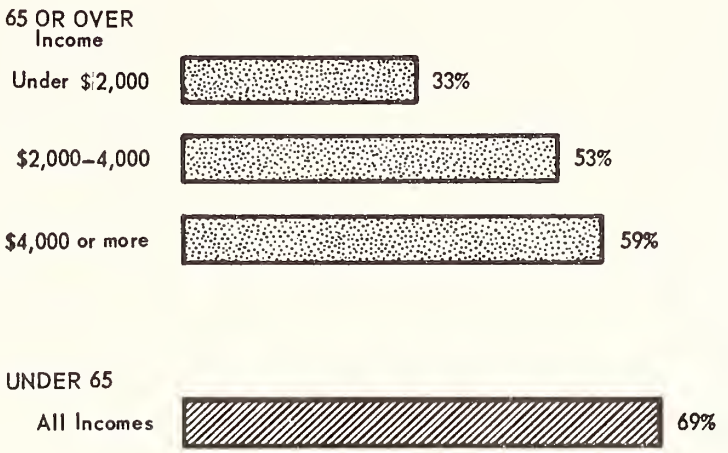
6. Hospital stays bring extra large total medical bills for the year.



*General hospital; excludes persons in chronic-care institution only.

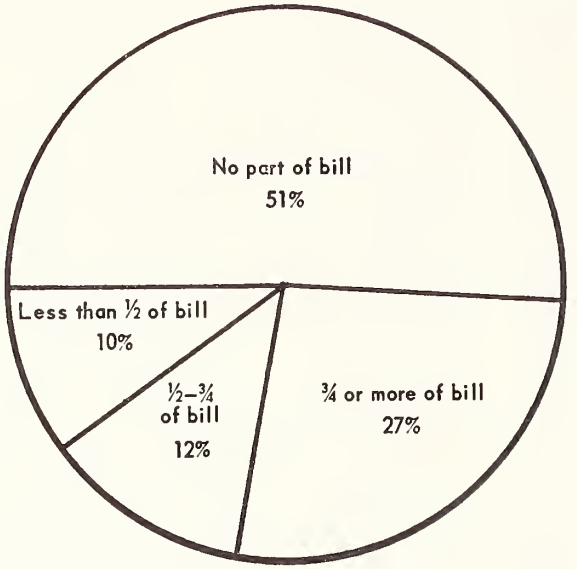
7. Only half of the aged have any insurance for medical bills.

HOSPITAL INSURANCE, 1959



8. For a majority of the hospital stays of the aged, insurance pays less than half of the bill.

PORTION OF HOSPITAL COSTS MET BY INSURANCE FOR EPISODES IN SHORT-STAY HOSPITALS, 1958–60



For those who actually had a hospital illness, however, costs were 7 times this much. Their doctors' fees for inhospital visits were twice as great as the average total bill for all doctors' visits in the year—in or out of hospital.

Aged OASI beneficiaries in general hospitals during 1957 had total medical bills for the year 5 times as high as those with no hospital illness—not counting the costs of persons unable to report them, often because some care was given without charge or paid for directly by a public or private agency. For beneficiaries who went to a hospital, the hospital charges alone represented close to half the total medical bills for the year. They were two to three times as large, on the average, as the total medical costs for the year for beneficiaries who did not have a hospital illness.

At December 1961 prices an elderly couple with one or both members receiving hospital care could expect their combined total medical bills for the year to total about $1,160. For the elderly person without a spouse, a hospital stay might mean average medical bills for the year of about $895. With half the aged couples having less than $2,500 income and more than half the other aged persons less than $1,000 it is obvious that most of them would be hard put to pay such a bill and still have enough left for groceries and housing—unless they had the benefit of health insurance, could count on getting free care or received help from relatives. Indeed, more than two-fifths of the beneficiary couples and roughly three-fifths of the nonmarried beneficiaries who were in a general hospital in 1957 did not meet all the year's medical costs out of their own income, assets or health insurance.

Except for an owned home, few of the aged have assets in substantial amounts. Those who do are more likely to be the relatively small number who already have the advantage of higher income. Sometimes the aged person with low income and some savings must choose between using them for every day needs, or doing without some essentials so as to leave savings intact for a medical emergency.

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

Some aged persons with medical problems ask for public assistance—either to meet the emergency itself, or for regular living needs after using their resources to pay for the medical care. In the first half of 1961, just about every third person approved for old-age assistance needed it directly or indirectly as a result of health difficulties. Among recipients getting the assistance to supplement OASI benefits—generally those with the greatest economic resources of their own—the proportion obtaining assistance on account of medical needs was as high as 2 in 5. Currently about half the aged going on the OAA rolls are OASI beneficiaries.

The kinds of medical services and the amount of care provided through public assistance vary greatly from State to State. Some State public assistance programs pay for relatively comprehensive services, others meet emergency medical needs only. In January 1962, vendor payments for medical care under old-age assistance averaged $13.62 per recipient; the range was from a low of 24 cents to a high of $61.29 per recipient per month.

The 1960 Amendments to the Social Security Act increased the Federal matching funds for vendor payments under old-age assistance. They also provided Federal matching grants for a new program of medical assistance to aged persons not eligible for old-age assistance but whose income and resources are insufficient to meet the cost of needed medical care. As of March 1962, medical assistance for the aged programs were in effect in 23 States, Puerto Rico, the Virgin Islands and Guam. The services provided under these new programs also vary widely. Currently, about five-sixths of all expenditures under the MAA program are being made in two States, States that transferred to MAA most of the nursing care cases on their OAA rolls. Liberalization of the Federal contribution in the federally-aided assistance programs, has often meant more improvement in States already doing a better-than-average job than in those where standards and available funds were low.

Many aged persons get medical care at public expense or at reduced rates. Probably close to 30 percent of total public expenditures for patient care in hospitals goes for treatment of the aged, who comprise only 9 percent of the population.

Hospital care, more costly and more often emergency in character, may be more likely to be obtained without charge than other types of service. In any case, aged persons with no health insurance and in need of hospitalization are more likely to go to a public hospital than patients with health insurance. Public hospitals more commonly than private institutions must tailor their charges to ability to pay, including taking as a public charge those who cannot pay at all.

Total public and private expenditures for medical care for aged persons are estimated to have been about $5 billion in 1960, or ap-

proximately 1 dollar out of every 5 spent for personal medical care services. Only 1 person in 11 is aged 65 or over. Public programs are now responsible for more than 1 dollar in every 4 spent for medical care for persons aged 65 and over. Thus much of the burden of medical care of the aged population already falls on the community at large. One may well question, however, whether the cost of this burden is prorated among all our citizens in the most efficient and equitable fashion.

Over the past decade, prices of all goods have gone up, but not as much as has income of the population. Real income, as measured in purchasing power, has improved for most Americans. On the other hand, medical care prices, and especially the cost of hospital care, have risen more than other prices, and by and large have outstripped gains in income. This has been a serious problem for all low-income groups; and particularly so for persons currently age 65 and over—many of whom receive retirement benefits based on low lifetime earnings.

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

Wage and salary levels of hospital employees have now largely caught up with those in other service industries and will probably increase in the future at more or less the same rate as general wage levels. We have certainly not reached the end of changes in medical science and technology. New breakthroughs in knowledge which can be expected from the large investments now being made in medical research may further increase the unit cost of medical care or they may drastically reduce prolonged illness and the cost of medical services.

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

By and large, in planning for the next decade, it seems reasonable to assume that the overall cost of medical care will increase at about the same rate as our total national output. Whatever the future costs may be, the question of how the benefits of modern medicine can best be assured to all who need them will be one of the most important challenges to our social ingenuity.

PART I

Characteristics and Health Needs of the Aged

CHAPTER 1. NUMBER AND CHARACTERISTICS OF THE AGED

The United States has a rapidly growing total population and an even more rapidly expanding population 65 years and older. Advances in medical technology, improvements in living standards, and other factors have increased life expectancy at birth to an overall average of 70 years. Those who live to be 65 can look forward to reaching on the average age 79 or 80. This lengthening life span, accompanied by a lowering of the age at which workers voluntarily or involuntarily withdraw from the labor force, brings with it its own special problems. A growing number survive to face the illnesses and infirmities of age, but many do not have the income to pay for the care they need and which modern medicine has to offer. For most of our aged, basic self-support in retirement is largely assured by old-age, survivors and disability insurance and related income-maintenance programs developed over the last quarter century except for burden of medical care costs in retirement.

Persons aged 65 and over now number about 17¼ million, or more than 9 percent of the population of the United States, and in less than another decade, it is expected they will exceed 20 million, and by 1980, 25 million. During the 1950's the proportion of persons aged 65 and over in the population increased 35 percent (table 1), or from 1 in 12 to 1 in 11, and by 1980, they may well make up more than 1 in 10 of the total.

In two-fifths of the States at least 10 percent of the population was aged 65 and over on April 1, 1960 and in only eight States and Puerto Rico were there fewer than 7 percent. (Appendix A, table 1)

Characteristics of persons 65 and over

The growth in the aged population has been accompanied by a change in its composition. There has been an increase in the relative numbers of women and, also, of persons in the 85 and over age group. These are trends which will continue.

TABLE 1.—*Age and Sex: Number and distribution of persons 65 and over in the United States,*[1] *1950 and 1960*

	Age						
	Total	65 to 69	70 to 74	75 to 79		80 to 84	85 and over
Number (thousands):							
Total, 1960	16,560	6,258	4,739	3,054		1,580	929
Male	7,503	2,931	2,185	1,360		665	362
Female	9,057	3,327	2,554	1,694		915	567
Total, 1950	12,295	5,013	3,419		[2] 3,284		578
Male	5,813	2,431	1,633		1,511		238
Female	6,482	2,582	1,786		1,773		340
Percent distribution:							
Total, 1960	100.0	37.8	28.6	18.4		9.5	5.6
Total, 1950	100.0	40.8	27.8		26.7		4.7
Percent female of total:							
1960	54.7	53.2	53.9	55.5		57.9	61.0
1950	52.7	51.5	52.2		54.0		58.8
Percent increase, 1950 to 1960:							
Total	34.7	24.8	38.6		41.1		60.7
Male	29.1	20.6	33.8		34.0		52.1
Female	39.7	28.9	43.0		47.2		66.8

[1] Includes Alaska and Hawaii in 1950 as well as 1960.
[2] Breakdown not available for 1950.

Source: Bureau of the Census, *United States Census of Population: 1960, General Population Characteristics, United States Summary* (Final Report PC (1)-1B), August 1961.

On reaching 65, women now have a life expectancy of 15.5 years; men, a life expectancy of 12.7 years.[1] In 1960, among the aged 65 and over there were more than 6 women to every 5 men (Chart 1). By 1980 the ratio will approach 7 to 5.

Accompanying the change in sex composition will be further aging of the population 65 years and older. Persons 85 and older made up 5.6 percent of the older population in 1960 as compared to 4.7 percent 10 years earlier, and may reach 8 percent by 1980.

In light of the sex-age composition of the 65 and over group, it is not surprising that the widowed make up almost two-fifths of this age group. Men are almost twice as likely as women to be living with a spouse, because their average age is less than that of women and, also, typically their wives are younger than they. About 7 in 10 of the men, but fewer than 4 in 10 of the women 65 and over, live with a spouse. Women are two and one-half times as likely as men to be widowed. Indeed, there are almost as many aged widows as there are married men aged 65 and over in the United States. Almost half of these widows are 75 and over (table 2).

With 2½ million who have passed their 80th birthday, and well over 900,000 who have passed their 85th, it might be expected that substantial numbers would be in institutions such as chronic care hospitals, nursing homes, and homes for the aged. The decennial

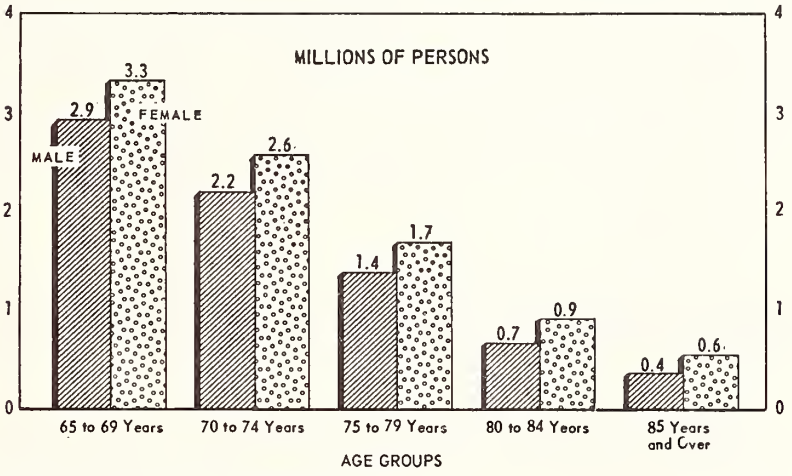
[1] Public Health Service, National Office of Vital Statistics, *Life Tables*, 1959, 1961.

TABLE 2.—*Marital Status and Living Arrangements: Distribution of persons 65 and over, by sex and age, for the United States, March 1961*

Status	Total 65 and over	Male			Female		
		Total	65 to 74	75 and over	Total	65 to 74	75 and Over
Total, 65 and over	100.0	44.8	29.8	15.0	55.2	35.0	20.2
Married, spouse present	50.9	31.2	23.0	8.3	19.7	15.5	4.1
Other, by marital status:							
Widowed	38.6	9.1	3.8	5.3	29.5	15.5	14.0
Separated	2.1	1.1	.8	.4	1.0	.8	.2
Divorced	1.5	.6	.4	.2	.9	.6	.3
Never married	6.8	7.7	1.8	.8	4.1	2.6	1.6
Other, by living arrangements:							
In families	23.1	6.0	2.6	3.3	17.2	8.8	8.4
Family head (spouse not present)	8.2	2.0	1.2	.8	6.2	3.7	2.5
Relative of head (other than wife)	14.9	4.0	1.4	2.5	11.0	5.1	5.9
Living alone or lodging	22.3	6.1	3.5	2.7	16.2	9.6	6.6
In institutions	3.7	1.5	.7	.7	2.2	1.1	1.1

Source: Bureau of the Census, *Current Population Reports; Population Characteristics*, Series P-20, No. 114. "Marital and Family Status: March 1961," January 31, 1962; and preliminary count of institutional inmates from the 1960 Census of Population.

Chart 1. U.S. Population 65 Years and Over, by Sex, 1960



SOURCE: 1960 Census of Population

Census, however, shows that only 615,000, or less than 4 percent of all persons 65 and over, were in institutions in 1960. Persons not in institutions, and not living with a spouse, divide almost equally between those who live with relatives and those who live alone or with nonrelatives (table 2). In all, about 7 in 10 aged persons live alone or in 2-person families.[2]

[2] Data for March 1959 (from Bureau of the Census, *Current Population Reports: Population Characteristics*, "Marital and Family Census: March 1961," Series P-20, No. 112, December 29, 1961) show 61 percent of all family members aged 65 and over were in 2-person families.

Age and employment

While more and more persons live to age 65, relatively fewer of them can count on continuing to earn their own living—or having husbands who do.

The long-run decline in employment of men 65 years or older has continued if not accelerated in recent years. During 1960, only one-sixth of the aged men worked full-time, one-third less than in 1950; only 43 percent worked at any time during the year, compared to 49 percent 10 years earlier. On the other hand, one-sixth of the aged women had work experience during 1960—a proportion considerably more than 10 years earlier (table 3).

TABLE 3.—*Work Experience: Distribution of persons 65 and over by sex, 1950 and 1960*

[Noninstitutional population of the United States]

Work experience	Men		Women	
	1960	1950	1960	1950
Total	100.0	100.0	100.0	100.0
Did not work during year	56.9	50.7	84.2	88.2
Worked during year	43.1	49.3	15.8	11.8
At part-time jobs	16.5	11.6	8.2	5.6
1 to 26 weeks	6.7	4.5	3.1	1.9
27 to 49 weeks	3.1	3.2	1.9	1.3
50 to 52 weeks	6.7	3.9	3.2	2.4
At full-time jobs	26.6	37.7	7.6	6.2
1 to 26 weeks	5.1	4.5	1.8	1.4
27 to 49 weeks	4.6	7.4	1.5	1.3
50 to 52 weeks	16.9	25.8	4.3	3.5

Source: Bureau of the Census, *Current Population Reports: Labor Force*, Series P-50, No. 35, "Work Experience of the Population in 1950," October 26, 1951; and Carl Rosenfeld, "Work Experience of the Population in 1960," *Monthly Labor Review*, December 1961.

In June 1961 fewer than 1 in 5 aged persons had any paid employment—about 3 in 10 of the men and 1 in 10 of the women. (Another 1 in 10 aged women were married to workers). Various public income-support and retirement programs—notably old-age, survivors, and disability insurance—have been developed to replace part of the income lost when earnings cease. A substantial majority of those with earnings were in fact retired, working as they could to supplement benefits. Only about 1 in every 20 persons 65 years or older has earnings and has no income from any public program (Appendix A, table 5). Private pension plans, whose coverage has expanded rapidly since they first became a prime objective of collective bargaining in 1950, are another important source of support for a relatively small number of retired workers many of whom draw benefits under a public program also.

The aged eligible for OASI benefits

Retirement and survivor benefits under the OASDI program were paid to more than two-thirds of all persons aged 65 and over in mid-1961. Including the 1.1 million insured workers (with 270,000 dependents) eligible for benefits but not receiving them because of employment, the proportion eligible was close to 75 percent.

By State the proportion of aged persons actually receiving OASI benefits in mid-1961 ranged from three-fourths in Rhode Island to less than half in Louisiana and the territories (Appendix A, Table 4). In 24 of the 50 States, at least two-thirds of all aged persons were on the OASDI rolls. Of the 13 States with the lowest rates, 10 were in the South; of the 13 with the highest rates, 9 were in the Northeast. The differences reflect, in large part, the fact that farmers and some farm laborers, domestics and urban self-employed were not covered until 1955.

Over 9 out of 10 of all those now reaching age 65 in the United States are eligible to draw benefits if they (or their husbands) retire. By the start of 1964, the proportion of aged persons who would have protection should exceed 80 percent, with 14.4 million, of the 17.9 million aged persons in the population, eligible under the OASDI program (Appendix A, table 2). By 1970 it is expected that all but 15 percent of those 65 and over will be eligible for OASI benefits and by 1980, all but 11 percent. In the long run 95 percent of the entire group 65 years and over will be eligible.

CHAPTER 2. HEALTH CONDITIONS OF THE AGED

Not only is the number of persons 65 and over growing rapidly, but those most likely to need medical care and least likely to have the resources to finance such care are increasing at an even more rapid rate.

The successes of modern medicine in preventing epidemics and curing or controlling diseases such as pneumonia, tuberculosis, and other once fatal infectious diseases have made it possible for an increasing proportion of the population to reach the age when they are more vulnerable to arthritis, rheumatism, heart disease, cancer, and other chronic illnesses. This development along with the high incidence of crippling accidents among the aged has brought the chronic conditions of old age to the fore as their major health threat.

The aged naturally face special health problems since advancing age is accompanied by a decline in health and physical capacity. Older people as a group naturally are more prone to chronic illness and, as a result, more likely to be partially or completely limited in activity than those of younger ages.

Chronic conditions

Older persons are twice as likely as younger persons to have one or more chronic conditions. The National Health Survey shows that almost four out of five aged persons are afflicted with one or more chronic conditions as contrasted with less than two out of five persons under 65.

Persons over 65 who were not institutionalized but who had one or more chronic conditions numbered approximately 11.8 million in 1960. This group represented almost four-fifths of all persons over 65 (Table 4). While the aged constitute 9 percent of the total noninstitutionalized persons, they make up 16 percent of all persons with chronic conditions.

Limitation of activity

Not all chronic conditions are necessarily disabling although such conditions often require medical care. However, reported limitation resulting from these chronic conditions provide a measure of the

TABLE 4.—*Chronic Conditions and Limitation of Activity: Percent distribution of persons by age, July 1959–June 1960*

[Noninstitutional population of the United States]

Age	Total	With no chronic conditions	With one or more chronic conditions		
			Not limited	Limited	
				Partially	Completely
65 and over, total	100.0	22.5	34.1	28.2	15.2
Under 65, total	100.0	62.3	30.2	6.4	1.0
75 and over	100.0	16.1	28.2	31.7	24.0
65 to 74	100.0	25.8	37.2	26.3	10.6
55 to 64	100.0	35.0	41.9	18.5	4.5
45 to 54	100.0	42.5	43.7	12.2	1.6
Under 45	100.0	69.0	26.6	4.0	0.5

Source: Public Health Service, U.S. National Health Survey, *Duration of Limitation of Activity Due to Chronic Conditions, United States, July 1959–June 1960* (Publication No. 584–B31), January 1962.

health status of the aged in relation to younger persons. Data from the National Health Survey for the 12-month period ending June 1960 indicate that older persons are more likely to be partially or completely limited in activity as a result of these chronic conditions than younger persons (Chart 2). Over 40 out of 100 elderly persons have some limitation of activity—6 times as many as for those under 65. One out of ten persons 65–74 is completely unable to work or keep house, and the proportion rises after 75 to almost one out of four persons (Table 4).

Days of disability

Days of restricted activity and bed disability are two measures of the extent of chronic and acute conditions in the population used by the National Health Survey in their household survey of civilian noninstitutional population of the United States. The survey for the year ending June 1960 gives further evidence that the impact of illness becomes more severe as age increases. Persons 65 and over reported an average of 38 days (more than 2½ time as many days as younger persons) during the year when their usual activities were restricted because of illness or injury. On 14 of these days, the aged person was confined to bed all or most of the time as compared with 5 days for the younger person. Also, according to the same survey data, the lower the family income, the greater the number of days of restricted activity or confinement to bed (Table 5).

Prevalence of specific chronic conditions

Arthritis, rheumatism, heart disease, and high blood pressure cause much disability in later life. More than 1 out of 4 aged persons

TABLE 5.—*Restricted-Activity and Bed-Disability Days: Number per person per year by age and family income, July 1959–June 1960*

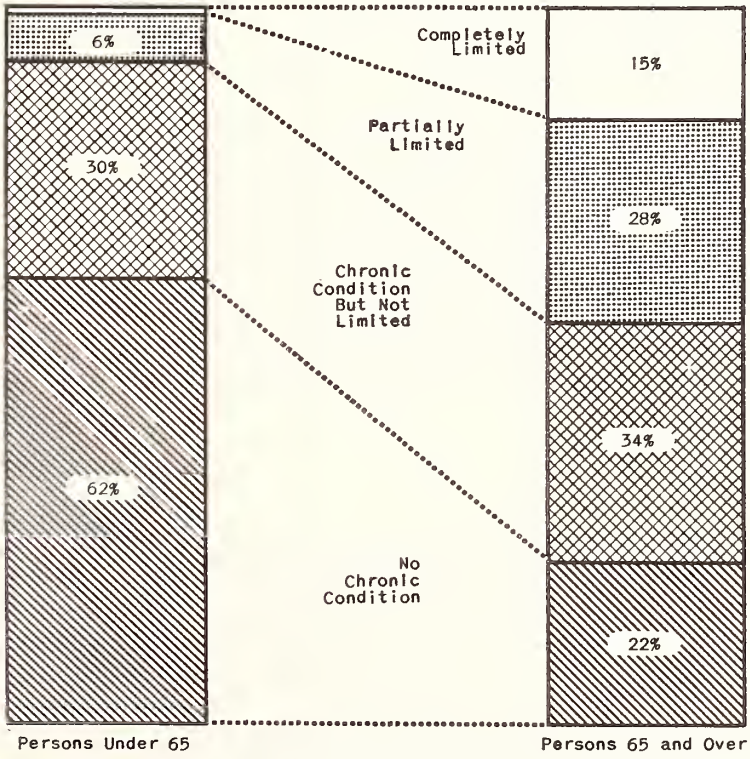
[Noninstitutional population of the United States]

Family income	Restricted-activity days		Bed-disability days	
	65 and over	Under 65	65 and over	Under 65
Total	37.8	14.2	13.6	5.3
Under $2,000	48.2	21.7	16.2	7.8
$2,000 to $3,999	32.0	15.1	11.5	5.7
$4,000 to $6,999	30.9	12.8	11.3	5.0
$7,000 and over	33.4	11.9	13.5	4.4

Source: Public Health Service, U.S. National Survey, *Disability Days, United States, July 1959–June 1960* (Publication No. 584–B29), September 1961.

suffers from arthritis and rheumatism; and 1 out of 8 has high blood pressure. The prevalence of physical impairments also increases with advancing age, particularly visual impairments, blindness and hearing deficiencies. Many aged persons suffer from more than one chronic condition—one-fifth had two and almost one-third had three or more

CHART 2. CHRONIC CONDITIONS AND LIMITATION OF ACTIVITY



SOURCE: Public Health Service, U.S. National Health Survey, *July 1959–June 1960*

such conditions. Although the percentage of cases that had never been seen by a physician was negligible or small in most diagnostic categories, a substantial portion of those with chronic conditions were reported as not under care at the time of the interview (Table 6).

TABLE 6.—*Selected Chronic Conditions: Rates per 1,000 persons 65 and over and percent medically attended, July 1957–June 1959*

[Noninstitutional population of the United States]

Selected conditions	Rate per 1,000 persons	Medically attended		Never Medically attended
		Under care	Not under care	
		Percent		
Arthritis and rheumatism	266	42.7	38.3	19.0
Hearing impairments	172	14.1	44.2	41.7
Heart conditions	149	83.1	15.6	1.3
High blood pressure	129	75.8	22.9	1.4
Visual impairments	103	40.8	51.9	7.3
Hernia	55	42.4	42.9	14.6
Asthma-hay fever	54	45.8	32.8	21.4
Diabetes	40	92.2	7.6	(1)
Paralysis of major extremities and/or trunk	22	53.4	43.6	(1)
Peptic ulcer	22	75.2	23.9	(1)
Chronic bronchitis	19	39.4	51.3	9.4

[1] Less than 0.05 percent.

Source: Public Health Service, U.S. National Health Survey, *Older Persons, Selected Health Characteristics, United States, July 1957–June 1959* (Publication No. 584-C4), September 1960.

Acute conditions and injuries among the aged

In addition to their many chronic conditions, aged persons have substantial problems with acute illness. Approximately 134 acute conditions for every 100 aged persons were reported in the 12 month period ending June 1959. Roughly three-fifths of the acute conditions involved the respiratory system and one-fifth a result of injuries. About 1 out of 4 older persons is injured annually, with about two-thirds injured in accidents occurring in the home. About 85 percent of the bed-disability days resulting from injuries were associated with fractures, dislocations, sprains, strains, contusions, and superficial injuries.[3]

Summary

The data on health conditions of the aged from the National Health Survey indicate clearly the extent to which aged persons are more prone to illness and disability than younger persons. These data are based on household interviews and exclude persons in nursing homes, homes for the aged and long-stay hospitals as well as persons

[3] Public Health Service, U.S. National Health Survey, *Older Persons, Selected Health Characteristics, United States, July 1957–June 1599* (Publication No. 584–C4), September 1960.

whose illness resulted in death during the survey year. The health situation of older persons, therefore, is actually more unfavorable than these data indicate.

Another factor in the possible underestimation of the severity of chronic conditions of the aged may well be the inaccuracy or under-reporting resulting from self-evaluation in the household interview. Methodological studies by the National Health Survey have shown that chronic conditions as diagnosed by the physician do not necessarily match the conditions as reported by the respondent in the household interview.[4] Other studies have also shown that some types of chronic conditions are actually under-reported in the household interview.[5]

---

[4] Public Health Service, U.S. National Health Survey, *Health Interview Responses Compared With Medical Records* (Publication No. 584–D5), June 1961.
[5] Trussell, R. E., and Elinson, J., "Chronic Illness in a Rural Area," from *Chronic Illness in the United States*, Vol. III, 1959.

CHAPTER 3. USE OF HEALTH SERVICES BY THE AGED

Precise measures of the needs of the aged for medical care are not available. However, the fact that the aged are more prone to illness and disability has been well documented. Evidence of their special needs is the higher rate of utilization of health services as compared with that of younger persons. They use a greater volume of physicians' services. They are admitted to hospitals more frequently and stay longer. They are heavy users of nursing homes and other long-stay institutions. They receive considerably more care at home, part of which is provided by nurses. They need and use more drugs. However, they do use less dental services than younger persons.

Physicians' services

Aged persons interviewed in household surveys averaged 6.8 physician visits per year—2 more visits than persons of younger ages—and would have been more had those who died in the survey year been included. One of the limiting factors in persons of any age getting all the care they need is the ability to pay. Persons with lower family incomes visit doctors less frequently than those with higher incomes, notwithstanding the fact that the former group has a higher rate of disability and a higher prevalence of chronic illness. (Table 7).

Persons with limitation of activity due to chronic conditions consult physicians more frequently than those reporting no such condition. The more severe the limitation, of course the higher the frequency of visits (Table 8).

TABLE 7.—*Physician Visits:* [1] *Number per person per year by age and family income, July 1957 to June 1959*

[Noninstitutional population of the United States]

Family income	Age	
	65 and over	Under 65
Total [2]	6.8	4.8
Under $2,000	6.5	4.0
$2,000 to $3,999	6.6	4.4
$4,000 to $6,999	6.9	5.0
$7,000 and over	8.7	5.6

[1] Includes consultation by telephone or in person, at the office, hospital clinic or home visit but does not include services to hospital inpatients.
[2] Includes a small number not reporting income.

Source: Public Health Service, U.S. National Health Survey, *Volume of Physician Visits, United States, July 1957–June 1959* (Publication 584–B19), August 1960.

TABLE 8.—*Physician Visits: Number per person per year for persons 65 and over by chronic condition status, July 1957 to June 1959*

[Noninstitutional population of the United States]

Chronic condition status	Number of visits
Total	6.8
No chronic condition	2.2
One or more conditions:	
No limitation of activity	5.3
Partial limitation	8.5
Major limitation	14.3

Source: Public Health Service, U.S. National Health Survey, *Older Persons, Selected Characteristics, United States, July 1957–June 1959* (Publication No. 584-C4), September 1960.

Other studies of aged persons and their utilization of medical services are in accord with the findings of the National Health Survey that aged persons use a great volume of physicians' services. One sample survey of a cross-section of aged persons conducted in 1957 by the National Opinion Research Center found that persons 65 and over averaged 7.6 annual out-of-hospital contacts with doctors.[6]

Since the aged enter hospitals oftener and stay longer than the rest of the population, presumably they also have a higher rate of use of physicians' services in the hospital. Recent data from the National Health Survey show that aged persons are more apt than younger persons to be hospitalized for conditions not requiring surgery—about two out of five aged persons discharged from general hospitals had surgery, as compared with three out of five younger persons. The length of stay for aged persons undergoing surgery is longer than for those aged discharged without surgery, while for younger persons it is just the opposite—shorter stay for those undergoing surgery than for those in for other reasons.[7]

Utilization of general hospitals

The use of hospitals varies by sex, income, and insurance status. The relationship of these factors to hospital utilization can be determined from information that is available from the results of some of the hospital utilization surveys. Measures of utilization of hospitals, used by the various surveys, include hospital admissions or discharges, length of stay, days of care, and the number of persons hospitalized. The number of persons hospitalized, if measured by either admissions or discharges, is overstated since some persons enter the hospital more than once in a year. This, despite the fact

[6] Health Information Foundation, "Use of Health Services by the Aged," *Progress in Health Services.*, April 1959.

[7] Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958–60* (Publication No. 584-B32). (In press.)

that these surveys generally omit from their count persons in the hospital on the survey date and those who have died during the year.

Results of the National Health Survey for the 2-year period ending June 1960 show that hospital stays of persons 65 and over discharged alive averaged approximately 15 days, and that there were almost 15 discharges per 100 hospitalized. (Chart 3) For younger persons, the average stay was about half as long as that of older persons and there were only 11 discharges per 100 persons. For every 100 aged persons (whether or not hospitalized) the survey shows a total of 218 days of hospital care—more than 2½ times the average for younger persons. (Table 9)

TABLE 9.—*Hospital Utilization:*[1] *Annual rates in short-stay hospitals by age, July 1958 to June 1960*

[Noninstitutional population of the United States]

Age	Discharges per 100 persons	Average length of stay	Hospital days per 100 persons
65 and over, total	14.6	14.9	217.6
Under 65, total	11.2	7.6	85.0
75 and over	15.4	15.8	243.5
65 to 74	14.1	14.4	204.1
55 to 64	12.2	12.2	148.7
45 to 54	11.1	11.5	128.0
Under 45	9.0	6.3	70.1

[1] Living at time of interview.

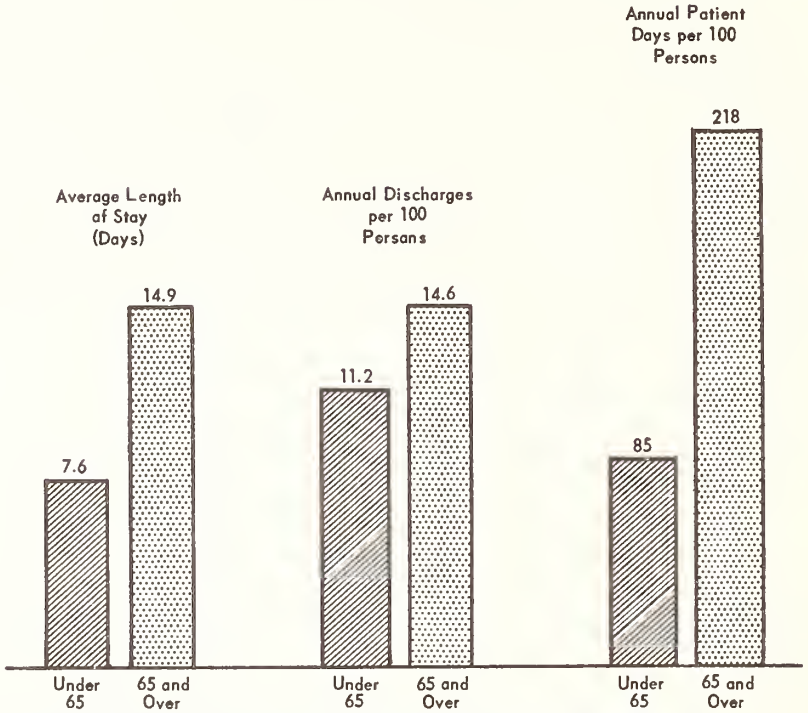
Source: Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958-60* (Publication No. 584-B32). (In press.)

The national survey of old-age and survivors insurance beneficiaries aged 65 and over conducted in late 1957 found that an average of 11.1 out of every 100 beneficiaries[8] used 236 days of general hospital care. The average number of days per year per person hospitalized was 21.2 as compared to the 15 days per stay shown by the National Health Survey. The difference is accounted for in part from the fact that the National Health Survey includes aged persons in the labor force, who are less likely than the retired to be hospitalized, and in part from the fact that it is restricted to the noninstitutional population, whereas the beneficiary survey includes time spent in a general hospital by persons who were otherwise in an institution.

Averages do tend to obscure the actual length of time that persons aged 65 and over are in hospitals. For example, 19 percent of the hospitalized stayed from 15 to 30 days per year, and an additional 9 percent stayed more than 31 days, for the two-year period ending June 1960. (Table 10.)

[8] Includes aged beneficiaries and their spouses aged 65 and over.

CHART 3. UTILIZATION RATES IN SHORT-TERM GENERAL HOSPITALS*



*Based on household interviews of persons living at the time of interview.
SOURCE: Public Health Service, U.S. National Health Survey, *1958–60*

TABLE 10.—*Hospital Discharges: Percent distribution of patients discharged annually from short-stay hospitals by age and length of stay, July 1958 to June 1960*

[Noninstitutional population of the United States]

Length of stay	Age	
	65 and over	Under 65
Total	100.0	100.0
1 day	4.1	11.8
2 to 5 days	22.6	49.9
6 to 14 days	44.1	28.9
15 to 30 days	19.4	6.6
31 days or more	8.7	2.6
Unknown	1.1	0.2

Source: Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958–60* (Publication No. 584–B32). (In press.)

The beneficiary survey of 1957 reported 21.2 days of care per hospitalized beneficiary, with beneficiaries (and their spouses aged 65 and over) distributed as follows by days in hospital, regardless of the number of hospital episodes within the year:

Days spent in hospital	Percent Hospitalized
Total	100.0
1–30 days	81.9
31–60 days	12.4
61–90 days	3.2
91 days and over	2.5

Factors affecting time spent in general hospitals

Various household surveys have shown that aged men are usually admitted more frequently and stay longer in hospitals than aged women. The National Health Survey reported that aged men are discharged at the rate of 16.5 per 100 persons a year; the discharge rate for women 65 and over is 13.0 per 100 persons. Aged men remain in hospitals an average of 15.9 days or approximately 2 days longer than aged women.

Data from the National Health Survey, based on live discharges, show no discernible relationship between discharge rates and income. However, there is an association between length of stay and income—the lower the family income, the longer the hospital stay. (Table 11) It cannot be assumed, however, that aged persons in the lower income groups (under $4,000) are currently getting all the hospital care they need since a greater portion of them have chronic and disabling illnesses (Table 5).

TABLE 11.—*Hospital Utilization: Annual rates in short-stay hospitals by age and family income, July 1958 to June 1960*

[Noninstitutional population of the United States]

Family income	Discharges per 100 persons		Average length of stay	
	65 and over	Under 65	65 and over	Under 65
Total [1]	14.6	11.2	14.9	7.6
Under $2,000	14.3	10.5	15.7	9.6
$2,000 to $3,999	14.8	11.7	15.0	7.4
$4,000 to $6,999	13.2	11.2	13.6	7.1
$7,000 and over	16.9	10.6	14.6	6.9

[1] Includes a small number not reporting income.

Source: Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958–60* (Publication No. 584–B32). (In press.)

Various studies have shown that persons having insurance protecting them against the costs of hospitalization are more likely to enter a hospital than those with no insurance protection. The 1957 OASI beneficiary survey found 14 per 100 aged insured beneficiaries (and their spouses aged 65 and over) had been in a hospital during the year as against 9 per 100 uninsured. However, because the length of stay was often longer for the uninsured patient (17 days for in-

sured; 26 days for noninsured), the total days of care received in the year was almost as much for the uninsured person as among the insured. These data suggest that persons without insurance may tend to postpone entering a hospital until the need is critical and that they then require longer care for recovery.

There is further evidence from the National Health Survey of the association between health insurance and recourse to hospital care. The interim data showed that elderly persons with insurance were hospitalized each year at a rate over 1½ times that for the uninsured. At age 75 and over, the differences in the proportions hospitalized of the insured and uninsured are even greater, as shown below:

Age	Percent of persons 65 and over hospitalized	
	Insured	Not insured
65 and over, total	13.7	8.2
65 to 74	12.9	8.7
75 and over	16.3	7.6

Utilization in last year of life

The National Health Survey data on hospital utilization exclude the 12-month period prior to the household interview of the persons who died in that period. Since the mortality rate of the 65 and over age group is high, household surveys considerably understate the hospital utilization of aged persons.

On the basis of a survey in the Middle Atlantic States, it is estimated that the inclusion of hospitalization received by decedents during the survey year results in increases of one-fourth to one-third in the total volume of hospitalization reported for persons 65 and over. Since the death rate for persons under 65 is substantially lower, the adjustment in hospital utilization for decedents in this age group is estimated to be considerably less than for older persons.[9] On this basis it may be estimated that aged persons are now receiving about 270–285 days of hospital care per 100 persons per year, as contrasted with about 90 days for persons under 65. In similar fashion, the number

[9] Data from the U.S. National Health Survey (*Hospitalization in the Last Year of Life*, Public Health Service Publication No. 584–D3, June 1961) suggest that at the time of the study in 1957, including the experience of persons dying during the survey year would increase by about 40 percent the earlier estimates of days of hospital care used by aged persons, and by about 10 percent the utilization rate for persons under 65, derived solely from the experience of survivors. However, current National Health Survey statistics for hospital utilization of the population alive at time of interview are already higher than heretofore as a consequence of improved collection procedures. Thus the rates obtained from the current National Health Survey data need be increased by a smaller amount to allow for days used by decedents, namely by no more than a fourth to a third in the case of the aged and only about one-sixteenth in the case of the younger population.

of aged persons likely to enter a hospital over the period of a year is estimated at 1 in 6—taking account of the experience of those who will die during the course of the year as well as those who survive, and allowing for those who go to the hospital more than once. As would be expected this 1 in 6 represents a somewhat higher incidence of hospitalization than the number of hospital discharges per 100 persons computed solely on the basis of the experience of aged persons alive at the end of a 12-month period (table 9).

The 1957 survey of OASI beneficiaries also gives some indication of the heavy volume of hospitalization which may characterize a person's last illness. Data for a small number of persons who died leaving a spouse drawing a retired worker's benefit (nonmarried beneficiaries dying during the survey year were not included) show that three times as many had one or both members hospitalized during the year as among those where both partners survived the year.

Nursing homes and other long-stay institutions

In addition to their high rate of utilization of general hospitals, aged persons are the primary users of nursing homes and chronic disease hospitals. A substantial portion of the patients in mental hospitals and tuberculosis sanatoriums are also elderly.

There are very little current data on the characteristics of the patients in these long-term care facilities. A 1953–54 survey of nursing homes in 13 States found the average age of patients was 80 years. One-fifth of the patients were bedfast; more than one-half were disoriented at least part of the time; one-third were incontinent; two-fifths of the patients had a cardiovascular condition which represented the main medical reason for their need for care in the nursing home. Public assistance financed, entirely or in part, the cost of care of one-half of all the patients in these nursing homes.[10]

A 1958 study of 530 residents of five Jewish homes for the aged which provide nursing-home type care found that half of the persons in the homes were 80 years of age or over and widows constituted the largest group.[11] A 1957 study of nursing home facilities in Michigan found that the average age was 76 years and that 63 percent of all patients in these facilities were 75 years of age or over.[12] A 1953–54 Public Health Service Survey of chronic disease hospitals in five States found that the patients' average age was 70 years, or 10 years younger than nursing home patients.[13]

---

[10] Public Health Service, *Nursing Homes, Their Patients and Their Care* (Public Health Monograph No. 46), 1957.
[11] Goldmann, Franz, *"Residents of Homes for the Aged: Their Health Conditions and Needs,"* 1959.
[12] Winter, Kenton E., *Michigan Nursing Facilities and Their Patients: A source book of State and County Data*, 1960.
[13] Public Health Service, *Nursing Homes, Their Patients and Their Care* (Public Health Monograph No. 46), 1957.

Aged persons in mental and tuberculosis hospitals also represent a substantial portion of the total patients. The National Institute of Mental Health reports that one in every three beds in public mental hospitals is occupied by a person 65 or older and that one-fourth of the patients admitted for the first time to such hospitals are aged 65 and over. Of this group, more than half (55 percent) were 75 or over.[14] The Public Health Service estimates that 20 percent of all patients in tuberculosis hospitals are aged 65 and over.

The 1957 survey of OASI beneficiaries found that there was one beneficiary aged 65 and over receiving care in a long-stay institution for every five beneficiaries (and their spouses aged 65 and over) in a general hospital. However, the aggregate number of days was close to two days in a long-stay institution for every one day in a general hospital. (Table 12.)

TABLE 12.—*Utilization of Long-Stay Institutions: Annual rates for aged OASI beneficiaries by type of institution, 1957*

Type of institution	Per 1,000 beneficiaries [1]		Average length of stay in days
	Number in institutions	Aggregate days	
Total	23.1	4,482	194
Nursing homes	13.2	2,759	209
Mental institutions	3.5	972	277
Tuberculosis sanatoriums	3.2	526	164
Other	3.2	225	70

[1] Includes aged beneficiaries and their spouses aged 65 and over.

Source: "Aged Beneficiaries of Old-Age and Survivors Insurance: Highlights on Health Insurance and Hospital Utilization, 1957 Survey," *Social Security Bulletin*, December 1958.

Another source of current data on the utilization of long-term care facilities by elderly persons is the volume of patient care as reported by the American Hospital Association for long-term hospitals and estimates based on Hill-Burton State Plan data for nursing home beds, which report 326,000 beds in nursing homes as of January 1, 1961.[15] Assuming that 85 to 95 percent of the nursing home beds were occupied by aged persons and assuming further an 80 to 85 percent occupancy rate, it may be estimated that nursing homes are annually providing between 480 and 580 days of care per 100 persons aged 65 and over. The nursing homes listed in the State Plans are those classified by the States as providing skilled care. In practice, there may be variations among the States so that the number reported may actually include some homes which are providing mainly custodial care.

[14] Elias S. Cohen, *Mental Illness Among Older Americans*, prepared for the U.S. Senate, Special Commitee on Aging (Committee Print, 87th Cong., 1st sess.), Sept. 8, 1961.

[15] Division of Hospital and Medical Facilities, Public Health Service, *Hospital and Medical Facilities in the United States as of January 1, 1961.*

The American Hospital Association reports an average daily census of 618,057 [16] in civilian long-term hospitals. Assuming, on the basis of various studies, that aged persons constitute one-third of the patients in mental hospitals, one-fifth of those in tuberculosis hospitals and approximately half in the remaining long-term hospitals, it estimated that these facilities are annually providing 450 days of care per 100 aged persons. Thus, it estimated that all long-term institutions are annually providing between 930 and 1,030 days of care per 100 aged persons—a considerably greater volume of care than that given to aged in short-term general hospitals.

Nursing services

Specific data are not available on the volume of special nursing care in the hospital or home received by aged persons in comparison with those of younger ages. The National Health Survey provides data on personal care in the home, but excludes all of the nursing services provided in hospital, nursing homes, and other institutions for the care of the sick, handicapped or aged persons in the population. However, on the basis of the data previously cited on the high rate of utilization of hospitals, nursing homes and other long-stay institutions by older persons, it may be concluded that the per capita amount of nursing services is much greater for older persons than for those of younger ages.

Data from the National Health Survey on the volume of personal care in the home show that the proportion of elderly people under constant or part-time care at home is far greater than among the rest of the population. Persons 65 and over are 15 times as apt to receive personal care at home than younger persons. These include persons who require constant or part-time help or nursing care for eating, dressing or toilet activities. As would be expected, the amount of constant or part-time care given at home increases substantially with age. Thus, the rate for persons 75 and over is 4 times that of persons 65 to 74 years of age (Table 13).

The National Health Survey data also show that care is provided by a nurse in 12 percent of the cases of persons receiving constant care at home and in 4 percent of the cases receiving part-time care. The available data do not show whether the situation varies markedly by age, but suggest that the aged receive far more nursing care at home than do younger people.

Further evidence of the volume of care at home required by aged persons is afforded by the 1957 survey of aged persons conducted by the National Opinion Research Center. This survey reported 74 per

[16] *Hospitals* (American Hospital Association), Guide Issue, August 1, 1961.

TABLE 13.—*Persons Receiving Care at Home: Rates per 1,000 population by age and type of care, July 1958 to June 1959*

[Noninstitutional population of the United States]

Age	Rates per 1,000 population		
	Total	Constant	Part time
65 and over, total	44.3	24.8	19.5
Under 65, total	3.0	1.8	1.2
75 and over	87.7	52.7	35.0
65 to 74	21.9	10.4	11.5
55 to 64	9.6	5.9	3.7
45 to 54	4.0	2.2	1.8
Under 45	2.0	1.2	0.8

Source: Public Health Service, U.S. National Health Survey, *Persons Receiving Care at Home, United States, July 1958–June 1959* (Publication No. 584-B28), October 1961.

1,000 aged persons had personal care at home with 80 percent provided by a relative.[17]

Drugs

Many elderly people having chronic illnesses are constantly in need of one or more drugs. The volume of drugs used by the aged may be measured by expenditures for this purpose. Average annual expenditures of aged persons for medicines (prescribed and unprescribed) are well over twice those of the entire population (Table 14).

TABLE 14.—*Drug Expenditures: Amount by private individuals, by age, 12-month period, 1957–58*

Age	Amount
Total	$19
0 to 5	14
6 to 17	9
18 to 34	13
35 to 54	22
55 to 64	31
65 and over	42

Source: Health Information Foundation, *Family Expenditure Patterns for Personal Services, 1953 and 1958* (Research Series, No. 14), p. 14.

Dental care

Dental care is the one health service of which the aged have less than the rest of the population. Data from the National Health Survey show that persons over 65 average 0.8 dental visits per capita per year compared with 1.5 for the entire population. There are 0.5 visits for aged persons in families of under $2,000 income compared with 1.1 in families of over $7,000 income, but in each income group the aged have fewer dental visits than those of younger ages.

[17] Health Information Foundation, "Use of Health Services by the Aged," *Progress in Health*, April 1959.

CHAPTER 4. HEALTH EXPENDITURES

Another measure of the medical needs of the aged is how much it costs to provide the care they receive. Expenditures by private individuals indicate the direct impact upon the aged themselves—or on the relatives and other persons who help assume some of the responsibility for payment. It is possible also to take cognizance of the care provided at public expense to those who cannot afford to pay. There then still remain some further costs not accounted for—namely, the value of services provided by doctors and other individuals at free or reduced rates as their personal recognition of a special problem.

Older persons not only spend more on medical care than younger persons, but these expenditures represent a larger share of their family's money income. The lower income of retired families is only partially offset by lessened needs of the aged for some items such as food, clothing, and transportation. Their outlays for medical care, on the other hand, average higher and would be higher still if they got all the care they needed and were themselves to pay for all they received.

Total medical costs

Combined public and private expenditures for medical care for aged persons in 1960 are estimated at about $5 billion, out of a total of $24.5 billion for medical care for the entire population. Thus approximately 1 dollar out of every 5 of the Nation's bill for personal medical care services is currently going for the care of someone age 65 or older, whereas only 1 person in 11 falls in this age group. Like other low-income groups the aged receive some of their care at public expense. Of the public funds expended for civilian patient care probably close to $1½ out of every $5 today goes to pay for an aged patient.[18]

The major portion of the aggregate outlay for personal health services for persons 65 and over represents expenditures by private individuals. In 1960, 72 percent of the total was spent by aged persons themselves or by relatives or friends on their behalf. More than

[18] See Appendix C; and Merriam, Ida C., "Social Welfare Expenditures, 1959–60," Social Security Bulletin, November 1961.

one-fourth of the expenditures were made by public agencies. A very small share of the total represented care provided by philanthropic agencies. The latter proportion would be larger if it included the value of services provided without charge to the aged by private physicians. The estimated aggregates for 1960 are as follows:

Source of funds	*Total (millions)*
Total	$5,045
Private persons	3,615
Public agencies	1,330
Private philanthropy	100

Leaving aside care provided out of the public purse, average private expenditures for medical care (counting costs met by insurance as well as bills paid directly by individuals) are at least twice as much for a person 65 or more as for one younger—e.g., $177 vs. $86 in 1957–58, according to the Health Information Foundation. These calculations take no account of the heavy costs of terminal illness for persons who were living alone at time of death—an omission of particular significance for the aged. If allowance is made for the costs incurred in their last illness by persons living apart from relatives, as well as for payments by individuals for medical care of inmates of nursing homes and other institutions, private medical expenditures probably would have averaged $187 per person in 1957–58 rather than the $177 shown in table 15.

TABLE 15.—*Per Capita Medical Expenditures: Amount by private individuals by age and type of service, 12-month period, 1957–58*

Type of service	Per person 65 and over		Per person under 65	
	Amount	Percent	Amount	Percent
Total [1]	$177	100	$86	100
Physicians	55	31	29	34
Hospitals	49	28	19	22
Drugs	42	24	18	21
Dentists	10	6	14	16
Other [2]	21	12	6	7

[1] Excludes expenditure for nursing home care.
[2] Special nurses in hospital or at home, optometrists and other health personnel, eyeglasses and other appliances, ambulance fees, nonhospital diagnostic procedures.

Source: Health Information Foundation, *Family Expenditure Patterns for Personal Health Services, 1953 and 1958* (Research Series, No. 14).

Not only is the expenditure for the older person's care greater than for a younger person but it differs also in the way it is distributed among the various types of service. In line with the utilization data presented earlier, the one item for which the older person spends less on an annual basis is dental care. His higher expenditures for doctor and hospital care and drugs, however, far outweigh his lower dental

costs. It is much more common, too, for older persons to have an "unusual" year in the sense of above-average expenses.

According to the Health Information Foundation the proportion of individuals in each age group who experienced "gross expenditures" of $200 or more for health services in a 12-month period in 1957–58 was as follows:

	Percent
All ages	13
0–17	5
18–54	15
55–64	17
65 and over	22

"Gross expenditures" as used here do not include the costs of free care. They cannot indicate how many aged persons not reporting as much as $200 in actual expenditures may have received at least that amount of care as gift or charity, or did not apply for what they could not afford.

Medical costs and income

Studies over the years have shown consistently that the amount of medical care (measured in dollar costs) a family obtains is influenced by the size of its income, and that the low-income family—though it spends less than one with high income—nevertheless assigns more of its current funds for the purpose. Older families, of course, are subject to the double jeopardy of low income and high medical need. With the large majority of the aged having little better than $1 in disposable income per person for every $2 in a younger family of the same size, it is obvious that their higher medical needs—needs which becomes increasingly greater with advancing age—can take a heavy toll of their meager resources, the more so because like other low-income families they often are without the benefit of health insurance to help foot the bill.

Thus moving from gross health expenditures, which include those financed in any part by insurance, to only those the family pays directly, a U.S. Department of Agriculture survey in 1955 for farm families reported on medical expenditures relative to the family's economic position. The fifth of the farm families headed by an operator 65 years of age or older had lower total income than the younger farm families. The older families, however, consistently spent more per person for their medical care than the younger families. The expenses incurred during the year—over and above any defrayed by health insurance—for physicians, dentists, surgeons, hospital care or medical insurance premiums (items accounting for two-thirds of the total medical care dollar of a farm-operator family) represented 13

percent of the net family income for families with a head age 65 or older, compared with 9 percent for all other families. With two-thirds of the aged farm families having net cash income less than $2,000, this level of spending can cut deep into the resources available for the other things which all families must buy, even when some of their food and housing is farm-furnished. The average aged farm-family with net cash for the year of less than $1,000 spent as much as 20 percent of its income for the medical services listed.[19]

The Health Information Foundation reported families with income under $2,000, many of whom are the aged, having out-of-pocket expenses for health services in 1957–58 (including health insurance premiums) amounting to 13 percent of their total income for the year. For families at all ages and all income levels the out-of-pocket cost came to no more than 5½ percent of aggregate income. Among families at all income levels with an aged head, one in six used at least 20 percent of money income for the year for health care, whereas only one in twenty families with head under 65 used so much income for this purpose (table 16).

TABLE 16.—*Out-of-Pocket Medical Costs:* [1] *Distribution of families by percent of income spent, 1957–58*

[In percent]

Percent of family income [2]	Family head 65 and over	Family head under 65
All families	100	100
No outlay	6	1
Under 5 percent	38	55
5 to 9 percent	20	27
10 to 19 percent	20	12
20 to 49 percent	12	4
50 percent or more	4	1
Aggregate outlay as percent of aggregate family income	7	5

[1] The family's actual cash outlay during the 12-month survey year for personal health services and the voluntary prepayment for such services. Includes medical bills as yet unpaid, that were incurred during the survey year.

[2] Gross family income (i.e., before deduction for taxes) from business, profession, or farm, from wages and salaries, and from all other sources such as interest, rents, and pensions. Excluded are income in goods and services, the value of free rent, and other noncash benefits.

Source: Health Information Foundation, National Opinion Research Center, unpublished data.

A study of hospital and medical expenses of Michigan residents in 1958 found aged families with less than $3,000 income—a group including nearly 3 out of 4 of all aged families in the sample—averaging out-of-pocket expenses of $242, about one-seventh of their average income of $1,700. The families incurred a sizeable amount of expense in addition, for which a welfare or other agency paid, raising the gross medical expense to the equivalent of nearly one-fifth of family

[19] Cowhig, J. D. and Stewart, E. O., "The Older Farm Family and Medical Costs," *Agricultural Information Bulletin* (Department of Agriculture) No. 235, December 1960, pp. 4–5.

income. By contrast the Michigan families headed by a person under 65 averaged medical costs representing only 5 percent of income for the medical bills they paid themselves, or 6 percent if costs paid by others are included.

Hospital costs

The large bills which come without much warning and must be paid all at once make a hospitalized illness the kind of emergency for which it is difficult to budget. Other medical costs also tend to be much larger when there is a period of hospitalization or nursing home care. For the aged person, who uses about three times as much hospital care a year, on the average, as the younger person, the spectre of heavy expenses attendant on hospitalization looms particularly large. Not only are the odds greater that he will enter a hospital, but when he does he is likely to be faced with a bigger bill than is common for the younger patient.

The average gross medical expenditure for an aged person in 1957–58 included $49 for hospital care, 28 cents out of every dollar spent for medical care. For persons under 65, hospital costs claimed 22 cents out of every dollar spent. The larger share of the older person's outlay going for hospital care is a particular burden because no more than half the aged have any insurance covering hospital bills, compared with about 7 out of 10 persons under 65. (These gross expenditure figures include costs met out of health insurance but not the costs of care coming out of public funds.)

As a measure of individual need, expenditures averaged over the total population have their limitations. This is particularly true for hospital care: The overall average greatly understates the burden of cost when the need does arise. As opposed to the average private expenditure for hospital care per person of only $49 for a 12-month period, aged persons who actually went to a hospital had total costs of $352—more than twice the bill for patients of all ages combined. On top of this a hospital admission for an aged person entailed an additional doctor's fee of $101 for inhospital care or a surgeon's fee of $160, rather than the average per person payment of $55 for all physicians' services in the year—in or out of hospital—as shown in table 15.

Similarly, elderly patients in Michigan general hospitals in 1958 ran up bills averaging about $400—counting all hospital charges regardless of who footed the bill, an individual or a welfare agency. For some conditions common to the elderly the costs were much higher. For example, hospitalization for fractures of the hip, to which aged persons are prone, resulted in an average bill of about $700 (table 17). For patients under 65 (other than newborn infants)

TABLE 17.—*Hospital Charges for Selected Diagnosis Categories: Average per patient by age, Michigan hospitals,*[1] *1958*

Diagnostic categories	Age of patient		
	Under 65	65 to 69	70 and over
All categories (excludes newborns)	$217	$404	$396
10 most frequent diagnostic categories:			
Diseases of circulatory system	276	339	398
Nervous system and sense organs	252	315	460
Malignant neoplasms	585	602	505
Diseases of digestive system	292	523	342
Accidents, etc	196	199	329
Diseases of genito-urinary system	217	607	383
Acute myocardial infarction	653	556	411
Fracture of neck of femur	764	840	671
Bones and organs of movement	275	388	284
Diabetes mellitus	374	376	334

[1] All types of hospitals combined; total charges include those footed by public or private welfare agencies as well as costs met out of insurance benefits or paid directly by private individuals.

Source: *Basic Facts on the Health and Economic Status of Older Americans: A staff report to the Special Committee on Aging,* U.S. Senate (Committee Print, 87th Cong., 1st sess.) June 2, 1961, p. 8.

the average bill was little more than half that of the aged person. The longer stay of the latter would be expected to result in higher total costs for the hospital room. In addition his laboratory, drug, and other ancillary costs are also greater than the younger patient's, as the figures in table 18 illustrate.

Information on the impact of hospital costs on aged persons is available also from the 1957 survey of OASI beneficiaries. Although limited to persons receiving OASI benefits, in several respects the data are more complete than those of other studies cited. First, they obtained detail not only on general hospitals, but on episodes in chronic-care institutions and nursing homes as well. Furthermore, they make it possible to study the total medical costs—including those not directly associated with the hospitalization. And finally they have been analyzed for married couples separately from other aged beneficiaries, an analysis particularly meaningful in considering

TABLE 18.—*Charges for Hospital Services: Average per patient by age, Michigan hospitals, 1958*

Selected hospital services	Age of patient	
	65 and over	Under 65
Total hospital bill [1]	$399	$217
Accommodation charges	228	117
Ancillary services	171	100
Laboratory	38	22
Drugs, dressings, supplies, oxygen	69	35
X-ray	23	12
EKG and BMR	6	2
Other	35	29

[1] All types of hospitals combined.

Source: *Basic Facts on the Health and Economic Status of Older Americans: A staff Report to the Special Committee on Aging,* U.S. Senate (Committee Print, 87th Cong., 1st sess.), June 2, 1961, p. 8.

ability to pay. It is the combined resources of husband and wife that will be tapped in the event either becomes ill.

Among married couples,[20] every fifth had one or both spouses in a hospital sometime during the survey year and just about one in seven of the nonmarried beneficiaries were in a hospital also. Almost all the married patients (96 percent) were in a general hospital (including short-stay special hospitals), but about 1 out of 5 of the nonmarried beneficiaries reported as hospitalized were treated in a chronic-care institution or nursing home.

Roughly a fourth of the hospitalized beneficiaries could not report in detail cost of their hospital care, because they did not know how much had been paid by others, they had not yet received the bill, or they knew only the combined total for hospital and doctor. As used here, costs include all incurred expenses regardless of how or by whom they were paid. About half of those not reporting costs had been treated in a public hospital where presumably limited ability to pay was a factor in admission. Of those who did report costs, half the couples with a general hospital stay incurred hospital charges of $250 or more, and half the nonmarried had charges of at least $200 (Appendix A, table 11). The average cost however, was much higher—a total of $430 per couple and $360 per nonmarried beneficiary.

Impact of hospitalization on total medical costs

Although 1 in 6 aged persons enters a hospital during a given year (counting those who died during the year), all must be prepared for the eventuality. It has been estimated that 9 out of 10 persons who reach age 65 will be in a hospital at least once in their remaining lifetime, and as many as 2 out of 3 will be in more than once. No one can foretell just when his turn will come, but all the evidence indicates that the year it does will find him experiencing considerably higher total medical costs than before. Thus, among OASI beneficiary couples with neither member hospitalized in 1957, median total medical costs for the year were $150 (excluding those unable to report costs). For couples having one or both members hospitalized in either a short or long-stay hospital median total medical costs for the year were $700—nearly 5 times as high. Corresponding median costs for the year for nonmarried beneficiaries were $600 for those with a hospital illness ($500 if only general hospitals are considered) and $80 for those without.

[20] As used here and throughout this report, the survey data for married couples apply to aged beneficiaries and their spouses, whether or not entitled to benefits. In some instances the spouses were under age 65.

Of the beneficiaries hospitalized in a general hospital and able to report all their costs, 1 out of 3 couples and 1 out of 5 nonmarried beneficiaries incurred at least $1,000 in total medical bills during the year (Appendix A, table 12). The average total medical bill for the year for those with a general hospital stay amounted to $960 for the couples, and $735 for the nonmarried. The hospital care costs alone represented about 45 percent and 49 percent, respectively, of these total costs for the year. If medical costs could be computed for all beneficiaries with a hospital illness, including those who did not pay their own way, the hospital expense might represent an even larger share of the year's total medical costs because hospital care is probably obtained free or at reduced rates more often than out-of-hospital services.

A beneficiary in a hospital sometime during the year was likely to find the hospital costs alone came to more than twice the medical costs of all kinds for the whole year by a beneficiary with no hospitalized illness, as the following figures illustrate:[21]

	Average medical costs incurred in 1957	
	Total	Hospital costs
Couples:		
One or both in general hospital	$960	$430
Neither in general hospital	195	
Nonmarried beneficiaries:		
In general hospital	735	360
Not in general hospital	115	

With the general climb in prices of medical care items since 1957, particularly marked in the case of hospital accommodations, aged persons having a hospital illness would face costs totaling considerably higher today. For instance, half the beneficiary couples with either or both members in a hospital at today's prices would be likely to incur total medical bills for the year of at least $825 rather than the $700 which represented median incurred costs under similar conditions in 1957. Total medical bills for the year at December 1961 prices would average about $1,160, of which hospital costs alone would represent 49 percent as opposed to the 45 percent of 4 years earlier.

[21] Based on those able to report costs. Hospitalization here implies a stay in a general hospital—including short-stay special hospitals. A small number of beneficiaries, mostly nonmarried, who spent no time in a general hospital but did have a stay in chronic-care institutions are excluded entirely. Adding in their costs would raise the average total costs for the year for beneficiaries not in a general hospital from $195 to $205 for the couples and from $115 to $145 for the nonmarried.

Limitations of expenditure data as a measure of need

Because of the difficulties of determining the dollar value of care for which they do not themselves pay, expenditures for medical care computed solely on the basis of reports by private individuals—as in the beneficiary survey or the HIF series—cannot measure the full impact of medical need: They leave out the experience of those who cannot themselves assume financial responsibility for their care because resources are inadequate or the need too great, as well as some cases where the individual does not feel it necessary to keep track of costs met by prepayment. They also give little indication of the share of the burden assumed by others—the adult children or other relatives, the community at large, or the paying patients whose charges may be greater because of others who do not pay their way.

Data for the aged, with their high mortality rates, are affected in addition by the omission of costs incurred in the last year of life by persons living apart from relatives at the time of death. The extent of utilization of hospitals in terminal illness was discussed in Chapter 3. The heavy cost of terminal illness is illustrated by data for a small group of OASI beneficiaries whose spouse had died during the 1957 survey year. The total medical expenses for the beneficiary and deceased spouse were more than twice those for other couples.

PART II

Individual Resources for Meeting Health Needs

CHAPTER 5. RESOURCES AND BUDGET NEEDS

While persons 65 and over have medical costs at least twice as large as younger persons, they have, on the average, only about half as much income. This discrepancy is not offset to any great extent by differences in needs for other goods and services. To be sure, aged persons are more likely than the younger persons to own a mortgage-free home and other assets, but relatively few, particularly among those with the lowest income, have enough cash savings or assets to finance a major illness.

Money income

Income and retirement.—Retirement from employment usually brings a sharp drop in income. For example, in 1960 aged men who did not work at all had only a third as much income as aged men with full-time jobs all year, and less than half as much as those who had full-time jobs during part of the year. Looked at in another way, those who had no earnings had on an average not much more than half as much as the men who did have earnings as well as other income. (Table 19)

Although women look to their husbands for some or all of their support, more than three-fifths of the women past 65 years of age must depend on themselves or on benefit rights earned by their deceased husbands. In 1960, nearly a fourth of all older women reported no cash income while the remaining ones had a median income of only $820, in some cases supplementing their husband's income and in other cases the income was the sole source of their support. As in the case of men, the large number of women who reported no earnings from employment had roughly half as much income as the small number who did have some earnings.

As would be expected, the association of income and extent of employment reflects itself in the income of families. In 1960, of the families with head 65 or older, a third reported no earnings and had

TABLE 19.—*Money Income of Men Aged 65 and Over: Annual amount and percent distribution by work experience and source of income, 1960*

[Noninstitutional population of the United States]

Characteristic	Percentage distribution	Percent with income	Income recipients		
			Median income	Percent with—	
				$1 to $1,499 or less	$4,000 and over
Total	100.0	96.4	$1,698	45.1	17.2
Work experience: [1]					
Did not work in 1960	56.8	94.7	1,363	57.2	5.1
Worked during 1960—					
At part-time jobs:					
49 weeks or less	9.8	99.6	1,560	48.3	9.1
50 to 52 weeks	6.7	99.1	1,779	43.9	17.1
At full-time jobs:					
49 weeks or less	9.7	99.0	2,930	20.8	34.1
50 to 52 weeks	16.8	97.6	4,115	18.5	51.0
Source of income: [1]					
No income	3.6				
Nonearned income only	53.1	100.0	1,324	59.7	4.3
Some earnings—					
And other income	33.4	100.0	2,482	27.4	29.5
No other income	9.9	100.0	3,604	26.8	46.0

[1] The data on income by source and by work experience differ slightly because the former were obtained in March 1961 and the latter in February 1961. Not all reports on income could be matched with those on work experience.

Source: Bureau of the Census, *Current Population Reports; Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962.

a median income of only $1,920. Only 10 percent of the families reported all their income from earnings, and they averaged $4,570 for the year (Appendix A, Table 6).

For aged persons living apart from relatives (23 percent of the aged population), three-fourths reported no earnings and had about half as much income as those with earnings.

Since most persons 65 and over have no earned income, and public maintenance programs are limited in what they pay, it is not surprising that most older persons must get along on relatively low incomes. Counted as individuals, more than half (53 percent of those not in institutions) had less than $1,000 in 1960 and 3 in every 4 had less than $2,000. (Appendix A, Table 7.) How "low" this is depends on the need for income and also how it compares in amount with the income of others in the population.

Income and family situation.—For 2-person families, which represent nearly three-fourths of all older families, the median income in 1960 was less than half as large when the family head was aged 65 or over—$2,530—as when he was under age 65—$5,314 (Table 20 and Appendix A, Table 8).

For persons living alone or lodging with nonrelatives, the economic disadvantage of the aged is even more marked (Table 21). This is because only about one-fourth of the former, as compared with more than five-sixths of younger persons in a similar situation had any earnings in 1960.

TABLE 20.—*Money Income of Families: Annual amount and percent distribution by amount of income, age of family head, and size of family, 1960*

[Noninstitutional population of the United States]

Income and age of family head	All families [1]	Families containing—			
		2 persons	3 persons	4 persons	5 or more persons
Median money income of family:					
Head 65 and over	$2,897	$2,530	$4,122	$6,100	$5,727
Head under 65	5,905	5,314	5,930	6,300	6,074
Percent of families with income of—					
Under $2,000:					
Head 65 and over	31.4	35.7	20.3	17.6	17.9
Head under 65	10.2	16.0	9.0	6.5	8.9
$7,000 and over:					
Head 65 and over	16.4	11.5	23.5	41.4	37.9
Head under 65	37.1	31.1	37.8	41.0	38.8
Percentage distribution by size:					
Head 65 and over	100.0	72.9	16.4	5.1	5.6
Head under 65	100.0	26.4	21.6	22.9	29.1

[1] Mean sizes: 65 and over, 2.5 persons; under 65, 3.9 persons.

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P–60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962.

The very large disparity in income for 2-person families doubtless reflects the relatively large proportion of older 2-person families in which neither member worked during 1960. Three-person families, often including an adult child living at home, are more likely to have at least one regularly employed member. Their median income was only about 30 percent less than that of younger families. For even larger families, which are very few in number, there was no significant difference in the average income, presumably because many of these families with an aged head contained several adults, including younger ones, in the productive ages. Regardless of the size of family, the proportion with less than $2,000 in 1960 was at least twice as large when the family head was over 65 as when he was younger (Chart 4).

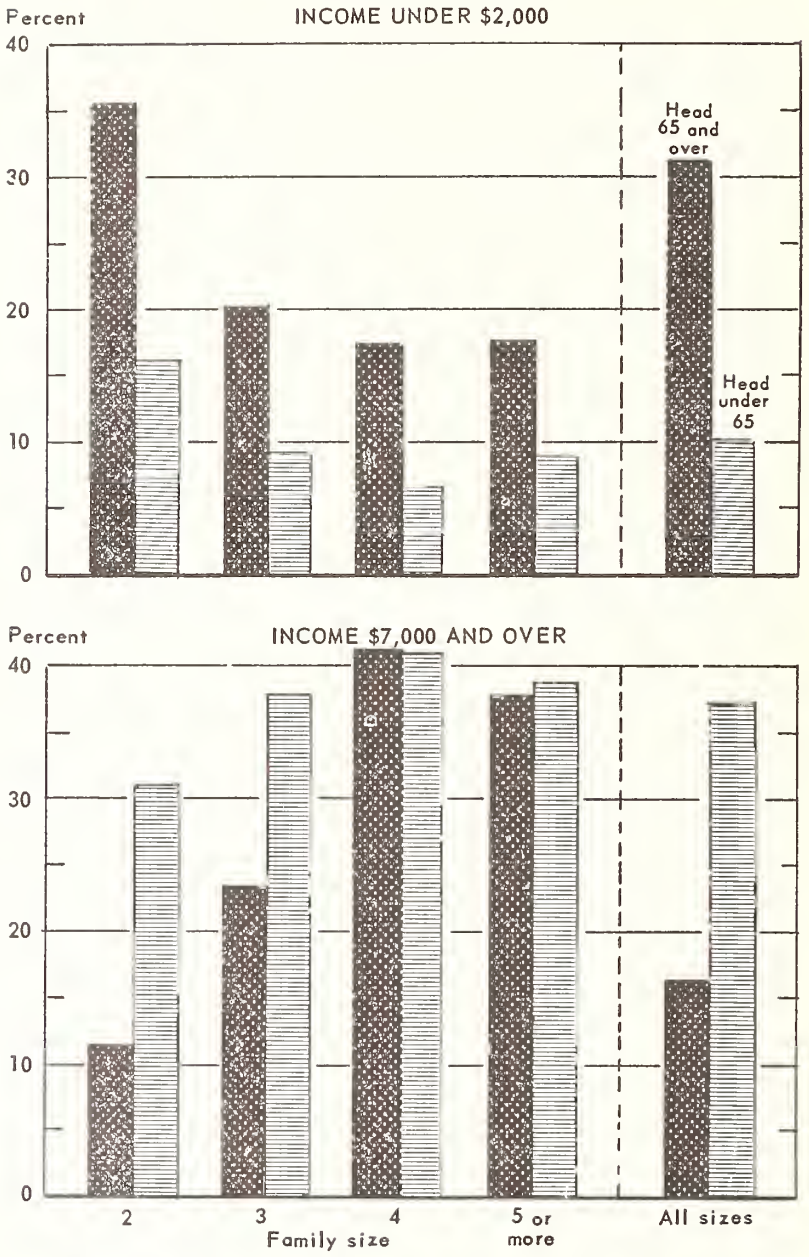
TABLE 21.—*Money Income of Persons Living Alone or Lodging: Annual amount and percent distribution by amount of income, age, and sex, 1960*

[Noninstitutional population of the United States]

Income and age	Total	Men	Women
Median money income:			
65 and over	$1,053	$1,313	$960
Under 65	$2,571	$3,371	$2,152
Percent with income of—			
Under $1,500:			
65 and over	69.0	59.2	72.9
Under 65	35.5	28.7	40.9
$4,000 and over:			
65 and over	6.4	9.8	5.0
Under 65	31.4	42.7	22.7
Percent distribution by sex:			
65 and over	100.0	27.5	72.5
Under 65	100.0	44.0	56.0

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P–60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, and related unpublished data.

CHART 4. MONEY INCOME OF FAMILIES, BY FAMILY SIZE, BY AGE OF HEAD, 1960



SOURCE: Bureau of the Census

In assessing income figures, allowance must be made for the fact that some types of income, such as realized capital gains and lump-sum insurance payments, are not included in the income definition used in the survey. The Bureau of the Census report calls attention also to the fact that understatements of income in field surveys tend to be more serious for nonearned than for earned income. It concludes, however, that even after allowance for these factors, available evidence suggests that a substantial proportion of older nonearner families still had incomes totaling less than $2,000 in 1960.[22]

Aged persons living in the homes of relatives (who "disappear" in any analysis of family income) typically have little or no income of their own. In 1960 more than half the aged men and four-fifths of the aged women in this situation had less than $1,000 cash income. Two-fifths of these older persons were living in the home of married couples, usually their married children likely to have dependent children also. A special analysis for March 1959 shows that of the aged persons who lived in the home of relatives and who had less than $1,000 income of their own in 1958, about one-third were members of families whose total money income was below $3,000. Half were in families with less than $5,000.

Other financial resources

Older persons are somewhat more likely than younger persons to have some savings, but in general those with the smallest incomes are the least likely to have other resources to fall back on. Moreover, most of the savings of the aged are tied up in their homes or in life insurance, rather than in a form readily convertible to cash.

According to the 1960 Survey of Consumer Finances, almost as many "spending units" [23] with head 65 and over had less than $200 in liquid assets, bank accounts or savings bonds, as those who had $2,000 or more (Table 22). Moreover, their liquid assets position was not strikingly better than that of spending units with younger heads, at least than those with heads 35–64. The relative number with no assets or less than $200 was about the same, at all ages; the number with $5,000 or more was progressively larger the older the unit. But fewer than one-fourth had as much as $5,000 even in the case of those 65 and over.

---

[22] U.S. Bureau of the Census, *Current Population Reports: Consumer Income*, Series P–60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, p. 11.

[23] A spending unit is defined to consist of related persons who pool their incomes. Married couples and their children under 18 are always considered members of one spending unit. Other related persons are separate spending units if they earn more than $15 per week and do not pool their income. Persons 65 and over living with and dependent on relatives (whose situation is not reflected by these data) almost certainly have fewer assets than the financially independent spending units with head aged 65 and over.

TABLE 22.—*Value of Liquid Assets: Distribution of spending units by size of holdings and age of head, early 1960*

[Noninstitutional population of the United States]

Value of liquid assets	Age of head			
	65 and over	45 to 64	35 to 44	Under 35
Total	100	100	100	100
Do not own	30	22	20	26
Own:				
$1 to $199	6	11	18	54
$200 to $999	14	22	26	
$1,000 to $1,999	10	13	14	17
$2,000 to $4,999	18	15	12	
$5,000 and over	22	17	10	2
Median value:				
All spending units	$1,000	$800	$700	$400
Holders only	$3,000	$1,100	$900	$700

Source: University of Michigan, Institute for Social Research, Research Center, *1960 Survey of Consumer Finances*, 1961.

It is noteworthy, also, that, in a special study of low-income families, about two-thirds of the older spending units who reported less than $500 liquid assets, had not had $500 within the previous 5 years.[24]

Relatively few of the aged hold any marketable securities (Appendix A, Table 9), and those who do usually are the ones who have other liquid assets also. Only one in seven of the aged spending units reported owning corporate stock in 1960. Three years earlier, when this question was last studied for the Federal Reserve Board, only one in nine had corporate stocks or bonds and virtually all of these stockholders were among the group that had over $2,000 in other liquid assets. About one in five in 1960 reported some real estate other than their own dwelling, but it appears from other sources that not infrequently this was a rental unit in their home, which therefore could not easily be converted to cash.

Having savings, as might be expected, is related to income. The 1959 Survey of Consumer Finances, conducted for the Federal Reserve Board, found that among spending units with head 65 and over:

When income was less than $3,000 (70 percent of the total)

47 percent had less than $200 in liquid assets, and

44 percent had liquid assets of $500 or more

When income was $3,000 to $5,000

21 percent had less than $200 in liquid assets, and

70 percent had liquid assets of $500 or more

Relatively few of the aged, according to the 1960 Survey of Consumer Finances, have more than one type of asset other than equity in a home. The distribution by number and pattern of their holdings for spending units with head 65 and over is shown in Table 23.

[24] Morgan, James, and David, Martin, "The Aged and Their Economic Position—Some Highlights of a Survey Taken Early in 1960," in *Retirement Income of the Aging, Hearings before the Special Committee on Aging*, U.S. Senate, (87th Cong., 1st sess.), 1961, Appendix IV.

TABLE 23.—*Pattern of Asset Holdings: Distribution of spending units by age of spending unit head and number and type of holding, early 1960*

Number and type of holding	Age of head			
	65 and over	45 to 64	35 to 44	Under 35
Total	100	100	100	100
None	13	11	13	20
1 only	30	25	23	44
Liquid assets	15	15	17	37
Equity in home or farm	13	9	5	5
1 other	1	1	1	1
2 only	34	36	39	25
Liquid assets and equity	26	29	32	17
2 others	8	7	7	8
3 only	19	21	20	8
Liquid assets, equity and stock	7	8	8	2
Liquid assets, equity and other real estate	11	9	7	3
3 others	1	4	5	3
4 or 5	4	7	5	3

Source: University of Michigan, Institute for Social Research, Survey Research Center, *1960 Survey of Consumer Finances*, 1961.

Reports on the value of the various types of assets (as shown in Appendix A, table 9) make it clear that in amount as well as frequency of ownership, the home is far more important than any other asset. Even with the equity in the home included, more than one-third have total assets of less than $5,000; only two-fifths have $10,000 or more.

In an effort to determine the relative numbers with various combinations of resources to meet medical care costs, data from a Survey Research Center study were tabulated by income in 1959, by savings cross-classified by whether or not any type of health insurance was owned. They show that while some older people have substantial resources in the bank or in Government bonds, the great majority do not (Appendix A, table 10). About 70 percent of the couples with head aged 65 or over and 85 percent of the other persons 65 years or over had less than $5,000 in savings. Almost three-fifths of these couples and almost three-fourths of the other aged persons with less than $5,000 savings had no health insurance.

This, as other studies, shows that the lower their income the less likely are the aged to have either substantial savings or any health insurance. Indeed, of these in the lowest income group (under $2,000 for couples, under $1,000 for others, including more than one-third of the couples and more than half the other aged) almost 90 percent had less than $5,000 savings with nearly four-fifths of them having no health insurance at all.

Life insurance is a fairly common form of saving, although less so among the aged than among younger families. The policies of the aged have a relatively low face value, and some of them have no cash

surrender value. The proceeds are therefore more likely to be used for burial costs or some of the bills outstanding after a terminal illness, than to meet costs of current medical care.

Among OASI beneficiaries studied in the fall of 1957, 71 percent of the married couples and half of the other aged beneficiaries carried some life insurance. The median face value was $1,850 for the policies carried by couples and less than half as much for nonmarried beneficiaries. More than two-thirds of all the beneficiaries either held policies with a face value of less than $1,000 per person, or had no insurance at all.

Home ownership

Equity in a home is the most common "saving" of the aged and represents the major portion of their net worth. Like other forms of saving, the advantage of home ownership is more common among those with higher incomes.

In early 1960, almost two-thirds of the nonfarm families headed by a person 65 and over owned their homes, with more than four-fifths of the homes clear of mortgage debt.

Among OASI beneficiaries studied in 1957, about two out of three of those married and one out of three of the nonmarried, owned a nonfarm home. Most of these homes were mortgage free, but the equity was relatively modest: The median amount was about $8,000 for couples and widows and about $6,000 for single retired workers. Nearly eight out of 10 of the beneficiary couples with income of $5,000 or more, but fewer than two out of three with less than $1,200, owned their homes.

While home ownership, particularly mortgage-free, can mean lower out-of-pocket costs, still it does not mean living without significant housing costs. Data from the 1957 beneficiary survey indicate that urban couples keeping house alone in a paid-up home averaged only about 30 percent less for taxes, upkeep and utilities than the average outlay for rent and utilities by couples renting their living quarters.

Noncash income

Many aged persons have noncash resources which enable them to enjoy better living than their money resources alone could make possible. Such "nonmoney" income, however, does not necessarily release an equivalent number of dollars for purchasing goods and services, such as health care.

According to the 1957 survey of OASI beneficiaries, four out of 5 couples and three out of five nonmarried beneficiaries had some non-

cash income of one or more of the following types: An owned home or rent-free housing, food home-grown or obtained without cost, or medical care for which the beneficiary did not pay.[25] Others received some support from the children or relatives with whom they lived.

A fourth of all beneficiary couples and almost a tenth of all other aged beneficiaries raised some food. Such food makes for a better and more interesting diet, but the net saving in family food expenditures is likely to be considerably less than dollar for dollar.

Evaluation of these noncash resources requires so many arbitrary decisions that it is rather seldom attempted. Survey Research Center staff members, however, did estimate for their analysis of income distribution and factors affecting low-income families, not only the imputed rental income earned on the net equity in owner-occupied homes, and the value of free medical care, but even the value of food and housing contributed by relatives in the same household and the money saved by growing food and doing home repairs. They report that adding such nonmoney components of income increases the income averages for couples and other persons aged 65 and over by only $300 or $400. It reduces the proportion with less than $2,000 in 1959 from 46 percent to 35 percent for units consisting of aged couples or nonmarried males; from 89 percent to 79 percent for aged women.[26]

Measures of need

Questions are raised from time to time as to the relative income needs of aged persons and of younger families. It is suggested that the actual incomes received by aged persons are not as low as they appear to be relative to those of younger persons, in view of the lesser budgetary needs of the aged.

Budget needs of retired and younger worker families.—Family budgets, designed to provide a measure of the amount of money required to support a given level of living, have usually been developed for a specific type of family. Comparisons between budgets have to take into account not only differences in family size and composition but also differences in concept and in implied standards of adequacy. Shared items of expense, such as housing, have a different impact on

[25] This assumes that home ownership yields noncash income in the long run, although about one-fifth of the homeowners reported current housing expenses for the survey year that exceeded the estimated rental value of the home. Roughly every third homeowner reported noncash income from another source, usually food, because homeowners are more likely than renters to have garden space.

[26] Morgan, James, and David, Martin, "The Aged and Their Economic Position—Some Highlights of a Survey Taken Early in 1960," in *Retirement Income of the Aging, Hearings Before the Special Committee on Aging*, U.S. Senate (87th Cong., 1st sess.), 1961, Appendix IV. Fuller description of procedures will be provided in a book entitled *Income and Welfare in United States*, to be published during 1962 by McGraw-Hill Book Co.

the total budget of a large family than on that of a single person or a couple.

The budget for a City Worker's Family of four persons and the budget for a Retired Couple, released by the Bureau of Labor Statistics in 1960, use the same methodology; both represent a "modest but adequate" level of living.[27] Since the City Worker's Family Budget applies to a family of 4 persons, the budget amounts cannot be compared directly with those for an elderly couple. Nor would it be entirely fair to place both budgets on a per capita basis. In order to compare the two budgets, an adult-equivalent relationship was used; specifically the amounts in the elderly couple's budget were divided by 2, those in the 4-person family budget by 3½, treating the 13-year old boy as an adult, the 8-year old girl as half an adult. The relationship between the per-adult cost for elderly couples and for a young worker's family is shown in table 24 for six cities in different regions of the country.

TABLE 24.—*Budget Costs: Relative costs for retired persons and members of city worker's family by category, 1959*

Item	Relative costs [1]					
	Atlanta	Boston	Chicago	Los Angeles	St. Louis	Washington, D.C.
Estimated total cost [2]	84	92	90	87	87	87
Cost of goods and services	98	108	105	102	103	103
Food and beverages	89	90	89	90	90	90
Housing	119	145	135	129	130	131
Rent, heat, utilities	118	145	135	128	131	131
House furnishings	86	89	89	87	87	86
Household operation and communications	181	210	200	219	189	195
Clothing	68	68	69	68	68	68
Medical care	156	172	176	151	160	156
Transportation	58	61	60	58	61	59
Other goods and services	102	108	106	106	105	107

[1] Ratio of per capita cost of retired elderly couple's budget to per adult equivalent cost of city worker's family budget, in which the boy is treated as an adult; the girl 8 as half an adult.
[2] Includes life insurance, occupational expenses, and personal taxes for the worker's family. The budget for a retired couple makes no allowance for life insurance nor Federal income taxes.

Source: "The Interim City Worker's Family Budget," *Monthly Labor Review*, August 1960, and "The BLS Interim Budget for a Retired Couple," *Monthly Labor Review*, November 1960.

With some variations from one city to another the amounts of money required for medical care of aged persons in reasonably good health were 50 to 75 percent higher than the comparable (per adult-equivalent) amounts for younger families. Housing costs were also significantly higher for the older persons, as might be expected with the smaller size household. Food costs were somewhat lower, the costs of clothing and transportation substantially lower. The cost of all the

[27] A detailed description of these budgets may be found in "The Interim City Worker's Family Budget," *Monthly Labor Review*, August 1960; "The BLS Interim Budget for a Retired Couple," *Monthly Labor Review*, November 1960; and Orshansky, Mollie, "Budget for an Elderly Couple: Interim Revision by the Bureau of Labor Statistics," Social Security Bulletin, December 1960.

goods and services budgeted for an aged person was very close to or slightly above the per adult-equivalent cost of all goods and services for the members of a younger family. However, when account is taken of the personal taxes, life insurance, and occupational expenses that would be paid by the younger families, the total costs incurred by an aged person are between 84 and 92 percent of the per adult-equivalent cost for a member of a young worker's family.

While the BLS budgets relate to families and elderly couples living in large cities or their suburbs, there is no reason to think that the *relationship* between the costs for older and for younger families would be markedly different in small cities or in rural areas.

By contrast, as previously noted, 2-person families have only half as much income on the average when the head of the family is 65 and over (including any still working) as when the head is younger. And almost three-fourths of all older families consist of only a husband and wife or the head and one relative.

Although older persons are somewhat more likely than younger persons to have some savings, as already mentioned, those with the smallest incomes are the least likely to have other resources, and most of their savings are tied up in their homes or in life insurance, not readily convertible to cash. Moreover, when a younger family goes into debt to purchase a home or durable goods, or to pay for medical care, it does so in the expectation of being able to pay off the debt from future earnings. When a retired aged person draws on his savings to pay for medical care, he does so without hope of recovering his former position.

Tax provisions favoring the aged

Federal tax provisions recognize the special problems encountered by older persons. It is apparent, however, that as with savings, home ownership and similar resources of the aged, the more favorable their income situation, the greater the advantage.

Federal tax savings.—The Treasury Department estimates that during the 1961–62 fiscal year, persons aged 65 and over will have a total tax savings of $742 million as a result of three special tax provisions of the Federal income tax. Of the total tax benefit, the double exemption for persons aged 65 and over accounts for $482 million in tax savings, the retirement income credit accounts for $120 million in tax savings, and the special medical expense deduction, over and above the deduction available to all age groups, accounts for $140 million.

State and local tax provisions.—No overall appraisal is available of the extent to which State and local taxes affect the aged. Of the 35 States that levy personal income taxes, 17 allow additional deductions for the aged. Some have favored treatment for older home owners in respect to real estate taxes.

CHAPTER 6. PRIVATE HEALTH INSURANCE

Availability of health insurance to the aged

The extent and quality of health insurance coverage of the aged is influenced by many factors: on the one hand, by their ability to pay full cost premiums which are likely to be high because of their morbidity rates; and on the other hand, the opportunities they have either to carry over into retirement the insurance they had while employed or to purchase insurance after reaching age 65.

Group coverage before retirement.—To the extent that the aged are gainfully employed, they have much the same opportunities as other active workers to obtain health insurance on a group basis. But only a small proportion have full-time employment and many of these are apparently in jobs for which health insurance is not available on a group basis through their work. The 1958 HIF–NORC study found that 93 percent of the uninsured individuals 65 and over in the labor force reported health insurance coverage was not offered through their work.

While in the early years of the Blue Cross movement, many plans would not enroll persons who were 65 years or older, these restrictions have been discarded except for some of the smaller plans. The practices of Blue Shield plans are virtually the same as Blue Cross. Neither has age restrictions on continuation of enrollment of elderly persons already in a group.

Some of the insurance companies formerly imposed age restrictions on employees for group coverage but these carriers now generally accept older employees in the work group enrollment unless the employer insists, due to cost factors, on age restrictions.

Few, if any, of the so-called independent plans have age restrictions on initial or continued enrollment of elderly persons under group enrollment.

Group coverage after retirement.—During the last 5 or 10 years, many employers and jointly managed union-management welfare funds have developed various types of plans to include retired em-

ployees under their group health insurance program.[28] Benefits may be the same as for active employees or they may be curtailed in various respects. The cost sharing arrangements as between the employer and employee may be the same as for active employees or different.

The extent to which health insurance is made available to retired employees depends not so much on the carriers as on whether the employer, union, or welfare fund will pay the added costs involved in coverage of the high-risk retired. Many Blue Cross and independent plans will also extend coverage to such groups of retired employees. Where the plans experience rate—and most Blue Cross-Blue Shield Plans now do—there is no problem for them in covering retired employees. Where the plan does not experience rate, acceptance of retired persons makes for problems for the carrier since the group in question is then apt to have higher than average utilization and costs.

No comprehensive data are available as to the extent to which health insurance has been made available to retired employees. However, the Bureau of Labor Statistics did make a study [29] of the provisions of 300 collectively bargained health and insurance plans in 1959 each with more than 1,000 workers. It showed that provisions for continuing hospital care insurance after retirement have been steadily increasing under collectively bargained plans, averaging about 1 to 2 percentage points a year from 1955 to 1959. Of the surveyed employees about 42 percent were in firms that provided hospital protection both before and after retirement. Major negotiations, since 1959, in the steel, aluminum and meatpacking industries for extending hospital insurance after retirement have brought this coverage figure up to an estimated 53 percent.

There are a number of important limitations on extension of hospital care protection to retired workers through employee-benefit plans even through the large, collectively bargained plans. First, even when such benefits are incorporated in a plan, they may refer only to future pensioners, not to those already retired.[30] Second, in

---

[28] Usually there is a requirement that the employee must have worked for the company or in the case of a multi-employer welfare fund, in the industry, for a designated period, say, five years preceding retirement.

[29] Bureau of Labor Statistics: *Health and Insurance Plans Under Collective Bargaining: Hospital Benefits, Early 1959* (Bulletin No. 1274), 1960; *Health Insurance Plans Under Collective Bargaining: Surgical and Medical Benefits, Late Summer 1959* (Bulletin No. 1280), 1960; and *Health and Insurance Plans Under Collective Bargaining: Major Medical Expense Benefits, Fall 1960* (Bulletin No. 1293), 1961.

[30] A 1960 BLS study shows that 69 percent of the plans that continued hospital benefits after retirement, covering 87 percent of the employees in such plans, provided hospital benefits to both prior and future pensioners; the remaining plans covered future pensioners only.

most instances, to continue receiving hospital expense protection workers must have had at least 5 to 15 years of service or of participation in a hospital expense plan. Third, because of the relatively high costs involved in providing elderly persons with hospital care protection, many plans extending such protection reduce the benefit provisions after retirement in a variety of ways—such as placing monetary or time limits on benefits. This particular limitation was true of 41 percent of the plans with hospital benefits for retired workers, covering 27 percent of the employees. Fourth, many plans require workers after retirement to bear a larger share of the costs. According to the BLS study, 3 out of 4 employees in plans where preretirement hospital benefits were jointly financed had to pay the entire cost after retirement.

The plans studied by the Bureau of Labor Statistics are more or less typical of those in unionized industries and among large employers and refer to less than 10 percent of all wage and salary workers. They undoubtedly do not reflect the situation in smaller or nonunionized firms, which generally offer less in the way of health and welfare benefits. It seems clear that fewer than half of today's workers can count on the extension of present health benefits into retirement years.

Policy conversion.—The Blue Cross and Blue Shield plans, without exception, have always followed the policy of permitting members, irrespective of age, who leave their groups to continue membership on an individual basis. The benefits offered under these group conversion contracts are generally reduced and the cost is higher because of adverse selection among these electing to convert and the higher administrative expense of non-group business.

Insurance companies formerly did not offer to persons leaving a group the right of conversion to an individual policy. However, today many companies writing group health insurance offer conversion privileges, i.e., will offer it if the employer or welfare fund wants this feature and is willing to pay any increased cost involved. Some of the independent plans serving the general public follow similar policies, i.e., permit subscribers leaving employed groups to convert to an individual contract; some do not.

Thus, to a very large extent, older persons retiring from employment have an opportunity to convert to an individual policy any health insurance which they had held as an employee. In general, however, the benefits are considerably reduced and the cost substantially increased on conversion, in large measure because the employer no longer shares in the cost.

Initial nongroup enrollment.—The situation is less favorable with regard to purchase of health insurance on an individual basis by older persons not in the labor force. There are a number of problems apart from cost. Some aged persons cannot buy insurance because of age-limits on nongroup enrollment or because they are poor risks due to pre-existing conditions. Some can obtain policies only if they accept a waiver of coverage for pre-existing conditions. Some find it impossible to renew individual policies or may have their policies cancelled. In all these respects, however, the situation has improved in recent years.

Restrictions because of age.—Almost all of the Blue Cross and Blue Shield plans now have non-group enrollment provisions. As of January 1962, all but 2 of the 79 U.S. Blue Cross plans had nongroup enrollment, but only 18 had no age limits for individual enrollment. Thirty-one plans among the 79 also offered "senior" certificates, i.e., without age limit, but these commonly restrict benefits and/or cost more as compared with nongroup contracts offered to younger persons. Nearly one-fourth of the plans did not accept initial nongroup enrollment from persons over 65 (table 25). All but 2 of the 68 U.S. Blue Shield plans had nongroup enrollment, 16 with no age limits, and 27 offering "senior" certificates. Although data on membership are not available by age limits, the situation seems somewhat more favorable than appears from a count of plans because the larger plans tend to have fewer age restrictions.

TABLE 25.—*Blue Cross and Blue Shield Plans: Age limits on initial non-group enrollment, end of 1961*

Age limits	Blue Cross plans	Blue Shield plans
Total	79	68
"Senior" certificates offered	31	27
No age limit	18	16
70 years	2	1
66 years	1	
65 years	15	17
60 years	10	4
56 years		1
No nongroup enrollment	2	2

Source. *Blue Cross Guide,* January 1, 1962, and *Blue Shield Manual,* late December 1961.

Although some of the 730 insurance companies which write individual (nongroup) policies do not sell insurance to individuals past 60 or 65, the majority now accept applications from persons up to 70 or even 75, and some have no age limits. All such insurance is written at rates which vary with age and sex, however. Rates for those persons 65 to 70 years are 50 to 100 percent higher than for persons of, say 30 years, and mount sharply for those beyond 70. Moreover, policies available to persons 65 and over generally have more limited benefits than those offered to younger persons.

Restrictions because of ill health.—The great majority of the Blue Cross and Blue Shield plans which enroll aged persons on a nongroup basis require a health statement from the person applying for coverage. An applicant with a health history which indicates that he may be a poor risk is apt to be rejected or the policy written with a waiver of coverage for specified conditions. Many of the plans exclude coverage for pre-existing conditions for a year or two, or even for life.

Nearly all insurance companies require a health history statement of the prospective individual enrollee with rejection likely if his statement indicates he is a poor insurance risk. In some cases policies sold contain a waiver of benefit for one or more specific conditions.

Renewal guarantees.—The assurance that a policy is non-cancellable and guaranteed renewable is always important to policyholders, but especially for those 65 years and older.

Most Blue Cross and Blue Shield plans follow a policy of never cancelling or refusing to renew a member's certificate because of his age or conditions of health. Exceptions are very rare.

The great majority of insurance companies, on the other hand, have reserved the right to refuse to renew an individual hospital, surgical or medical insurance policy on its anniversary date. Despite steady public complaint over the years, most individual health insurance policies are renewable only at the option of the company and companies do not hesitate to refuse to renew a policy on an insured person who has become a poor risk.

These practices are less common than they were, however. Some 30 to 40 commercial companies now issue policies which are guaranteed non-cancellable and renewable for life. If the company wishes to raise the rate on an individual policy of this character, it can do so only if it raises the rate on all policies of the same class. An estimated 500,000 of the 2½ million aged persons covered by insurance companies have individual policies which are guaranteed renewable.[31]

New York State prohibits cancellation or refusal to renew an individual policy, unless similar action is taken with respect to all policies of the same class. North Carolina has enacted similar legislation and some other States have considered or are considering such legislation.

Promotion of sales to the aged.—Availability of individual policies without age restrictions does not mean that the Blue Cross-Blue Shield Plans or the commercial companies make an effort to sell such insurance. Indeed, some contracts may be available to aged persons only during a limited period, such as two weeks or a month, each year.

A number of insurance companies have experimented with mass sales to older persons of policies which are guaranteed non-cancellable

[31] U.S. House of Representatives, *Health Services for the Aged Under the Social Security Insurance System, Hearings Before the Committee on Ways and Means on H.R. 4222* (87th Cong., 1st sess.) 1961, Vol. 2, p. 853.

and renewable. The policies are made available, without a health history inspection, to all aged persons in a city or some larger area for a limited period following extensive advertising. One company has a contract with the American Association of Retired Persons for specified health insurance benefits for all members who desire to take such insurance. Over 400,000 aged persons are reported to be covered under these contracts.

The State of Connecticut passed legislation authorizing cooperative action among insurance companies which offer health insurance "against major financial losses" to aged persons. An organization known as Associated Connecticut Health Insurance Companies has been formed, underwritten by some 30 companies. The organization offers a number of major medical and basic benefit policies to all aged persons in the State, such policies being available during limited enrollment periods. During the first enrollment period—the month of September 1961—21,850 persons enrolled. Some of them may already have other coverage. Losses or gains are shared among the companies on a prearranged basis.

Low benefit ratio on individual insurance.—Individual insurance, which is all that is available to many aged persons, is a relatively poor buy as compared to group insurance. In 1960 benefits amounted to only 53 percent of premiums, on the average, in the case of individual health insurance policies sold by commercial companies.[32] This compared with 90 cents in benefits per premium dollar for group enrollees with insurance companies and 92 cents for Blue Cross-Blue Shield plans (the latter including some individuals but mainly group coverage). The operating expenses of individual health insurance are necessarily high because of high initial sellings costs and subsequent premium collection costs.

Paid-up-at-retirement policies.—There has been considerable discussion of paid-up-at-retirement policies. Such a policy guarantees that a specified set of health insurance benefits will be available to the policyholder during the remainder of his life. The benefits are on a cash indemnity basis (a specified number of dollars for up to a specified number of days of care, plus an allowance for hospital extras). It would be very difficult for an insurance company to estimate the future cost of a service benefit (guaranteeing up to a specified number of days of care regardless of rising hospital costs). This is a new approach and little of this type of coverage has been sold. If the policy is not purchased until the date of retirement, the initial costs are high ($700 to $1,300 per individual). Similarly, even if purchased prior to retirement, the annual payments required for persons already approaching retirement would be substantial.

---

[32] Reed, Louis S., "Private Medical Care Expenditures and Voluntary Health Insurance, 1948–60", *Social Security Bulletin*, December 1961.

If the costs were spread over the full working life of the individual, the annual payments would be small, and might be coupled with current health insurance premium payments throughout his working life. There is a practical barrier, however, since most workers obtain their health insurance through their place of employment. Few persons spend their entire working lives with one employer, so continuous coverage under a single insurance carrier would be difficult to maintain. Aside from the uncertainty as to whether they will still be with the same employer when they retire, there are other factors that could make workers reluctant to participate in purchasing this form of insurance. They may anticipate that their existing health insurance coverage will continue after retirement or they may fear that a specified set of cash indemnity health benefits may prove inadequate if the trend of rising medical costs continues.

The extent of health insurance protection for the aged

It is estimated that about 8.7 million persons aged 65 and over had some protection against hospital costs as of July 1, 1961, and about 7.9 million against surgical costs. This assumes the same ratio of duplication (i.e., coverage under more than one policy) among Blue Cross-Blue Shield plans, insurance company policies and independent plans as assumed by the Health Insurance Council for the population of all ages.

The Blue Cross plans reported in July 1961 that they had 4,250,000 persons enrolled who were aged 65 and over and the Blue Shield plans had 3,250,000 aged members.[33] Virtually all of the Blue Shield members are included among those who have Blue Cross coverage. On the basis of a recent survey in which 90 companies that write two-thirds of the health insurance business participated, the Health Insurance Association of America estimates that some 4¾ million aged persons have hospital coverage through insurance companies. This is after allowance for duplication of persons with both group and individual policies sold by insurance companies.[34] Assuming that the pro-

[33] Colman, J. Douglas, and Stubbs, Donald, M.D., Statements in *Health Services for the Aged Under the Social Security Insurance System, Hearings Before the Committee on Ways and Means on H.R. 4222*, U.S. House of Representatives (87th Cong., 1st Sess.), 1961, Vol. 3, pp. 1692 and 1718.

[34] The Association supplied the following unpublished summary of the responses by the 90 companies as of July 1, 1961, in thousands:

Type of coverage	Total	Group	Individual or family
Hospital	3,615	1,715	1,900
Surgical	3,186	1,711	1,475
Regular medical	1,099	952	147
Major medical	730	595	135

portion of members who are aged 65 and over is the same as for all other types of health insurance coverage, there would have been nearly 370,000 aged persons in independent plans with hospital protection and about 430,000 with medical-surgical service coverage.

These figures are based in considerable degree on estimates and may be somewhat wide of the mark. The estimated net numbers with hospital and surgical care protection are equivalent to 51 and 42 percent, respectively, of the total aged population as of July 1, 1961, compared to 73 and 68 percent for the population of all ages.

Probably more reliable data on the extent of health insurance among the aged come from a survey conducted by the National Health Survey in July–December 1959.[35] They found that of all aged persons not in institutions, 46 percent had some type of hospital insurance, 37 percent had surgical insurance and 10 percent had insurance covering doctors' visits in the home, office, and hospital. Among the general population, by contrast, 67 percent had hospital, 62 percent surgical, and 19 percent medical insurance. Some part of the difference between the National Health Survey figures and the estimates set forth above may be due to growth in coverage of the aged between July–December 1959 and the middle of 1961; a part may also be due to underestimation by the Health Insurance Council of the extent of duplicating coverage.

As might be surmised, persons 65 to 74 are more likely to have insurance protection than those 75 and over. The data from the National Health Survey on the percent with insurance follows:

Age group	Hospital	Surgical
65 to 74	53	44
75 and over	32	24

Of the aged who had hospitalization insurance, the survey found:

43 percent were covered by Blue Cross;

7 percent by a "Blue Plan" and other type of plan;

49 percent by some other plan, i.e., an insurance company or independent, and

1 percent did not know the type of insurer

A survey by the Health Insurance Institute in 1957 found that among persons 65 and over who had health insurance, approximately twice as many had "individual" as had "group" insurance.[36]

[35] Public Health Service, U.S. National Health Survey, *Interim Report on Health Insurance, United States, July–December 1959* (Publication No. 584–B26), December 1960.

[36] Health Insurance Institute, *A Profile of the Health Insurance Public*, 1959, p. 9.

The proportion of the aged having health insurance was greater in urban than in rural areas and higher in the Northeast and North Central areas than in the South and West.

The extent of health insurance coverage is much lower among the aged with low incomes than among those of middle or high income. Thus, as with the general population, they are least able to meet sickness costs out of pocket. (See Table 26).

TABLE 26.—*Insurance Coverage of Aged Persons: Percent of aged persons with hospital insurance by income, July to December 1959*

[Noninstitutional population of the United States]

Family income	Percent
Total	46.1
Under $2,000	33.3
$2,000 to $3,999	53.2
$4,000 to $6,999	59.6
$7,000 and over	59.4

Source: Public Health Service, U.S. National Health Survey, *Interim Report on Health Insurance, United States, July–December 1959* (Publication No. 584-B26), December 1960.

The proportion of the aged with some type of health insurance has been increasing. Thus, two surveys conducted by the Census Bureau found 26 percent of persons 65 and over had some type of health insurance in March 1952 and 37 percent in September 1956.[37] Another pair of surveys found an increase from 31 percent in mid 1953 to 43 percent in mid 1958,[38] compared to the 46 percent found by the National Health Survey in the second half of 1959.

Figures showing the percent of the aged who have some health insurance must be understood for what they are. The scope and adequacy of coverage varies widely. An aged person who has hospital insurance paying $5 a day for 30 days against the room cost and $50 against the cost of the specific services ranks on the same footing as one who has insurance that will pay all of his bill in semi-private accommodations for 180 days or more.

Among all cases of aged persons discharged from short-stay hospitals during a survey, July 1958–June 1960, some portion of the bill was paid by insurance in 51 percent of the cases. Three-fourths or more of the hospital bill was paid in 30 percent of the cases.[39] Among persons under 65, insurance met some part of the hospital bill in 70 percent of all discharged cases, and three-fourths or more of the bill in 54 percent of the cases.

[37] Division of Program Research, Social Security Administration: *Health Insurance Coverage by Age and Sex*, by Agnes W. Brewster (Research and Statistics Note No. 13), 1958; and *Health Insurance in the Population 65 and Over*, by Agnes W. Brewster (Research and Statistics Note No. 17), 1958.

[38] Health Information Foundation, "Voluntary Health Insurance: 1953 and 1958," *Progress in Health Services*, May 1959.

[39] Public Health Service, U.S. National Health Survey, *Proportion of Hospital Bill Paid by Insurance, Patients Discharged From Short-Stay Hospitals, United States, July 1958–June 1960* (Publication No. 584-B30), November 1961.

Reasons why aged persons do not have insurance

There are various reasons why those of the aged who do not have health insurance are without it. Inability to afford it, unavailability of insurance, unawareness of any need for it, indifference, neglect—all play a part. Some indication of the relative role of these and other factors is given by various surveys.

A study conducted by the National Opinion Research Center for the Health Information Foundation found that in 1957 about half the aged persons without health insurance would have liked to be covered, just over one-quarter had not thought about it, and just under a quarter didn't want it.[40] Among those who wanted coverage, 68 percent couldn't afford it and 32 percent had been refused insurance or had insurance formerly but it had been cancelled.

About one-sixth (16 percent) of the aged surveyed in this HIF–NORC study had formerly been covered by health insurance but were not covered at the time of the survey. Among the reasons given for not continuing health insurance were: Could no longer afford it (31 percent); retired or gave up working (26 percent); dissatisfied with policy's coverage (24 percent). Other reasons were that "company discontinued plan"; "did not feel need"; "job change without policy's carrying over."

A similar picture emerges from the responses of OASI beneficiaries to the question as to why they do not have health insurance. According to a survey of beneficiaries in 1957, 68 percent of the aged beneficiaries who did not have hospitalization insurance had never had such insurance. Thirty percent had been insured at one time, but the policy was dropped before the survey year. For 2 percent the insurance status before the survey year was unknown. The reasons given by those without insurance for not having it are given in Table 27.

Cost and benefits under current policies and recent proposals for the aged

Some indication of the extent to which aged persons may find health insurance to be beyond their economic reach is given by consideration of charges for health insurance in comparison with income of aged persons.

One insurance company widely advertises a "senior citizen" health insurance policy which provides up to $10 a day for hospital room and board charges for up to 31 days per hospital confinement, up to $100 toward the cost of the special hospital services (operating room, X-ray, drugs, etc.) and reimbursement of costs of surgery in accordance with

[40] Health Information Foundation, "Voluntary Health Insurance Among the Aged," *Progress in Health Services*, January 1959.

TABLE 27.—*Reasons for No Hospitalization Insurance: Percent of aged OASI beneficiaries who did not have insurance, 1957*

Reason	Percent
Aged beneficiaries never insured	100
Could not afford it	41
Never thought about it	30
Not interested	18
Refused by insurance company	9
Other reasons	2
Insured at one time, policy dropped	100
Could not afford it	39
Group policy could not be converted at retirement	29
Not interested	14
Cancelled by insurance company or terminated at deaths of husband	13
Other reasons	5

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, *1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.*

a schedule that pays a maximum of $200 for the most expensive operation. (The policy has a six months' waiting period for pre-existing conditions but no other limitations because of physical condition.) The premium charged is $6.50 a month—$78 a year.

The average daily room and board cost in general non-Federal hospitals in 1961 was approximately $16; total costs including special services such as operating room, X-ray, etc., averaged $32 a day. A benefit of $10 a day and up to $100 for extra services would cover a varying proportion of hospital costs, but in few cases would it provide full coverage.

The American Association of Retired Persons offers to its members a hospital and out-of-hospital major medical plan. This is under a contract written with an insurance company. The hospital contract provides $10 a day against room and board costs for up to 31 days per hospital confinement, 50 percent of the cost of the hospital extras up to a maximum payment per confinement of $125, 50 percent of outpatient hospital charges for care in an accident, and reimbursement of surgical costs in accordance with a schedule with maximum payment of $200. The cost is $6 a month.

The out-of-hospital major medical contract pays 80 percent of eligible expenses above a deductible of $100 in any calendar year, and up to a maximum of $2,500 in any year. Eligible expenses include prescribed drugs, doctor visits in the office and home and hospital consultation, nursing home care up to $10 a day and up to a maximum of $500, diagnostic X-ray and laboratory services and special nursing in the patient's home up to $10 per shift. The cost is $7.50 a month.

For both these contracts an aged person would pay $13.50 a month or $162 a year, and would not receive any benefits under the second contract until he has paid $100 out-of-pocket.

Still another illustration may be given. The American Hospital Association and the Blue Cross Association have outlined a Blue Cross contract of hospital and related benefits which they say should be made available to all aged persons. The contract would provide complete hospital care for 70 days in accommodations of three or more beds, emergency outpatient care within 72 hours of an accident, up to 210 days care in a skilled nursing home upon discharge from a hospital or in lieu of hospital care, and up to 70 visiting nurse visits per year. They estimate the cost of such a contract at about $12 per aged person per month.

The American Medical Association and the Blue Shield plans have outlined a Blue Shield contract which they hope to make available to all aged persons. This contract would pay the cost of surgery, the cost of non-surgical physician care in a hospital (up to 30 to 70 visits a year) and X-ray and laboratory services in a physician's office. Physicians would accept a specified fee schedule as full payment of their charge for a single person with annual income under $2,500 and a couple with annual income of $4,000. The estimated costs of such a contract is $3 a month.

For both contracts the annual cost would be $180 a year for a single person, $360 for a couple. Clearly, policies that cost these amounts are beyond the reach of a substantial portion of elderly persons. The AHA and Blue Cross have recognized this and have proposed that the Government help pay the cost of the premium for aged persons who meet an income test.[41]

---

[41] See recommendations from January, 1962 meetings of Blue Cross Association and American Hospital Association in *Hospitals*, February 1, 1962.

CHAPTER 7. METHODS OF PAYING FOR MEDICAL CARE

Many older persons, as has been demonstrated, have large medical bills, more so than younger persons. For most young families the uneven and unpredictable impact of heavy medical costs is likely to be offset at least in part by private health insurance. Relatively fewer retired aged persons, particularly those in poor health and in the older age groups where the burden of medical costs is greatest, have such protection. Older persons too, lack the possibility often open to those younger of accommodating to a medical emergency through increasing family earnings.

For medical care expenditures, more than for other items of family living, there is wide variation not only from family to family but for any given family from year to year. An unanticipated medical emergency can change expenditures from a comfortably manageable level to a new peak of crisis.

How then, do the aged manage when ill? A number are able to manage on their own, especially if they have insurance against some costs. Some seek help from others—relatives if there are any, and public assistance if relatives cannot help. Some get free care under other public programs or through private charity. Some borrow money. And there are probably some, albeit an unknown number, who do not get care they need.

Using own resources

A 1957 study for the Health Information Foundation (HIF) on resources to pay for health services among those aged 65 and over reported as follows:

"In early 1957 the older population could be divided into three groups: Those who had resources from which they could meet a medical bill as large as $500; those who had no ready resources for meeting such a bill; and a small amorphous middle group whose position cannot be clearly ascertained * * *. No categorical statement can be made to summarize how older people said they would meet a large medical bill. Some felt they could pay a medical bill as large as $500 from a combination of current income and savings. This group included roughly six of every ten couples, five of every ten unmarried older men, and four of every ten unmarried older women. On the other hand, some older persons would have to mortgage property, borrow on life insurance, ask help from their children, turn to public assistance or charitable aid, or say in despair, 'No one

would charge me that * * * I just couldn't pay it.' This group included about three of every ten couples, four of every ten unmarried older men, and five of every ten unmarried older women." [42]

The HIF study asked people how they thought they would handle a large bill. The OASI survey in the same year obtained fairly comprehensive data on the means by which aged persons actually met their medical emergencies. More than two-fifths of the couples and roughly three-fifths of the nonmarried beneficiaries studied who spent some time in a general (or short-stay special) hospital in 1957 did not meet all the year's medical costs out of their own income, assets and health insurance. Almost all beneficiaries hospitalized paid some of their medical bills from their own income and savings, but those with very long stays were least able to stretch their resources to cover all costs. For example, 78 percent of the nonmarried beneficiaries in a general hospital longer than 60 days did not assume responsibility for all their own medical costs for the year, compared with 55 percent of those hospitalized for shorter periods.[43]

Medical debts were incurred—or increased—by 21 percent of the couples and 12 percent of the nonmarried beneficiaries with a hospital episode during the year. (For all the beneficiaries, whether or not hospitalized, the proportions were much smaller—7 percent and 3 percent, respectively.) And this does not count the cases where a doctor, for example, reduced his fees because he knew that the patient could not pay. Moreover, a considerable number of the beneficiaries who had more unpaid medical bills at the end that at the beginning of the year got help from outside as well.

Help from others

Fifteen percent of the couples and 29 percent of the nonmarried beneficiaries who had a hospital episode relied for at least part of their medical care on public assistance agencies, hospitals, or other public and private health and welfare agencies. Less than half as many of the nonhospitalized beneficiaries had to turn to welfare agencies.

The number receiving help from relatives in one form or another was at least as large. When beneficiaries were asked how they met their medical bills, 15 percent of the couples and 26 percent of the nonmarried with one or more hospital episodes reported that relatives helped pay for them. (Less than half as many of the other beneficiaries had to turn to relatives.) Some additional beneficiaries with hospital bills in effect received as much or more help with their medi-

[42] Health Information Foundation, *Meeting Medical Care Costs Among the Aging* (Research Series, No. 17), 1960, p. 26.

[43] Bureau of Old-Age and Survivors Insurance, Social Security Administration, *Impact of Hospitalization Costs on Aged Beneficiaries*, by Edna C. Wentworth (1957 National Survey of Old-Age and Survivors Insurance Beneficiaries, Highlight Report No. 6), 1961, table 4.

cal costs from relatives who helped support them either by sharing their home or by paying other regular living expenses.

The longer the period of hospitalization the more frequently relatives contributed to help out with expenses. Most of the relatives who were contributing to an aged person living in the household were themselves in the middle or lower end of the income scale.

If the relatives—both in and out of the household—on whom responsibility fell were typical, many would have children of their own to take care of. Others, with no children, were themselves already at or close to the age when their own problems of retirement would loom large. The aforementioned study by the HIF asked the persons 65 and over to whom they would turn (other than their own husband or wife) in event of illness. More than 6 in 10 named a son or daughter or the spouse of a son or daughter. Those designated were described as follows:

"Those to whom older people would turn for help in a health crisis were already involved with many family responsibilities. If these individuals were sons or daughters of older people they were usually young or middle-aged adults. Three of every four among them (73 percent) had children of their own . . . The relatives to whom older people without children would turn for help were themselves likely to be in the older age groups, and many of these were over 65 years of age; also, many were widowed or single." [44]

When asked how they would pay a medical bill of $500 or more, about one-fourth of the aged women who were widowed, divorced or single, and about one-eighth of the men who were not married, said they would turn to children or other relatives. Fewer of the married persons—1 in 13—mentioned relatives as a resource presumably because those still married tend to be younger and to have more income and savings than the widowed.[45]

Medical need and public assistance

The exact number of aged who must seek public assistance because of medical need cannot be measured with exactitude. Depending on facilities available for the medically indigent and on local assistance practices, as well as on personal differences in reaction to a means test, some come for help at the time of medical need while others come to seek help in meeting daily living expenses only after using up their resources to pay their medical bills.

For example, the 1957 BOASI survey found that among all aged beneficiaries who incurred medical costs during the survey year, about 1 in 14 of the couples and 1 in 8 of the nonmarried were on public assistance at some time during the same 12-month period.

---

[44] Health Information Foundation, *Family Relationships of Older People* (Research Series, No. 20), pp. 11–13.

[45] Health Information Foundation, *Meeting Medical Care Costs Among the Aging* (Research Series, No. 17), table 12.

An analysis of the reasons for approving old-age assistance grants in about half the States in January–June 1961 shows that nearly 1 in 3 recipients needed assistance, at least in part, as a result of health problems in the 6 months preceding. Interestingly enough, aged persons receiving OASI benefits (numbering just about every other newly approved assistance recipient) were more likely to require the aid because of medical needs. Health problems of one sort or another were the reason for opening the case for two-fifths of the recipients drawing benefits as against one-fourth of those not on OASDI (See table 28).

TABLE 28.—*Old-Age Assistance: Distribution of cases opened by reasons for opening, by OASDI status, 25 States, January–June 1961*

Reason for opening	Total opened	Receiving OASDI benefits	Not receiving OASDI benefits
All cases	100	100	100
Total involving health problems	31	39	25
Recipient's earnings reduced because of illness, injury, or impairment	11	11	9
Assets exhausted to meet medical care	7	9	7
Increased need for medical care (with no material change in income or resources)	13	19	9
Other reasons	69	61	75

Source: Bureau of Family Services, Social Security Administration, *Reasons for Opening and Closing Public Assistance Cases*, January–June 1961. (In process.)

Although OASI beneficiaries who receive supplementary old-age assistance are older, have smaller benefits and less income from other sources, are in poorer health and experience considerably more hospital illness than other beneficiaries, they are younger, in better health, and have more resources on the average than the recipients of assistance not on the OASDI rolls.[46]

New York State, which has one of the better medical care programs for old-age assistance recipients, reported that 54 percent of all payments for old-age assistance in 1960 represented expenditures for medical care. This proportion takes into account not only payments made directly to the vendors by the assistance agency, but also the amount included in the cash grant for the recipient himself to spend on his medical requirements. The average annual medical bill per recipient was over $700, while payments for living costs averaged only $600. Much of this medical bill represented payments for care of the chronically ill in public and private nursing homes, but a fourth went to pay for hospital stays:[47]

[46] Ossman, Sue, "Characteristics of Aged Old-Age and Survivors Insurance Beneficiaries Who Also Receive Public Assistance," *Social Security Bulletin*, October 1959.

[47] New York State Department of Public Welfare, *Analysis of Medical Care Expenditures by Local Public Welfare Districts for Public Assistance Recipients in New York State During 1960*, by W. Kaufman (Special Research Statistical Reports, No. 17), September 1961.

	(Millions of dollars)
Total assistance payments	$106.6
Medical expenditures	57.8
Nursing home care for chronically ill	37.0
Hospital care	14.8
All other medical	5.9

With New York one of the States now participating actively in the Medical Assistance to the Aged program, data for 1961 will be somewhat different. Much of the nursing home care previously provided under old-age assistance is transferred to the new program.

The role of hospital insurance

Were it not for health insurance many more aged persons would have to turn to relatives or welfare agencies, or both, to meet their pressing medical needs.

Having the protection of prepayment for some or all hospital costs is an extension of individual ability to pay for illness when it strikes. As such it has been shown to have a bearing on the decision to seek (or accept) admission to a hospital and on the length of stay. It can affect also the hospital chosen—as between a voluntary or proprietary institution, and one maintained by public funds. The actual differentials between those with insurance to defray hospital costs and those without are in some measure obscured by the fact that the latter as a group tend to be the more disadvantaged in health and economic status.

Among the aged, perhaps even more than among the working population, those most likely to need the benefit of health insurance—the chronically ill and those with the lowest income— are least likely to have the advantage of prepayment. Even those who do have insurance often find their protection incomplete, either because many costs are excluded from coverage or because a protracted illness outlasts the benefit period.

Length of stay and portion of bill covered.—Data from the National Health Survey for 1958–60 reveal that for half the short-stay hospital episodes of aged persons during a year health insurance paid no part of the bill.

Even when insurance was available to the aged it was less effective for long than for short stays, defraying three-fourths of the hospital bill for 47 percent of the stays lasting over a month, compared with 60 percent of those lasting no more than 30 days (table 29). Although the average elderly patient in a general hospital who leaves the hospital alive does so within 15 days, nearly 1 in 10 remains a month

TABLE 29.—*Insurance Coverage of Hospital Costs: Distribution of short-stay hospital discharges according to proportion of bills paid by insurance, by age and length of stay, July 1958–June 1960*

[Noninstitutional population of the United States]

Age and length of stay	Total discharges	Proportion of bill paid by insurance			
		None of bill	Any part of bill		
			Less than ½	½ to ¾	¾ or more
65 and over	100.0	48.8	9.0	11.9	30.3
1 to 5 days	100.0	48.9	10.1	11.5	29.4
6 to 14 days	100.0	46.4	8.6	11.9	33.1
15 to 30 days	100.0	49.8	9.2	11.0	30.0
31 or more days	100.0	54.7	8.1	15.8	21.4
Under 65	100.0	30.0	4.9	11.2	53.8
1 to 5 days	100.0	31.6	4.6	11.1	52.7
6 to 14 days	100.0	25.1	5.3	11.7	57.9
15 to 30 days	100.0	28.2	5.2	12.3	54.4
31 or more days	100.0	49.1	7.2	8.7	34.7

Source: Public Health Service, U.S. National Health Survey, *Proportion of Hospital Bill Paid by Insurance. Patients Discharged From Short-Stay Hospitals, United States, July 1958-June 1960* (Publication No. 548-B30), November 1961.

or longer. The longer his hospitalization lasts, the more likely it is the aged person will have to seek help from others to pay for his care.

The OASI beneficiary survey also provides a measure of the degree to which insurance met hospital costs of aged patients. About 1 in 5 married beneficiaries and 1 in 4 of the nonmarried with insurance found it met all of the hospital charges. On the other hand about 5 percent of those with a hospital insurance policy found it did not cover any of the costs of their care in a nongovernmental general hospital (table 30).

For all the aged who go to a hospital the actual proportion of hospital bills paid in some part by insurance is probably smaller than shown, because terminal illness cases are excluded. Those at the older ages, most likely to die, are least likely to have any insurance and thus often leave a heavy legacy of expenses. The small number of beneficiaries (referred to previously) in the OASI survey whose spouse died during the survey year reported greater difficulty in meeting total medical costs for the year than other beneficiaries. Insurance covered some medical costs in only one-fourth of the cases where one of the partners had died, and a fourth of the survivor beneficiaries reported they still had unpaid bills at the end of the survey year.

Amount of insurance and amount of hospital utilization.—That ability to pay affects the rate at which people can get needed care was demonstrated in Chapter 3. Aged persons having insurance against costs appear to enter a hospital with greater frequency but have a shorter average stay than those with no insurance protection. The

TABLE 30.—*Insurance Coverage of Hospital Costs of OASI Beneficiaries: Distribution of aged beneficiaries in general hospitals according to proportion of costs paid by insurance, by marital status and hospital ownership, 1957*

Proportion of general hospital costs paid by insurance [1]	Married couples [2 3]		Nonmarried beneficiaries	
	Total	Non-Government	Total	Non-Government
Total hospitalized	100	100	100	100
With no hospital insurance	43	39	48	41
With some hosp. insurance	57	61	52	59
With some hosp. insurance	100	100	100	100
No costs met by insurance	7	6	9	5
Less than 25 percent met by insurance	7	8	4	3
25 to 49 percent met by insurance	18	20	6	5
50 to 74 percent met by insurance	22	22	29	30
75 to 99 percent met by insurance	20	19	21	23
100 percent met by insurance	19	19	24	27
Unreported amount met by insurance	6	6	6	7

[1] Excludes surgeons' and inhospital physicians' fees. In the case of married couples, with both members hospitalized, represents hospital costs for the couple. (General hospitals include short-stay special hospitals.)

[2] Insurance status for married couples refers to the hospitalized person. If both were hospitalized, but only one insured, the couple is classified in the "with insurance" category and by the proportion of total general hospital costs for the couple which was met by the insurance.

[3] Aged beneficiary and spouse, whether or not entitled to benefits; spouse may be under 65 years of age.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, *1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.*

inhibiting effect of limited resources for payment can be demonstrated further by the finding that even among those with insurance, differentials exist corresponding to the degree of protection provided: Those with a higher benefit policy use the hospital more often than those with a lower benefit policy. A study of subscribers to the Rhode Island Plan in 1959 showed considerably more hospital use among the subscribers to the higher cost (benefit) plan—primarily because of higher admission rates. The average length of stay is only modestly greater for those with better coverage. Among individual subscribers aged 65–69 years, there were nearly twice as many hospital cases per 100 contracts on the $20 a day plan as on the $8 a day plan. Among the 70–79 year old subscribers, there were about 1⅔ as many admissions per 100 $20-plan contracts as on the $8-plan contracts.[48]

In like fashion, the study of hospital use in Michigan in 1958 noted with respect to ability to pay that "persons with the highest degree of coverage (70 percent and more of hospital bill paid by coverage) had almost twice the admission rate of those without insurance after allowing for the effects of [age, sex, family income, family composition, attitudes towards early medical care, education, and region where family head grew up]." [49]

[48] Blue Cross Association and American Hospital Association, *Financing Health Care of the Aged, Part I. A Study of the Dimensions of the Problem.* 1962.

[49] *Ibid.*

Insurance and utilization of public hospitals

Public hospitals more commonly than private institutions must be prepared to provide care at charges geared to ability to pay—including care at no charge to those who cannot pay at all. In many localities State, county, and municipal hospitals provide much of the care for assistance recipients by arrangement with local welfare departments. Some persons with insurance who need to go to the hospital will select a Government institution out of preference; others, because they know the current illness will not be covered under terms of their contract; and some, because they cannot afford the doctor's fees and other charges attendant upon a stay in a private hospital. But persons with no insurance whatever are much more likely to go to a public institution than those who have insurance to defray some of the bills.

The National Health Survey found about one out of three hospital discharges with no part of the bill paid by insurance came from Government hospitals, as compared with 1 in 7 of those for which insurance did pay part of the bill. These proportions are the same for patients under 65 as for persons 65 and over. However, because fewer of those over 65 have any insurance, the Government hospitals accounted for a somewhat larger share of total general hospital stays of the aged than of persons under 65 (23 percent vs. 20 percent respectively). The fact that the aged patient is likely to remain in hospital longer than the younger patient gives this differential added significance.[50]

The 1957 OASI beneficiary study also demonstrates the effect of ability to pay—as measured by health insurance protection—on the type of hospital used and on completeness of reporting of medical costs. Among four out of five of the couples with either member hospitalized and a little better than 7 out of 10 of the nonmarried, the hospitalization took place in a nongovernment hospital. But, as table 31 indicates, beneficiaries with no hospital insurance policy were just about twice as likely to enter a Government hospital for their care as those who could anticipate insurance defraying some of the bills. Moreover, although very few of the hospitalized beneficiaries received their care in a Federal general hospital, almost all who did came from among the noninsured.

About 1 in 4 were not able to report their medical costs in detail, often because they had received some care free.[51] As one might expect, having to go to a hospital was a prime factor in the situation. Al-

---

[50] Public Health Service, U.S. National Health Survey, *Proportion of Hospital Bill Paid by Insurance, Patients Discharged from Short-Stay Hospitals, United States, July 1958–June 1960* (Publication No. 584–B30), November 1961.

[51] Care supplied by a hospital or doctor who tended no bill to anyone or care for which a public assistance agency paid directly to the hospital or doctor. Bureau of Old-Age and Survivors Insurance, Social Security Administration, (*Social Security: Aged Beneficiaries and Older Workers Under OASDI*), September 1960, table 11.

TABLE 31.—*Insurance Status and Hospitalization in Public Institutions: Distribution of aged OASI beneficiaries in general hospitals by hospital ownership and insurance status, 1957*

Hospital ownership [2]	Married couples [1]		Nonmarried beneficiaries	
	With no hospital insurance [3]	With hospital insurance [3]	With no hospital insurance	With hospital insurance
Total hospitalized	100.0	100.0	100.0	100.0
Nongovernment	72.3	85.2	61.5	83.5
Government	30.1	17.0	39.2	16.5
State, county, and city	26.6	16.2	31.5	15.8
Federal	3.5	.9	7.7	.7
Hospital costs reported	100.0	100.0	100.0	100.0
Nongovernment	84.1	88.6	76.4	83.8
Government	18.6	14.1	23.6	16.2
State, county, and city	18.6	14.1	22.2	16.2
Federal			1.4	
Hospital costs not reported [4]	100.0	100.0	100.0	100.0
Nongovernment	50.0	71.1	43.1	81.8
Government	51.7	28.9	58.6	18.2
State, county, and city	41.7	24.4	43.1	13.6
Federal	10.0	4.4	15.5	4.5

[1] Aged beneficiary and spouse, whether or not entitled to benefits; spouse may be under 65.
[2] A few had more than 1 stay in a general hospital involving more than 1 type of ownership. (General hospital includes shortstay special hospital.)
[3] For the hospitalized person. If both members were hospitalized but only one had hospital insurance the couple is classified in the "with insurance" category.
[4] In many cases, includes some "free" care, i.e., no bills rendered to anyone, or vendor paid directly by public assistance or other agency.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.

though a fifth of all couples and a seventh of all nonmarried beneficiaries had been hospitalized, half of those who could not state their total medical expenses for the year had been in a hospital. The data for hospitalized beneficiaries show that those unable to report hospital costs more often were beneficiaries with no insurance (Appendix A, table 11). Furthermore among both the insured and the uninsured, those unable to report costs were more likely to have been treated in a public hospital than other beneficiaries (table 31).

PART III

Public Programs and Philanthropic Arrangements for Medical Care

CHAPTER 8. MEDICAL CARE UNDER THE OLD-AGE ASSISTANCE PROGRAM

Public programs are now responsible for more than $1 in every $4 spent for medical care for persons 65 and over. It is estimated that public expenditures for medical care for the aged amounted to $1.3 billion in 1960 [52] and that about two-thirds of these public funds went for care in hospitals (Table 32).

TABLE 32.—*Public Expenditures for Medical Care for the Aged: Estimated amount by type of program and type of care, 1960*

[Millions of dollars]

Type of medical care	Total	Public assistance	Veterans' Administration	Other
Medical care, total	$1,330	$455	$265	$610
Hospital care, total	895	100	235	560
General	470	100	165	205
Mental and tuberculosis	425		70	355
Other	435	355	30	50

Source: Division of Program Research, Social Security Administration.

Some medical care programs—notably those under public assistance and those for veterans' nonservice-connected disabilities—are open only to the needy. Others—notably those for veterans' service-connected disabilities, or for military personnel and their families—provide for all in these special population groups without regard to income or ability to pay. Publicly administered general hospitals in many localities provide care at no charge, or at charges related to income, for persons who cannot afford to pay in full. Traditionally, nongovernmental hospitals also provide some free medical care to the needy, but these hospitals are increasingly being paid for their services to the needy through public programs and public grants.

[52] See Appendix C for sources and methodology of estimates.

The public assistance programs are the most important single source of public funds for medical care for aged persons outside of mental and tuberculosis hospitals. From the beginning of the Federal-State old-age assistance program in 1935, the cost of medical care could be included in monthly cash payments to OAA recipients. However, the fact that the monthly payments for a recipient were subject to Federal and State maximums very much limited the care made available in most States.

In 1950 the Social Security Act was amended to permit Federal matching of payments for medical care made directly to suppliers. However, these so-called vendor payments had to be within existing maximums on Federal participation in payments. In 1956, old-age assistance was again broadened by establishing separate Federal matching for medical care payments over and above the cash assistance payment. In 1958, the effective ceiling on Federal matching was increased.

The 1960 (Kerr-Mills) amendments to the Social Security Act provided two extensions of medical care for the aged under the public assistance program: (1) increased Federal matching of medical care payments under old-age assistance, and (2) a new program of medical assistance for the aged, designed to provide help with medical bills for the so-called medically indigent. The 1961 amendments included an additional liberalization of the Federal matching provisions for vendor medical payments under old-age assistance. Since 1960 the Federal Government has matched State expenditures in the form of vendor payments to old-age assistance recipients on a more favorable basis than expenditures made for assistance in the form of money payments.[53]

Some 2.3 million persons—more than 13 percent of all those 65 years and older—are presently receiving old-age assistance. The proportion varies widely from State to State, however, from 3 percent

[53] Prior to the 1960 amendments, the Federal Government matched State expenditures for assistance in an amount equal to (a) 80 percent of expenditures up to an average of $30 per month per recipient, plus (b) 50 to 65 percent—depending upon relative State per capita income—of expenditures over an average of $30 and up to an average of $65 per month per recipient including vendor medical payments. Under the Kerr-Mills amendments, as further modified by the 1961 amendments, if the average payment exceeds $66, the Federal Government matches from 50 to 80 percent—depending on relative State per capita income—of the amount of vendor medical payments up to an average of $15 a month per recipient, or the amount by which the average payment exceeds $66, whichever is less. For States with average monthly payments of $66 or less the Federal share in average vendor medical payments up to $15 a month is an additional 15 percent over the usual Federal percentage applicable to the amount of payments falling between $31 and $66. This percentage, when added to the usual Federal percentage for the second part of the formula for payments, gives a total Federal share of 65–80 percent. The additional Federal share of 15 percent is also available to States with average monthly payments of more than $66, when it is advantageous to them as an alternative to the method described above.

in Delaware and New Jersey to 51 percent in Louisiana. In general, it is high in the rural Southern States and low in the industrial Northern States (Appendix A, Table 4). In some States the public assistance agencies assume virtually complete responsibility for providing all needed medical care to public assistance recipients. In a few States the public welfare agencies make no provision for medical care of recipients. Most States fall between these extremes.

To receive Federal aid for its old-age assistance program a State must submit a State Plan which meets certain requirements laid down in Federal law. Among the requirements are that the program be operated or supervised by a single State agency, be effective in all parts of the State, provide for appeal by persons denied assistance, etc. Within the terms of Federal aid, the States have considerable leeway in operating their programs, including determining standards of eligibility and of need.

Services provided under Old-Age Assistance

There is considerable variation among the States with respect to the amount of care and types of health services that are provided under the OAA programs. In those States which provide medical care to OAA recipients by means of vendor payments, various limitations are placed on the amount of care provided. When a State pays for care through money payments, there is usually a maximum which limits the amount of care which can be paid for. A summary of the number of States providing services under the OAA programs and the method of payment for each service provided, i.e., by vendor payments or through money payments is shown in Table 33. The specific limitations on the amount of payments and care provided are shown in detail by State in Appendix B, Table 14.

TABLE 33.—*Old-Age Assistance Programs: Summary of number of States providing major types of medical services by method of payments, October 1, 1961*

Type of service [1]	Number of States		
	Total	Money payments [1]	Vendor payments [1]
Hospital care	46	3	43
Physicians' services	42	7	35
Office visits	39	7	32
Home calls	42	7	35
Hospital inpatients	26	5	21
Hospital outpatients	29	6	23
Dental care	36	10	26
Fillings	32	7	25
Extractions	34	8	26
Dentures and repairs	33	10	23
Prescribed drugs	40	[2] 12	[2] 31
Nursing home care	48	[3] 28	[3] 31

[1] There are substantial limitations among the States on amounts and care provided. See Appendix B, Table 14 for the detail by State.
[2] Includes 3 States using both money and vendor payments.
[3] Includes 11 States using both money and vendor payments.

Source: Bureau of Family Services, Social Security Administration.

In 46 States the assistance agency assumed some responsibility for the provision of hospital care as of October 1, 1961, the latest date for which State Plan characteristics have been summarized.[54] In 25 of these States necessary hospital care for all types of cases (except care in mental or tuberculosis hospitals) is provided for as long as may be needed. In the remaining States limitations are imposed relating to type of conditions which may be hospitalized—acute, critical, life-endangering illnesses or accidents, the number of days covered, and the maximum payments per day.

Some responsibility for the provision of some physicians' services under OAA is taken in 42 States. Home calls are provided in all of these States, but definite limitations are imposed in many States on the number of calls or visits that will be paid for in a given time period or case of illness. A few States pay for physicians' services only in acute conditions and/or life endangering conditions.

Dental services are provided to old-age assistance recipients in 36 States. Some States providing dental services under vendor payments limit these to emergencies, or when required for care of a medical condition, or to maximum payments. Most of the States providing dental care through money payments have grant limitations which would curtail the amount of dental care that could be paid for in this way.

Prescribed drugs for old-age assistance recipients are provided in 40 States, with limitations in some States on the maximum allowable or the type illness for which drugs may be prescribed.

Nursing home care is provided in 48 States, with maximum monthly limitations in many States ranging from $40 to $200. In 10 States the maximum grant is $100 or less.

Selection of physician, hospital, dentists, etc.

Analysis of State plans suggests that in most States which provide for physician service under the OAA program through vendor payments, recipients have free choice among the doctors in the area who are willing to serve assistance recipients at the fees paid by the assistance agency. No information is available, however, as to the proportion of physicians in the various States who have agreed to accept welfare fees and to serve assistance recipients.

Where money is included in the grant to pay for services of physicians or dentists, the assistance recipient makes his own arrangements and may choose among those physicians or dentists who are willing to accept the fees he can pay. Where the assistance agency pays for

[54] Bureau of Family Services, Social Security Administration, *Characteristics of State Public Assistance Plans Under the Social Security Act: Provisions for Medical and Remedial Care* (Public Assistance Report No. 19), 1962.

physicians' services in the office or home but not in the hospital, recipients requiring hospitalization ordinarily must go to hospitals where the medical staff has agreed to provide service free to welfare patients.

With respect to drugs, assistance recipients generally have a choice among the pharmacists in their localities. However, in those States where local welfare departments have entered into agreements with individual pharmacists who are willing to provide drugs at less than the going rate, welfare recipients have to purchase their drugs from these pharmacists.

If an aged recipient needs nursing-home care his choice is apt to be confined to those homes which are willing to accept welfare rates. Welfare departments pay for approximately half of all nursing home care in the United States—almost all of it for old-age assistance recipients. The low amounts which they pay for such care have, in considerable measure, set the standards of nursing home care in this country and set them at low levels.

Payment of physicians, hospital, etc.

In States and localities where medical care is paid for through vendor payments, the physicians, hospitals, and other suppliers are paid on the basis of rates mutually agreed upon. In most States the rates are negotiated on a State-wide basis between the welfare department and the State hospital association, State medical association, or other appropriate group. Comprehensive data are not available as to how these rates or fees paid compare with those paid by the general public.

In most States hospitals are paid either on the basis of a flat negotiated per diem rate or on their per diem cost but not in excess of a specified limit. Hence, many of the hospitals receive less than cost, some very much less. Hospitals generally hold that they should be paid for services to welfare recipients on a basis which reflects costs. State and local welfare departments frequently plead inability to pay full cost. Hospitals frequently agree to accept less than their costs on the assumption that some payment is better than none.

Administration

In most States (31 of 54) the OAA program is administered by a State agency—the State welfare or assistance department. This department usually has local or district offices. In the other 23 States the program is administered by the welfare departments of local political subdivisions (counties and cities, etc.) under supervision of the State agency. In the State-supervised programs the State agency

sets the main policies and procedures (including standards of eligibility, standards of assistance, medical care to be furnished, etc.) and the local welfare departments must hold to these policies. In 4 States (New York, Indiana, Kansas, and Wyoming) the program is administered by the counties under procedures in which the counties have considerable freedom of action but must submit a plan which meets State approval.

In the States with State administered programs the State generally bears the full cost of the program over and above Federal aid; in the State supervised programs, the localities generally bear a portion of the cost. In the State administered programs, arrangements for the provision of and payment for medical care are uniform throughout the State. In the State-supervised programs, there may be difference among the local subdivisions in the rates of payment for care and other particulars.

In a number of States the State welfare department has entered into arrangements with the State health department for administration of, or assistance in administering, the medical care part of the assistance program. In a number of States contracts have been entered into with Blue Cross plans, Blue Shield Plans or State or local associations of physicians or other professional groups for the provision of care or for paying hospitals, physicians, etc., for services or supplies provided to recipients.

In Puerto Rico, the Virgin Islands, and the District of Columbia the health department operates major facilities serving the whole population or the indigent and medically indigent and is reimbursed by the welfare department for services provided to assistance recipients.[55]

Utilization

Tables 34 and 35 present data on hospital, nursing home, medical service and drug utilization by OAA recipients in States which have thus far developed data of this type. Mainly these are States which are making above average expenditures per recipient for medical care.

From these data, it is apparent that at least in some States, OAA recipients are a most atypical population. In the general population 65 and over about 1 in 6 is admitted annually to general hospitals, and it is estimated that aged persons are receiving 270 to 285 days of hospital care annually per 100 persons (after adjustments for decedents). By contrast, in some States as many as a quarter or a third of all old-age assistance recipients were hospitalized, and in a recent year assistance recipients in 2 States received 1,221 and 1,348 days of hospital care per 100 recipients—approximately 5 times the expected

[55] See Appendix B, Table 15, for a more detailed description of these arrangements.

rate for the general population of this age. Part of this extraordinary use of service is undoubtedly due to the fact that old-age assistance recipients as a group are of advanced age—much older than the general population 65 and over. (The median age of all persons receiving OAA in 1960 was 76.4 years as compared with 72.1 for all persons 65 and over.) But in addition, it seems plain, illness and the need for medical care have been major reasons for persons coming on to the public assistance rolls.[56]

TABLE 34.—*Old-Age Assistance: Hospital utilization rates of recipients, selected States, recent periods*

State	Report period	Percent of recipients hospitalized	Rates per 100 recipients		Average days of care
			Hospital admissions	Days of care	
Colorado	1959	27.5	42.7	505	11.8
Connecticut	(1)	19.0	28.5	560	19.4
Florida	Nov. 1959–Oct. 1960	(1)	12.1	121	10.1
Illinois	Jan. 1958–June 1958	(1)	(1)	(1)	16.7
Maryland	(1)	[2] 10.0	13.0	240	17.2
Massachusetts	Fiscal year 1959–60	(1)	(1)	1,348	(1)
Michigan	1955	(1)	(1)	1,221	(1)
New Mexico	Fiscal year 1959–60	19.6	(1)	270	[3] 13.8
North Carolina	Fiscal year 1957–58	11.8	15.6	195	12.5
North Dakota	Fiscal year 1959–60	33.3	(1)	911	[3] 27.3
Oklahoma	Fiscal year 1959–60	(1)	23.1	(1)	(1)
Rhode Island	Fiscal year 1957–58	16.2	22.0	328	14.9

[1] Not reported.
[2] Estimated.
[3] Average days per patient rather than for hospital admission.

Source: Bureau of Family Services, Social Security Administration.

TABLE 35.—*Old-Age Assistance: Percent of recipients receiving nursing home care, physicians' services and drug prescriptions paid for through vendor payments, selected States, recent periods*

State	Report period	Percent of recipients receiving—		
		Nursing home care	Physicians' services	Drug prescriptions
California	Novemher 1957 to April 1958	(1)	51.4	44.5
Colorado	1959	9.5	(1)	(1)
Connecticut	(1)	(1)	62.0	65.0
Illinois	August 1960	14.5	(1)	(1)
Maryland	(1)	(1)	62.0	56.0
New Mexico	Fiscal year 1959–60	6.3	65.3	(1)
North Dakota	Fiscal year 1959–60	9.1	67.6	65.1
Oklahoma	Fiscal year 1959–60	[2] 10.0	(1)	(1)
Rhode Island	Fiscal year 1957–58	(1)	69.9	77.9

[1] Not reported.
[2] Includes some duplication of cases.

Source: Bureau of Family Services, Social Security Administration.

Expenditures for medical care under OAA

Expenditures for medical care for old-age assistance recipients in the form of vendor payments amounted to $315 million in 1961. It will shortly be possible to estimate the amount of expenditures for medical

[56] See Chapter 7, Table 28.

care provided through money payments to recipients on the basis of special statistical reports for January 1962 to be submitted by the States by April 1962. Expenditures in this form have undoubtedly dropped below the 1960 level (of $149 million) both because of transfers from OAA to MAA and because of changes in method of payment for medical care under OAA, but probably by not much more than the increase in vendor payments under OAA.

In January 1962 vendor payments for medical care averaged $13.26 per recipient.[57] Four States made no vendor payments; the range among the States which made vendor payments—from a low of 13 cents per recipient per month in Georgia to a high of $61.29 per recipient in Connecticut—was as follows:

Average Monthly Vendor Payments for Medical Care	*Number of States*
Total	50
Under $5.00	9
$5.00–$9.99	9
$10.00–$14.99	11
$15.00–19.99	6
$20.00–$24.99	4
$25.00 and over	11

The proportion of OAA expenditures going for medical care through direct payments to vendors is large—18.7 percent for the country as a whole in January 1962, the latest month for which data are available. In some States a major portion of all OAA funds are going for medical care in the form of vendor payments, e.g., 60 percent in Wisconsin, 57 percent in Connecticut, 49 percent in Minnesota, 44 percent in Illinois, and 43 percent in New Jersey.

Effect of 1960 amendments

The 1960 Social Security Amendments have resulted in increases in vendor payments under old age assistance in a number of States. By March 26, 1962, 8 States which had no vendor payment programs for OAA recipients before September 1960 had placed such provisions in operation. Some 26 States[58] which already had vendor payment programs have made their programs more comprehensive, i.e., provide services which they formerly did not provide through vendor payments.

The extent of improvement in services provided, however, varies considerably among the States. A change in method of payment may

[57] The number of recipients, total, and average payments by State are shown in Appendix B, Table 13.

[58] Arkansas, California, Connecticut, District of Columbia, Florida, Hawaii, Idaho (Nursing home care withdrawn from scope of OAA and provided in MAA), Indiana, Iowa, Louisiana, Maine, Maryland, Michigan, Missouri, Nevada, New Mexico, Ohio, Oklahoma, North Carolina, Tennessee, Utah, Vermont, Virginia, Virgin Islands, Washington, West Virginia.

or may not be important to the recipient. It could result in more adequate cash payments to meet both his subsistence needs and also his medical needs. Changes in average vendor payments provide a more definite indication of the impact of the 1960 amendments, even though OAA recipients in States with relatively high vendor payments do not necessarily receive comprehensive and high quality medical care, and those in States with relatively low vendor payments may receive care through other programs.

Between September 1960, the month before the amendment was effective, and January 1962 the U.S. average vendor payment per recipient increased from $10.75 to $13.26. Ten States did not make vendor payments for medical care for old-age assistance recipients in September 1960, but six of these States were providing vendor payments in January 1962. In 37 States average vendor payments per recipient were higher in January 1962 than in September 1960, but in 21 of them average money payments were lower, presumably at least in some cases because the State changed its method of payment to take advantage of more favorable matching provisions for vendor than for money payments. One State reported the same vendor payments and 6 States smaller average vendor payments in January 1962 than 16 months earlier. In 4 of these 6 States, the decrease was due to transfer of cases to the new medical assistance for the aged program, and opening new nursing home cases under MAA, also in order to take advantage of the more favorable Federal matching. Massachusetts and New York gained most, by transferring most of their nursing home cases from OAA to MAA.

Further consideration of overall changes in expenditures for medical care for aged persons who are needy or medically indigent will follow the description of the MAA program in Chapter 9.

Summary

It is clear that in some States the medical needs of OAA recipients are not being met through assistance programs. Four States assume no responsibility whatever under their old-age assistance program for provision of medical care through vendor payments. In 29 other States average expenditures for medical care in January 1962 through vendor payments were less than $15 a month per recipient, an amount certainly well below that required for purchase of adequate care.[59]

[59] The AHA and AMA proposals for Blue Cross and Blue Shield contracts (see Chapter 6) which they would like to see available to all aged persons, would cost in the neighborhood of $15 a month, and would provide services which would meet only about 50 percent of the total health needs of aged persons. Old-age assistance recipients, being older than the whole body of aged persons and having more illness and disability, require more care on the average than other aged persons.

The limitations imposed by many State programs on the conditions for which care will be provided or the amount or duration of care furnished also preclude provision of adequate care to old-age assistance recipients through the assistance programs.

Of course, in many States other medical resources are available to old-age assistance recipients: other public programs for providing medical care to the indigent and medically indigent; charity services of physicians; care paid for by community chests; free care provided by hospitals. The availability of these resources, which will be briefly described later, varies from State to State, and within States. It is difficult to assess their contribution. A recent attempt at such assessment reached the conclusion that in many States and localities assistance recipients were not obtaining adequate care.[60]

---

[60] *Medical Resources Available To Meet the Needs of Public Assistance Recipients;* Report by the Department of Health, Education, and Welfare to the Committee on Ways and Means, U.S. House of Representatives (Committee Print, 87th Cong., 1st sess.) 1961.

CHAPTER 9. THE MEDICAL ASSISTANCE FOR THE AGED PROGRAM

The 1960 (Kerr-Mills) amendments to the Social Security Act provided, effective October 1, 1960, not only for additional matching of expenditures under OAA in the form of vendor payments for medical care but also for Federal aid to the States in providing medical assistance to aged people not receiving old-age assistance whose income and resources are insufficient to meet the cost of needed medical care.

To obtain Federal aid, a State must submit a plan providing for medical assistance to the aged which meets certain requirements laid down in the Act. In addition to meeting most of the same requirements as those for old-age assistance the State's plan for medical assistance for the aged must provide (a) for some institutional and some noninstitutional services; (b) that no enrollment fee, premiums or special charges will be imposed as a condition of eligibility; (c) for service to individuals who are residents of the State but absent from it; (d) reasonable standards for determining eligibility and the extent of medical assistance given; (e) that no lien may be imposed against the property of any individual prior to his death on account of medical assistance properly paid in his behalf and that there shall be no recovery from his estate until after the death of the surviving spouse, if any; (f) that there shall be no durational residence requirement; and (g) that there will be no disclosure of information concerning benefits paid on behalf of individual recipients.

A State plan of medical assistance for the aged must be administered by the same State agency that administers old-age assistance.

In MAA the Federal Government participates only in expenditures made in the form of vendor payments, i.e., payments to hospitals, physicians, etc., for medical care provided to recipients. It does not participate in amounts paid directly to recipients.

There is, however, specific provision in the statute for Federal financial participation in State expenditures "for insurance premiums for medical or any other type of remedial care or the cost thereof" paid as medical assistance in behalf of eligible individuals.

The extent of Federal aid varies from State to State within a range of 50 to 80 percent, depending upon relative State per capita income. There are no limitations upon the amount in which the Federal

Government will participate for any one individual or for the State as a whole, as contrasted with OAA, in which Federal participation is limited to payments up to a specified maximum on the average. For this reason States whose average payment is above this maximum can increase Federal payments by transferring high cost medical care cases from OAA to MAA.

Through the end of March 1962, programs were in effect in 26 States (23 States plus Puerto Rico, Virgin Islands, and Guam).[61]

According to reports from State welfare directors, it is likely that programs will be placed in operation in 2 other jurisdictions early in 1962.[62] New Jersey still has under consideration legislation to begin an MAA program. Since very few State legislatures meet in 1962, it is unlikely that during 1962 many of the remaining 24 States will pass the required legislation or appropriate funds to implement legislation already passed. Five States have chosen to expand their old-age assistance programs for medical care to include needy persons who need only medical care, rather than to begin MAA programs. Under these programs, the same requirements apply as do for the States' OAA program generally including durational residence requirements, current liens on recipients' estates, and the publication of lists of recipients, where these are applicable.

Services provided

The services provided under the MAA programs of the States vary widely. A summary of the number of States providing these services is shown in Table 36. Detail on limitations by State may be found in Appendix B, Table 16.

TABLE 36.—*Medical Assistance for the Aged: Summary of number of States providing major types of services, October 1961*

Type of service [1]	Number of States
Hospital care	21
Nursing home care	14
Physicians' services	20
Office	16
Home or in nursing home	17
Hospital outpatient	16
Hospital inpatient	12
Dental care	10
Prescribed drugs [2]	12

[1] There are substantial limitations among the States on amounts and care provided. See Appendix B, table 16.

[2] Other than for hospitalized patients; drugs for hospital patients are included as part of hospital care.

Source: Bureau of Family Services, Social Security Administration.

[61] Alabama, Arkansas, California, Guam, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Utah, Virgin Islands, Washington, West Virginia.

[62] Connecticut and Vermont.

Of the 21 States for which detailed data were available as of October 1, 1961, all provided some inpatient hospital care. However, 11 States imposed limitations on the number of days covered and/or the type of condition hospitalized. Several States also specified that the patient must pay part of the cost.

Nursing home care was provided under MAA programs in only 14 States as of October 1, 1961. Most of these States had limitations with respect to the number of days covered or the maximum payment allowed. Some had further qualifications relating to provision of care only on transfer from a hospital.

Physicians' services were provided in 20 of the 21 States having MAA programs. The physicians' services in the office, home, or outpatient department were generally limited in terms of visits or services paid for in a given period.

Ten States provided some dental services, but frequently provided only in emergencies, for relief of pain, or for treatment of acute infection. The services were usually limited to extractions and fillings.

Twelve States paid for some drugs outside the hospital, with limitations in some States on type of illness for which they may be prescribed.

With respect to the extent of overall coverage of the major kinds of services, three States [63] provided all types with no significant limitations, fourteen States [64] provided what might be termed intermediate coverage because of the limitations affecting one or more of the services, and four States [65] provided what might be termed a minimum coverage—only two major services.

The States vary widely in the conditions of eligibility for MAA. Some 17 States set maximums on the income and assets a recipient may have; an aged person with income or assets under these limits is eligible; one with income or assets above these limits is ineligible no matter what his medical needs or costs. Other States (four) say, in effect, "*A certain* level of income and resources is necessary for subsistence; any amount *beyond* this level will be evaluated to determine its availability to meet medical need. If the amount available is still not enough to pay for the person's necessary medical care, he is eligible for medical assistance for the aged."

The maximums on income and assets established by the States for a single recipient with no dependents range from $1,000 to $3,000. Varying allowances are made for dependents. Again it should be emphasized that these maximums take no account of a person's previous or anticipated medical costs. Thus, in a State with an income

---

[63] Hawaii, North Dakota, and Puerto Rico.

[64] Arkansas, Idaho, Kentucky, Louisiana, Massachusetts, Maryland, Michigan, New York, Oklahoma, Oregon, South Carolina, Virgin Islands, Washington, and West Virginia.

[65] Illinois, New Hampshire, Tennessee and Utah.

limit of, say, $1,200, an aged person with an income of $1,400 a year, who has Parkinson's disease and needs medical and nursing home care costing some $3,000 a year, is ineligible for medical assistance because of his income. (See Appendix B, Table 17 for detailed eligibility provisions.)

All States with a medical assistance program for the aged exempt the real property used as a home in determining eligibility, i.e., an aged person would not be required to sell his home or to place a mortgage upon it. Some, however, place a maximum on the equity allowable. West Virginia, which originally excluded the homestead as a resource, when tightening its eligibility requirements inserted "up to a value of $15,000." All States take into account the resource value of other real estate, although about half the States do not require liquidation. Most of the States exempt a life-insurance policy with a small cash surrender value. Medical insurance policies and similar resources designed to meet medical need are also considered as assets to be taken into account in determining whether payment will be made for medical care and in what amount. A number of States exclude premiums for such insurance, up to a stated maximum, from inclusion in income of an individual or a couple.

A small reserve of cash or "resources convertible to cash" is specifically permitted in most States. The amount permitted a single person ranged from $300 in Arkansas to $2,500 in Maryland.

Provisions regarding relatives' responsibility, i.e., the extent to which relatives will be held responsible for care, vary widely. Of the 21 States, 13 do not require that relatives of the aged applicant for medical assistance must contribute to the extent that they can towards the cost of needed care; 8 have a requirement which is identical with or similar to their requirement under OAA for support of applicant by relative.[66] The States vary in the standards used to assess the ability of relatives to pay for medical care of an applicant and the circumstances under which they will deny an application of an aged person if his children or other relatives are considered able to pay for the care required, often without regard to whether the relative fulfills this obligation.

Administration

Federal law requires that this program must be administered by the same agency as administers the State's OAA program. Hence, the administration of MAA programs is similar to that described above regarding OAA programs.

[66] California, Maine and Pennsylvania—which are not among these 21 states but which have begun MAA programs—also require relative responsibility.

Practices in opening MAA cases vary among the States. In 8 States, persons may apply concurrently with or in advance of their need for medical care. Once eligibility is established they remain eligible for any and all needed medical care for a continuing period, usually a year. After a year or some shorter period specified, continuing eligibility for medical care assistance is redetermined for all open cases.

The general practice in the other 13 States is to determine eligibility anew each time medical care may be needed, taking account of the kind and cost of the medical care needed. West Virginia, which initially provided for preauthorization as to financial eligibility for persons who were not immediately in need of medical care discontinued this practice effective December 1, 1961 and notified all persons who had been certified eligible for MAA (30,567 as of end of November) but who had not found it necessary to use the services that their cases would be closed, but that they could re-apply if in the future they needed medical services.

Selection of hospital, physician, etc., and method of payment

In all or virtually all States the provisions affecting choice or lack of choice of hospital, physician, nursing home, and druggist, which apply under the OAA program apply also under the MAA program. With minor exceptions in the case of States using a pooled fund for OAA, hospitals, physicians and other suppliers of care would be paid in the same way and on the same basis under both programs.

In general, the States which have for their OAA program contractual arrangements with the health department, Blue Cross or Blue Shield plans, or State or local medical societies either to provide service or to act as fiscal agents in paying for services (as described in Appendix B, Table 15), use the same arrangements for their MAA programs.

It is noteworthy that West Virginia, which was among the first States to initiate a program for MAA originally planned the schedule of fees and limitations of services for hospital, physician, and drug services to be identical with that of the general medical care program for other categories of assistance. This schedule was liberalized about January 1, 1961 for recipients of MAA. Thus, where the hospital rate was 90 percent of hospital costs up to $20 per day for the regular assistance recipients, the rate for MAA was actual reimbursable cost without maximum. Other items in the schedule were correspondingly higher for comparable services under MAA. In the late summer, the agency became concerned that the rate of expenditure under MAA would exhaust appropriations. It began making plans for a general modification of procedures as to authorization, tighten-

ing financial eligibility requirements, and bringing the fee schedules and limitations on service back in line with that prevailing for other categories of assistance.

Recipients and expenditures under the program

The number of recipients [67] of medical assistance to the aged increased gradually from October 1960 through December 1961 (table 37) as the programs in effect got under way and additional States established programs. In December 1961, there were 72,159 persons receiving medical assistance to the aged and in January 1962, 64,690 as West Virginia deferred payments for January causing a decrease of 8,100 recipients and Maryland changed its method of reporting, resulting in a decrease of 3,300. Payments, which had increased steadily up to November when they were just over $15 million, amounted to $14.9 million in January.

In January, 82 percent of all recipients were in three States, Massachusetts, Michigan, and New York (table 38). Of the total payments for medical care for recipients some 92 percent were made by these three States.

TABLE 37.—*Medical Assistance for the Aged: Number of States reporting, number of recipients, and total payments, each month, October 1960 to January 1962*

Year and month	Number of States reporting	Number of recipients [1]	Payments
1960			
October	0		
November	3	12,791	$2,441,175
December	5	14,922	2,922,261
1961			
January	5	16,734	3,437,412
February	5	18,678	3,852,628
March	5	21,492	4,033,741
April	7	27,998	5,890,726
May	8	41,388	8,295,631
June	9	46,247	9,311,027
July	10	52,030	10,943,079
August	14	59,093	11,959,747
September	15	60,928	12,654,268
October	16	66,396	13,681,550
November	16	71,655	15,015,298
December	18	72,159	13,919,808
1962			
January [2]	22	64,690	14,852,990

[1] Number of recipients are persons on whose behalf payments were made during the report month to suppliers of medical services.
[2] For State detail, see table 38.

Source: Bureau of Family Services, Social Security Administration.

[67] The term "recipient" means the number of persons for whom bills from suppliers of medical care were paid in the report month. The bills generally represent the services provided in a preceding month. The count of recipients does not necessarily reflect the number of persons actually receiving medical care services during the month covered by the report.

TABLE 38.—*Medical Assistance for the Aged: Recipients and payments for recipients, by State, January 1962* [1]

State	Number of recipients	Payments for recipients	
		Total amount	Average
Total	64,690	$14,852,990	$229.60
Arkansas	667	29,729	44.57
California	600	89,946	149.91
Hawaii	*230*	*44,996*	*195.63*
Idaho	1,060	165,112	155.77
Illinois	*181*	*91,738*	*506.84*
Kentucky	1,444	22,558	*15.62*
Louisiana	129	29,429	228.13
Maine	*432*	*97,896*	*226.61*
Maryland	3,510	124,492	35,47
Massashusetts	18,637	[2] 3,283,182	176.16
Michigan	4,741	1,463,361	308.66
New York	29,915	8,908,818	297.80
North Dakota	691	[2] 129,114	186.85
Oklahoma	267	67,180	251.61
Oregon	65	15,647	240.72
Puerto Rico	224	3,672	16.39
South Carolina	781	121,759	155.90
Tennessee	210	12,897	61.41
Utah	457	66,324	145.13
Virgin Islands	85	2,222	26.14
Washington	312	78,200	250.64
West Virginia	52	4,718	90.73

[1] Figures in italic represent program under State plan not yet approved by the Social Security Administration. All data subject to revision.

[2] Excludes money payments not subject to Federal participation as follows: $97,817 in Massachusetts and $2,226 in Nortb Dakota.

Source: Bureau of Family Services, Social Security Administrstion.

Prior to the inception of the MAA program New York and Massachusetts had a considerable number of cases on their OAA rolls who were in nursing homes. Since average monthly assistance payments per recipient in both States were well above the maximum of $65 per recipient matchable by the Federal Government, these two States received relatively little Federal aid toward the cost of care for these nursing home cases. At the start of their MAA program, or soon after, both States transferred all or most OAA cases receiving nursing home care to their MAA program, because of more advantageous Federal matching. (It is apparent that these two States have recived a very large portion of all Federal aid under the MAA program.) Just over half of all MAA cases opened in these two States through December 1961 were transfers from OAA: 63 percent in Massachusetts, 41 percent in New York. In Idaho and North Dakota about two-thirds of the MAA cases opened through December were transfers from OAA. By contrast, in the other 17 States reporting on openings, only about 5 percent of the cases opened were transfers from OAA. (Table 39.)

About 1 percent of all cases opened in the United States had previously received other types of assistance and about one-fifth of this small group continued to receive other assistance: needy persons may not receive MAA and OAA simultaneously, but they may receive MAA and other types of assistance concurrently.

TABLE 39.—*Medical Assistance for the Aged: Cases opened by type of previous assistance, if any, October 1960 to December 1961*

State	Total cases opened	Assistance received previously			
		OAA	AB, APTD, ADC	GA	None
Total	166,851	45,900	1,574	600	118,777
Arkansas	2,103	0	0	0	2,103
Hawaii	397	148	0	0	249
Idaho	1,663	977	51	0	635
Illinois	696	0	0	0	696
Kentucky	5,294	0	0	180	5,114
Louisiana	110	0	0	0	110
Maine	244	0	0	0	244
Maryland	7,524	0	0	0	7,524
Massachusetts	29,191	18,439	443	70	10,239
Michigan	14,557	2,743	85	258	11,471
New Hampshire	66	0	0	0	66
New York	54,910	22,768	701	82	31,359
North Dakota	1,042	786	0	0	256
Oklahoma	2,589	0	0	0	2,589
Oregon	2,852	10	92	4	2,746
South Carolina	2,645	0	0	0	2,645
Tennessee	2,441	0	0	0	2,441
Utah	582	0	198	0	384
Virgin Islands	365	0	1	0	364
Washington	3,649	29	3	6	3,611
West Virginia	33,931	0	0	0	33,931

Source: Bureau of Family Services, Social Security Administration.

In January 1962, payments under MAA were half as much as total vendor payments under OAA ($30 million) for the country as a whole (table 40). The relation between the two programs varies widely from State to State. In some States (Massachusetts, New York, Michigan, West Virginia, Hawaii, Idaho and Maryland) the MAA expenditures are larger than the vendor payments under OAA. New York's MAA program dwarfs not only its OAA vendor payments but total payments under OAA. Massachusetts is spending almost three times as much for medical care under MAA as under its OAA program. On the other hand, in other States the expenditures thus far under MAA have been trifling as compared with vendor payments under OAA.

Summary and appraisal

Some 26 States now have MAA programs in effect. Undoubtedly these programs have been and will be useful in bringing medical care to aged persons who might otherwise have gone without, have exhausted slender resources to pay medical bills or been forced to ask for private charity.

In assessing the accomplishments of the Kerr-Mills provisions, OAA and MAA must be considered simultaneously. In effect, in many States MAA is not a new program. Many States previously took aged persons on their OAA rolls who needed only medical care,

TABLE 40.—*Vendor Payments Under OAA and MAA Programs: Comparison of expenditures in States with MAA programs, January 1962*

State	Vendor payments under OAA	Payments under MAA
All States	$29,941,701	$14,852,990
States reporting MAA payments	14,774,903	14,852,990
Arkansas	394,626	29,729
California	3,228,464	89,946
Hawaii	15,185	44,996
Idaho	45,451	165,112
Illinois	2,463,206	91,738
Kentucky	167,388	22,558
Louisiana	1,219,760	29,429
Maine	240,134	97,896
Maryland	53,133	124,492
Massachusetts	911,655	1,283,182
Michigan	707,238	1,463,361
New York	972,116	8,908,818
North Dakota	138,485	129,114
Oklahoma	1,301,775	67,180
Oregon	546,714	15,647
Puerto Rico	17,207	3,672
South Carolina	160,771	121,759
Tennessee	244,673	12,897
Utah	195,002	66,324
Virgin Islands	1,683	2,222
Washington	1,625,343	78,200
West Virginia	124,894	4,718
Other States	$15,166,798	----------

Source: Bureau of Family Services, Social Security Administration.

and many aged persons were taken on the rolls because an illness had used up available financial resources.

The changed matching provisions for medical care under OAA and the MAA program together have resulted in greater expenditures for medical care of the indigent and medically indigent aged. In September 1960, expenditures for vendor payments under OAA amounted to $25.3 million. In January 1962 vendor payments under OAA amounted to $29.9 million and those under MAA to $14.9 million, a total of $44.8 million. By no means all of the $19.5 million increase represents new money, however; a part represents expenditures made as vendor payments that were formerly made through inclusion in the money payments. In part because of such changes in method of payment, in part because the monthly OAA caseload dropped by 93,000 between September 1960 and January 1962 while MAA cases totalled only 65,000 in January, total expenditures for assistance under MAA and OAA combined in January 1962 were only $13.4 million larger than OAA payments in September 1960.

Thus far the 1960 amendments liberalizing Federal matching for medical care have been advantageous chiefly to the high income States. Federal matching provisions are such that it makes little or no difference to many lower income States whether they provide medical care through OAA or MAA. But to higher income States MAA offers increased opportunities for Federal matching of expenditures for medical care of the indigent or medically indigent aged. New York alone

accounts for almost two-fifths ($5.1 million) of the $13.4 million increase in total monthly payments under OAA and MAA combined, when January 1962 expenditures are compared with those for September 1960. The additional Federal share in these payments was $4.0 million, or about 80 percent of the total increase. Massachusetts, the other high income State which has transferred its general nursing home caseload from OAA to MAA, had increased total expenditures by about $25,000 when the two months are compared. The Federal share in these two programs in Massachusetts increased by about $1,455,000.

With respect to the adequacy of care provided to MAA recipients, it is clear that most States with programs limit the types and extent of care provided and some States the conditions for which care will be provided, as is true of medical care for OAA recipients. The low-income States where need is likely to be greatest have the greatest difficulty in financing even minimal services.

CHAPTER 10. OTHER PROGRAMS AND PHILANTHROPIC PROVISIONS FOR MEDICAL CARE FOR THE AGED

In addition to the medical services provided to needy or medically indigent persons through public assistance, a substantial amount of medical care is provided to aged persons through other public programs.

Public mental hospitals

The greater part of all prolonged hospital care for persons suffering from mental illness or who are mentally defective is provided by mental hospitals owned and operated by the State governments. The cost of such care represents in almost all States the largest single health expenditure of State governments.

State mental hospitals customarily provide care whether or not the patient or his family is able to pay any part of the cost. A few States provide free hospitalization for all, making no charge to anyone. However, in most States the patient or family is asked to pay as much of the cost as they can, with some examination being made of the person's or family's resources so as to determine how much it is feasible for them to pay. Some States bill the localities for care provided to their residents who cannot pay. For the country as a whole, total receipts from patients or from local governmental units on behalf of their resident patients have amounted in recent years to about 13 percent of the total maintenance costs of State and local mental hospitals.

In 1960 there were 313 State and local mental hospitals, with 704,000 beds and an average daily census of 658,000.[68] Almost one in three beds in these hospitals is occupied by a person 65 and over. Twenty-seven percent of all first admissions in 1960 were of persons 65 and over.

There seems little question but that many of the aged now in public mental hospitals could be better cared for at home or in a local nursing home or chronic hospital or hospital wing, if only the needed services were physically and financially available to them. Undoubtedly there

[68] *Hospitals* (American Hospital Association), Guide Issue, August 1, 1961, pt. II.

will be a decrease in the aged population of mental hospitals as more nearly adequate local services for older people are developed and brought within their financial reach.

Other public hospitals

Traditionally State and local governments have assumed responsibility for the care of persons with tuberculosis, with such charges as might be made for their care ordinarily scaled to the person's or his family's ability to pay. In many States, hospitalization for tuberculosis is available as a free public service—no charge being made to any patient.

As of the end of 1960, there were 207 State and local governmental tuberculosis hospitals, with 48,000 beds, an average daily census of 36,000. Approximately 20 percent of the beds in these public tuberculosis hospitals were occupied by persons 65 and over.

Many State and local governments own and operate general hospitals. Some of these hospitals serve the general population, are conducted like voluntary community hospitals, and their operating expenses are met wholly or mainly out of payments by or on behalf of patients. Other State, county, and city general hospitals are designed primarily to serve indigent or medically indigent persons and their operating expenses are met wholly or mainly from tax funds. The cost of care for public assistance recipients in some State or local governmental hospitals is paid for by the public assistance agencies; in other hospitals they will receive care without cost to the public assistance agency. A one day census of hospitals made by the American Medical Association in 1953 showed that patients 65 and over comprise 26 percent of the patients in all non-Federal governmental general hospitals.

Veterans Administration care for the aged

The Veterans Administration operates the largest organized medical care system in the United States—170 hospitals with 120,542 beds, and 93 outpatient clinics. Generally, three groups of veterans are eligible for care in Veterans Administration hospitals. Those needing care for service-connected disabilities are unconditionally eligible for hospital care. Veterans with service-connected compensable disabilities who need care for nonservice-connected disabilities are eligible for care if a bed is available. War veterans with no service-connected disabilities needing care are eligible for care if a bed is available and if they sign an affidavit certifying their inability to defray the cost of hospitalization.

Some 22.4 million men and women are veterans. Of these about 2.2 million or over 9 percent are 65 and over. More than 28 percent of the patients in Veterans Administration Hospitals in 1961 were 65 and over. By 1965 the proportion of patients who are 65 or over is expected to reach 40 percent.

Care for the aged through private charity

A certain amount of medical care is available through private charity to aged and other persons unable to pay for the care they need.

Services by the medical profession.—The medical profession has always given much service to those unable to pay.

On the basis of a questionnaire survey of its readers, the magazine, New Medical Materia, estimated that physicians in this country provided $658 million worth of free care in 1960—$3,360 worth per general practitioner and $4,812 worth per specialist. Of the total value of free service 39.9 percent was reported as given to private patients, 22.7 percent in outpatient clinic service, 26.5 percent in hospital ward service and 10.9 percent to courtesy cases, athletes, blood donors, etc.[69]

A recent survey by the Louisiana State Medical Society of its members found that the average doctor gave $3,531 worth of free service annually.[70] A survey in 1960 by the Philadelphia County Medical Society found that the physicians in the city gave free care to a value of $6,431 per physician.[71] The Texas Medical Association has estimated that the average doctor in that State contributed 15 percent of his working hours to free treatment.[72]

Voluntary agencies.—There are some 60 to 70 national voluntary organizations with primary interest in the health field. These include such well-known organizations as the American National Red Cross (though it is mainly concerned with relief aid in national calamities), American Cancer Society, the National Foundation, National Tuberculosis Association. Total receipts of all these organizations are estimated at about a third of a billion dollars in 1960.

The health agencies spend their funds for research, lay and professional education, community services and medical care. No satisfactory data are available as to total expenditures of these organizations for medical care. Nine major health organizations reported expenditures of $31 million for medical care in a recent year and the Red Cross reported additional expenditures of approximately $7,000,000 for health and safety services. All health agencies may have spent in the neighborhood of $50 million a year for health serv-

---

[69] *New Medical Materia*, October 1960, p. 35.
[70] *Medical Economics*, December 7, 1959, p. 1.
[71] AMA *News*, May 16, 1961, p. 13.
[72] Texas Research League, *Indigent Medical Care Service for Texas Public Assistance Recipients*, 1961, p. 23.

ices. How much of this went for persons 65 and over can only be conjectured.

A certain amount of medical care for the indigent and medically indigent is paid for by United Fund and Community Chest agencies and service organizations, such as Rotary, Lions and Shriners. In 1960, of the sums raised in all united fund and community chest campaigns, some $127 million were allocated to health agencies and purposes. Of this amount $21 million went to hospitals and clinics largely, if not entirely, for care of the indigent, $57 million to the Red Cross, and $49 million to various health agencies, including visiting nurses associations and national health agencies dealt with above.

Services by voluntary hospitals.—While most of the care provided by hospitals to "free" or charity cases is paid for in one way or another by Government or community organizations, a considerable amount of care is provided by hospitals without reimbursement from any other party. This "free care" includes services provided to persons for whose care no governmental or other agency will assume responsibility, and services for which the hospital charges but is unable to collect.[73] It includes also the difference between the cost to the hospital of providing care and the amount actually paid by governmental or community agencies for the care of indigent and medically indigent persons. Frequently welfare departments, other State and local governmental units and community agencies pay hospitals for indigent care at rates below the full cost of care.[74]

Some of the free care provided by hospitals from their own resources is made possible by income from endowments and private gifts and contributions and governmental grants or subsidies. However, in all probability much the larger share is financed by paying patients who are billed at higher rates than would otherwise be necessary. Thus, paying patients, in effect, help to subsidize care for the indigent.

---

[73] The 1959 rate survey of the AHA found that among responding hospitals 5.1 percent of the billed hospital charges were "uncollected." (AHA, *Hospital Rates 1959*, pp. 34–6).

[74] Some instances follow: In Delaware the counties have been paying hospitals at the rate of $4 a day for the indigent cases. Pennsylvania under its statewide program has been paying hospitals $10 a day for care which it costs them $25 to $30 to provide. New York City has been paying voluntary hospitals $24 a day for care costing at least $32. North Carolina pays hospitals $8.50 per diem for inpatients on old-age assistance; the average cost to the hospitals is $22.98 per diem. New Hampshire pays from $4 to $18 a day; New Mexico from $12.19 to $18.50; Maryland pays 80 percent of costs but not in excess of 60 percent of the statewide average. (Data from various sources, including (a) American Hospital Association, *Report on Survey of Hospital Reimbursement Under State Public Assistance Programs, July 1959*, and (b) *Medical Economics*, January 19, 1961, p. 111).

PART IV

Trends in Health Services and Health Costs of Older Persons

CHAPTER 11. TRENDS IN SELECTED HEALTH SERVICES AND COSTS

Outstanding advances in scientific medicine have contributed not only to improved health and the well being of people generally, but in addition have made for higher medical care costs. New advances in medicine are already in sight and the tremendous investment now being made in medical research promises still further discoveries and changes. The dynamic nature of modern medicine makes it very difficult to predict what the medical services of the future will be. It is possible to identify certain developments that are already in process.

Changing health care technology

Medical research has made it possible for many people, with the support of continuing care from physicians and other health personnel, to live useful lives despite the handicaps of heart disease, arthritis, and other chronic diseases. But the adequate care of chronic illness is aptly termed "extensive" and over time usually requires a wide variety of health specialists and often varying facilities such as the specialty hospital, general hospital, nursing home, or organized home health service organization.

Accompanying the advances in health care technology, there has been a sharp increase in the number of professional health personnel other than physicians. In 1900, for every physician in practice there was one other professional health practitioner. Today there are four such persons including nurses, laboratory technicians, therapists, and other health professionals for every physician.[75] The professional health care team today comprises more than thirty auxiliary or "paramedical specialty" occupations.

---

[75] Public Health Service, *Physicians for a Growing America* (Publication No. 709), September 15, 1959, p. 65.

Enlarging role of hospitals.—In the modern hospital, the full complex of health care technology is represented both in range of specialized personnel and number of types of facilities to serve the needs of both inpatients and outpatients.

There has been a pronounced increase in the ratio of full-time hospital personnel per 100 patients during the past decade. In 1950, there were 178 such hospital personnel per 100 patients while by 1960 the ratio had stepped up to 226 full-time hospital personnel per 100 patients.

There has been a significant increase generally in the proportion of hospitals offering more of certain specialized services (table 41).

TABLE 41.—*Special Services in Short-Term General and Other Special Hospitals: Percentages with selected services, 1950 and 1960*

Service	1950	1960
Clinical laboratory	84	96
Electrocardiograph	76	93
Blood bank	45	56
Pathology laboratory	(1)	49
Physical therapy department	35	41
Radioactive isotope facility	(1)	22
Electroencephalograph	10	14
Home care program	(1)	3

[1] Data not available.

Source: *Hospitals* (American Hospital Association), Guide Issue, June 1, 1951, and August 1, 1961.

The range of hospital services indicates that the modern general hospital represents a "pooling of resources" to provide "specialized equipment and highly trained personnel that no patient or doctor could provide individually, and which no patient could afford to use and maintain by himself." [76]

It is likely that the trend toward more complete availability of a wide range of technical equipment will continue with more area-wide pooling of the more expensive and specialized equipment such as the electroencephalograph. Sharing in use of specialized equipment is a major benefit of active working relationships among hospitals in a given area or region.

In both urban and rural areas, the general hospital is increasingly a principal center of health care activities. Some 15 years ago, the Commission on Hospital Care recommended that the general hospital be the center for preventive, curative, and rehabilitative services to the chronically ill as well as the acutely ill. There is high unanimity among professional health personnel with respect to the central role of the general hospital in modern health care.

The experimentation and development of arrangements for inpatient hospital care underway in several hospitals often bear directly on the functioning of the hospital as a community health center in-

[76] Public Health Service, *Principles for Planning the Future Hospital System*, by Ray E. Brown (Publication No. 721), 1959, p. 4.

cluding care for older people. An approach for tailoring services to the needs of the individual patient has been termed "progressive patient care."

Another significant trend is the movement away from specialized hospitals to the provision of as full a range of services in general hospitals as circumstances permit. General hospitals today are covering more long-term illness care through having specialized units for such service, by having nursing homes affiliated with them, and in development of organized home care services.

Of particular interest to the older patients with chronic illnesses, active interrelationships are developing among hospitals. Transfers of patients from community hospitals to the larger hospitals for specialized treatment including radioisotope treatments for malignant neoplasms, working relationships between hospitals for intensive laboratory analyses, and the regularized services of highly specialized medical personnel from the larger hospitals to community hospitals in anesthesiology and radiology are illustrations of types of systematic and regular teaming up of services of two or more hospitals.

Developments in skilled nursing homes.—Of all the inpatient facilities, nursing homes have had the most rapid development in recent years. As of January 1, 1961 there were approximately 326,000 skilled nursing home beds in the country as reported under the Hill-Burton Program.[77] Availability of skilled nursing homes is of particular importance to older people. Various studies have shown that the nursing home is primarily a long-term care home for the aged, many of whom are disabled and chronically ill. Some of the care provided in these skilled nursing homes is also custodial.

Increasing attention is being directed to differentiation of nursing homes in accordance with service requirements of patients, to improved licensure and regulation of nursing homes, and to the quality of care provided including around-the-clock presence in the facility of a registered nurse. All of the States now license nursing homes although the standards vary considerably among the States. Considerable progress has been made in recent years in revising and improving nursing home laws and regulations which have resulted in raising standards. With the continued growth and upgrading in quality of nursing homes, with more active working relationships with other health services and particularly general hospitals, and with increased coverage under health insurance these facilities will be strengthened as a resource for health care.

Rise of home care services.—Home health services include community visiting nurses, organized home care programs, and homemaker services.

---

[77] Public Health Service, Division of Hospital and Medical Facilities, ***Hospital and Medical Facilities in the United States as of January 1, 1961.***

As of 1957, there were 8,200 public health agencies employing some 29,400 public health nurses. However, not all of these agencies provided bedside care of a nurse functioning under the direction of a physician. Visiting nurse associations serve 88 percent of the cities with populations of 100,000 or more and almost half of the smaller cities of 25,000 to 100,000.[78]

In July 1961, there were 45 communities in 25 different States having organized home care programs.[79] These programs are intended to meet the needs of homebound patients who generally require the services of several health specialities. Such programs may be headquartered in a hospital, visiting nurse association, health department, or other agency. They often involve a team of health workers for consultation and services, including medical specialists, physical and occupational therapists, medical social workers, and psychologists. The relationships between the patient, his family, his physician, and nurse are nevertheless important in home care. This type of care is particularly appropriate for the long-term illness of the elderly—heart disease, cancer, arthritis, and other illness. For some individuals, it reduces the length of stay and the number of readmissions to the hospital and for other persons it replaces need for custodial institutional care.

Homemaker service programs were functioning as of July 1961, in 163 communities in 38 different States.[79] There were 215 agencies which sponsored these programs, 70 having been established since 1958. This sizeable increase indicates how readily this type of program can be developed when large numbers of professionally trained personnel are not involved. Homemaker services are a substitute for the personal care and homekeeping duties that adult family members would ordinarily perform if they were available and able to do them.

Community facilities development.—Since 1946, the Federal Government has provided funds for hospital construction. Last year, it extended its support to a wide range of community health facilities. Matching funds are now available to the States to build up community health services and for the construction of nonprofit nursing homes. Expanded homemaker services and home nursing care can also be supported under the program. Special project grants are available to develop improved methods of providing out-of-hospital community health services particularly for the chronically ill and aged. This new program should stimulate and encourage the more rapid expansion of newer types of services of special importance to the aged.

---

[78] Public Health Service, *Areawide Planning for Hospitals and Related Health Facilities* (Publication No. 885), July 1961, p. 39.

[79] U.S. Senate, *Problems of the Aging, Hearings Before the Subcommittee on Federal and State Activities of the Special Committee on Aging,* (87th Cong., 1st sess.), 1961, Part 1.

Health care costs

The rising costs of health care are of particular concern for older people because of their relatively high utilization of hospital and other health services and their comparatively low financial resources for meeting such costs.

Trends in health care costs.—The standard measure of price movements in the United States is the Bureau of Labor Statistics' Consumer Price Index. The "price" of medical care began to climb in 1941, but the big increase came after 1950. Between that year and 1961, medical care prices went up more than twice as much as the average "price" for all the goods and services used by families, whereas over the longer period, from 1940 to 1961, they went up only slightly more than the average for all goods and services (Table 42).

TABLE 42.—*Consumer Price Index: Percent increase by category and for selected medical care items, 1950 to 1961 and 1940 to 1961*

Item	1950 to 1961	1940 to 1961
All items	24.3	113.4
Medical care [1]	51.8	121.3
Hospital daily service charges	109.7	376.8
Physicians' fees	43.0	99.6
Dentists' fees	29.0	96.7
Prescriptions and drugs	16.7	45.8
Food	19.7	153.3
Apparel	12.3	107.1
Housing	24.9	73.4
Transportation	32.9	111.9
Personal care	32.5	125.2
Reading and recreation	20.0	93.6
Other goods and services	26.6	83.0

[1] Includes optometric examinations and eyeglasses not shown separately. Hospitalization and surgical insurance included in the index for 1961 but not for the two earlier years.

Source: Bureau of Labor Statistics, *Price Indexes for Selected Items and Groups.*

Hospital daily service charges (and hospitalization insurance premiums) have risen most among the components of the medical care index. The rise in physicians' fees, dentists' fees, eye examinations, surgical insurance, and drug outlays has been more in line with the general price increase, or at least the increase in prices of other services, such as transportation and personal care.

Total expense per patient day in nonfederal short-term general and special hospitals, as reported by the American Hospital Association, somewhat more than doubled between 1950 and 1960, going from $15.62 to $32.23. This was slightly more than the increase in the price index of hospital daily service charges, presumably because the expense per patient day reflected some increases in services provided. Comparable data on expense per patient day are not available prior to 1946 when the average was only $9.39, hospital wages and hours were generally at pre-war levels, and there were severe staff shortages.

Factors in rise of health costs.—With the array of technological facilities in the hospital today, there has been need for a larger proportion of skilled workers plus an attempt to bring hospital salaries into line with the general wage level. In 1946, the average annual earnings of full-time general hospital employees was only $1,226, or approximately half as much as that of a full-time worker in industry (Table 43). In the 14-year period since 1946, annual earnings for all hospital employees nearly tripled, while those of industrial workers doubled. This means that in 1960, the earnings of the average hospital employee ($3,240 a year) had gone up to almost 70 percent as much as those of the average industrial worker. Accompanying the rise in earnings has been a significant reduction in the length of the work week in hospitals, and a corresponding increase in the number of hospital employees needed.

TABLE 43.—*Earnings of Hospital Employees and Industrial Workers: Comparison of earnings and payroll costs as percent of total hospital expenses, 1946–60*

Year	Payroll costs as percent of total hospital [1] expenses	Annual earnings		
		Hospital [1] employees	Industrial workers	Hospital employees as percent of industrial workers
1946	53.0	$1,226	$2,356	52.0
1950	56.7	1,817	3,008	60.4
1955	61.6	2,563	3,847	66.6
1960	62.3	3,240	4,705	68.9

[1] Short-term general and other special hospitals.

Source: *Hospitals* (American Hospital Association), Guide Issue, August 1, 1961, and Department of Commerce, *Survey of Current Business*, July 1961.

Hospital payrolls have thus assumed an increasingly larger share of the hospital expenses, constituting a significant factor in the increased cost of hospital care. In 1946, payroll accounted for a little more than one-half of total hospital expenses. In the ten year period, 1946 through 1955, the percent increased steadily to 61.6. In the next 5 years, however, the ratio of payroll to total hospital expenses remained relatively stable at approximately 62 percent (except for a slight decrease reported in 1957 and 1958), indicating that other factors are contributing toward the increased costs during this period (table 43).

The labor displacement possibilities, with the introduction of new types of hospital equipment, are limited.[80] Expensive hospital equipment has often required additional and more costly labor. "As newly developed and diagnostic and treatment equipment is added to hospitals, more—not fewer—people are required to operate it. Hos-

[80] Brown, Ray E., "The Nature of Hospital Costs," *Hospitals*, (American Hospital Association), April 1, 1956.

pital equipment is expensive, its cost is impressive, but the enduring element of cost for these new services is the newly trained personnel who must accompany it." [81]

In attempting to anticipate trends in health costs for the next 15 to 20 years, there are many pertinent factors to be considered. On the supply side there are the changing medical technology and hospital payroll costs. Progress toward regional and community planning offers promise for slowing the increase in hospital rates. As hospital wage rates, hours and other conditions of employment meet prevailing community standards, this component of hospital costs will probably rise at a slower rate. On the demand side is the growing size of the older population, probable changes in their ability to pay for medical care, the strengthening interest in greater health protection, resulting in higher standards of care, and the expanding scope of services. All of these point toward further increases in the cost of health care.

Costs of health care will probably rise over the next 15 or 20 years at least as much as the rise in general price level. However, it seems fairly certain that the increase in health costs, particularly hospital costs, will not continue to exceed the increase in the general level of prices to the extent they have in the last decade.

Overall health costs and prospects.—Public and private expenditures for health services, health research, construction of health facilities, and public health activities in 1960 took 5.4 percent of the Nation's total output.[82] In 1929, all such health expenditures amounted to about 3.5 percent of the gross national output. Whether the proportion of the national output going into health services in the next two decades will change significantly depends both upon developments in the health technology and applied health care fields and upon the rate of growth of total output. The public needs and demands for health protection, including services for older people, will be a basic factor in determining its priority in relation to other living needs for sharing in the national income. If the productivity of our economy continues to grow, we shall be able to expand our health services well beyond present levels without strain and without significant change in the present ratio of health expenditures to total output.

---

[81] Nelson, Dr. Russel A., "The Case for Hospitals," statement before the Insurance Commission for the State of Maryland, May 26, 1958.

[82] Merriam, Ida C., "Social Welfare Expenditures, 1959–60," *Social Security Bulletin*, November 1961, p. 9.

APPENDIXES

Appendix A

Table 1.—*Population Aged 65 and Over: Number, percent of total population, and percentage increase, by region and State, April 1, 1960 and 1950*

Region [1] and State	Number of persons (thousands)		Percent of total population		Percent increase 1950–60
	1960	1950	1960	1950	
Total (including Puerto Rico and the Virgin Islands)	16,684.0	12,382.3	9.2	8.1	34.7
United States [2]	16,559.6	12,294.7	9.2	8.1	34.7
New England	1,121.8	906.6	10.7	9.7	23.7
Maine	106.5	93.6	11.0	10.2	13.9
New Hampshire	67.7	57.8	11.2	10.8	17.2
Vermont	43.7	39.5	11.2	10.5	10.6
Massachusetts	571.6	468.4	11.1	10.0	22.0
Rhode Island	89.5	70.4	10.4	8.9	27.2
Connecticut	242.6	176.8	9.6	8.8	37.2
Mideast	3,708.0	2,785.8	9.6	8.3	33.1
New York	1,687.6	1,258.5	10.1	8.5	34.1
New Jersey	560.4	394.0	9.2	8.1	42.2
Pennsylvania	1,128.5	886.8	10.0	8.4	27.3
Delaware	35.7	26.3	8.0	8.3	35.8
Maryland	226.5	163.5	7.3	7.0	38.5
District of Columbia	69.1	56.7	9.0	7.1	22.0
Great Lakes	3,358.5	2,595.9	9.3	8.5	29.4
Michigan	633.2	461.6	8.2	7.2	38.2
Ohio	897.1	709.0	9.2	8.9	26.5
Indiana	445.5	361.0	9.6	9.2	23.4
Illinois	974.9	754.3	9.7	8.7	29.2
Wisconsin	402.7	309.9	10.2	9.0	29.9
Plains	1,720.0	1,377.6	11.2	9.8	24.9
Minnesota	354.4	269.1	10.4	9.0	31.7
Iowa	327.7	273.0	11.9	10.4	20.0
Missouri	503.4	407.4	11.7	10.3	23.6
North Dakota	58.6	48.2	9.3	7.8	21.6
South Dakota	71.5	55.3	10.5	8.5	29.3
Nebraska	164.2	130.4	11.6	9.8	25.9
Kansas	240.3	194.2	11.0	10.2	23.7
Southeast	3,256.4	2,298.1	8.4	6.8	41.7
Virginia	289.0	214.5	7.3	6.5	34.7
West Virginia	172.5	138.5	9.3	6.9	24.5
Kentucky	292.3	235.2	9.6	8.0	24.3
Tennessee	308.9	234.9	8.7	7.1	31.5
North Carolina	312.2	225.3	6.9	5.5	38.6
South Carolina	150.6	115.0	6.3	5.4	30.9
Georgia	290.7	219.7	7.4	6.4	32.3
Florida	553.1	237.5	11.2	8.6	132.9
Alabama	261.1	198.6	8.0	6.5	31.5
Mississippi	190.0	153.0	8.7	7.0	24.2
Louisiana	241.6	176.8	7.4	6.6	36.6
Arkansas	194.4	149.0	10.9	7.8	30.5
Southwest	1,135.7	784.6	8.0	6.9	44.7
Oklahoma	248.8	193.9	10.7	8.7	28.3
Texas	745.4	513.4	7.8	6.7	45.2
New Mexico	51.3	33.1	5.4	4.9	55.1
Arizona	90.2	44.2	6.9	5.9	103.9
Rocky Mountain	367.7	270.6	8.5	7.8	35.9
Montana	65.4	50.9	9.7	8.6	28.6
Idaho	58.3	43.5	8.7	7.4	33.8
Wyoming	25.9	18.2	7.8	6.3	42.6
Colorado	158.2	115.6	9.0	8.7	36.8
Utah	60.0	42.4	6.7	6.2	41.3

See footnotes at end of table.

TABLE 1.—*Population Aged 65 and Over: Number, percent of total population, and percentage increase, by region and State, April 1, 1960 and 1950*—Continued

Region [1] and State	Number of persons (thousands)		Percent of total population		Percent increase 1950–60
	1960	1950	1960	1950	
Far West	1,891.6	1,275.6	8.8	8.3	48.3
Washington	279.0	211.4	9.8	8.9	32.0
Oregon	183.7	133.0	10.4	8.7	38.1
Nevada	18.2	11.0	6.4	6.9	65.4
California	1,376.2	895.0	8.8	8.5	53.8
Alaska	5.4	4.7	2.4	3.7	13.6
Hawaii	29.2	20.4	4.6	4.1	46.0
Puerto Rico	122.2	85.6	5.2	3.9	42.8
Virgin Islands	2.2	2.0	6.9	7.5	9.7

[1] The regional classification follows that now used by the Department of Commerce for analysis of personal income by State.
[2] Includes Alaska and Hawaii for 1950 as well as for 1960.

Source: Bureau of the Census, *United States Census of Population: 1960, General Population Characteristics, United States Summary* (Final Report PC (1)–1B) August 1961.

TABLE 2.—*Aged Population and Eligibility for OASI: Estimated number of persons by age, 1964, 1970, and 1980*

[In millions]

Age	January 1, 1964	July 1, 1970	July 1, 1980
Total population:			
Total 65 years and over	17.9	20.2	25.3
68 years and over	13.7	15.8	19.8
70 years and over	11.2	13.1	16.4
72 years and over	9.1	10.7	13.5
Total 62 years and over	22.4	25.5	31.4
Total eligible for OASI:			
Total 65 years and over	14.4	17.1	22.6
68 years and over	10.5	13.2	17.6
70 years and over	8.6	10.7	14.4
72 years and over	6.7	8.8	12.0
Total 62 years and over	18.2	21.5	27.9

Source: 1970 and 1980—Chief Actuary, Social Security Administration; 1964—Actuarial Branch, Division of Program Analysis, Bureau of Old-Age and Survivor's Insurance, Social Security Administration.

TABLE 3.—*Aged Population Eligible for OASI: Estimated number of persons aged 65 and over, by State, January 1, 1964*

[In thousands]

State of residence	Number [1]	State of residence	Number [1]
Total	14,448	Montana	57
		Nebraska	137
Alabama	195	Nevada	15
Alaska	4	New Hampshire	63
Arizona	83	New Jersey	541
Arkansas	148	New Mexico	39
California	1,191	New York	1,555
Colorado	122	North Carolina	271
Connecticut	233	North Dakota	50
Delaware	33	Ohio	788
District of Columbia	47	Oklahoma	176
Florida	535	Oregon	175
Georgia	208	Pennsylvania	1,024
Hawaii	27	Rhode Island	86
Idaho	53	South Carolina	117
Illinois	856	South Dakota	61
Indiana	410	Tennessee	243
Iowa	276	Texas	565
Kansas	198	Utah	53
Kentucky	239	Vermont	38
Louisiana	156	Virginia	239
Maine	96	Washington	250
Maryland	189	West Virginia	149
Massachusetts	505	Wisconsin	377
Michigan	624	Wyoming	22
Minnesota	304	Puerto Rico	83
Mississippi	137	Virgin Islands	1
Missouri	404		

[1] Excludes eligible persons residing outside the United States and about ½ million eligible under the railroad retirement program.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration.

TABLE 4.—*Aged Population Receiving OASDI and OAA Benefits: Number and percent of aged population, June 30, 1961*

State of residence [1]	Total number		Percent of aged population		
	OASDI	OAA	OASDI	OAA	OASDI or OAA or both
Total	11,256,125	2,296,190	65.7	13.4	74.9
Alabama	149,941	99,881	56.2	37.4	84.2
Alaska	3,326	1,420	57.3	23.7	72.3
Arizona	57,784	14,136	59.6	14.6	69.6
Arkansas	115,814	56,414	58.8	28.6	82.1
California	911,147	253,937	63.7	17.8	72.6
Colorado	94,898	51,270	58.6	29.3	75.7
Connecticut	182,838	13,871	73.1	5.5	76.1
Delaware	25,364	1,205	68.6	3.3	71.0
District of Columbia	37,158	3,045	53.1	4.4	56.0
Florida	375,772	70,100	62.4	11.6	69.7
Georgia	159,260	95,325	53.6	32.1	79.5
Hawaii	20,332	1,439	67.8	4.8	71.4
Idaho	41,858	7,253	69.8	12.1	77.8
Illinois	672,656	70,259	67.3	7.0	72.3
Indiana	327,065	26,157	72.4	5.8	76.7
Iowa	221,542	33,480	66.9	10.1	73.9
Kansas	157,126	27,531	64.4	11.3	72.7
Kentucky	189,106	55,727	63.9	18.8	78.7
Louisiana	118,673	126,040	47.9	50.8	82.9
Maine	78,561	11,072	73.4	10.3	79.7

See footnote at end of table.

TABLE 4.—*Aged Population Receiving OASDI and OAA Benefits: Number and percent of aged population, June 30, 1961*—Continued

State of residence [1]	Total number		Percent of aged population		
	OASDI	OAA	OASDI	OAA	OASDI or OAA or both
Maryland	145,665	9,615	62.5	4.1	65.6
Massachusetts	405,306	62,766	69.9	10.8	75.0
Michigan	486,718	56,494	73.9	8.6	79.5
Minnesota	238,578	45,627	65.7	12.6	74.3
Mississippi	106.900	81,132	55.7	42.3	85.7
Missouri	320,785	113,361	62.7	22.1	77.3
Montana	44,999	6,484	67.2	9.7	73.6
Nebraska	109,814	14,377	65.8	8.6	72.2
Nevada	11,577	2,535	60.9	13.3	67.1
New Hampshire	50,497	4,834	74.3	7.1	78.6
New Jersey	418,353	18,952	72.1	3.3	74.2
New Mexico	28,936	11,061	53.6	20.5	70.3
New York	1,219,081	61,297	70.3	3.5	72.5
North Carolina	209,457	47,593	65.5	14.9	77.7
North Dakota	39,762	7,075	67.4	12.0	76.4
Ohio	621,809	89,814	68.0	9.8	74.5
Oklahoma	137,520	88,161	54.4	34.8	80.0
Oregon	137,691	16,469	72.9	8.7	78.3
Pennsylvania	807,802	49,977	70.2	4.3	73.2
Rhode Island	69,017	6,615	75.8	7.3	79.9
South Carolina	90,741	30,928	59.3	20.2	77.9
South Dakota	48,687	8,479	66.7	11.6	75.4
Tennessee	187,444	53,995	59.5	17.1	74.5
Texas	426,550	220,594	55.2	28.5	76.4
Utah	40,682	7,516	65.6	12.1	74.4
Vermont	30,825	5,611	70.1	12.8	78.3
Virginia	186,605	14,459	63.3	4.9	67.6
Washington	196,302	46,930	68.9	16.5	78.6
West Virginia	119,716	18,678	69.2	10.8	78.8
Wisconsin	298,321	33,542	72.4	8.1	77.8
Wyoming	17,292	3,105	64.0	11.5	71.0
Puerto Rico	61,714	37,926	49.0	30.1	79.0
Virgin Islands	738	527	32.8	26.4	59.1
Guam	20	99	1.8	9.9	11.7

[1] Distribution by State estimated for OASDI beneficiaries.

Source: Bureau of Family Services and Bureau of Old-Age and Survivors Insurance, Social Security Administration.

TABLE 5.—*Persons Aged 65 and Over in the United States With Money Income: Estimated number and distribution of persons by type of money income, June 1961* [1]

Type of money income	Number (in thousands)			Percent of total		
	Total	Men	Women	Total	Men	Women
Total population aged 65 and over	17,130	7,760	9,370	100.0	100.0	100.0
Employment, total [2]	4,100	2,290	1,810	23.9	29.5	19.3
Employment and no income from public programs	910	630	280	5.3	8.1	3.0
Employment and social insurance benefits	2,610	1,230	1,380	15.2	15.9	14.7
Employment and payments under other public programs	580	430	150	3.4	5.5	1.6
Social insurance (retirement and survivor) benefits, total [3] [4]	12,430	5,940	6,490	72.6	76.5	69.3
Benefits and no earnings or veterans' or public assistance payments	7,950	3,660	4,290	46.4	47.2	45.8
Benefits and veterans' payments	1,090	710	380	6.4	9.1	4.1
Benefits and public assistance	780	340	440	4.6	4.4	4.7
Veterans' pension or compensation, total [4]	1,890	1,110	780	11.0	14.3	8.3
Veterans' payment and no earnings or social insurance [5]	310	30	280	1.8	.4	3.0
Public assistance, total [6]	2,400	820	1,580	14.0	10.6	16.9
Public assistance and no earnings or payments under other public programs	1,510	420	1,090	8.8	5.4	11.6
No income from employment or public programs	1,390	310	1,080	8.1	4.0	11.5

[1] The 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

[2] Includes 3,200,000 earners and an estimated 900,000 nonworking wives of earners. The figures on earners differ from those published by the Bureau of Labor Statistics, not only because of the inclusion of Puerto Rico and the Virgin Islands but, more important, because they take account of the larger-than-expected number of persons aged 65 and over reported in the Decennial Census and not yet reflected in the population totals shown in the Monthly Reports on the Labor Force.

[3] Includes persons with income from one or more of the following sources: old-age, survivors, and disability insurance, railroad retirement, and Government employee retirement as follows:

Type of money income	Number (in thousands)			Percent of total		
	Total	Men	Women	Total	Men	Women
Old-age, survivors, and disability insurance	11,260	5,389	5,880	65.7	69.4	62.8
Railroad retirement	640	320	320	3.7	4.1	3.4
Government employee retirement	1,040	520	520	6.1	6.7	5.5

Excludes persons with benefits under unemployment or temporary disability insurance or workmen's compensation programs.

[4] Includes estimated number of beneficiaries' wives not in direct receipt of benefits.

[5] Includes a small number receiving supplementary public assistance.

[6] Old-age assistance recipients and persons aged 65 and over receiving aid to the blind or to the permanently and totally disabled, including a relatively small number receiving vendor payments for medical care but no direct cash payment under either old-age assistance or medical assistance for the aged.

Source: Lenore A. Epstein, "Sources and Size of Money Income of the Aged," *Social Security Bulletin*, January 1962.

TABLE 6.—*Money Income of Families: Distribution by amount for families with head aged 65 and over, by source of income, and number of earners, 1960*

[Noninstitutional population of the United States]

Money income class	Total	No earnings [1]	Some earnings			
			And other income	No other income	1 earner	2 or more earners
Total	100.0	100.0	100.0	100.0	100.0	100.0
Under $2,000	31.4	53.6	19.8	18.7	23.3	13.1
Under $1,000	9.2	15.4	5.0	10.9	7.2	3.5
$1,000 to $1,499	10.3	16.4	7.3	5.6	8.0	5.5
$1,500 to $1,999	11.9	21.8	7.5	2.2	8.1	4.1
$2,000 to $3,999	32.4	37.0	31.1	24.8	34.6	22.6
$2,000 to $2,499	11.6	18.8	8.5	4.9	10.1	4.0
$2,500 to $2,999	8.8	9.4	9.0	5.3	9.4	7.1
$3,000 to $3,999	12.0	8.8	13.6	14.6	15.1	11.5
$4,000 and over	36.1	9.3	49.2	56.6	42.1	64.2
$4,000 to $4,999	8.4	3.8	10.8	10.9	11.5	9.8
$5,000 to $6,999	11.3	2.6	16.0	15.6	15.6	16.7
$7,000 to $9,999	8.5	1.4	11.4	17.0	8.6	19.0
$10,000 and over	7.9	1.5	11.0	13.1	6.4	18.7
Median income	$2,897	$1,916	$3,925	$4,571	$3,423	$5,519
Percent distribution	100.0	35.8	54.4	9.9	40.9	23.4

[1] Includes a small group with no income.

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, and related unpublished data.

TABLE 7.—*Money Income of Persons 65 and Over: Distribution by amount and sex, 1960*

[Noninstitutional population of the United States]

Money income class	Total [1]	Men	Women
Total	100.0	100.0	100.0
Less than $1,000	52.6	27.1	73.9
Zero	14.5	3.6	23.6
$1 to $499	11.7	5.5	16.8
$500 to $999	26.4	18.0	33.5
$1,000 to $1,999	23.7	32.0	16.8
$1,000 to $1,499	15.3	20.1	11.2
$1,500 to $1,999	8.4	11.9	5.6
$2,000 to $2,999	10.2	17.3	4.2
$3,000 to $4,999	7.2	11.8	3.4
$5,000 or more	6.3	11.8	1.7
Median income, all persons	$950	$1,620	$640
Income recipients	1,150	1,698	821
Year-round, full-time workers	3,630	4,115	2,838

[1] The distributions for men and women were combined using population figures estimated in the Division of Program Research by updating the decennial census counts after adjustment to exclude institutional inmates.

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, and related unpublished data.

TABLE 8.—*Money Income of Families and Persons Living Alone or Lodging: Distribution by amount and age, 1960*

[Noninstitutional population of the United States]

Money income class	All families		Families containing specified number of members								Persons living alone or lodging	
			Two		Three		Four		Five or more			
	Head 65 and over	Head under 65	Head 65 and over	Head under 65	Head 65 and over	Head under 65	Head 65 and over	Head under 65	Head 65 and over	Head under 65	65 and over	Under 65
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Under $2,000	31.4	10.2	35.7	16.0	20.3	9.0	17.6	6.5	17.9	8.9	79.4	41.2
Under $1,000	9.2	4.4	10.0	7.0	8.0	3.7	7.2	2.8	3.6	3.9	47.7	26.2
$1,000 to $1,499	10.3	2.8	11.5	4.4	6.8	2.3	5.2	1.8	9.4	2.4	21.3	9.3
$1,500 to $1,999	11.9	3.0	14.2	4.6	5.5	3.0	5.2	1.9	4.9	2.6	10.4	5.7
$2,000 to $3,999	32.4	16.5	35.5	18.8	28.2	16.6	15.7	14.5	20.0	15.8	14.1	27.4
$2,000 to $2,499	11.6	3.5	13.7	4.1	5.9	3.5	7.1	3.1	4.0	3.2	6.2	7.8
$2,500 to $2,999	8.8	3.5	9.8	4.2	6.6	3.7	2.9	2.6	8.0	3.4	3.2	6.6
$3,000 to $3,999	12.0	9.5	12.0	10.5	15.7	9.4	5.7	8.8	8.0	9.2	4.7	13.0
$4,000 and over	36.1	73.3	28.8	65.1	51.6	74.6	66.6	79.1	62.0	75.3	6.4	31.4
$4,000 to $4,999	8.4	10.8	7.9	11.2	12.2	11.5	8.6	10.5	4.9	10.3	2.4	12.8
$5,000 to $6,999	11.3	25.4	9.4	22.8	15.9	25.3	16.6	27.6	19.2	26.2	4.0	18.6
$7,000 to $9,999	8.5	21.8	5.9	18.7	14.8	22.5	18.6	24.5	17.4	21.8		
$10,000 and over	7.9	15.3	5.6	12.4	8.7	15.3	22.8	16.5	20.5	17.0		
Median income	$2,897	$5,905	$2,530	$5,314	$4,122	$5,930	$6,100	$6,300	$5,727	$6,074	$1,053	$2,571
Mean size	2.5	3.9	2.0	2.0	3.0	3.0	4.0	4.0	6.4	6.2	1.0	1.0
Percent distribution	100.0	100.0	72.9	26.4	16.4	21.6	5.1	22.9	5.6	29.1	----------	----------

Source: Bureau of the Census, *Current Population Reports:* Consumer Income, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," January 17, 1962, and related unpublished data.

TABLE 9.—*Total Assets: Distribution of spending units with head 65 and over according to type by value of assets, 1960*

Value of assets	Total assets	Liquid assets	Corporate stock	Equity in home	Other real estate	Unincorporated business
Do not own	13	30	86	36	79	97
Own	87	70	14	64	21	3
Less than $1,000	8	20	2	1	3	1
1,000 to 4,999	15	29	3	14	5	1
5,000 to 9,999	22	10	2	18	3	(1)
10,000 to 24,999	23	8	2	26	6	(1)
25,000 and over	18	4	3	4	3	(1)
Not ascertained	2	(1)	1	(1)	1	(1)
Total	100	100	100	100	100	100
Median, all spending units	$8,000	$1,000	0	$4,700	0	0
Median, holders only	$9,400	$3,000	$7,500	$9,700	$8,300	(2)

[1] No cases reported or less than one-half of 1 percent.
[2] Too few cases.

NOTE.—Details may not add to totals because of rounding. There were 425 cases in the sample.

Source: University of Michigan, Institute for Social Research, Survey Research Center, *1960 Survey of Consumer Finances* (1961).

TABLE 10.—*Savings and Health Insurance: Distribution of couples with head aged 65 and over and other persons aged 65 and over according to savings and insurance coverage by money income, 1959*

[Noninstitutional population of the United States]

Money income class	Total	Less than $5,000 in savings		$5,000 or more in savings
		No health insurance	Health insurance	
COUPLES WITH HEAD 65 AND OVER				
Total	100	42	29	29
Under $2,000	100	68	20	12
$2,000 to $2,999	100	42	34	24
$3,000 to $4,999	100	28	44	28
$5,000 to $7,499	100	14	45	41
$7,500 and over	100	7	16	77
OTHER PERSONS 65 AND OVER				
Total	100	62	23	15
Under $1,000	100	73	16	11
$1,000 to $1,999	100	59	23	18
$2,000 to $2,999	100	44	28	28
$3,000 and over	100	11	69	20

Source: University of Michigan, Institute for Social Research, Survey Research Center, unpublished data.

TABLE 11.—*Hospital Costs: Distribution of costs of hospital care for hospitalized aged OASI beneficiaries by marital status and insurance status, 1957*

Cost of hospital care [2]	Married couples [1]				Nonmarried beneficiaries			
	All [3] hospitals	General hospitals [4]			All [3] hospitals	General hospitals [4]		
		Total	With no hospital insurance [5]	With hospital insurance [5]		Total	With no hospital insurance	With hospital insurance
Total hospitalized	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Costs reported	72.5	73.9	65.3	80.3	70.4	70.0	55.4	84.2
Less than $100	13.6	14.2	16.2	12.7	16.8	20.4	20.8	20.1
$100 to $199	16.5	17.7	17.9	17.5	12.3	15.2	13.8	16.5
$200 to $299	10.5	10.9	9.8	11.8	6.9	8.1	6.9	9.4
$300 to $399	6.0	6.0	4.0	7.4	6.9	7.4	4.6	10.1
$400 to $499	5.7	6.2	5.2	7.0	3.6	3.7	1.5	5.8
$500 to $999	11.7	11.7	8.1	14.4	11.1	11.1	5.4	16.5
$1,000 to $1,499	3.8	3.7	2.3	4.8	5.1	2.2	.8	3.6
$1,500 to $1,999	2.4	2.0	1.7	2.2	4.2	1.1	.8	1.4
$2,000 to $2,499	1.0	.7	----	1.3	2.4	.4	----	.7
$2,500 or more	1.2	.7	----	1.3	1.2	.4	.8	----
Costs not reported [6]	27.5	26.1	34.7	19.7	29.6	30.0	44.6	15.8
Nongovernmental hospitals	15.1	15.4	17.3	14.0	14.7	15.9	19.2	12.9
State, county and city hospitals	10.3	9.0	14.5	4.8	12.3	10.4	19.2	2.2
Federal hospitals	2.2	2.0	3.5	.9	3.0	3.7	6.9	.7

[1] Aged beneficiary and spouse, whether or not entitled to benefits (spouse may be under 65).
[2] Hospital costs do not include fees of surgeon or inhospital physician. For married couples, includes hospital costs of the hospitalized member. If both were hospitalized, data tabulated represent the combined costs for both members.
[3] Includes chronic-care institutions and nursing homes.
[4] Includes short-stay special hospitals.
[5] For the hospitalized person. If both spouses were hospitalized, but only one insured, the couple is classified in the "with insurance" category.
[6] In many cases, includes some "free" care, i.e., no bills rendered to anyone, or vendor paid directly by public assistance or other agency.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.

TABLE 12.—*Hospitalization and Total Medical Costs: Distribution of total medical costs for the year incurred by aged OASI beneficiaries with a general hospital stay, by marital status and insurance status, 1957*

Total medical costs incurred [2]	Married couples [1]			Nonmarried beneficiaries		
	Total	With no hospital insurance [3]	With hospital insurance [3]	Total	With no hospital insurance	With hospital insurance
Total hospitalized [4]	100.0	100.0	100.0	100.0	100.0	100.0
Costs reported	81.3	75.1	86.0	71.5	61.5	81.3
Less than $100	1.2	2.3	.4	2.2	3.1	1.4
$100 to $199	3.7	4.6	3.1	11.5	10.0	12.9
$200 to $299	5.7	5.2	6.1	9.3	11.5	7.2
$300 to $399	8.0	6.9	8.7	7.0	6.2	7.9
$400 to $499	9.5	8.7	10.0	7.0	4.6	9.4
$500 to $999	25.1	24.3	25.8	18.9	15.4	22.3
$1,000 to $1,499	13.9	12.1	15.3	8.5	4.6	12.2
$1,500 to $1,999	6.7	4.0	8.7	3.7	4.6	2.9
$2,000 to $2,499	3.2	4.0	2.6	1.5	----	2.9
$2,500 or more	4.2	2.9	5.2	1.9	1.5	2.2
Costs not reported [5]	18.7	24.9	14.0	28.5	38.5	18.7
Nongovernmental hospitals	10.2	10.4	10.0	14.4	13.1	15.8
State, county and city hospitals	6.2	11.0	2.6	10.0	18.5	2.2
Federal hospitals	2.0	3.5	.9	3.7	6.9	.7
Two stays involving two kinds of ownership	.2	----	.4	----	----	----

[1] Aged beneficiary and spouse whether or not entitled to benefits (spouse may be under 65).
[2] For the survey year. For married beneficiaries, represents total medical costs for the couple.
[3] For the hospitalized person. If both spouses were hospitalized, but only one insured, the couple is classified in the "with insurance category."
[4] In general hospital, including short-stay special hospital.
[5] In many cases, includes some "free" care, i.e., no bills rendered to anyone, or vendor paid directly by public assitance or other agency.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Adminstration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.

Appendix B

Table 13.—*Old-Age Assistance: Recipients, total payments, and average money and vendor payments per recipient, by State, January 1, 1962*

State	Number of recipients	Total assistance payments	Average payment per recipient			Vendor payments as percent of total
			Total	Money payments to recipients	Vendor payments for medical care	
Total [1]	2,258,450	$160,190,570	$70.93	$57.67	$13.26	18.7
Alabama	100,185	6,038,900	60.28	55.44	4.83	8.0
Alaska	1,401	97,314	69.46	69.46	----------	----------
Arizona	13,945	828,626	59.42	59.42	----------	----------
Arkansas	55,640	2,821,927	50.72	43.63	7.09	14.0
California	252,043	25,441,412	100.94	88.13	12.81	12.7
Colorado [1]	50,002	4,873,165	97.46	80.52	16.94	17.4
Connecticut	13,906	1,489,286	107.10	45.81	61.29	57.2
Delaware	1,156	56,893	49.22	49.22	----------	----------
District of Columbia	3,032	205,898	67.91	55.09	12.81	18.9
Florida	70,239	4,177,373	59.47	46.69	12.79	21.5
Georgia	93,657	4,353,392	46.48	46.35	.13	0.3
Hawaii	1,239	77,217	62.32	50.07	12.26	19.7
Idaho	5,989	412,894	68.94	61.35	7.59	11.0
Illinois	68,005	5,615,074	82.57	46.35	36.22	43.9
Indiana	25,327	1,666,318	65.79	44.43	21.36	32.5
Iowa	32,532	2,793,971	85.88	58.31	27.58	32.1
Kansas	26,666	2,243,131	84.12	69.17	14.95	17.8
Kentucky	55,796	2,970,319	58.24	50.24	3.00	5.6
Louisiana	126,601	9,566,678	75.57	65.93	9.63	12.7
Maine	11,169	773,289	69.24	47.74	21.50	31.1
Maryland	9,505	617,843	65.00	59.41	5.59	8.6
Massachusetts	61,648	5,103,068	82.78	67.99	14.79	17.9
Michigan	54,458	4,330,076	79.51	66.53	12.99	16.3
Minnesota	44,624	4,080,882	91.45	46.50	44.95	49.2
Mississippi	79,749	2,788,541	34.97	33.64	1.33	3.8
Missouri	111,121	6,727,119	60.54	55.29	5.25	8.7
Montana	6,347	417,918	65.84	65.61	.24	0.4
Nebraska	13,931	1,057,999	75.95	48.01	27.93	36.8
Nevada	2,530	206,695	81.70	66.06	15.64	19.1
New Hampshire	4,726	424,515	89.83	67.83	21.99	24.5
New Jersey	18,566	1,745,756	94.03	53.56	40.47	43.0
New Mexico	10,884	758,473	69.69	55.86	13.83	19.8
New York	59,271	4,923,090	83.06	66.66	16.40	19.7
North Carolina	46,428	2,312,894	49.82	44.82	5.00	10.0
North Dakota	6,385	522,911	81.90	60.21	21.69	26.5
Ohio	88,777	7,023,691	79.12	64.00	15.12	19.1
Oklahoma	86,742	7,164,797	82.60	67.59	15.01	18.2
Oregon	16,099	1,363,006	84.66	50.70	33.96	40.1
Pennsylvania	49,077	3,292,783	67.09	62.85	4.24	6.3
Rhode Island	6,375	519,715	81.52	66.52	15.00	18.4
South Carolina	29,685	1,306,696	44.02	38.60	5.42	12.3
South Dakota	8,397	637,253	75.89	64.01	11.88	15.7
Tennessee	52,058	2,338,346	44.92	40.22	4.70	10.5
Texas	219,158	13,887,113	63.37	54.38	8.98	14.2
Utah	6,932	553,584	79.86	51.73	28.13	35.2
Vermont	5,518	405,587	73.50	47.99	25.52	34.7
Virginia	14,312	774,890	54.14	41.34	12.80	23.6
Washington	45,551	4,145,058	91.00	55.32	35.68	39.2
West Virginia	17,944	745,823	41.56	34.60	6.96	16.7
Wisconsin	32,563	2,942,096	90.35	36.44	53.91	59.7
Wyoming	2,859	223,326	78.11	64.14	13.97	17.9
Puerto Rico	37,045	325,878	8.80	8.33	.46	5.2
Virgin Islands	539	17,985	33.37	30.24	3.12	9.3
Guam	116	2,086	17.98	17.98	----------	----------

[1] Includes 3,658 recipients aged 60–64 in Colorado and payments of $308,011 to these recipients. Such payments were made without Federal participation.

Source: Bureau of Family Services, Social Security Administration.

TABLE 14.—*Old-Age Assistance: Provision of major types of medical care to recipients of old-age assistance and methods of payment by State, October 1, 1961*

State	Hospital care	Physicians' services				Dental care			Prescribed drugs	Nursing home care
		Office visits	Home calls	Hospital		Fillings	Extractions	Dentures and denture repair		
				In-patient	Out-patient					
Alabama	V									V
Alaska										
Arizona										
Arkansas	V	V	V		V		V		B*	V
California	M*	V	V		V	V	V	V	V	M
Colorado	V	V	V	V	V				V	MV
Connecticut	V	V	V			V	V	V	V	V
Delaware		M*	M*	M*	M*	M*	M*	M*	M*	M*
District of Columbia	V		V			V	V	V	V	M[1]
Florida	V							M*	B*	V
Georgia										M*
Guam										
Hawaii	V	V	V	V	V	V	V		V	M
Idaho	V	V	V	V						
Illinois	V	V	V	V	V	V	V	V	V	MV
Indiana [1]	V	V	V	V	V	V	V	V	V	MV
Iowa		V	V		V	V	V	V	V	V
Kansas [1]	V	V	V	V	V	M	M	M	V	M
Kentucky	V	V	V			V	V		V	M*
Louisiana	V	V	V	V					B*	V
Maine	V									V
Maryland	V	V	V		V	V	V	V	V	B*
Massachusetts	V	V	V			V	V	V	V	V
Michigan	V	M*	M*	M*	M*		M*	M*	M*	M*
Minnesota	V	V	V	V	V	V	V	V	V	MV
Mississippi	V									M*
Missouri [2]	V	M*	M*	M*	M*	M*	M*	M*	M*	V
Montana	V	V	V	V	V					V
Nebraska	V	M*	M*	M*	M*	M*	M*	M*	M*	V
Nevada	M	V	V		V	V	V	V	V	M
New Hampshire	V	V	V	V	V	V	V	V	V	B*
New Jersey		M	M			M	M	M	M	V
New Mexico	V	V	V	V		V	V	V	V	V
New York [1]	V	V	V	V	V	V	V	V	V	MV
North Carolina	V									M
North Dakota	V	V	V	V	V	V	V	V	V	V
Ohio	V	V	V	V	V	V	V	V	V	M
Oklahoma	V		V	V	V					MV
Oregon	V	V	V	V	V	V	V	V	V	V
Pennsylvania		V	V		V	V	V	V	V	M
Puerto Rico	V								V	
Rhode Island	V	V	V			V	V	V	V	M
South Carolina	V								M*	V
South Dakota	V	V	V					M	M	M
Tennessee	V									MV
Texas	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*
Utah	V	V	V	V	V	V	V	V	V	V
Vermont	V	V	V							V
Virgin Islands	V		V			V	V	V	V	
Virginia	V	M	M		M	M	M	M	M	V
Washington	V	V	V	V	V	V	V	V	V	B*
West Virginia	V	V	V	V	V	V	V	V	V	M*
Wisconsin	V	V	V	V	V	V	V	V	V	V
Wyoming [1]	V	V	V	V						MV

[1] Medical care provisions in Indiana, Kansas, New York, and Wyoming are based on individual county (or welfare district) plans, subject to State review; hence there is some area variation in the method of paying for a given service but the scope, content, and general policies are applicable to all jurisdictions within the State.

[2] Missouri has an additional maximum $100 for completely bedfast or totally disabled persons.

CODE

V—Vendor payments to suppliers of medical care.
M—Money payment to recipient.
M*—Money payment to recipient, subject to maximum on money payment.
MV—Combined money and vendor payment.
B—Both methods used, each in particular situations.
B*—Same as B, but money payment is subject to a maximum.

Source: Bureau of Family Services, Social Security Administration.

TABLE 14 (Continued).—*Limitations (excluding those which can be lifted by administrative action)*

Hospital care:
- Alabama: Acute conditions and major injury only; 15 days per fiscal year.
- Arkansas: Acute conditions primarily; 30 days per year. Up to 90% of costs up to $20 per day.
- California: 2 months except for diagnoses.
- Colorado: Critical or serious conditions or with prior approval.
- Florida: Acute conditions only; not to exceed 30 days in 12 months' period.
- Kentucky: Acute and life-endangering conditions only; 6 days per admission.
- Maine: 45 days per year. Not to exceed $20 for first 10 days, $15 for remaining 35 days.
- Mississippi: Acute conditions only; 15 days per year. $15 per day maximum.
- Missouri: Medical emergency or acute serious illness only; 14 days per admission.
- Montana: Only for remedial eye care for prevention of blindness or restoration of sight.
- Nevada: Room and board only, up to $75 per month.
- New Mexico: Primarily for life-endangering illness, accidents, relief of severe pain, and diagnostic procedures.
- North Carolina: Up to $16 per day.
- North Dakota: 60 days per year.
- Oklahoma: Life-endangering, emergency conditions, and sight-endangering conditions only.
- South Carolina: Acute conditions only; 40 days per year.
- South Dakota: 30 days per admission.
- Tennessee: Acute conditions only; 10 days per admission with a maximum of 30 days in any year (85% of reimbursable cost).
- Utah: 30 days per admission. Essential care.
- Vermont: 30 days per admission or within a quarter.
- Virginia: 28 days per year. Maximum $24.65 per day.
- West Virginia: Acute conditions 30 days per year; defined remedial care as needed.

Physicians' services:
- Arkansas: 2 home visits per month to patients in nursing home, 2 office or clinic visits per month for all others.
- Colorado: As a standard, same number of visits as is set in Blue Shield policy, plus 2 additional visits per quarter, home or office; for patients in nursing homes, 12 visits per quarter.
- Illinois: Acute conditions: home visits, 1 daily per week; office visits, 6 per 30 days. Long term conditions: 2 home visits or 2 office visits per month. Inpatient hospital calls also limited.
- Kentucky: Payment will be made for 2 visits per month per patient.
- Louisiana: Only for persons with approved medical care plan for treatment of serious continuing illness requiring care for relief of severe suffering or for correction of or prevention of permanent impairment.
- Montana: Limited to ophthalmologist (and optometrist) for prevention of blindness and restoration of sight.
- Nebraska: Acute illness, 1 per day; for chronic conditions, 1 per week.
- New Hampshire: Home, office, or clinic: for chronic illness, 2 calls per month. Hospital, inpatient: 14 calls per 30 days of hospitallzation.
- North Dakota: For patients in hospital for more than 30 days, payment will be made for not more than 3 calls per week.
- Ohio: For acute conditions, 10 calls per month; for chronic, 2 calls per month.
- Oklahoma: Outpatient clinic, for acute injury only; home or hospital, no limitation on condition.
- Pennsylvania: For chronic illness, 3 calls per month. For acute, no limit.
- Rhode Island: For chronic illness, 2 per month. For acute conditions, as needed.
- South Dakota: Limited to 14 visits per year.
- Texas: Only for chronic illness. $6 per month except for cancer and certain eye conditions.
- Utah: Limited to 4 calls in 60 days for chronic conditions.
- Vermont: Limited to 12 necessary visits in any calendar quarter.
- Virgin Islands: Home calls made only to patients under the Home Care Program.
- West Virginia: Services relating to acute and life-endangering conditions or those which enable an increase in self-support and self-care, or strengthen family life.

Dental Services:
- Arkansas: Relief of pain and X-ray and dental surgery in approved clinics.
- Hawaii: Emergency care only.
- Kansas: Dentures and bridges only when ordered by a physician.
- Kentucky: Only for relief of pain and treatment of acute infection; $16 per month, $48 per year.
- Maryland: Dentures limited to replacement and repairs.
- Michigan: Services other than those related to dentures included only when recommended by a physician as part of other medical procedures.
- North Dakota: Dentures and bridgework provided only if extraction of recipient's teeth occurred within previous 5 years.
- New Mexico: Limited to relief of pain and infection.
- Oklahoma: Only services performed in licensed general hospital for life-endangering conditions involving fractures, infections, and mouth tumors.
- Puerto Rico: Only as included in hospital care.
- South Dakota: Up to $55 for purchase or repair of dentures.
- Texas: Up to $40 for cost of dentures; other services planned for only as part of treatment for chronic illness, maximum of $40.
- West Virginia: Emergency and defined remedial care.

Prescribed Drugs:
- Arkansas: Drugs dispensed by approved outpatient clinic or for patient in nursing home up to $5 per month.
- Colorado: Only for patients in nursing homes.
- Puerto Rico: Only for drugs prescribed while person is hospitalized.
- South Carolina: Verified cost of drugs up to a maximum of $15 per month per individual for chronic conditions. For non-chronic conditions, up to $5 per month may be budgeted monthly and payment prorated over 12-month period.
- South Dakota: As prescribed on a continuing basis for treatment of heart conditions, diabetes, and anemia.
- Texas: Treatment for chronic illness only.
- Utah: Essential needs up to $20 per month.

TABLE 14 (Continued).—*Limitations (excluding those which can be lifted by administrative action)*

Nursing Home Care:*
- Alabama: $125 monthly maximum.
- Arkansas: $90 monthly maximum.
- California: $116 monthly maximum.
- Colorado: $195 monthly maximum.
- Delaware: $75 monthly maximum.
- Florida: $100 monthly maximum.
- Georgia: $65 monthly maximum.
- Kentucky: $110 monthly maximum.
- Maine: $180 monthly maximum.
- Maryland: $116 monthly maximum. In addition, nursing home care paid for by vendor payment in 5 chronic care homes.
- Massachusetts: Short-term care only.
- Michigan: $90 monthly maximum.
- Mississippi: $40 monthly maximum.
- Missouri: $65 monthly maximum; $100 if recipient is completely bedfast or totally disabled.
- Montana: Only for remedial eye care.
- Nevada: $135 monthly maximum.
- New Hampshire: $165 monthly maximum. Vendor payment for care in public nursing homes; money payment for care in private nursing homes.
- New Jersey: $180 monthly maximum; $190 in exceptional cases.
- North Carolina: $175 monthly maximum; limited to post-hospital care.
- North Dakota: Limited to 30 days per year (long-term care under MAA).
- Oklahoma: $129 monthly maximum plus room and board.
- Oregon: $192 monthly maximum.
- Pennsylvania: $165 monthly maximum.
- Rhode Island: $185 monthly maximum.
- South Carolina: $150 monthly maximum; limited to post-hospital care.
- Tennessee: $80 monthly maximum.
- Texas: $71 monthly maximum.
- Utah: $200 monthly maximum.
- Vermont: $165 monthly maximum.
- Virginia: $150 monthly maximum.
- Washington: $191 monthly maximum.
- West Virginia: $100 monthly maximum.
- Wyoming: $180 monthly maximum.

TABLE 15.—*Old-Age Assistance: Welfare department arrangements with health departments, Blue Cross, Blue Shield, or other groups for provision of services to old-age assistance recipients*

State	*Health Department Arrangements*
Alabama	Health department has contracted with the welfare department to perform certain specified services relating to hospital care for OAA recipients.
District of Columbia.	Health department administers the D.C. General Hospital which provides virtually all hospital inpatient and outpatient care to indigent persons and in addition operates a program whereby physician home calls to indigent persons are provided by a number of "District" physicians employed for this purpose. The welfare department reimburses the health department for inpatient and outpatient care provided to OAA recipients.
Florida	State Board of Health acts as the fiscal agent of hospitals; it pays the hospitals for services provided to OAA recipients and is reimbursed by the welfare department. In Kentucky the State Health Department provides professional guidance on medical aspects of the welfare medical program.
Maryland	The State Health Department handles all aspects of medical care for welfare recipients except in Baltimore County; in Baltimore these functions are performed by the Baltimore Health Department. The State Welfare Department pays the two health departments a stipulated amount per month for each welfare recipient; the health departments pay hospitals, physicians, dentists and other suppliers for services provided.
Puerto Rico	The Health Department operates most of the large hospitals on the island—hospitals which provide over 50 percent of all patient days of care in general hospitals. The Health Department's hospitals provide inpatient and outpatient care (including the services of the medical staff) to all welfare recipients, and are paid by the welfare department for services to OAA recipients. A similar arrangement exists in the Virgin Islands where the Health Department of the Territory operates all hospitals on the Islands.

Source: Bureau of Family Services, Social Security Administration.

TABLE 15.—*Old-Age Assistance: Welfare department arrangements with health departments, Blue Cross, Blue Shield, or other groups for provision of services to old-age assistance recipients*—Continued

State	*Blue Cross, Blue Shield, or Other Arrangements*
Colorado	The Welfare Department has contracted with the Blue Cross and Blue Shield plans, acting as the fiscal agent for the hospitals and doctors, respectively, to pay hospitals and physicians for services provided to old-age pensioners. The Welfare Department supplies a list of these to Blue Cross–Blue Shield and pensioners are provided with identification cards. Upon admission of a pensioner the hospital applies to the Blue Cross plan for confirmation of eligibility in the same way as for Blue Cross members. Blue Cross pays the hospitals on the same basis as for its own members and is reimbursed for its administrative expenses at the rate of $2 for each claim paid. Blue Shield pays physicians in the same manner as for its own members and is reimbursed by the welfare department for its outlays together with a payment to cover administrative expense.
Kansas	Welfare departments in 23 counties have entered into group prepayment contracts with the local medical society; the welfare department pays a stipulated amount per recipient per month to cover a defined content of care and the medical society in turn contracts with and pays local hospitals, physicians and pharmacists for services provided to recipients.
Mississippi	State Welfare Department has an agreement with the Mississippi Hospital and Medical Service (Blue Cross) which acts as fiscal agent for the hospitals. Admission notices and billings are reviewed by the Blue Cross, but payments are made by the Department of Public Welfare directly to hospitals.
Nevada	State Welfare Department has a group prepayment plan contract with the State Medical Association covering physicians' services, dental care and drugs, and another prepayment contract with the State Optometric Association covering the services of optometrists. The Welfare Department pays a stipulated amount per recipient per month. The professional associations under contract have responsibility for fee schedules, proportion of payment when necessary, audit, medical review of services and practices, and paying physicians, dentists, optometrists and druggists for services and drugs supplied.
New Mexico	Welfare Department has a contract with the State Pharmaceutical Association. Pharmacists submit their bills to the latter association which prices them according to a pricing formula and submits them to the Department of Public Welfare; the latter makes payment to the individual pharmacists.
South Dakota	State Welfare Department has agreements with the Blue Cross and Blue Shield plans in accordance with which these plans pay hospitals and physicians, respectively, for services provided to welfare recipients. The same type of arrangement exists in Utah.
Texas	Effective January 1962, the Welfare Department contracts with the Texas Blue Cross and Blue Shield plans for hospital care and for surgical, physician inhospital visits and X-ray and laboratory services for all OAA recipients. The department pays $8.68 per month per recipient. For this the plans provide 15 days of hospital care per admission with half benefits thereafter and the specified physician services. If, after six months' experience, the amounts paid out by the Blue Cross and Blue Shield plans are less than 97 percent of the premiums—3 additional percent being allowed for administrative expenses—benefits will subsequently be adjusted upwards. If the costs to Blue Cross-Blue Shield are more than the premiums receivd, the plans bear any loss.

TABLE 15.—*Old-Age Assistance: Welfare department arrangements with health departments, Blue Cross, Blue Shield, or other groups for provision of services to old-age assistance recipients*—Continued

State	*Blue Cross, Blue Shield, or Other Arrangements*
Washington	State Welfare Department purchases medical and dental services for recipients through Washington Physicians' Service and Washington Dental Service, respectively. Washington Physicians' represents the County Medical Service Corporation or Bureaus which have signed agreements with individual physicians to participate in the Public Assistance Medical Program. Washington Dental Service represents individual dentists who have signed agreements to participate in the dental program. The Department of Public Welfare pays to each organization a stipulated amount per OAA recipient per month. In return the two organizations agree that stipulated services will be available to welfare recipients. The two organizations pay the bills submitted by physicians and dentists, respectively, prorating when total bills exceed the amount available.

TABLE 16.—*Medical Assistance for the Aged: Provision of major types of services under State plans, October 1961*

State	Hospital care	Nursing-home care	Physicians' services				Dental care	Prescribed drugs [1]
			Office	Home or in nursing home	Hospital			
					Out-patient	In-patient		
Arkansas	X	X	X	X	X	--	X	X
Hawaii	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	--	--	--	--
Illinois	X	--	X	X	X	X	--	--
Kentucky	X	--	X	X	--	--	X	X
Louisiana	X	X	X	X	X	X	--	X
Maryland	X	--	X	X	X	--	X	X
Massachusetts	X	X	X	X	--	--	X	X
Michigan	X	X	X	--	X	X	--	--
New Hampshire	X	--	X	X	X	X	--	--
New York	X	X	X	X	X	X	--	X
North Dakota	X	X	X	X	X	X	X	X
Oklahoma	X	X	--	X	X	X	X	--
Oregon	X	X	X	X	X	X	--	--
Puerto Rico	X	X	--	--	X	--	--	--
South Carolina	X	X	--	--	X	--	--	--
Tennessee	X	--	--	--	--	--	--	X
Utah	X	--	X	X	X	X	--	--
Virgin Islands	X	--	--	X	--	--	X	X
Washington	X	X	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X	X	X

[1] Other than for hospitalized patients; drugs for hospital patients are included as part of hospital care.

NOTE.—Code:
X—Service is provided.
--—Service is not provided.

Source: Bureau of Family Services, Social Security Administration.

TABLE 16 (Continued).—*Limitations (excluding those which can be lifted by administrative action)*

Hospital care:
- Arkansas: To 15 days in any 12-month period. Maximum daily rate $25.50.
- Idaho: For care of acute conditions and emergencies only; 14 days per admission.
- Kentucky: For care of acute, emergency and life endangering conditions only; 6 days per admission. No limit on number or frequency of admission.
- Louisiana: Up to 30 days.
- New Hampshire: 7 days per admission, plus a maximum of $75 for auxiliary services. No eye care.
- Oklahoma: Care for conditions which endanger life or sight only; not to exceed 6-months care in any 12-month period.
- Oregon: Up to 14 days per year. Patients pays $7.50 per day for first 10 days up to maximum of $75 per year.
- South Carolina: Care only for acute illness, injury or condition that endangers sight; not to exceed 40 days per year.
- Tennessee: Care only for acute illness or injury; up to 10 days per year. Patient pays first $100 in any year.
- Utah: Up to 30 days per admission. Patients pays first $50 per admission.
- Washington: Care only for acute and life-endangering conditions.

Nursing home care:
- Arkansas: Up to maximum of $90 per month.
- Idaho: Up to maximum of $175 per month.
- Louisiana: Only for persons eligible for OAA except for durational residence requirement. Up to $165 monthly.
- Michigan: Only within 30 days following hospitalization for acute illness and limited to 90 days in a 12-month period.
- Oklahoma: Limited to 6 months care in any 12-month period. Excludes room and board.
- Oregon: Upon transfer from hospital. Number of days available is based on hospital entitlement—14 days per year—with allowance of 4 days of nursing home care for each remaining day of hospital entitlement. Up to $6 per day.
- South Carolina: Following hospitalization. Ordinarily up to 90 days per year. Maximum payment, $150 per month.
- Virgin Islands: Facilities not available.
- West Virginia: After hospitalization or to prevent hospital care. Limited to acute conditions. Maximum payment $100 per month.
- Washington: Care only for acute and life-endangering conditions.

Physicians' services:
- Idaho: Acute conditions; 2 calls per month. Nursing Home: 1 call per month. 1 eye examination per 6-month period.
- Illinois: Only in 30-day period immediately following release from hospital. Acute conditions: 1 home call daily for 1 week, 6 office calls per 30-day period. Chronic care: 2 home calls per month, 2 office calls per month.
- Kentucky: 2 office and/or home calls per month.
- Louisiana: Serious continuing illness requiring care for relief of severe suffering or for correction or prevention of permanent impairment.
- Michigan: Office services limited to emergency treatment, office surgery, and procedures involving therapeutic X-ray.
- New Hampshire: 6 office and/or home calls per year.
- North Dakota: Inpatient hospital care of more than 30 days limited to 3 calls per week.
- Oklahoma: Patients receiving nursing care: 2 calls per month. In hospital not more than 15 visits per month in certain hospitals, less in others.
- Oregon: Patient pays first $50 of any combination of physicians' services, X-rays, or laboratory procedures; then eligible for maximum of $150 for physicians' care and maximum of $500 for surgery, $100 for X-rays and laboratory costs.
- South Carolina: 3 clinic visits per month.
- Utah: Patient pays first $20 per benefit period of 90 days; if more care is needed and authorized patient pays first $20 for each additional benefit period.
- Virgin Islands: Available to patients under Home Care program.
- Washington: Only for acute and life-endangering conditions.
- West Virginia: Services must be related to acute and life-endangering conditions or defined remedial care.

TABLE 16 (Continued.)—*Limitations (excluding those which can be lifted by administrative action)*

Dental services:
- Kentucky: Services as related to relief of pain and treatment of acute infection. Up to $16 per month and $48 per year.
- Maryland: Restorative dental care only, including repair and replacement of dentures.
- North Dakota: Dentures and bridgework limited to when extractions occurred within previous 5 years.
- Oklahoma: Only for in-hospital patients having life endangering conditions involving fractures, infections, or tumors of the mouth.

Prescribed drugs other than for hospitalized patients:
- Arkansas: Maximum of $5 per month and dispensed only by an approved clinic. Maximum of $5 per month for patient in nursing home.
- Louisiana: Only for patients in nursing homes.
- Washington: Only for acute and life-endangering conditions.
- West Virginia: Limited to 1 refill for care of acute illness.

TABLE 17.—*Medical Assistance for the Aged: Financial eligibility provisions, income and property holdings, by State, October 1961*

State	Income	Assets		Use of own resources as a condition of receiving assistance
		Real property	Personal property	
Arkansas	Cash income for single person not to exceed $1,200 annually; for family $1,500.	May have home or an equity in home not to exceed $7,500. Value of other real property must come under the maximum on personal property.	Including value of non-home real estate, livestock, motor vehicle, tools, equipment, and cash surrender value of life insurance. Household furnishings are excluded. Applicant may have a cash reserve of up to $300 for one person and an additional $300 for dependents, with a family maximum of $600. Total value of all other property and resources may not exceed $2,500.	Benefits from health or hospitalization insurance must be applied to that portion of the hospital bill (based on the hospital's established reimbursable cost figure) which comes within the MAA maximum rate of $25.50 per day before MAA funds are used. (Revision since October 1961.)
Hawaii	Insufficient to meet the standards of assistance established for MAA, including non-medical and medical requirements (approximately $50 per month above the standards of assistance for OAA) and if the resources available to him within 12 months after date of application are insufficient to pay the cost of needed medical care.	Home with tax-appraised value of less than $14,000 is exempt; also other real property with value not to exceed $150. All excess value is considered a resource for payment of medical costs.	All liquid assets beyond $50 cash savings (of unemancipated minor) are considered available after allowances for payments on obligations contracted for defined essential purposes. May own automobile 4 years old or older or when necessary for essential transportation. Full loan value of life insurance is resource. Under exceptional circumstances, conservation of readily available resources allowed.	Health insurance, Veterans Administration care, workmen's compensation, and similar resources must be taken into account in determining extent to which MAA is needed.
Idaho	Cash income from all sources is considered available to meet costs of medical care except for amount needed to meet "ordinary expenses and obligations" (calculated on basic requirements in State's "Standards of Assistance" plus $50 a month additional allowance to cover other obligations); in addition, for any month, 1/12 of the savings and cash resources owned above $2,000 and less than $10,000 is considered available.	May own home not excessive in value in relation to community standards. Value of other real property which can be made available is considered among cash assets. Total available assets—real and personal—may not exceed $10,000.	Value of real property other than home plus personal property other than exclusions listed below may be held up to $2,000. Value in excess of this amount and under the maximum is considered available to meet costs of medical care, as stated in Income. Excluded from assets available are: household furniture and personal possessions of reasonable value, a "popular priced" car.	Eligibility is determined after medical care has been provided and is directly related to the costs of medical care incurred or predicted and the applicant's resources considered available to meet such costs. (Potential eligibility is determined when there is a "complaint of illness or injury" for which medical care is sought.)

TABLE 17.—*Medical Assistance for the Aged: Financial eligibility provisions, income and property holdings, by State, October 1961*—Continued

State	Income	Assets		Use of own resources as a condition of receiving assistance
		Real property	Personal property	
Illinois	Maximum gross income (after deducting amounts necessary to maintain in force a medical, surgical, hospital, or other health insurance policy) for single person, $1,800; for applicant and spouse or other dependent, $2,400; plus $600 for each dependent living with applicant. Contributions received from responsible relatives are included in income.	Value of property used as a home and contiguous land is excluded.[1]	Value of all other property (except for exclusions listed below) may not exceed $1,800 for single person; $2,400 for applicant and 1 dependent; plus $400 for each additional dependent living with applicant. Excluded from consideration as liquid or marketable assets are: clothing, personal effects, automobile, life insurance with a face value of $1,000 or less, and tangible personal property used in earning income with a fair market value of $1,000 or less.[1]	MAA is not available unless cost of allowable medical care exceeds 10% of total income of applicant (or 10% of combined income of applicant and dependents living with him). Benefits from health or hospital insurance policies covering applicant may meet or be applied to this "deductible" or to apply toward further cost of medical care.
Kentucky	Annual gross income for single person may not exceed $1,200; for couple, $1,800. Special provisions for determining income from self-employment or from farming operations.	Homestead is not considered; the equity in nonhomestead real property may not exceed $5,000, single person or married couple.	Limited to $750 for single person, $1,000 for applicant and spouse; excluding cash surrender value of life insurance not to exceed $3,000. (Personal property is defined as "cash on hand, money in the bank, stocks, bonds, and other resources that can be converted into liquid assets"; excluded from consideration is cash surrender value of insurance within the maximum stated and tangible personal property not listed in definition.)	Availability of health insurance is to be determined and evaluated.
Louisiana	Income in excess of maximum allowable monthly income of $250 for single person or $325 for couple disqualifies; income less than this amount but in excess of (1) basic income and (2) allowable increases, as defined below, must be applied to costs of needed hospital care. (1) Basic income: $125 single; $175 married couple, combined income. (2) Allowable increases: $30 per month for each dependent minor child or disabled adult declared as dependent on applicant's income tax return; $15 additional income allowable for single person with hospitalization insurance, $25 for couple with such insurance.	May own home as defined for homestead tax exemption; other real property not to exceed $5,000 assessed value if income-producing or $1,000 value if not income-producing; excess value is considered a liquid asset.	Liquid assets not to exceed $1,000 for single, $1,500 for couple; excluding: insurance with cash or loan value up to $1,500 (couple $2,000), motor vehicle used for transportation, farm equipment or business assets which are income producing. Excess value of insurance, care or non-home real property must come under the liquid assets maximum.	Persons with a monthly income of over $90 ($140 for couple) participate in payment of the first $50 of costs of hospital care when the cost of such care exceeds $10; the amount of participation is based on a sliding scale applied to available income. Medical insurance must be utilized fully and must be assigned to hospital before MAA is used; amounts thus paid toward hospital costs considered "participation". Free resources for medical care, available from other than State facilities, must be used if possible to do so without undue hardship.

Maryland	Regular income not to exceed: (1) in Baltimore city and 5 larger counties—$1,140 for single person; $1,560 for applicant with 1 dependent; plus allowances for additional dependents; (2) in 18 other counties—$1,080 for single person; $1,500 for applicant and 1 dependent. Income includes that of spouse or of any other person claimed as dependent. Scale of value for income-in-kind.	Home is exempt; real property other than home is included in other resources convertible to cash.	Resources in cash or convertible to cash (savings, insurance, real property other than the home) may not exceed $2,500 cash value.	A person is ineligible who has any insurance or other benefit the terms of which provide for payment for the medical care items included in the plan.
Massachusetts	Income (for married couple it is combined income of husband and wife) in excess of amount stated is deemed available to meet costs of medical care; (1) *receiving medical care in own home*—single, or married and husband is applicant, $150 a month; if wife is applicant, $225 a month, combined income. (2) *receiving medical care in a hospital, nursing home, or public medical institution*—(a) *short-term:* single person or, if married, for spouse remaining at home, $150 a month; income between $150 and $300 a month is deemed available for costs of medical care for 3 to 6 months based on amount of excess; income beyond $300 a month disqualifies; (b) *long-term:* patient, $15 a month for personal needs; for a spouse remaining at home, $150 a month.	Real estate used as home does not disqualify; ownership of any interest in other real property disqualifies.[1]	Value may not exceed $2,000 if single or if married and applicant is the husband; $3,000 if married and the applicant is the wife, including combined ownership of husband and wife.[1]	Liability of adult children for costs of medical care of parents is established by statute according to income scale, with additional exemptions to meet specified needs of the immediate family of such adult child.
Michigan	Not more than $1,500 annual income for single person; $2,500 if married and living with spouse, including income of spouse.	Homestead is excluded from assets; value of other real property is included in limits on marketable assets given in personal property.[1]	Liquid or marketable assets may be held not to exceed $1,500 for single person, $2,000 for married couple living together. Excluded in making this determination are: clothing and household effects; cash surrender value (not value of matured policies) of life insurance; personal property used in earning income of fair market value not exceeding $1,000. All other property, real and personal, must be considered under the $1,500 and $2,000 maximum on marketable assets.[1]	"Income" includes contributions which son, daughter, or estranged spouse should be making to applicant, according to agency standards or court determination. However, such contributions are not included in computing income during the first 30 days of hospitalization for each determination or redetermination of relative's ability to make contributions.

See footnote at end of table.

TABLE 17.—*Medical Assistance for the Aged: Financial eligibility provisions, income and property holdings, by State, October 1961*—Continued

State	Income	Assets		Use of own resources as a condition of receiving assistance
		Real property	Personal property	
New Hampshire	Annual net income from all sources may not exceed $1,200 for single person, $1,800 for married couple living together; plus $600 allowed for support of each dependent child. If both members of a couple are in the same nursing or boarding home, they are considered as single individuals.	Home owned and occupied by applicant is excluded. Also excluded is net equity in other real property up to $500 for 1 person, $800 for couple. Net equity beyond $500 but less than $4,500 for single person (beyond $800 but less than $4,800 for couple) does not disqualify if real property is income-producing.[1]	May hold livestock and equipment used to earn income up to a net cash value of $1,500; net cash equity of all other personal property, including cash value of life insurance, may not exceed $500 for single person, $800 for married couple.[1]	All medical resources, e.g., health insurance or workmen's compensation, are taken into account in determining extent of need for MAA. Ability of adult children to support parents is determined according to income scale, with provision for taking into account specified family expenses of the adult child if they exist.
New York	(1) Person in medical or nursing institutions for chronic care may have up to $10 a month for personal items, annual premium for health insurance policy up to $150 for single person or $250 for married recipient if policy covers spouse also; if married, up to $1,800 for support of spouse, including any income of spouse. (2) Person not in facility for chronic care may have $1,800 for single applicant, $2,600 for married applicant living with spouse; health insurance premiums up to $150 per year for single recipient or $250 if married and policy includes spouse also. All income in excess of these amounts is deemed available to apply to costs of medical care.	Home is exempt; other real property must be utilized to apply to costs of care.[1]	May have life insurance with cash surrender value of not more than $500 (single person or couple); excess value of insurance or non-essential personal property must be utilized; clothing and household effects are excluded. *Cash reserve*, for person not living in a medical facility, may be held up to $900 for single or $1,300 for married couple. If value of non-home real estate, non-essential personal property, and excess insurance together with cash or liquid assets does not exceed "cash reserve" maximum, such resources need not be utilized and applied to costs of care.[1]	All income and resources shall be deemed available to meet costs of medical care except the amounts and kinds of resources specified in the columns on *Income* and *Assets*.
North Dakota	Annual income in excess of the following is deemed available to meet costs of medical care: single person, $1,200; married couple, $1,800. Living in nursing home or hospital: single, $96; married, both in such institution, $192; one of married couple in nursing home or hospital, the other not, $1,296.	Homestead is exempt (town: house and up to 2 acres of land; rural: 160 acres contiguous to house). Other real property that is saleable or in which applicant has an equity must be utilized to apply to medical care costs.[1]	Total value not to exceed $2,500, of which not more than $500 for single or $1,000 for married couple may be in cash, stocks, or bonds. Cash value of insurance comes under total value maximum but not under liquid assets maximum. Excluded from consideration as personal property are household goods, wearing apparel, or personal effects.[1]	An applicant must have paid or obligated himself to pay $50 for medical care during the 12 months preceding the application; benefits paid from health or hospital insurance will be considered as meeting this requirement.

Oklahoma	Annual income, single person, up to $1,500; for man and wife, up to $2,000. Exempts the income required by legal dependents according to ADC standards.	May have equity up to $8,000 in home owned and occupied as home (urban includes necessary lots; rural includes up to 40 acres of land). Equity above this amount and value of other real property are considered among "other resources." Home to which recipient or spouse has no feasible plans to return is no longer considered eligible for exemption as home occupied by recipient.	Maximum set for each of 4 kinds of property: (a) Insurance—single person, cash value of first $1,000 face value; married, cash value of first $2,000 face value; married, living together and having separate policies, cash value of first $1,000 face value for each; (b) equity in tools for earning a living, up to $1,500; (c) equity in small business which he operates, up to $2,500; (d) "other resources" limited to $700 for single person or $1,000 for married couple, including cash, stocks, bonds, etc., automobiles, excess of value of items listed in (a) and (b) preceding, excess equity of home, or property of any kind which can be made available for use of recipient or spouse.	Eligibility is determined concurrently with need for medical care as defined in State's plan and is directly related to total resources of applicant available to meet known or predictable costs of such care.
Oregon	Single person, less than $1,500; married, combined income of husband and wife less than $2,000. Where it is not possible to determine the income of an absent spouse, applicant is treated as a single person.	Home used by applicant or legal dependents, exempt; value of other real property together with personal property may not exceed $5,000 fair market value.[1]	Excluded from consideration are: 1 automobile; household furnishings; personal property holdings used in earning a living (clothing, tools, machinery, and other goods and equipment). All other property must come under maximum. (See column 2.) *Liquid assets* (cash or equivalent) shall be less than $1,500 for single person, $2,000 for couple. Excluded from consideration is cash surrender value of life insurance held by applicant not to exceed $1,000.[1]	Recipient participates in payment of costs through a system of deductible amounts related to the kind of care received. Private medical insurance policies may be utilized in payment of such "deductible" and must be utilized to the fullest extent possible as an "offset" before MAA benefits are payable. MAA and partial benefits supplement each other.
Puerto Rico	Annual income and available liquid resources of individual may not exceed $1,500.	Home where applicant resides is excluded from consideration; all other real property is taken into account in determining eligibility.	Loan value of life insurance and any other available resources will be taken into account.	Membership in organizations which provide medical care or payments therefor (such as Blue Cross, Blue Shield, State retirement or compensation systems, health insurance of any appropriate type, and veterans' benefits) make applicant ineligible for MAA.

See footnote at end of table.

TABLE 17.—*Medical Assistance for the Aged: Financial eligibility provisions, income and property holdings, by State, October 1961*—Continued

State	Income	Assets		Use of own resources as a condition of receiving assistance
		Real property	Personal property	
South Carolina	Maximum annual income for single person is $1,000; for married couple, combined income may not exceed $1,800. In determining income from the operation of a business, net income will be considered.	Home and land upon which it stands. Owned and occupied by applicant or to which he has reasonable plans to return, is exempt as a resource. Other real property may be held if income-producing; if non-income producing, sale value of the property is considered under the income maximums.	May hold (1) savings of $500 if single or $800 combined savings of married couple; (2) insurance with cash, loan, or surrender value of $1,000 for single person and of $2,000 for married couple. Savings and insurance in excess of these amounts are considered under the maximum on income. Not considered as assets available for payment of medical care costs is value of such personal property as automobile needed for transportation, household furnishings, and farm equipment.	Eligibility is determined concurrently with need for medical care as defined in State's plan and is directly related to total resources of applicant available to meet known or predictable costs of such care.
Tennessee	Maximum annual income $1,000 for single, $1,500 for couple; excluding actual cost of support of totally dependent children. Special provision for application of any benefit designated specifically for support of such dependent child (e.g., VA or SSA) who lives in applicant's home.	Equity in all real property (including the home) owned by applicant cannot exceed $5,000 and the total real value of such property cannot exceed $7,000 (figured on the county assessment percentage for the county in which the real property is located).	Total of cash, savings, or items readily convertible into cash may not exceed $1,000 for single person or $1,500 for married couple, excluding cash value of life insurance up to $1,000 for single person or $1,500 for a couple. Excess cash value must be considered under the liquid assets maximum. Contributions by friends or relatives for the particular purpose of meeting costs of allowable medical care will be taken into account in determining amount of MAA needed.	For hospital care, applicant must have incurred hospital expenses amounting to $100 within a fiscal year before MAA is available. Benefits from hospital insurance of applicant may be applied to meet this $100 prior to being considered available to meet costs of days of care for which MAA would be charged.
Utah	Net monthly income available may not exceed $110 for single person, $170 for two persons or couple, $210 for three persons.	Home owned and occupied is excluded; net value of other real property is included in total allowable as available to meet costs of medical care needed.[1]	Net value of all property other than the home and excluded non-liquid assets defined below may not exceed $10,000. Negotiable or liquid assets available to meet costs of medical care may not exceed $1,000 for single, $2,000 for couple or family. Amounts in excess of these maximums must be applied to cost of major medical care before MAA may be granted to cover additional costs. Excluded from consideration as liquid assets are: furniture, household equipment, livestock, implements, tools, and a necessary automobile.[1]	Patient pays first $50 of cost for each hospital admission; first $20 of costs of physician's services for each benefit period of 90 days. Health and hospital insurance will be applied on medical bills in determining amount of MAA needed or may be assigned to the hospital or to the county department of public welfare to fulfill the "deductible" requirement.

Virgin Islands	Current continuing gross annual income of $1,200 or less for single persons, $2,400 for married couple living together.	Total real property, including home owned and occupied, may not exceed $10,000.	Cash assets, or those readily convertible into cash, may not exceed $1,200 for single person, $2,400 for married couple living together.	Health insurance and "government entitlement such as Veterans Medical Services" are available assets which are taken into account in determining need for and extent of MAA.
Washington	Net income (cash or kind) regularly and predictably received by the applicant, the combined dollar value of which is in excess of that needed to meet his and his legal dependents' maintenance requirements as measured by the Department's OAA Standards of Assistance, is considered as income available which must be applied toward meeting the cost of approved medical care.	Home used by applicant or his legal dependents, together with reasonable amount of contiguous land, is not considered as a available asset. Value of other real estate is included in total of assets available.	All other resources and liquid assets, including cash surrender value of life insurance, are considered to determine extent to which they may be utilized for payment of needed medical care, except; household furnishings and personal clothing, 1 automobile, and personal property "used and useful or of great sentimental value".	Medical insurance in force at time of application and any potential compensation for injury must be utilized to the fullest extent.
West Virginia	Annual net income may not exceed $1,500 for single; $3,000 for married person living with spouse, combined income. Includes contributions received from relatives.	Homestead is excluded. Value of all other real property limited to $15,000 for single person, $20,000 for a man and wife residing together.	All other liquid or marketable assets, limited to $5,000 for single person or $7,500 for combined assets of husband and wife. (Excludes clothing, jewelry, household effects, livestock, farm machinery, and other needed vehicles.)	Insurance for medical purposes or eligiblity for payment of medical services from other agencies and organizations, such as Veterans Administration, United Mine Workers of America, Workmen's Compensation, must be taken into account in determining the amount of MAA to be granted. (Revision as of December 1, 1961: "* * * applicant will be ineligible for payment of medical services (from MAA) until such time as the benefits are exhausted.")

[1] Has provision for recovery from estate of deceased recipient after death of surviving spouse, if any.

Extracts from Bureau of Family Services, Social Security Administration, *Characteristics of State Public Assistance Plans Under the Social Security Act: Provisions for Medical and Remedial Care* (Public Assistance Report No. 49), 1962.

Appendix C

Aggregate Expenditures for Medical and Hospital Care for the Aged

Estimating aggregate medical expenditures for any particular segment of the population is, at best, an inexact art, and may be approached in different ways. The estimates that follow nevertheless supply a reliable indication of the magnitude which medical expenditures for the aged have reached and the relative importance of various sources for these expenditures.

Estimated Total Expenditures for Medical Care of the Aged, 1960

Source of funds	*Amount (millions)*
Total expenditures for medical care	$5,045
Private expenditures	3,715
Personal expenditures [1]	3,615
Philanthropy [2]	100
Public Expenditures	1,330
Public Assistance Programs	455
Veterans Administration Program	265
Other public programs	610

[1] Includes expenditures by recipients of care and on their behalf by relatives or friends and by health insurance.
[2] Does not include payments made on behalf of particular individuals.

Personal medical care expenditures by and for the aged were estimated as a proportion of total private medical care expenditures as reported for 1960 (at $19.6 million) in the December 1961 Social Security Bulletin. It was assumed that the ratio of per-capita expenditures for persons 65 and over and under 65 was the same as reported by the Health Information Foundation Study for medical services exclusive of nursing home care, in 1957–58. For nursing home care in 1960, personal expenditures are estimated at $280 million, and it is assumed that some 85 percent of nursing home beds are used by aged persons. Total personal expenditures for medical services for aged persons thus derived amount to $3,615 million.

Total *philanthropic expenditures* for medical care in 1960 are estimated at $715 million, following concepts used in the social welfare expenditure series published each year in the November issue of the Social Security Bulletin. If it is assumed first that about one half of this total, or $360 million, was expended for personal medical care services, and second that roughly one quarter of the latter was expended for the aged, the philanthropic expenditures for medical care for the aged would approach $100 million. Included are funds raised by philanthropic institutions or by organized fund drives, such as United Givers Funds, or the American Heart Association. (A cumulation of estimated expenditures in behalf of the aged by such organizations yields roughly the same total). Services that physicians or hospitals provide without the anticipation of payment are not included. Such services, along with the sources of philanthropic funds, are discussed in Chapter 10.

Public expenditures for medical care for aged persons in 1960 are for the most part known in the case of Federal or Federal-State programs and may be estimated for other categories on the basis of expenditure trends since earlier estimates were prepared.

The public assistance total comprises all vendor payments for medical care under the old-age assistance and medical assistance for the aged programs, half of those under the aid to the blind program, and estimated expenditures for medical care provided through the money payments under old-age assistance.

In estimating Veterans Administration expenditures, the age distribution by type of condition of the patient load on census survey days was taken to represent the age distribution of patients in hospitals for these types of conditions throughout the fiscal year in which the census day fell. The percentages of aged persons obtained in this manner were applied to the costs of maintaining and operating the Veterans Administration's neurological and psychiatric, tuberculosis, and general medical hospitals in fiscal years 1960 and 1961. The average of these expenditures was used to represent calendar year 1960. Expenditures for contract hospitalization were estimated on the basis of the age distribution of patients in contract hospitals on the census days, and estimates for fiscal years 1960 and 1961 were likewise averaged to obtain a calendar year 1960 estimate. Expenditures for outpatient care for the aged were estimated at about 30 percent of the total expenditures for outpatient care.

The estimates of expenditure for the aged under other public programs are based upon estimated unreimbursed expenditures for care of the aged in State and local hospitals (as described below), augmented by $75 million for other public expenditures, including items such as payments for care in nonprofit hospitals, Health Department medical services to the aged, care in U.S. Public Health Service hospitals, publicly owned nursing homes and infirmaries, workmen's compensation medical care and care provided Indians.

Estimated public expenditures for hospital care of the aged, 1960

[In millions of dollars]

	All hospitals	General hospitals	Mental and tuberculosis hospitals
Total	895	470	425
Public assistance	100	100	----------
Veterans' Administration	235	165	70
Other	560	205	355

The estimated expenditures under public assistance programs for hospital care include vendor payments for hospital care plus an estimated share of the money payments for medical care.

The estimate of expenditures by the Veterans Administration for hospital care was developed as described above.

The estimate of expenditures in other hospitals includes a portion of the reported expenditures of State and local mental, tuberculosis, and general hospitals which are not met through patient payments, the proportion being determined by the estimated aged patient load in these institutions—26 percent in general hospitals, 20 percent in tuberculosis hospitals, and 33 percent in mental institutions. An estimated $25 million was assumed to cover the care of aged persons under Federal auspices in Public Health Service hospitals, in military hospitals, and in the Soldiers' Home infirmary, and also the hospitalization of aged Indians.

Appendix D

Major Legislative Proposals for Financing Personal Health Services for the Aged, 1939–1961

Many and varied proposals have been made over the years for Federal legislation to provide health insurance, to stimulate the spread of voluntary health insurance, or to support State medical care programs. The various proposals which have been made in bills introduced in the Congress since the late 1930's and which relate to the aged are summarized below.[1]

The following discussion of these proposals is not limited to those specifically designed to provide insurance against the cost of hospitalization, or hospital and nursing home care, for the beneficiaries of old-age, survivors, and disability insurance. It is limited, however, to approaches that could be used for this purpose. It omits, therefore, proposals in which the primary basis for selecting the population group is not only unrelated to age but is one which is likely to encompass only a few aged people or a specified limited group of aged persons, such as retired Federal employees. Thus excluded are proposals relating to exemptions or credits on Federal income taxes for amounts paid as health insurance premiums, or to special groups such as farm families or migrant workers, and temporarily unemployed persons.

Also omitted, although they may affect substantial numbers of aged persons, are proposals related to the public assistance system. The role of the public assistance programs in providing medical care is described in chapters 8 and 9, with additional detail in Appendix B. Some proposals express their coverage in terms of "low income families" or "medically indigent" persons wherever found in the total population. They are included because most aged persons could come within the scope of programs with such comprehensive coverage.

The detailed summary which follows includes only those bills which were introduced before 1962, that is, bills introduced prior to the second session of the 87th Congress. Up to March 15, 1962, three new bills of major importance had been introduced; S. 2664, H.R. 10513, and H.R. 10755. S. 2664, introduced on January 11 by Senator Javits, would provide every "retired" person aged 65 or over who is not receiving medical care through the public assistance program with a choice among several health insurance benefit packages. The benefits generally follow those in S. 937 (described below). Benefits for old-age and survivors beneficiaries would be financed by an increase in the payroll tax; those for persons not eligible for such benefits, from general revenues. H.R. 10513, introduced by Congressman Durno, would establish a National Advisory Medical Commission of 21 members to study the proper role of the Federal Government in relation to the States and private agencies providing medical care and insurance and to report by January 31, 1963, on a plan to provide adequate medical, hospital, outpatient and nursing home care for the aged. H.R. 10755, introduced by Congressman Bow, would use the income tax mechanism to distribute a Federal

[1] For a detailed legislative history of health insurance considerations during the Eighty-sixth Congress, see William L. Mitchell, "Social Security Legislation in the Eighty-sixth Congress," *Social Security Bulletin*, v. 23, no. 11, November 1960.

subsidy of up to $125 per aged person toward the purchase of private health insurance for the aged which provides certain Federally-established minimum benefits.

A. HEALTH INSURANCE FOR OASDI BENEFICIARIES

The first bill embodying a proposal for hospitalization benefits for beneficiaries under Title II of the Social Security Act was introduced into Congress in 1952. With minor variations, similar proposals have been introduced in each of the Congresses since then. However, as interest in health care for the aged increased, the variations among the proposals for financing health insurance through the old-age, survivors, and disability insurance system became more significant and bills incorporating modifications from those introduced earlier became more numerous.

1. Proposals Before the 82nd Through 85th Congress

The essential features of the proposals advanced between 1952 and 1957 are as follows: Persons eligible for insurance benefits, whether currently drawing benefits or not, would be insured for up to 60 days in a year for semiprivate room care in short-term hospitals. The hospital benefit would be a service benefit and would include those services, drugs and supplies which the hospital customarily furnishes its bed patients. The Forand bill (H.R. 9467) in 1957 also proposed to pay the costs of skilled nursing home care for patients transferred from the hospital (up to a total period, including the hospital stay, of not more than 120 days in a year) and of surgical services provided in a hospital (or, in case of emergency or minor surgery, in the outpatient department of a hospital or in a doctor's office).

Hospitals would be paid on a cost-incurred basis or on a reasonably equivalent basis. The methods of paying the hospital varied with the administrative arrangements suggested in the various bills. Under the early proposals where the Federal Government was to use State agencies as its agent, the State agency would either pay hospitals within the State for the care rendered eligible persons or would utilize private nonprofit health insurance plans to negotiate with and pay the hospitals. Under more recent proposals national administration has been proposed, with the Secretary of HEW given authority to negotiate agreements directly with hospitals or to use the services of such agencies as Blue Cross.

Benefits would be financed through the social security payroll tax paid compulsorily by covered employees, their employers, and the self-employed. The amount of the additional payroll tax would, of course, depend on the exact benefits proposed. The level premium cost of the Forand proposal for hospitalization, nursing home and surgical benefits was first estimated at one-half of 1 percent of covered payrolls, and taxes were set at that level.

The earliest proposals contemplated that the program would utilize the States, and preferably the State public health agencies, as administrative agents. Only in a State which did not effect an agreement to administer the program would the overall administrative functions be performed federally. (Necessary regulations relating to the program in general and determinations as to an individual's insured status would, of course, be made at the Federal level). As a result

of the post-1952 development of national Blue Cross contracts and the implementation of Medicare, the later proposals contemplated national administration of the hospitalization benefits.

The following bills have embodied this proposal:

Year	Congress	Session	Bill Number	Sponsor
1952	82d	2d	S. 3001	Murray.
1952	82d	2d	H.R. 7484	Dingell.
1952	82d	2d	H.R. 7485	Celler.
1953	83d	1st	H.R. 8	Dingell.
1953	83d	1st	H.R. 390	Celler.
1953	83d	1st	S. 1965 [1]	Murray, Humphrey, and Lehman.
1955	84th	1st	H.R. 638	Celler.
1955	84th	1st	H.R. 2384	Dingell.
1956	84th	2d	H.R. 9868	Dingell.
1956	84th	2d	H.R. 9980	Metcalf.
1957	85th	1st	H.R. 1092	Celler.
1957	85th	1st	H.R. 4765	Dingell.
1957	85th	1st	H.R. 9448	Roberts.
1957	85th	1st	H.R. 9467 [2]	Forand.

[1] Includes provisions permitting States to extend hospitalization coverage to noninsured aged persons.
[2] Includes nursing home benefits and surgery.

Hearings before the House Committee on Ways and Means on all titles of the Social Security Act, in June 1958, included testimony on H.R. 9467.

2. Bills Introduced During the 86th Congress

The bills introduced during the first session of the 86th Congress followed much the same pattern as those introduced in earlier Congresses. However, those introduced during the 2nd session show a wider variety in both coverage and in benefits provided.

Essentially, the tendency in the later proposals was to concentrate upon the aged or upon a retired or presumed retired group of the aged old-age and survivors insurance beneficiaries rather than all beneficiaries. Indeed, as the issue came to be viewed more explicitly as a problem of the aged, several bills provided for the extension of coverage to all retired aged, irrespective of whether they were eligible for old-age and survivors insurance benefits. Under these proposals, benefits for old-age and survivors insurance eligibles were to be financed by an increase in the payroll tax, while those for persons not eligible for old-age and survivors insurance were to be paid for from general revenues.

Under all proposals the basic benefit was hospitalization, with individual variations in the duration of the benefit and the use of a deductible which must be paid by the beneficiary. Aside from this base benefit, the proposals varied in their inclusion of skilled nursing home services, outpatient diagnostic services, home health services, physicians' services, and assistance in the purchase of drugs.

The unifying feature of all bills was that benefits for old-age, survivors, and disability insurance beneficiaries were to be financed through an increase in the payroll tax. All proposals called for Federal administration and administrative responsibility; some provided for a delegation of certain administrative functions to either State agencies or to voluntary, nonprofit health insurance plans.

The following bills introduced during the 86th Congress would provide health benefits for certain old-age, survivors, and disability insurance beneficiaries:

Bill number	Sponsors	Persons covered	Benefits
H.R. 4700	Forand	All OASDI eligibles, except disability insurance beneficiaries.	(*a*) Hospitalization up to 60 days; (*b*) skilled nursing home services following and associated with hospitalization up to 120 days less days of hospitalization; and (*c*) surgical services.
H.R. 10816	Harmon		
H.R. 11093	Gilbert		
S. 881 [1]	Morse		
S. 1151 [2]	Humphrey	Same as H.R. 4700	Same as H.R. 4700, except omits surgical services.
H.R 412	Roberts	All OASDI eligibles	Hospitalization up to 60 days.
S. 2915	Kennedy and Hart	All OASDI eligibles	(*a*) Hospitalization up to 90 days; (*b*) skilled nursing home care (following hospitalization), and (*c*) home nursing services (following hospital or nursing home stay), with overall 120-day combined care limit on (*a*), (*b*), and (*c*): 1 day of (*a*), 1½ days of (*b*), or 2 days of (*c*) equals 1 combined-care-day; and (*d*) diagnostic outpatient hospital services.
H.R. 12255	Gallagher		
H.R. 12418	Metcalf	(*a*) OASI eligibles aged 68 or over; (*b*) all noneligibles 68 or over (except railroad retirement or Federal civil service retirement eligibles).	(*a*) Hospitalization up to 365 days, with initial 3 days deductible, and additional 3 days deductible after 24 days; (*b*) skilled nursing home care (after and associated with hospitalization) up to 18 days; (*c*) visiting nurse services up to 365 days; and (*d*) for OASI eligibles, $4 a month additional cash benefit if elected in lieu of (*a*), (*b*), and (*c*), above.
Amendment 6-30-60—B to H.R. 12580.	Anderson, Humphrey, and McCarthy.	OASI eligibles aged 68 or over	(*a*) Hospitalization up to 365 days, with $75 initial deductible and $75 additional deductible after 24 days; (*b*) skilled nursing home care (after hospitalization) up to 180 days; and (*c*) visiting nurse services up to 365 visits.
Amendment 8-17-60—A to H.R. 12580.	Anderson, Kennedy, Humphrey, Douglas, Gore, McNamara, McCarthy, Hartke, Randolph, and Engle.	OASI eligibles aged 68 and over	(*a*) Hospitalization up to 120 days after an initial $75 deductible; (*b*) skilled nursing home services (after hospitalization) up to 240 days; (*c*) home health services up to 365 visits; and (*d*) outpatient hospital diagnostic services.
S. 3503 [3]	McNamara, Kennedy, Clark, Randolph, Symington, Humphrey, Williams of New Jersey, Magnuson, McGee, Young of Ohio, Douglas, Gruening, Long of Hawaii, Murray, Hart, Morse, Hennings, Jackson, Pastore, McCarthy, Bartlett, Engle, Green, and Mansfield.	(*a*) Retired OASI eligibles aged 65 (62 for women) and over. Retired when earnings less than $2,000 in preceding year or $100 in each of preceding 3 months, or if aged 72 or over; (*b*) all other aged persons meeting same requirements as OASI eligibles, except railroad retirement and Federal civil service retirement eligibles.	(*a*) Hospitalization up to 90 days; (*b*) skilled nursing home services up to 180 days; and (*c*) home health services up to 240 days, with overall limit of 90 service units, and 1 day of (*a*), 2 of (*b*), or 2½ of (*c*) equal 1 service unit; (*d*) diagnostic outpatient services, and (*e*) very expensive prescribed drugs, per Secretary's regulations.

Bill Number	Sponsors	Persons covered	Benefits
S. 3763	Gore and Yarborough	Same as S. 3503	(*a*) Hospitalization up to 60 days; (*b*) skilled nursing service up to 120 days; (*c*) home health services up to 180 days; and (*d*) medical services up to 25 home or office visits, with an overall limit of service units, and with 1 day of (*a*), 2 of (*b*), 3 of (*c*), or 2 home or 4 office visits equal to 1 service unit; (*e*) surgical services; (*f*) diagnostic outpatient services; and (*g*) specified prescribed drugs, per Secretary's regulations.

[1] Amendment 6-27-60—F to H.R. 12580 is identical.
[2] Amendment 6-28-60—G to H.R. 12580 is identical.
[3] Amendment 6-24-60—C to H.R. 12580 is similar.

NOTE.—Hearings were held on H.R. 4700 by the Committee on Ways and Means in July 1959. Medical care for the aged also was the primary issue discussed during hearings before the Senate Committee on Finance in June 1960, on the Social Security Amendments of 1960 (H.R. 12580), which provided for the medical assistance for the aged program and for increased Federal participation in medical vendor payments under the old-age assistance program. Likewise, medical care for the aged was a major element in the hearings before the Senate Subcommittee on Problems of the Aged and Aging throughout the session. Hearings specifically related to health needs of the aged and aging were held in April 1960.

3. Proposals Introduced During the 87th Congress, 1st Session

During the first session of the 87th Congress, the primary new measure introduced was the Administration-sponsored King-Anderson Bill, under which the cost of certain hospitalization, skilled nursing home, home health, and outpatient hospital diagnostic services would be provided for persons who have reached age 65 and are entitled to monthly cash benefits under the old-age, survivors and disability insurance or railroad retirement systems. The identical bills which were introduced are as follows:

Bill No.—	*Sponsors*
S. 909	Anderson, Douglas, Hartke, McCarthy, Humphrey, Jackson, Long of Hawaii, Randolph, Engle, Magnuson, Pell, Burdick, Neuberger, Morse, Long of Missouri, Moss, and Pastore.
H.R. 4222	King.
H.R. 4309	Dingell.
H.R. 4313	Karsten.
H.R. 4314	Machrowicz.
H.R. 4315	Green.
H.R. 4316	Ullman.
H.R. 4447	McFall.
H.R. 4534	Pucinski.
H.R. 4921	O'Neill.
H.R. 7793	Santangelo.

The services for which payment would be made under the proposal would be:

(1) inpatient hospital services for up to 90 days, subject to a deductible amount of $10 a day for up to 9 days, with a minimum of $20; hospital services would include all those customarily furnished by a hospital for its patients; payment would not be made for the hospital services of physicians except those in the fields of pathology, radiology, physical medicine, and anesthesiology provided by or under arrangement with the hospital, or services provided by an intern or resident-in-training under an approved teaching program;

(2) skilled nursing home services, after the patient is transferred from a hospital, for up to 180 days;

(3) outpatient hospital diagnostic services, as required, subject to a $20 deductible amount for each diagnostic study;

(4) home health services for up to 240 visits during a calendar year. These services would include intermittent nursing care, therapy, and part-time homemaker services.

No service would be covered as a nursing home, outpatient diagnostic, or home health service if it could not be covered as an inpatient hospital service.

An individual could be eligible for up to 90 days of hospital services and 180 days of skilled nursing home services in each period of illness, but subject to a maximum of 150 "units of service." A unit of service would be equal to 1 day of inpatient hospital services or 2 days of skilled nursing home services. A "new period of illness" would not begin until 90 days had elapsed in which the patient was neither in a hospital or a skilled nursing home.

Payments to the providers of service would be made on the basis of the reasonable cost incurred in providing care for beneficiaries. The amount paid under the program would be payment in full for covered services, except that the provider could charge the patient the

deductible amounts and extra charges for a private room or private duty nursing.

Responsibility for administration of the program for social security beneficiaries would rest with the Secretary of Health, Education, and Welfare. The Secretary would consult with appropriate State agencies and recognized national accrediting bodies in formulating the conditions of participation for providers of service. Provision would be made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration. In order to be eligible to participate in the program, providers of service would have to meet specified conditions to assure the health and safety of the beneficiaries. State agencies could be used in ascertaining whether providers met these qualifications and in providing consultative services to them. If it desired, a State could recommend that more strict conditions be applied with respect to providers of service within the State than elsewhere.

The program would be financed by an increase in the social security contribution rates of ¼ of one percent on employers and ¼ of one percent on employees and of ⅜ of one percent for the self-employed, and by the net increase in income to the system from raising the annual taxable earnings base from $4,800 to $5,000. (According to testimony by the Secretary of HEW in July 1961 before the House Committee on Ways and Means the increase should be to $5,200 in order to meet in full the estimated costs of the proposal.) Raising the earnings base would in addition improve the benefit structure of the system.

Hearings were held by the Committee on Ways and Means during July and August, 1961 on H.R. 4222.

Several proposals from earlier Congresses were resubmitted. The following bills, identical to the Forand Bill (H.R. 4700 in the 86th Congress) were introduced:

Bill No.—	*Sponsor*
H.R. 94	Holland.
H.R. 676	Gilbert.
H.R. 1765	Dulski.
H.R. 4168	St. Germain.

H.R. 2762, introduced by Representative Gilbert, provides for the same benefits as did the Forand Bill, but extends the scope of those eligible for benefits to encompass all persons eligible for old-age, survivors, and disability insurance benefits, including persons eligible for disability insurance benefits.

The McNamara Bill from the 86th Congress was reintroduced with minor changes in both the Senate and the House of Representatives, as follows:

Bill No.—	*Sponsor*
S. 65	McNamara.
H.R. 2407	Dingell.
H.R. 2518	Rabaut.

Representative Roberts reintroduced, as H.R. 2443, a proposal for hospitalization benefits for all persons eligible for old-age, survivors and disability insurance benefits identical to H.R. 412 which he had introduced during the 86th Congress. The bill proposed during the 86th Congress by the then-Senator Kennedy (S. 2915) was reintroduced as H.R. 195 by Representative Ashley.

Representatives Kowalski and Halpern introduced bills (H.R. 3448 and H.R. 4111 respectively) which would extend hospitalization, skilled nursing home, and surgical benefits identical with those in the Forand bill (H.R. 4700, 86th Congress) to aged persons. In addition, under H.R. 4111 diagnostic outpatient services would be provided. In essence, these bills would provide for extending health insurance benefits to all persons entitled to old-age, survivors and disability insurance benefits and to all persons who would be entitled if their earnings prior to January 1, 1962 from railroad or Federal civil service employment were counted as covered earnings, and automatically, to all persons attaining retirement age (65 for men, 62 for women when bills were introduced), before January 1, 1964. For health insurance benefits under the old-age, survivors and disability insurance program for future beneficiaries, there would be a new test for insured status, with a person insured if he had one quarter of coverage for each two of the quarters elapsing after December 31, 1961, or if later, the year in which he became 21 and the year in which he reached retirement age (or died, if earlier), and six quarters of coverage. Earnings from employment by the railroads or as a Federal civilian employee would be counted in determining quarters of coverage. Special provisions are included for States to enter agreements to extend benefits to their employees. The program would be financed by an increase in the payroll tax of ¼ percent each on employers and employees (⅜ percent for self-employed) and an increase in the earnings base to $6,000 and making such increase applicable to Federal civilian and railroad employment. Self-employed persons not presently covered by the old-age, survivors and disability insurance system might elect to become eligible for health insurance benefits by an irrevocable decision to pay the taxes associated with the health insurance benefit.

B. FEDERAL GRANTS FOR STATE PROGRAMS OF HEALTH INSURANCE FOR THE AGED

During the 86th and 87th Congresses, several proposals were advanced for programs of Federal grants to the States to help finance health insurance programs for aged persons. The proposals all provided that coverage for eligible aged individuals under the program depended upon their electing such coverage, and established or authorized enrollment fees to be paid by the individual. They all also provided for State administration, either directly or through contracts with insurance carriers.

1. The Javits Proposal [1]

This proposal would authorize Federal grants to participating States which extend health insurance to persons aged 65 or over and their spouses, either through an insurance carrier set up by the State for the purpose or by private commercial, prepayment or nonprofit insurance carriers under contract with the State. A choice between service and indemnity benefits must be offered. Physicians' home and

[1] This discussion relates to Amendment 6–27–60–H to H.R. 12580, rather than the earlier S. 3350. These differ in that the earlier bill established no minimum benefit and contained an individual contribution schedule ranging from nothing for persons with incomes under $500 in the preceding year to $13 a month (or the cost of the policy, if less) for those with incomes of $3,600 or over.

office visits and other ambulatory treatment must constitute one third of the premium cost. The substitution of skilled nursing home care for care of equal cost in hospitals must be permitted. As a minimum, the health insurance shall insure against the cost of 21 days a year of hospital care or equivalent nursing home care, physicians' services up to 12 home or office visits per year, the first $100 of ambulatory, diagnostic, laboratory and X-ray services a year, and visiting nurse services for not less than 24 visits a year.

The program would be financed by individual contributions, State moneys, and Federal appropriations from general revenue. Individual contribution schedules were to be established by each State, with contributions based upon the income of the subscriber and with a maximum of the total premium cost if this were less than $13 a month. The Federal portion of the Federal-State share of the program would range between 33⅓ and 75 percent of the premium cost up to $13 a month per capita less the individual contributions.

Bills embodying this approach were:

Bill No.—	*Sponsors*
S. 3350	Javits, Cooper, Case of New Jersey, Scott, Fong, Aiken, Keating, and Prouty.
Amendment 6–27–60–H to H.R. 12580	Javits, Cooper, Scott, Fong, Aiken, Keating, and Prouty.
H.R. 11661 [1]	Weiss.
H.R. 11677 [1]	Lindsay.
H.R. 11683 [1]	Pirnie.
H.R. 11685 [1]	Riehlman.
H.R. 11702 [1]	Dwyer.
H.R. 11820 [1]	Glenn.
H.R. 13020 [2]	Lindsay.

[1] Identical to S. 3350.
[2] Identical to Amendment 6–27–60–H to H.R. 12580.

2. The 1960 Administration Proposal

As embodied in S. 3784, introduced by Senator Saltonstall, the proposal would authorize Federal grants to the States to assist them in establishing health insurance programs for persons electing to participate who were aged 65 and over and who did not pay an income tax in the preceding year or whose adjusted gross income, plus old-age and survivors insurance benefits and railroad retirement and veterans pensions, in the preceding year did not exceed $2,500 ($3,800 for a couple).

Benefits would be provided in any year after an eligible person had incurred medical expenses of $250 ($400 for a couple). The insurance program would then pay 80 percent (100 percent for old age assistance recipients) of the cost of hospital care up to 180 days, skilled nursing home care, organized home-care services, surgical procedures, laboratory and X-ray services (up to $200), physicians' services, dental services, prescribed drugs (up to $350), private duty nurses, and physical restoration services. For old age assistance recipients, the initial $250 would be paid by the public assistance program.

An eligible person so electing could receive 50 percent up to a maximum of $60 a year of a private major medical insurance policy in place of the benefits under the government program.

The program would be financed by individual enrollment fees, and Federal and State funds. Persons participating in the government

benefits (except old age assistance recipients, would pay a $24 annual enrollment fee. The Federal share of government costs would be 50 percent on the average, ranging from 33⅓ to 66⅔ percent depending upon the relative per capita income of the State.

3. The Javits-Saltonstall Amendment

Amendment 8–20–60–A to H.R. 12580, sponsored by Senators Javits, Cooper, Scott, Aiken, Fong, Keating, Kuchel, Prouty and Saltonstall, blended the earlier Javits proposal with the Administration proposal. Under this program, the Federal Government would provide grants to the States to help pay for health services for all persons aged 65 and over who did not pay an income tax or whose income, including old-age and survivors insurance benefits, railroad retirement and veterans pensions did not exceed $3,000 ($4,500 for couples) in the preceding year and who elected to participate.

The States were required to offer each participant a choice of 1) a diagnostic and short-term illness plan providing as a minimum, 21 days of hospitalization or equivalent skilled nursing home services, 12 physicians' visits in home or office, diagnostic laboratory and X-ray services up to $100, and organized home health care services for up to 24 days; or 2) a long-term illness benefit plan providing as a minimum after a deductible of $250, 80 percent of the costs of 120 days of hospital care, up to a year of skilled nursing home and home health services, and inpatient surgical services; or 3) an optional private insurance benefit plan providing 50 percent of the cost of a private insurance policy up to a maximum of $60 a year. In addition, the Federal Government would share in the cost of improved programs of the first two types up to a maximum per capita cost of $128 a year.

To be eligible for benefits of the first two types, the individual was required to pay the fee established by the State in a schedule related to participants' income. This fee may not be less than 10 percent of the estimated full per capita cost of the benefits provided under the program. The Federal share of the government costs of the program would range from 33 1/3 to 66 2/3 percent, depending upon the relative per capita income in the State.

During the 87th Congress, 1st Session the Javits-Saltonstall Amendment was reintroduced by Senator Javits and by two Representatives. The bills embodying the proposal are as follows:

Bill No.—	*Sponsors*
S. 937	Javits, Cooper, Scott, Aiken, Fong, Cotton, Keating, Prouty, Saltonstall, and Kuchel.
Amendment 6–22–61–B to H.R. 6027	Javits, Cooper, Scott, Aiken, Fong, Cotton, Keating, Prouty, Saltonstall, and Kuchel.
H.R. 4731	Curtis of Massachusetts.
H.R. 4766	Stafford.

4. The Gubser Proposal

In H.R. 12272, Representative Gubser proposed a system of Federal grants to the States to provide for voluntary health insurance for persons aged 65 and over who pay a $5 enrollment fee and whose net taxable income in the preceding year did not exceed $4,900 ($6,200 for couple).[2] The States must contract, subject to the approval of

[2] H.R. 12670 is a reintroduction of H.R. 12272 correcting technical errors and making some minor substantive changes.

the Secretary of Health, Education and Welfare, with private insurance companies for service benefit plans, indemnity benefit plans, employee organization plans, group practice prepayment plans and individual practice prepayment plans. The Federal grant to the States operating the program would be a specified amount per participating individual, the amount based upon the individual's income and ranging from $5 a month for persons with net taxable incomes of $2500 or below the previous year ($3800 for couples) to $3 a month for persons with net taxable incomes between $3,700 and $4,900 the previous taxable year ($5,100 to $6,400 for couples).

Representative Gubser has reintroduced his bill as H.R. 6181 in the 87th Congress.

C. OTHER FEDERALLY OPERATED HEALTH INSURANCE

Various proposals have been made over the years for national health insurance operated by the Federal Government. These include a proposal for voluntary insurance, one which combines compulsory coverage for workers with low earnings with voluntary coverage for others, and a proposal for compulsory hospital insurance for persons covered by old-age, survivors, and disability insurance.

1. National Voluntary Health Insurance

As proposed by Senator Hunt in 1950 in S. 2940 (81st Cong., 2d sess.), any individual who, with his dependents, had an annual income of $5,000 per year or less, who applied for the insurance, and who paid the prescribed premiums would be covered along with his dependents.

The benefits contemplated included medical, surgical, and dental services regardless of location; home nursing care; hospital care and related services for up to 60 days per person per year; such auxiliary services as laboratory tests, X-ray, diagnosis or treatment, optometrists' services, appliances, unusually expensive drugs, and so forth.

The program would be administered by a National Health Insurance Board with the Surgeon General as chairman and four additional appointive members, within a proposed Cabinet-level Department of Health.

Insured persons would be free to select and change physicians, dentists, hospitals, and so forth.

It was proposed that a Personal Health Insurance Account be created in the U.S. Treasury. All premiums, as set by the National Health Insurance Board, would be paid into this account. Reserves in the account could be invested in the same manner as those of the Federal old-age and survivors trust fund. Congress was authorized to appropriate additional money to the account when needed to carry out the program. No participation by State or local governments or private organizations is indicated in this proposal.

Payments to the providers of medical care benefits were to be made directly from the personal health insurance account under regulations promulgated by the National Health Insurance Board.

2. National Health Insurance Combining Compulsory and Voluntary Coverage

In 1938 Congressman Treadway introduced this proposal in H.R. 9847 (75th Cong., 2d sess.). Compulsory coverage was proposed for almost all employees (including dependents) earning $1,800 per year or less (agricultural employees excepted), with voluntary coverage for all other persons.

The proposed benefits included almost all physicians' services; hospital services up to 10 consecutive weeks per illness per person; "necessary" drugs and laboratory and diagnostic services. Services for diagnosis and treatment of any disability or disease for which public care was available "free" or "at nominal charges" or for which some agency or other person was required to pay would not be included.

Each employee covered compulsorily would contribute 2 percent of his remuneration, but not less than 35 cents per week nor more than 70 cents per week or $36 per year. His employer would contribute 1 percent of such employee's remuneration, but not less than 20 cents per week nor more than 35 cents per week or $18 per year.

All voluntarily covered persons would make sufficient contributions, as determined by Federal authorities, to pay benefit and administrative costs for such persons.

Moneys would become part of a "health insurance fund" operated by a "Health Insurance Commission" set up as a public corporation to administer the plan.

The Commission could pay physicians on a salary, a capitation, or a fee-for-service basis, except that, if fees were paid, maximum amounts, based on the number of patients, would be set and fees prorated accordingly.

Workers in any industry having a private medical services insurance plan would be excepted from compulsory coverage if the private benefits were at least equal to those under the public plan.

3. Compulsory Hospitalization Insurance for Persons Covered by OASDI

The Eliot and Green bills (1942–45) included provisions for a federally operated program of hospitalization insurance through an expansion of the coverage and benefits of the old-age, survivors, and disability insurance system.

Almost all employed and self-employed persons would have been covered by OASDI, and they and their dependents insured for up to 30 days of hospital care. (Government employees could be covered by special arrangements.)

The hospital insurance would be financed through payroll taxes, applying to the same portion of earnings taxed for purposes of cash benefits.

Administration was to be entirely through the Social Security Board. The Board would pay hospitals directly for the costs of hospital care or might accept and pay claims from insured individuals who have received care. Participating hospitals would be approved by the Board with respect to care offered.

The proposal was introduced by Congressman Eliot in 1942 (H.R. 7534) and by Senator Green in 1943 (S. 281) and 1945 (S. 1188).

D. NATIONAL COMPULSORY INSURANCE WITH STATE OPERATIONS

A series of proposals for a national compulsory system of health benefits was introduced by Senators Wagner and Murray and Congressman Dingell during the period 1943–61. These proposals provided for the setting up of a separate account in the U.S. Treasury and for payments to this account computed as a percent of the taxable earnings of insured persons.

The compulsory coverage of the proposals included almost all employees and self-employed in private pursuits, Federal civilian employees and annuitants, and persons entitled to OASDI benefits, and their dependents. Groups not compulsorily covered, such as recipients of public assistance, the unemployed, and certain persons in temporary employment (and their dependents) could be insured for any periods for which payments were made by or for them or for which guarantees of payment were made by any local, State, or Federal agency.

The benefits proposed included almost all physicians', dental, and home nursing services; hospital services for periods up to 60 days per beneficiary per year; prescribed auxiliary services and appliances and usually expensive drugs. All benefits except general practitioner and dental services would be available only by referral or prescription.

Since the Wagner-Murray-Dingell proposal was introduced as a health rather than a tax measure, the exact methods of raising Federal revenues to finance the benefits were not specified in the bill itself. However, the bill was so drafted as to make it clear that revenues would come, in the main, from payroll taxes.

The proposals contemplated administration by the States as agents. Any State could assume responsibility for administering the specified benefits within its boundaries by submitting to the National Insurance Board a plan which complied with listed provisions in the bill. The National Insurance Board could itself administer the program in States without approved plans.

Federal authorities would divide funds among the States on the basis of population, availability of health resources, and differing costs of services in various areas. State administrative agencies would contract with providers of care and fix rates of payments for services; State agencies would pay providers' bills or might utilize local health region officials or nonprofit voluntary prepayment plans as agents for making such payments. Physicians would select the manner in which they would be reimbursed, whether by fee-for-service, capitation, or salary.

This proposal was included in the following bills:

Year	Congress	Session	Bill Number	Sponsors
1943	78th	1st	S. 1161 [1]	Wagner and Murray.
1943	78th	1st	H.R. 2861 [1]	Dingell.
1945	79th	1st	H.R. 395	Dingell.
1945	79th	1st	S. 1050	Wagner and Murray.
1945	79th	1st	S. 1606	Wagner and Murray.
1945	79th	1st	H.R. 4730	Dingell.
1947	80th	1st	S. 1320	Wagner, Murray, Pepper, Chavez, Taylor, and McGrath.
1947	80th	1st	H.R. 3548	Dingell.
1947	80th	1st	H.R. 3579	Celler.
1949	81st	1st	S. 5	Wagner, Murray, Pepper, Chavez, Taylor, and McGrath.
1949	81st	1st	H.R. 345	Celler.
1949	81st	1st	H.R. 783	Dingell.
1949	81st	1st	S. 1679	Wagner, Murray, Pepper, Chavez, Taylor, McGrath, Thomas, and Humphrey.
1949	81st	1st	H.R. 4312	Biemiller.
1949	81st	1st	H.R. 4313	Dingell.
1950	81st	2d	H.R. 6766	Bosone.
1951	82d	1st	H.R. 27	Celler.
1951	82d	1st	H.R. 54	Dingell.
1953	83d	1st	H.R. 1817	Dingell.
1955	84th	1st	H.R. 95	Dingell.
1957	85th	1st	S. 844	Murray.
1957	85th	1st	H.R. 3764	Dingell.
1959	86th	1st	H.R. 4498	Dingell.
1959	86th	1st	S. 1056	Murray.
1961	87th	1st	H.R. 4413	Dingell.

[1] These 1943 bills called for Federal administration rather than a State plan.

There were hearings on S. 1606 in April–July 1946; on S. 1320 in May–July 1947 and January, February, May, and June, 1948; on S. 1679 in May and June 1949; and on H.R. 4312 and H.R. 4313 in July 1949.

E. OTHER FEDERAL GRANTS FOR STATE HEALTH PROGRAMS

These earlier proposals for Federal grants to State-operated medical care programs lay out only broad outlines of the type of program envisaged, leaving to the States the specific provisions.

1. The Wagner Proposal of 1939

The coverage of the Wagner proposal of 1939 was in terms of all persons included in benefits of those State plans approved by the Social Security Board "for extending and improving medical care"; persons living in rural areas and those in greatest need were specifically mentioned. Similarly, the benefits contemplated were to be determined by the States in plans approved by the Social Security Board and could include "all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability."

State funds were to be provided according to a variable matching formula, but no Federal matching was allowed for so much of the State expenditure as was in excess of $20 a year per individual eligible for medical care.

The method of paying the providers of services was left to the State.

This proposal was included in S. 1620 (76th Cong., 1st sess.) introduced by Senator Wagner in 1939. There were hearings on this bill in the period April to July 1939.

2. The Capper Bills (1939–41)

The Capper bills were designed to foster State programs of medical care for lower income workers with coverage, for most of them, on a compulsory basis. The population groups to be covered were to be determined by the State, with workers' contributions related to their income and with Federal financial participation limited to persons with lower earnings.

Minimum benefits to be provided in approved State plans were specified. Details differed in various versions of the proposal but, in general these included general practitioners' services in the home, office, and hospital, most dental services, home nursing care, maternity care, and if prescribed, hospital and specialists' and laboratory services and care.

Contributions would be made to a health insurance fund in each State by the Federal and State Governments, by compulsorily covered workers and their employers and by other workers requesting voluntary coverage. While details differed, each of the bills introduced by Senator Capper (S. 658 in 1939; S. 3660 in 1940; and S. 429 in 1941) provided that the amounts of workers' contributions would vary directly with their incomes, with compensating increases for the lowest income workers from either employer or State-Federal contributions.

The method of paying the providers of care would be determined by the States or by local areas within the States.

3. The Taft Bills (1946–49)

Another proposal in which Federal grants would be used for State-operated programs was embodied in the Taft bills of 1946–49. In these proposals it was recognized that the State-operated programs might utilize voluntary health insurance in the provision of service.

The Taft proposals would have covered all those families and individuals in the State unable to pay the whole cost of needed medical and dental services.

Federal grants would be made to each State, on the basis of State population, to carry out surveys of existing medical, hospital, and dental services and to formulate "in detail" a 5-year plan for extending such services to persons unable to pay. The Federal share was to be matched by each State.

Federal matching grants for carrying out approved State plans would be made on a variable matching basis, varying between 33⅓ and 75 percent inversely with each State's per capita income.

Total contributions from the State and from local governments could not be less than their expenditures for medical services to the covered groups prior to initiating the program and not less than the difference between the Federal grant and the cost of the approved State plan. Contributions from private institutions were allowed.

Collection of part of the costs of services from those patients or their families able to pay part of such costs could be provided for in the State plan.

Each State might choose any one (or a combination) of several ways to provide and to pay for services to eligible recipients. Use of nonprofit prepayment plans as insurers or agents and the reimbursement of local governments and private, nonprofit organizations for services rendered to eligible recipients were mentioned.

This proposal was embodied in the following bills:

Year	Congress	Session	Bill number	Sponsors
1946	79th	2d	S. 2143	Taft, Smith of New Jersey, and Ball.
1947	80th	1st	S. 545	Taft, Smith of New Jersey, Ball, and Donnell.
1949	81st	1st	S. 1581	Taft, Smith of New Jersey, and Donnell.

There were hearings on S. 545 in May, June, and July 1947 and January, February, May, and June 1948. Hearings on S. 1581 were held in May and June 1949.

4. The Lodge Bills (1940–49)

This proposal restricted the subsidization to certain high-cost drugs and medical services and would not have covered hospitalization costs.

The population group affected was described in terms of "such persons as may require 'X-ray services, laboratory diagnostic services, respirators, and the drugs useful in treating or preventing the listed diseases' and such other infectious or chronic diseases as the Surgeon General may from time to time prescribe."

Federal grants to each State would constitute one-half of all funds spent under the State's plan. Conditions under which recipients would pay for part of these services, while not mentioned in the proposal, could presumably be specified in State plans and could include use of voluntary health insurance plans.

Senator Lodge introduced the proposal in 1940 (S. 3630), 1947 (S. 678), and 1949 (S. 1106). There were hearings on S. 678 in April 1948 and on S. 1106 in May and June 1949.

F. FEDERAL SUBSIDIES TO PRIVATE CARRIERS

In recognition of the problem to low-income groups, including the aged, of financing their own voluntary health insurance premiums, there have been a variety of proposals whose aim is to provide a form of Federal subsidy for either part of their premiums or the excessive cost of the care they will require, or both.

The purpose of these proposals is to make possible the inclusion under voluntary health insurance of groups inadequately represented in the existing enrollment without excessive financial burdens on those with low incomes and without either a differential premium on high cost risks or higher premium rates for the entire enrollment.

1. Flanders-Ives Proposal

This proposal, incorporated in a series of bills introduced during the period 1949–55, would have built on existing nonprofit plans subsidizing them from Federal funds indirectly through State plans.

Among its more important features were (1) scaling of premiums to income; (2) encouragement of expansion of coverage and improvement in the scope of benefits by subsidizing premiums of low-income families and losses incurred from above average risks; (3) recognition of the fact that existing prepayment plans vary widely in the scope of the benefits they provide—the program was designed to be adaptable to the existing level of voluntary health insurance benefits; (4) costs reflecting local scales of payment to hospitals and pro-

viders of services; (5) State operation and control of the program; (6) development of health service areas.

The bill did not attempt to secure uniformity of prepaid protection throughout the Nation, or even within a given State, leaving the scope of benefits to be determined locally in relation to those locally available.

Any resident of a State having an approved State plan would be eligible for participation. Eligible persons could request payroll deductions for premiums. Premiums could be paid on behalf of welfare clients.

The bill spelled out a rather complete list of personal health services which might be provided including hospital room and board, services of physicians, dentists, nurses, and other auxiliary personnel, and related drugs, appliances, and ambulance service.

The regional health authority was to determine for its locality which of the benefits spelled out above might be included in contracts with prepayment plans in their local area. The regional health authority and each local prepayment plan would then enter into a contract for specific benefits selected from among these. The premiums established under these contracts were to be determined by the relationship of the benefits afforded to a so-called cost norm, priced to provide fairly complete coverage of physicians' services and 30 days of hospital care per person per year.

Financing the costs of the benefits agreed on would involve funds from three sources—subscriber premiums which would be related to family income as well as benefits insured; State and local subsidies to bring actual premium income up to an "allowed cost"; and Federal grants to the States, varying according to the State's per capita income, to share one-third to three-fourths of the subsidies paid to the prepayment plans.

Under the Flanders-Ives proposal, the local prepayment plan could provide either service benefits or cash indemnification of the claimant.

The following bills embodied this proposal:

Year	Congress	Session	Bill number	Sponsors
1949	81st	1st	S. 1970	Flanders and Ives.
1949	81st	1st	H.R. 4918 through H.R. 4924.	Case of New Jersey, Fulton, Hale, Herter, Javits, Morton, and Nixon.
1949	81st	1st	H.R. 5087	Auchincloss.
1951	82d	1st	H.R. 146	Auchincloss.
1953	83d	1st	S. 1153	Flanders and Ives.
1953	83d	1st	H.R. 3582	Hale.
1953	83d	1st	H.R. 3586	Javits.
1953	83d	1st	H.R. 4128	Scott.
1955	84th	1st	S. 434	Case of New Jersey, Flanders, and Ives.
1955	84th	1st	H.R. 481	Scott.

Hearings held in June 1949 included testimony on S. 1970; hearings were held on H.R. 4918 and other identical bills in July 1949.

2. *Hill-Aiken Proposal*

These bills (1949–53) were intended to provide voluntary health insurance for persons unable to pay part or all of the usual premium. Each State was to establish a State agency which would administer the means test. It would collect the portion of the premium from persons able to pay part of the cost, and pay the insurance plan the entire premium with respect to all such insured persons. The State agency

would reimburse the plan for payments made to hospitals, etc., for care of persons certified as eligible for State payment (i.e., unable to pay any of the cost).

The plan contemplated service benefits covering 60 days of hospital care per year; surgical, obstetrical and medical services in the hospital; and diagnostic and outpatient services in hospitals or diagnostic clinics.

Of the public outlays for low income groups paying none of their costs or only part of their premiums, the Federal Government would provide from one-third to three-fourths (depending on the State's financial ability) and States and localities would share equally the remainder.

It was specifically provided that persons eligible for State payment were to be issued "membership cards," indistinguishable from those of regular members.

This proposal was introduced in the following bills:

Year	Congress	Session	Bill number	Sponsors
1949	81st	1st	S. 1456	Hill, O'Connor, Withers, Aiken, and Morse.
1951	82d	1st	S. 2171	Hill and Aiken.
1953	83d	1st	S. 93	Hill and Aiken.

Hearings were held on S. 1456 in May and June 1949.

3. The Smathers Proposal

In 1960, during the 86th Congress, Senator Smathers introduced a bill (S. 3646) which would provide tax credits for any life insurance company to the extent of the company's net losses from approved health insurance policies issued persons aged 65 and over. Life insurance companies (as defined in the Internal Revenue Code), including companies issuing noncancellable or guaranteed renewable health insurance policies under Section 802 of the Code, would be eligible to receive the credit for their losses on policies submitted to the Secretary of Health, Education, and Welfare and approved by him. To be approved, the contract would be required to provide insurance against the total cost of not less than 60 days of hospital care a year, not less than 120 days of nursing home care per year, and the total cost of drugs above $50 a year. In addition, the policy premium could not be greater than $72 a year. The policy also could not impose unreasonable standards for filing and proving claims, waiting periods, loss of insurability, or any limitation unreasonably restricting the right to benefits.

(In addition, the bill provided for increased medical care income tax deductions for aged persons and altered the formula for Federal sharing in vendor payments for medical care under the old-age assistance program.)

G. REINSURANCE, POOLING, AND REGULATION

These proposals were designed to encourage the growth of voluntary health insurance without requiring any permanent form of Federal subsidy or tax. They therefore held Federal subsidization to a minimum, involving only direct Federal expenditures for costs of administration and for sums needed to launch the proposed reinsurance cor-

poration. They were intended to encourage expansion of the availability of voluntary insurance coverage (1) through legislation waiving the antitrust laws so as to permit insurance carriers to pool their resources in developing policies and methods for extending insurance to substandard health risks, (2) through Federal participation in the reinsurance, and (3) through Federal regulation of interstate insurance.

1. Reinsurance and Pooling

Existing antitrust laws constitute a barrier to collective efforts of groups of private insurance carriers who might wish to pool their experience and technical know-how and their financial resources in the development of new policies to cover unusual risks.

A bill whose purpose was "to encourage the extension and improvement of voluntary health prepayment plans or policies" was introduced in the 2d session of the 84th Congress. It authorized the Secretary of Health, Education, and Welfare, after consultation with the Federal Trade Commission and approval by the Attorney General, to approve voluntary agreements between certain private insurance organizations to make available new or improved types of insurance coverage.[1]

While the population groups affected were not spelled out, proponents of the proposal believed carriers might be more willing to experiment with coverage of substandard risks such as the aged or those with disabling conditions if they were able to take collective action to develop such policies. Experiments in coverage of rural and low income families might also have been undertaken.

Improvements in benefits could have been tried, such as the sale of more noncancellable policies, extension of existing benefits, major medical expense policies, and the like.

No Federal funds were involved in this proposal. The insurance carriers would fix their own premiums.

The following congressional bills embodied this proposal:

Year	Congress	Session	Bill number	Sponsors
1956	84th	2d	H.R. 12153	Priest.
1956	84th	2d	H.R. 12140	Thompson.
1956	84th	2d	S. 4172	Hill and Smith.
1957	85th	1st	H.R. 489	Thompson
1957	85th	1st	S. 1750	Hill and Smith.
1957	85th	1st	H.R. 6506	Harris.
1957	85th	1st	H.R. 6507	Wolverton.

2. Federal Reinsurance Corporation

These proposals contemplated the formation of a federally operated reinsurance fund to which the Federal Government would make an initial contribution and to which insurance carriers would contribute a small percentage of their premium income. The fund would provide partial idemnification to the companies for extraordinary losses experienced under those health insurance contracts which were reinsured.

[1] Also the 1957 proposal applied only to nonprofit plans and to the smaller commercial companies (defined as companies paying out less than 1 percent of all health insurance benefits or having less than 0.5 percent of the assets of all health insurance companies and plans in the United States).

As first roughly outlined in a proposal made by Mr. Harold Stassen in 1950 the reinsurance fund would have repaid insurance carriers for a portion of any hospitalization claims exceeding a maximum such as $1,000 and for medical-surgical bills above a certain maximum. Bills actually introduced in Congress have taken three forms.

(a) *The 1950 Wolverton reinsurance proposal.*—Congressman Wolverton's proposal embodied the Stassen suggestions with some additional features. It contemplated a Federal Health Reinsurance Corporation. Nonprofit organizations could reinsure their health service contracts with this corporation for a premium if these contracts met some specific criteria as to population groups covered and benefits offered. Separate funds to reinsure hospitalization and medical care were to be established. The reinsurance could be invoked and the corporation become liable for 66⅔ percent of each claim in excess of $1,000 for any 12-month period for any one individual.

Subscription charges for the contracts were to be related to subscribers' incomes, to encourage participation of low income families.

The benefits contemplated were as follows: Six months of hospital care per year with the subscriber himself to pay 5 percent or $1 a day whichever was less as coinsurance; 95 percent of physicians' charges in hospitalized cases; 12 visits with a doctor in his office or at home with the subscriber paying out-of-pocket 25 percent. The scale of charges to be paid by the insurer was to be fixed; the doctors were to agree not to make an additional charge of more than the 25 percent the subscriber was to pay directly. The plan did not cover the first visit to the doctor.

The sources of financing the reinsurance corporation proposed were $50 million from Federal general revenues divided equally into the hospital and the medical care funds, and 2 percent of gross premiums received for health service contracts.

The following bills embodied this proposal:

Year	Congress	Session	Bill number	Sponsors
1950	81st	2d	H.R. 8746	Wolverton.
1954	83d	2d	H.R. 6949	Wolverton.
1955	84th	1st	H.R. 400	Wolverton.
1955	84th	1st	H.R. 401	Wolverton.

(b) *The 1954 administration proposal.*—The administration's proposal for reinsurance departed from the earlier concept of repaying insurance carriers a portion of an individual's claims and dealt with a carrier's average losses which resulted when the plan paid out more than it received in premiums. Both nonprofit and commercial insurance companies could participate.

Encouragement of underwriting major medical expense was anticipated as well as broadening of basic benefits, noncancelable insurance, etc. The 1954 proposal would have established a reinsurance fund which would pay 75 percent of a plan's losses on reinsured contracts that exceeded the premium income of the contracts less 87.5 percent of the administrative expenses predetermined for the contract. The Federal Government would lend the fund $25 million which would eventually be refunded from reinsurance premiums. Premiums of unspecified size (but 2 percent of reinsured premium income was discussed) would be paid by the carriers to the fund.

The 1954 administration proposal was introduced in the following bills:

Year	Congress	Session	Bill number	Sponsors
1954	83d	2d	H.R. 8356	Wolverton.
1954	83d	2d	S. 3114	Ives, Flanders, Purtell, Cooper, Upton, Ferguson, Bush, and Saltonstall.
1955	84th	1st	H.R. 2533	Wolverton.

There were hearings on H.R. 8356 in March, April, and May 1954 and on S. 3114 in April 1954. The House Committee on Interstate and Foreign Commerce reported out H.R. 8356, but it failed to carry and was referred back to the committee, which took no further action.

(c) *The 1955 administration proposal.*—A revised version of the reinsurance proposal of the 83d Congress was included as title I of an omnibus health bill introduced in 1955. The reinsurance fund was divided into four parts and each separate fund was to receive an initial $25 million in Federal money to launch it. The four funds dealt with: (1) plans for low and average income families, (2) major medical expense contracts, (3) plans specifically designed for rural areas, and (4) certain other plans.

Other features, including the terms of the reinsurance premiums and the claims formula, were the same as in the earlier administration proposal.

A type of contract providing a wide range of benefits but with coinsurance features was included for low income families.

Under the 1955 proposal, the Federal Government would contribute up to $100 million which would eventually be paid back. Participating insurance companies were to pay the fund an unspecified percentage of their premium income as reinsurance premiums.

The following bills embodied the proposal:

Year	Congress	Session	Bill numher	Title or part of bill	Sponsor
1955	84th	1st	H.R. 3458	Title I	Priest.
1955	84th	1st	H.R. 3720	Title I	Wolverton.
1955	84th	1st	S. 886	Title I	Smith and others.
1957	85th	1st	S. 1750		Hill and Smith.
1957	85th	1st	H.R. 6506		Harris.
1957	85th	1st	H.R. 6507		Wolverton.

3. Federal Regulation

In 1956 and 1957 three bills were introduced in the House of Representatives whose purpose was to encourage improvements in available voluntary health insurance policies, and thus indirectly to promote the spread of such protection. The method proposed was to prohibit the issuance of health insurance policies which could be canceled after a stated period for any reason other than nonpayment of premiums. The prohibition would apply to insurers engaged in interstate business.

Through applicable both to group and individual policies, the prohibition would be most meaningful in relation to individually purchased policies. Such policies are frequently the only ones older

persons, rural residents, widows and the self-employed can purchase.

Bills introduced in sessions of the U.S. Congress were as follows:

Year	Congress	Session	Bill number	Sponsors
1956	84th	2d	H.R. 8216	Christopher.
1957	85th	1st	H.R. 116	Christopher.
1957	85th	1st	H.R. 5041	Rhodes.
1957	85th	1st	H.R. 7087	Christopher.

LISTING OF REFERENCE MATERIALS

LISTING OF REFERENCE MATERIALS

87th Congress, 1961–62

U.S. Congress. Senate. *Basic Facts on the Health and Economic Status of Older Americans,* A Staff Report to the Special Committee on Aging (Committee Print) June 2, 1961.

U.S. Congress. Senate. *State Action to Implement Medical Programs for the Aged,* A Staff Report to the Special Committee on Aging (Committee Print) June 8, 1961.

U.S. Congress. Senate. *Mental Illness Among Older Americans,* Prepared for Consideration by the Special Committee on Aging (Committee Print) September 8, 1961.

U.S. Department of Health, Education, and Welfare. *Medical Resources Available to Meet the Needs of Public Assistance Recipients. Report Submitted to the Committee on Ways and Means by the Department of Health, Education, and Welfare.* (Committee Print) September 27, 1961.

U.S. Department of Health, Education, and Welfare. Public Health Service. *Health Statistics From the U.S. National Survey, Proportion of Hospital Bill Paid by Insurance, patients discharged from short-stay hospitals, United States, July 1958–June 1960* (Series B, Number 30, November 1961).

U.S. Congress. House. Committee on Ways and Means. *Health Services for the Aged Under the Social Security Insurance System. Hearings, 87th Congress, 1st session on H.R. 4222.*

U.S. Department of Health, Education, and Welfare. *Report on "Medical Care Under Public Assistance" (October 1960–October 1961) by the Department of Health, Education, and Welfare to the Committee on Ways and Means* (Committee Print) March 15, 1962.

U.S. Department of Health, Education, and Welfare. Public Health Service. *Health Statistics From the U.S. National Survey, Hospital Discharges and length of stay: short-stay hospitals, United States, 1958–1960* (Series B, Number 32, April 1962).

U.S. Congress. Senate. *Background Facts on the Financing of the Health Care of the Aged, Special Committee on Aging, Excerpts from the Report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare* (Committee Print) May 24, 1962.

U.S. Congress. Senate. *Performance of the States, Eighteen Months of Experience with the Medical Assistance for the Aged (Kerr-Mills) Program, A Report to the Special Committee on Aging* (Committee Print) June 15, 1962.

American Hospital Association. *Principles of Payment for Hospital Care,* Second Revision Approved September 1962.