

Old age- Medical care ✓

MEDICAL CARE for the AGED...

A REPORT BY THE EMPLOYEE HEALTH AND BENEFITS COMMITTEE

ROBERT D. LOVE, *Chairman*

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MEDICAL CARE FOR THE AGED
A report by the
EMPLOYEE HEALTH AND BENEFITS COMMITTEE
of the
NATIONAL ASSOCIATION OF MANUFACTURERS

Introduction

Over the years there have been many proposals for Federal legislation to provide health insurance; to stimulate the spread of voluntary health insurance and to support state medical-care programs.

This report deals primarily with the implications of the Forand bill (H.R. 4700) which proposes to provide OASI beneficiaries and their dependents as well as those people eligible for OASI benefits and their dependents with insurance against the cost of hospital, nursing-home and surgical care. It is proposed that the cost of these services be paid by increasing Social Security taxes paid by employers, employees and the self-employed.

Realistically, it must be recognized that the bill is an initial step toward a compulsory national health insurance scheme. The passage of the bill would most certainly be followed by the exertion of strong pressures to extend the benefits to other components of the medical bill and eventually extend the services to the entire working population and their dependents.

Walter P. Reuther, President of the UAW, in his testimony before the House Ways and Means Committee, during the recent hearings on this bill, enumerated a number of items which he considered shortcomings of the bill. In so doing he outlined the demands that undoubtedly would soon be made if the bill was passed. His demands, which are quoted below, if enacted into law, would represent a long step toward the national health insurance scheme advocated by the UAW, among other organizations.

"The Forand bill does not even attempt to meet all of the health needs of those Social Security beneficiaries it proposes to cover — the aged, widows, fatherless children and dependent parents of the insured population. 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 would have liked to see the proposal cover Social Security beneficiaries drawing disability benefits. I would have liked to see it cover more of medical care — at least that portion provided in the hospital, which is commonly covered for the unretired. I would have liked to see the inclusion of an entirely

appropriate benefit for qualified nursing services in the home — a feature that might encourage home care rather than hospitalization. I would have liked to see rehabilitation written into the bill as one of its basic benefits, because the present rehabilitation program is confined to persons who are potentially employable and, especially, because I believe there is a great job to be done in rehabilitating older people . . . No initial piece of legislation of this type was ever perfect at its inception. The Forand bill will establish an Advisory Council that would study the operation of the measure and its ultimate effects on health care."

According to proponents of the bill and compulsory national health insurance most of the aged people in the country are not able to pay for proper medical care.

Nelson H. Cruikshank, of the AFL-CIO, testified before the same Committee on July 14, 1959, to the effect that, "In spite of the recent increases in benefits proposed last year by your Committee and wisely enacted by Congress, most persons over 65 still have too little money to meet the rising cost of medical care."

Examination of the facts, however, quickly shows that the actual situation differs substantially and markedly from the picture painted by proponents of the bill.

Coverage By Voluntary Health Insurance

Probably one of the most significant factors to be considered is the current extent of voluntary health insurance coverage among people 65 years and over. Equally significant is the pattern of growth of this coverage and its predicted trend.

There are various estimates of the amount of current coverage among this age group. All of them, however, agree that there is a very substantial amount of coverage.

For example, the Health Information Foundation conducted a survey in 1957 in cooperation with the National Opinion Research Center of the University of Chicago. Its findings were based on information gathered from some 1,700 persons, age 65 years and over, who represented a random cross-section of the country's non-institutionalized aged population.

It was found that about 39 per cent of the aged population had voluntary health insurance at the end of 1957. It is interesting to note that the comparable figure in March, 1952, was only 26 per cent.¹ This illustrates that in a relatively few years the proportion of the aged with such coverage increased by about 50 per cent.

The Foundation found that the average insured person in this age group had obtained his insurance ten years before, generally through his employer. The cost to the insured averaged about \$4 a month and about three out of every four persons paid the entire cost of the insurance themselves.

Another estimate by the Department of Health, Education, and Welfare indicated that about 43 per cent of OASI beneficiaries had some form of voluntary health insurance in the fall of 1957.²

Mr. E. J. Faulkner appeared before the House Ways and Means Committee on July 16, 1959, as the representative of the American Life Convention, the Health Insurance Association of America and the Life Insurance Association of America.

He pointed out that significant as is this finding by the Department of Health, Education, and Welfare (that 43 per cent of OASI beneficiaries had some coverage) it underestimates the full extent of voluntary health insurance among older people. Any estimate of the percentage of the insured aged in relation to either the total number of non-institutionalized population 65 years or over or to the total of OASI beneficiaries, is likely to be misleading. This is so, he said, because a good percentage of the aged do not want or need health insurance.

Some 18 per cent of the aged population are public welfare recipients and are, therefore, eligible for health care.

He pointed out also that there is a sizable percentage of the aged who for various reasons do not need, want, or believe in health insurance. These people include those who receive care from the Veterans Administration or other government agencies or from private sources; those who receive care as being totally disabled or as members of the armed forces; seamen, members of religious organizations or as professional courtesy.

In addition, there are those who do not need or want voluntary health insurance because they have sufficient income, assets, or family resources to feel no need for insurance. Others do not want it for religious or other reasons.

When the estimated four million people over age 65 who do not want health insurance or who are eliminated from the potentially insurable group are taken into account we can arrive at a more realistic estimate of the number of aged who need health insurance and the number of those who have such insurance protection. On this basis, Mr. Faulkner estimated that by the end of 1957 more than 50 per cent of the potentially insurable aged had health insurance.

In his testimony before the Committee, Secretary Arthur S. Flemming, of the Department of Health, Education, and Welfare, pointed out that the steady growth of voluntary health insurance, if unimpeded by unwise governmental action, would eventually cover the bulk of the older population. He said:

"If the same average yearly increase in the proportion of the aged covered during the last few years is maintained, private hospital insurance will reach about 56 per cent of the aged population in 1965 and 68 per cent in 1970."

Further, he said, in view of the special efforts and the experimentation being made by the non-profit plans and insurance companies to accelerate the extension of coverage among this age group it can safely be assumed that by 1965, about 70 per cent of the aged would have some form of health insurance coverage.

The insurance business estimates that by the end of 1960, 65 per cent of aged needing and wanting such protection will be insured; by the end of 1965, 80 per cent will be insured; and by 1970, 90 per cent will have coverage.

The basis of these insurance-business estimates is of interest. In a recent speech, Mr. J. F. Follmann, Jr., Director of Information and Research, of the Health Insurance Association of America said, that

"... it is important to recognize that a delayed reaction in the recent growth of coverage among the population under age 65 and not yet retired is inherent, and that, therefore, the percentage of the aged covered in the years to come can safely be expected to increase. The voluntary health insurance movement is a development largely of the post-World War II period. At the beginning of 1947, for example, 30 per cent of the entire population are estimated to have had some voluntary health insurance protection. Today, about three-quarters of the population under age 65 have some voluntary health insurance coverage. It would appear self-evident that the growth of coverage among persons under age 65 would bear some direct relationship to the number of the aged who will eventually be covered as those now under age 65 move into retirement. This is graphically demonstrated by the fact that the percentage of all aged persons over age 70 having some form of voluntary health insurance in 1956 was exactly the same as the percentage of the entire population at all ages which was covered in 1946, namely, 30 per cent.

"Hence, as individuals, employers, employees, and labor unions became increasingly cognizant of the importance of health insurance protection in the later years, and since the voluntary mechanism by which this protection might be provided now exists, it is reasonable to expect that the coverage of persons over age 65 in future years will increase more rapidly than has been so in the past."

¹ U. S. Social Security Administration — Research and Statistics Note No. 13, 1958.

² National Survey of Old Age and Survivors Insurance Beneficiaries — 1957 — No. 3, U. S. Department of Health, Education, and Welfare — December, 1958.

New Methods of Providing Coverage

The insurance business has developed and is aggressively promoting a wide variety of ways by which older persons may obtain insurance coverage, among them are the following:

- a) Continuation of insurance on older active workers under group plans. This coverage is generally available and, therefore, older active workers are generally insured today.
- b) Continuation of group insurance on retired workers and their dependents, usually with all or part of the premium paid by the employer. Most group insurers offer such coverage, and its growth has been rapid since 1952. One large insurer reports that 99 per cent of employees covered under its major medical group contracts and 56 per cent of those insured under its hospital expense group contracts had provision made for continuation of coverage after retirement.³
- c) Continuation of coverage originally provided by group insurance through conversion of that insurance to an individual form by the retiring employee. The majority of group insurers today will, upon request from the employer, allow retiring employees to convert group to individual policy coverage upon termination of employment without evidence of good health.
- d) New issuance of group insurance at advanced ages. Several insurers have written coverage on groups of persons already retired. These include associations of retired people such as retired teachers, retired civil servants or Golden Age Clubs.
- e) Continuation into the later years of individual health insurance purchased in the productive years. More than 175 insurance companies offer such contracts and of them 110 insurers renew such coverage for the lifetime of the policyholder. Some 31 of these write coverages which are guaranteed renewable for life. Another 58 voluntarily restrict their right to refuse renewal of coverage in instances where the health of the policyholder deteriorates. Of the 162 companies which make this coverage available, at least 65 offer hospital expense coverage up to \$20 or \$25 per diem after age 65 and at least 138 offer hospital coverage for 60 or more days (11 are known to offer coverage up to 365 days and 2 up to 500 days). At least 81 offer coverage of \$200 or more for special hospital service benefits and \$300 or more in surgical benefit schedules. At least 63 also offer coverage for physicians in-hospital visits and at least 15 offer coverage for physicians home and office visits.

- f) New issuance of individually purchased policies at advanced ages. More than 122 insurers issue policies to persons aged 65 and over with the upper age limit of issue varying from 70 years of age to no upper age limit. Recently, two prominent companies have been widely advertising the availability of coverage to older people at any age and regardless of the condition of their health. At least 17 companies are known to make available to persons over age 65 coverage which is guaranteed renewable for life and at least 44 voluntarily restrict their right to refuse renewal of the coverage in instances where the health of the policyholder deteriorates. A study by the New York State Insurance Department⁴ indicates that non-cancellable lifetime coverage is available up to age 70 and over. The quality of these coverages appears to follow the pattern described with respect to those purchased in the earlier years but which might be renewed into the retirement years except that, additionally, one large company is known to include nursing-home care in the coverage.
- g) Issuance of insurance that becomes paid up at age 65. Several of the larger insurers recognizing the desirability to some people of individually purchased policies that become paid up at retirement, now offer this contract.

This listing is merely illustrative. Voluntary health insurance in the United States is unique in that it assumes many forms written or provided by various types of insurers. These include insurance companies, service plans such as Blue Cross and Blue Shield, group medical practice plans operating on a prepayment basis, plans that are self-administered by employers or labor unions, fraternal societies, etc.

Coverage may be had on an individual, group, family, or association basis.

These diverse means provide the buyer of medical insurance with the opportunity to select the type of plan that best meets his wants and his ability to pay.

The competition which exists among the various types of insurers in this country assures continued experimentation to devise new and better benefits and approaches and makes insurers highly responsive to changing needs. Thus the system evolves to the benefit of the American people.

The Financial Position of the Aged

The above figures indicate that a very substantial proportion of the aged population are able to purchase and, in fact, do purchase, health insurance. Despite this fact, it is asserted repeatedly that aged persons generally are unable to finance their health care.

While there is no question that the average *money* income of older people is less than that of persons still in their working years, in evaluating the adequacy or inadequacy of this income, other factors must be taken into consideration. The needs of aged persons are normally

³ "The Significance of Recent Developments Affecting Employee Benefit Plans," C. A. Siegfried, Metropolitan Life Insurance Company, Address made 11-12-58.

⁴ "Voluntary Health Insurance and the Senior Citizen," New York State Insurance Department, 1958.

more modest. For example, many own their own homes and they are no longer confronted with the expenses of raising a young family.

A very considerable proportion of our aged citizens appear to be in relatively comfortable circumstances. Table 8 of page 10 of the June, 1959, *Social Security Bulletin* shows that of some 5.7 million families whose heads are 65 and over, 60 per cent have incomes of over \$2,000 and 32 per cent have incomes of over \$4,000.

The Health, Education, and Welfare report of April 3, 1959, to the House Ways and Means Committee⁵ contained a summary of a 1957 survey of the income of OASDI beneficiaries.

More than half of the retired beneficiary couples had an annual income of \$2,190, or \$183 a month. These couples characteristically had some other income. Half were reported to have \$900 or more of such income for the survey year. But the source of this additional income was such that it could not be reasonably expected to continue in future years at about the same level as in the survey year.

The average couple had no income from an employer or union pension plan. About one-quarter had income from such sources.

The typical retired couple did not receive income from public assistance nor did relatives outside the household contribute money to their support.

The majority of couples had some income from assets — dividends, interest, or rental income.

Earnings were not a source of income for the retired worker in most of the couples but of the 37 per cent who had earnings, half earned more than \$1,030 during the year.

Half of these retired couples had a net worth of more than \$9,620. Equity in a home was the major asset. Stocks, bonds, owned mortgages and other assets were a relatively small part of their net worth. Almost three in every four of the couples owned a mortgage-free home and in half the cases the equity in non-farm homes for these people was over \$8,360.

The majority of these couples (seven out of ten) carried some life insurance. In more than half the cases the face value of the insurance was above \$1,810.

Care for the Needy

In our assessment of the extent of the problem another group demands our attention — those who are provided free medical care through public or private channels.

There are a substantial number of older people receiving public assistance. Their needs have been found to exceed their resources and income.

As of March of this year, medical care provided old-age-assistance recipients was at a rate in excess of 237 million dollars a year — well over a quarter of a billion dollars. Almost one quarter of the old-age-assistance recipients are also OASI recipients.

It is an ironic note that more than three out of every four of these people receiving public assistance would not

benefit by the enactment of the Forand bill since the benefits would be provided only through the OASI mechanism.

1958 Amendments and Current Practice

The matching limits of Federal grants of one-half of so-called medical care "vendor payments" up to an average of \$6 per month for the aged and disabled and \$3 per month for children were removed by the 1958 amendments to the Social Security Act. As a result, matching for medical care expenditures is now under the general matching formula and subject only to the general over-all matching ceilings applicable to Federal public assistance grants. Thus, under the new law the Federal Government pays up to a ceiling of \$30 multiplied by the number of people on the rolls, or four-fifths of all old age and disability assistance expenditures including "expenditures for vendor medical care payments or insurance premiums for medical or any other type of remedial care." Also, there is a fifty-fifty Federal matching of all additional expenditures between this \$30 and \$65 per month multiplied by the total number of people on the rolls.

These great liberalizations have greatly encouraged more adequate provision of medical care by the states. Persons may now come on the state rolls for medical care alone.

The effect of the 1958 amendments in increasing the adequacy of medical care available to persons who are not in a position to pay for their own hospitalization and medical attention has become apparent. The comparison of Table 9 of the April, 1958, *Social Security Bulletin* and Table 10 of the April, 1959, issue which set forth public assistance expenditures for January of both years shows that under the Old Age Assistance Program, total "vendor payments for medical care" and per-recipient payments for medical care increased by over 40 per cent in this one year.

In addition to the medical care obtainable under these state programs very substantial numbers of aged veterans look to the Veterans Administration for hospitalization and surgery. The above mentioned report of the Secretary of the Health, Education, and Welfare Department on April 3, 1959, to the House Ways and Means Committee, page 60, states, "Out of a total of 22,560,000 veterans in 1957, there were 1,034,000 who were 65 and over . . . About a fifth of all patients in VA general hospitals are 65 or older . . . The Veterans Administration estimates that as of June, 1957, for veterans of all ages, VA general hospitals were providing 45.1 per cent of the care for medical, surgical and neurological patients whose disabilities were non-service-connected. But for veterans who were 65 and older, the VA was providing 56.6 per cent of the general hospital care of such patients."

Besides the "vendor medical care" Public Assistance Program and the VA Program, there are public hospitals in many states and cities where "medically needy" cases may receive free medical care.

Statement of the Actual Problem

In summarizing the foregoing facts and trends it is clear that statements to the effect that the aged generally are not able to finance their medical care do not accu-

⁵ *Hospitalization Insurance for OASDI Beneficiaries*: A report submitted to the Committee on Ways and Means by the Secretary of Health, Education, and Welfare, April 3, 1959.

rately reflect the actual situation. The situation is as follows:

- ... There are now large and ever-growing numbers of our aged population who are able to either finance their own medical-care expenses or have some form of insurance protection against such costs. The extension of insurance coverage among this age-group has been considerable and all indications are that there will be an even greater degree of coverage in the immediate year ahead.
- ... The various voluntary service and insurance organizations are rapidly expanding their operations to meet the medical insurance needs of aged persons who desire to be insured rather than to risk exhausting their resources by the expenses of prolonged and expensive illness.
- ... There is no discernible evidence that anyone, of any age, in need of medical care cannot obtain it because of lack of ability to pay. Existing government programs are, in general, providing a solution for the medical care problems of the aged who are, in fact, in bad economic circumstances.

The problem facing the economy is not the need to provide medical care for our aged population but rather to alleviate the problem of that small proportion of the aged who require assistance to meet their medical care costs or who may become indigent when catastrophic medical situations occur.

Proposed Solution By Governmental Action

Since the usual proposed solution to the problem of enabling the aged to obtain medical care is to have the Federal Government enter the field, it may be well to examine the effects and the practicality of this course:

- A) *The Problem Does Not Warrant Such An Action.* It is clear from the factors outlined above that there is no justification for the imposition of a huge, permanent, and compulsory Federal program to handle what is largely a temporary problem,⁶ and one which will be resolved largely by the normal workings of the voluntary insurance system provided that the government does not interfere.

There is a real distinction between a national problem and a nationwide one — a fact which proponents of these national health schemes seem to overlook. It is true that some aged who cannot pay for their medical care or who may become indigent when faced with catastrophic medical situations can be found in all parts of the nation. But long experience indicates that this is a situation best handled on a state or local level.

⁶ The number of aged needy has been declining steadily for the past three years according to the Bureau of Public Assistance, Social Security Administration, U. S. Department of Health, Education, and Welfare. The downward trend is reflected in the June, 1959, figures. The number on the rolls dropped from 2,427,900 to 2,420,000. This decline is expected to continue as more of the aged qualify for OASI benefits.

—N. Y. TIMES, 8-20-59.

Briefly, reviewing the situation, we find:

First, a substantial proportion of the aged can pay for their medical care or can purchase some form of insurance protection against such costs.

Second, we find that the insurance industry is constantly experimenting with new forms of insurance designed to meet the needs of the aged. These new forms and the more traditional forms are being aggressively pushed. The trend of coverage clearly indicates that by far the greatest part of the aged who want or need such protection will have it within a relatively few short years.

Third, it has not been shown that any aged person who needed and sought medical care has been denied it because of lack of ability to pay.

And, finally, the 1958 amendments of the Social Security Act enabled the several states to improve their medical benefit programs for the needy.

- B) *The Forand Bill Cannot Resolve the Problem.* The Forand bill requires that the machinery of the OASI be utilized. However, a substantial proportion of the persons who need such protection cannot be reached since they are not eligible for OASI benefits. Three out of every four recipients of old age assistance are not OASI beneficiaries and thus not eligible for the medical care benefits proposed by the Forand bill.
- C) *The Forand Bill Would Hamper Voluntary Efforts.* If the Forand approach is adopted, it is very likely that it will impede or stop current voluntary efforts to provide this protection. A compulsory program to provide insurance against the cost of medical care would leave little opportunity for private insurance to sell insurance to people eligible for these benefits. The insurance industry would be pushed out of this field almost completely. A decision to enact a compulsory insurance program would be practically irreversible.
- D) *The Forand Approach Is Merely An Initial Step.* If the Forand bill is adopted, experience indicates that pressures will soon develop to extend the protection to other components of the medical bill. Moreover, pressure would be exerted eventually to extend protection to the entire working and retired population and their dependents. It may also be added that once the principle is accepted there are no limits as to what could be demanded — housing, recreation, rehabilitation, etc.
- E) *Even The Foot-In-Door Forand Proposal Would Be Extremely Expensive.* The cost of current proposals is substantially underestimated. For example, Mr. Faulkner, in his testimony before the House Ways and Means Committee said

that, "We estimate the costs under H.R. 4700 in 1960 would range from \$2,074 million to \$2,387 million, while by 1980 they would range from \$5,981 million to \$7,660 million. These costs can be expressed as a level premium of from 2.32 per cent to 2.97 per cent of taxable payroll. These costs are much higher than could be supported by the one-fourth of one per cent of taxable payroll proposed as the tax to be imposed on both employer and employee, or the three-eighths of one per cent proposed by the bill as the tax on the self-employed. In point of fact, the level premium cost for the hospitalization benefit alone, as developed by the substantially lower cost estimates of the Department of Health, Education, and Welfare, exceeds the tax proposed by this bill by .08 per cent on the low-cost estimate and by .24 per cent on the high-cost estimate.

"Our estimates are significantly higher than those submitted to your Committee by HEW."

The ultimate cost of the compulsory national insurance scheme into which the Forand proposals would very likely evolve are almost beyond estimate. A brief examination of the British experience will indicate what we could expect.

At the start of the British National Health Service it was estimated that the costs would start at about 170 million pounds a year, rise to a peak, and then decline. It was believed that the continuing demand for medical care generated by the plan would be offset by the need for less care as the backlog of health needs was satisfied and the over-all health of the people improved. Instead, however, the cost continued to increase steadily and has broken through a ceiling of 400 million pounds imposed by the British Treasury. In 1958, the spending was at a rate of 748 million pounds annually. Current proposals to expand and revise the Service would cost another 100 million pounds a year and, in addition, capital expenditures of 50 million pounds are proposed to build new hospitals and modernize old ones.⁷

This experience illustrates that there is no ultimate limit to the cost of providing unlimited medical care without direct payment. The question as to who will pay these proposed costs may be considered at this point. The proponents of national health insurance would load it onto the working force on a compulsory basis. They would have no choice but to accept the cost and the benefits provided. The insurance industry and the service organizations, on the other hand, have the flexibility, the incentive and the willingness to experiment with various types of plans and pricing and thus to offer the public a range of plans and prices from which individ-

uals may choose that which best suits their needs and means.

It should be noted also that the enactment of H.R. 4700 would intensify and aggravate present and future governmental monetary and fiscal problems. Social Security taxes are a fixed and continuing cost of doing business for practically every enterprise in the country. When these costs increase without commensurate increases in productivity inflationary pressures are intensified.

F) *National Health Schemes Fail And Lead To Regimentation.* Despite the huge cost involved, experience has proved that various forms of national health insurance fail of their objectives. For example, in England, after a decade of operation of their National Health Service plan, people must wait as long as two years for surgical care for such common chronic ailments as tonsils, appendix, and gall-bladder.

Such schemes inevitably lead to complete regimentation of medicine. The Congress cannot appropriate money without erecting appropriate safeguards to assure that the money is spent in the manner and for the purpose for which it was appropriated. The Supreme Court long ago has said that "it is scarcely lack of due process for government to regulate that which it subsidizes."

G) *The Forand Bill Departs From the Essence Of Social Security.* Since providing Forand-type benefits is, in essence, an increase in Old Age benefits, such proposals are a further departure from the basic philosophy of Social Security — that the program is to provide a floor of subsistence upon which the individual could build further old-age protection if he so desired.

The proposals are also a departure from the basic Social Security philosophy in that they adopt the "flat benefit" principle. There is no relationship between the benefits provided and the amount of contribution made.

H) *The Forand Bill Would Impose An Unfair Tax.* It would impose a double tax on some groups — for example — veterans — who already have free protection.

I) *The Forand Bill Invades Another Area Of Free Choice.* Finally, such proposals represent another stimulus to the ever-increasing dependency of the individual on Washington and to the ever-increasing control of individual disposable income by Washington. The Forand bill proposes to provide a service rather than a cash benefit. This would remove another area in which the individual now has freedom of choice. If it is thought that the aged cannot manage their funds so as to take care of their medical bills — why stop there? Why not control their spending for housing, food, etc.?

⁷ New York Times, August 26, 1959.

This is an unhealthy tendency and one which may be dangerous to the welfare of the nation. It is vital that the nation's political and economic climate be one which will foster the development of a self-reliant population able to take care of themselves through their own efforts.

President Eisenhower, when addressing the American Medical Association last June, pointed out: "The cost of inflation is not paid in dollars alone, but in increasingly stagnated progress, lost opportunities and eventually, if unchecked, in lost freedoms for the doctor and the patient." He said further: "If the time ever comes when large numbers of our citizens turn primarily to the government for assistance in what ought to remain a private arrangement between doctor and patient, then we shall all have suffered a great loss."

The Voluntary Solution

In reviewing the implications of governmental compulsory health insurance schemes, it can only be concluded that the disadvantages of this approach far outweigh any advantages that may exist.

Governmental action on a compulsory basis in this field would have the following results:

- 1) If the OASI mechanism is used, as proposed in the Forand bill, it would not alleviate the bulk of the real problem — the problem of the aged who require assistance to meet their health care needs.
- 2) The Forand approach would almost certainly evolve into a compulsory national health insurance plan covering the entire population.
- 3) The Forand approach would seriously impede, if not halt, the extension of voluntary health insurance coverage to the aged which now gives every promise of eventually covering all of them except the indigent and those who do not want such coverage. As the Forand approach evolved toward a compulsory national medical system, it would likely destroy the voluntary health insurance industry completely.
- 4) The Forand approach would impose additional taxes which would become heavier and more burdensome as the system evolved toward a complete compulsory plan.

- 5) Despite the heavy taxes, it is likely that the medical care that would be available would not be adequate. The British experience highlights this situation.
- 6) Such schemes would be another invasion of our right of free choice.

Committee Recommendations

In view of these actual or potential results of the imposition of any form of compulsory health insurance by the Government, the Employee Health and Benefits Committee is firmly convinced that such action, i.e., compulsory health insurance imposed by the Government, is not justified. Compulsory health insurance is not the remedial solution for the health problem of a limited segment of the American people.

Therefore, we oppose any action by the Federal Government which would involve compulsion of any sort — on the public — on employees — on employers — on the insurance business or on any other group, organization, or segment of the economy.

The Committee recognizes that various legislative proposals have been made in the past and that others undoubtedly will be made in the future having the objective of stimulating the expansion of voluntary health insurance; for providing individuals with an incentive to obtain coverage, or for providing them with some method of obtaining voluntary coverage. The Committee believes that such proposals should be measured objectively against the criteria of (1) Would the participants be completely free to choose whether or not they wish to act? (2) Would the government impose any controls, direct or indirect, upon any involved individuals, groups or organizations?

The Committee is convinced that the voluntary health insurance business (including service organizations) will eventually provide insurance against the cost of medical care to every individual who wants and needs such coverage.

The Committee recognizes also that there are groups of people in the country who cannot be protected by these voluntary means; the indigent, the disabled, the unemployable, etc. The Committee feels that handling this problem through state and community efforts is a humane and efficient method highly responsive to the needs of the group. Therefore, this aspect of old-age assistance — as with all others — should be based on needs and financed and administered by states and communities.

TASK FORCE
on
MEDICAL CARE FOR THE AGED

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