

Old age - Medical care

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MEDICARE FOR THE AGED:
An Account of the Debate and How It Started.
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THE GIST OF THE DEBATE

Medicare would be extremely expensive. It would undermine private health insurance and prepayment mechanisms. "It would expand into a full-pledged system of socialized medicine, eventually covering every citizen of this nation."

It would cover millions of people "who neither need help in paying the costs of their health care, nor want much help. It would determine eligibility on the basis of age rather than need. It would destroy the concept of individual and familial responsibility.

Medicare would compel the nation's younger workers to pay for these unnecessary benefits through an increased compulsory gross payroll tax."

BUT

Older persons utilize health facilities and medical services almost three times as often as younger people, and for longer periods. Relatively fewer aged persons than young ones have any part of their medical bills paid by insurance. The older a person gets, the more he uses up his income, the more he has greater health needs, the greater is the likelihood that he does not have this protection. Many private policies for the aged cost a great deal, pay little, do not cover certain illnesses, and can be cancelled at any time.

The Kerr-Mills bill passed in 1960, providing federal subsidies to states with medical care programs for the medically indigent aged, has far from solved the problem. A number of states still have no program, and some states that have programs provide very little. Furthermore, applicants for medical aid must prove they cannot pay their own medical bills and are subject to a welfare investigation.

Providing for medical care under Social Security has advantages. The aged in every state would have equal access to benefits. The Social Security system is nationwide and well administered. It does a sound and economical job of distributing monthly benefits to 20 million people, mostly oldsters. Social Security would avoid the onus of charity because everyone receiving benefits would eventually have contributed to the system providing them. No welfare investigation would be necessary.

This is the gist of the debate that has been going on for some time. How did it start and when? What are the facts of the matter? Or are there no facts but only opinions? Let us examine the course of the debate before we take up the argument.

HOW IT STARTED

In one form or another, proposals for medical care under Social Security have been before Congress for more than 30 years, ever since President Franklin Roosevelt set up the Committee on Economic Security to study the problems growing out of the Great Depression. The report of the committee endorsed the principle of compulsory health insurance as part of the social security system. Health insurance was not included in the bill setting up the Social Security Act, however, because the President feared that such a provision would endanger passage of old age insurance.

Plans for health insurance for the aged have received strong backing for organized labor, groups representing the elderly, and Presidents Truman, Kennedy, and Johnson. Opposition to them as "socialized medicine" by the American Medical Association, however, has succeeded in blocking action. No medical care bill tied to Social Security payroll taxes has ever been approved by the House Ways and Means Committee. Two attempts to pass such bills in the Senate were defeated by narrow margins. In September 1964, however, the Senate voted 49-44 in favor of Social Security financed Medicare.

No disagreement exists about providing medical care for people who need it. The disagreement is over how to provide it. Should it be given on the basis of charity and paid for out of general taxation, or should it be given as a right and paid for by payroll taxes under Social Security, or can the private sector of the economy take care of the problem through voluntary insurance?

Public Medical Care Before September 1960

State and local public welfare agencies traditionally provided some medical care to needy persons through public institutions for medical care of the indigent, sometimes through a salaried physician or by paying for medical care by private physicians. Systems of medical services for the poor had been established under public auspices before 1930 in most large cities. A great many other cities, many counties, and some states furnished at least emergency medical services to persons for whom public responsibility otherwise had been assumed. A large number of physicians and hospitals also gave free or part-pay services to the poverty stricken.

The federal government provided hospitalization and other types of medical care for members of the armed forces, veterans, merchant seamen, Indians, and certain other groups. But general medical care as an essential relief need was not accepted as a federal responsibility until the economic depression in the 1930's. Between 1933 and 1935 federal funds for paying the medical care costs of the needy unemployed were first made available to the states through the Federal Emergency Relief Administration (FERA).

This program sought to retain the traditional patient-physician relationship by giving patients free choice of practitioner. Payments from federal funds were made according to state fee schedules adopted by agreement with the organized medical, dental, and nursing professions. The services provided were limited to physician's care in the home and office, emergency dental care, bedside nursing service, drugs, and emergency appliances. Hospital care was not included, and sharp restrictions were placed on the amount of service available.

The FERA program lasted only two and a half years. Although it was not applied uniformly throughout the country and had many serious shortcomings, the plan exercised great influence on subsequent medical care programs. It emphasized the role of governmental agencies as purchasers of medical care in contrast with previous reliance on free services of physicians and hospitals, and it set a precedent for increased participation of state and federal governments in financing medical care for the needy.

The Social Security Act passed in 1935 made no special provision for medical assistance, but federal financial participation in the costs of medical care--within the limits of federal participation in the monthly assistance payment--was available to states when it was included in the cash payment to recipients of old age assistance, aid to the blind, and aid to dependent children. Although amendments to the Social Security Act in 1939, 1946, and 1948, increased the maximums of federal participation, the medical care that could be provided within the cash payment was limited, and its nature and extent varied greatly from state to state. The cash payment to the recipient--instead of payments to the grocer or the landlord--was one of the standards for the assistance programs set up by the Social Security Administration. This policy of an unrestricted

money payment, which allowed the recipient the fullest possible independence, resulted in neglecting the area of medical care. Payments in many states were so low that any increase to meet medical bills was used for food and shelter. Statutory maximums on assistance payments in most states, moreover, made it impossible to increase allowances sufficiently to pay large bills, even in installments, within a reasonable time. Many states, however, adopted this procedure in order to obtain the greatest advantage from federal funds.

As early as 1939, Senator Wagner introduced a bill proposing that the Social Security Act be amended to include specific appropriations for making separate payments to states that set up programs for direct medical services. (S.1620, 76th Congress) Such an amendment was not enacted until 1956, and had the effect of stimulating medical care programs for recipients of federally subsidized public assistance. This included persons receiving old age assistance.

The Social Insurance Approach

In 1938 a National Health Conference, called by the Interdepartmental Committee to Coordinate Health and Welfare Services, had discussed a comprehensive system of health insurance, with funds obtained from the direct contributions of insured persons, with assistance from employers and from government. It was not until 1943, however, that Senators Murray and Wagner and Representative Dingell introduced bills calling for the creation of a national health insurance plan, financed through a payroll tax.

In 1944 "the economic bill of rights," included in President Roosevelt's State of the Union message, specified the right to "adequate medical care," and the eighth annual report of the Social Security Board called for compulsory health insurance.

The Wagner-Murray-Dingell bill was reintroduced in November 1945. It proposed a comprehensive plan to cover physicians' services, hospital, nursing, laboratory, and dental services, with free choice of physician and hospital, paid for by a four percent increase in the Social Security contribution and by use of general revenue funds for those not covered, through federal grants to the states to enable them to provide care for persons unable to pay and to pay part of private health insurance premiums for other needy persons.

Hearings were held on both bills but no action was taken.¹

Bills for the Aged

In 1952 the first bills that would have provided 60 days of hospital care for OASI beneficiaries aged 65 and over were proposed to the 82nd Congress by Representatives Dingell and Celler and Senators Murray and Humphrey. The program would have functioned through the Social Security system, but certain administrative aspects would have rested with the states, acting as agents of the federal government either in making payments to the hospitals or in using nonprofit health insurance plans to make such payments. Identical or similar bills were introduced in 1952, 1955, 1956, and 1957.

The Forand Bill

In 1957, Representative Forand (Rhode Island) introduced a bill that would have provided OASI beneficiaries with 60 days of hospital care and up to 120 days of nursing home care following hospitalization, plus surgical benefits. Administration was to be solely through the federal government, using nonprofit agencies as might be found desirable. It was the debate on this bill that created a more general interest in the subject of providing health care for the aged. The House Ways and Means Committee held hearings on the bill but failed to report it out.

In 1959, the Forand bill, slightly modified, was reintroduced and hearings were held. Supporters included the AFL-CIO, the American Public Welfare Association, the American Nurses Association, the Group Health Association of America, The Physicians' Forum, and the National Association of Social Workers. Those in opposition included the American Medical Association, a number of state and county medical societies, the American Hospital Association, the Chamber of Commerce of the United States, the Health Insurance Association of America, the American Life Convention, and the Life Insurance Association of America. No action was taken by the committee.

¹. Senator Murray and Representative Dingell tried again in 1959, introducing a bill (S.1056) which would have set up a national health insurance program providing certain health benefits for all persons covered by the Social Security Act, regardless of age. No action was taken.

Ten other essentially similar bills were introduced the same year both in the Senate and in the House, some omitting surgical services, some providing variously 90, 120, or 365 days of hospitalization, some including home nursing services, physician home and office visits, or prescribed drugs, and some providing that the patient share in the costs of care in various ways.

Meanwhile, the Senate had passed a resolution authorizing the Senate Committee on Labor and Public Welfare to establish a subcommittee on problems of the aging. The subcommittee held hearings in a number of cities and submitted a report on January 29, 1960, entitled "The Aged and Aging in the United States: A National Problem." The report recommended, among other things, that legislation be enacted to expand Old Age, Survivors and Disability Insurance to include health care for all persons eligible for OASDI benefits. On January 27, 1961 a further report "Action for the Aged and Aging" was made.

The McNamara and Other Bills

During 1960 Senator McNamara introduced a bill, based on the Senate subcommittee's report on the aged, which was designed to overcome certain criticisms of the Forand bill. It was sponsored by 18 other Senators, including Senator Kennedy. This bill would have financed medical benefits through Social Security, giving participants a right to medical services without a means test. The bill would have provided medical insurance benefits to:

- (1) persons who have attained retirement age, are retired, and are receiving or are entitled to receive old age insurance benefits; (2) the dependent spouse of (1) who has attained retirement age; (3) persons who have reached retirement age, are retired, and are American citizens, but are not entitled to medical benefits under (1) and (2); (4) the aged dependent spouses of (3).

Medical insurance benefits were defined as:

- (1) hospitalization--90 days; (2) nursing home care--180 days; (3) home medical services--240 days; (4) diagnostic outpatient services--limits to be set by regulation; (5) expensive drugs--definition and limits to be set by regulation.

Maximums for (1), (2), and (3) in one benefit year were limited to 90 units; one unit was defined as 1 day of hospital care, 2 days of nursing home care, or 2-2/3 days of home care. Home care included

professional nursing care, part-time homemaker, physical and occupational therapy, medical social service, dietary counseling, ambulance--all furnished by a nonprofit home health service agency (coordinated home care service agency).

The Secretary would have been authorized to make agreements with nonprofit agencies like Blue Cross to the extent that he found such agreements economical and otherwise advantageous. Patients would have had free choice of hospital, nursing home, etc.

Other bills introduced that year would have increased OASDI cash benefits so that the aged and disabled might arrange for their own medical care; would have provided for credits on federal income taxes for health insurance premiums; provided for federal grants-in-aid to assist the states in establishing protection for their aged citizens; or increased existing federal grants to the states to aid the medically indigent.

The Committee on Ways and Means held no hearings but gave executive consideration to the Forand bill and to several other proposals having to do with medical care of the aged. On June 13, 1960 the committee voted out the Mills bill providing federal grants to the states and applicable only to aged persons whose financial need was to be verified by a state standard.

In August 1960 the Senate Finance Committee reported out the Kerr version of the Mills bill. Senator Anderson and others, including Senator Kennedy, offered amendments to add Social Security financing for medical benefits for OASDI beneficiaries aged 68 and over. For the first time, the Social Security approach to financing was taken to the floor of one house of Congress. It failed by a vote of 51 to 44.

The Kerr-Mills bill was accepted by both houses and approved by President Eisenhower September 13, 1960 (PL 86-778). The implementation of this law is described in a later section of this paper.

The King-Anderson Bill

In 1961 Senator Anderson and Representative King introduced another version of the program to provide medical benefits to the aged with Social Security financing. HR 4222 and S 909, urged upon Congress by President

Kennedy, closely followed the McNamara bill except that drugs outside the hospital were no longer included. The bill would have created Title XVI to the Social Security Act to provide a maximum of 150 units of medical service to persons 65 years of age or more, who were receiving Social Security or Railroad Retirement benefits. One day of hospital care (maximum 90 days), or two days of nursing home care (maximum 180 days) would be equal to one unit of service. Nursing home benefits would be available only after immediate discharge from the hospital.

In addition, a maximum of 240 home health service visits would be allowed, including intermittent nursing care, therapists' visits, and part-time homemaker services.

No provision was made for paying physicians or surgeons.

For hospital care the patient would be required to pay the first \$10 of costs for the first nine days (minimum of \$20). For diagnostic outpatient hospital services the patient would be required to pay the first \$20 of cost for each diagnostic study.

Services would be financed by increasing the Social Security tax by 1/4 of 1 percent on employee and employer and raising the wage base from \$4800 to \$5200.

The House Ways and Means Committee was opposed to the bill 15 to 10 and did not report it out. In July 1962 Senator Anderson, with the co-sponsorship of Senator Javits and four other Republican Senators,¹ offered a compromise to the Administration program as a Senate floor amendment to a welfare bill already passed by the House. It was defeated by a 52-48 vote. For the second time the Social Security approach had been taken to the Senate floor and defeated.

Representative King and Senator Anderson re-introduced their program into the 1963 Congress (HR 3920-S 880). This was essentially the compromise plan offered on the Senate floor in 1962. Benefits were similar but coverage was wider since persons 65 and over who were not under Social Security and were not receiving special health service benefits from the federal government would have been blanketed in, with costs paid from the general revenue. In addition, an option would be offered of (1) payment

1. Including Senator Kuchel of California. Democratic Senator Engle of California also backed the Social Security approach.

for 90 days' hospitalization with \$10 a day to be paid by the patient for the first 9 days; or (2) free payment for 45 days' hospitalization' or (3) 180 days with the patient paying the cost of the first 2-1/2 days, figured at a national average rate.

The bill remained locked in the Ways and Means Committee.

In January 1964 a group of Republican Senators who favored the Social Security approach introduced a new bill that would use both governmental and private insurance, with benefits available to all citizens 65 or over. Backed by Senators Javits, Keating, Kuchel, Case, Cooper, and Smith, the bill would raise Social Security taxes to finance 45 days of hospital care and 180 days' nursing home benefits or 200 days of home health care, following hospitalization. It would make the same benefits available, through general taxation, for persons not covered by Social Security. The private insurance feature would create a national, federally chartered association of private insurance companies authorized to issue a low-cost standard medical-surgical policy to persons 65 years and older. It would cover doctor and surgeon fees. This would be done by waiving the anti-trust laws and permitting carrier income from premiums on these policies to be tax-free.

No action was taken on this bill. Instead, the House Ways and Means Committee in June 1964 voted for a 5-percent increase in Social Security benefits, financed by increased payroll taxes. A higher benefit would presumably permit Social Security beneficiaries to pay their own doctor bills or buy insurance. This is a highly questionable assumption. The average Social Security retirement benefit is \$77 a month. Raising it by

5 percent gives \$3.85 more---hardly enough to pay the premium on even the cheapest insurance. Moreover, in states like California, which supplement low Social Security benefits with old age assistance, the increase would be deducted from the assistance payment as an added resource, and would therefore be unavailable for insurance.

The House of Representatives approved the Social Security amendments without Medicare. When the bill reached the Senate floor, however, Senator Albert Gore offered an amendment to include Medicare as well as larger cash benefits. The Senate approved the amendment 49-44, and the bill went into conference. The Senate-House conference failed to reach agreement before Congress adjourned, with the result that neither Medicare nor higher Social Security benefits were provided by the Congress that year.

The Charity Approach

One of the telling arguments against the Social Security approach is that all the aged would be eligible for free care, whether or not they can afford private care. Yet it is recognized that a great many elderly people do not have the means to pay for medical services.

Public Assistance Medical Care

Since 1950 Congress has attempted to meet the problem by making it easier for state governments to provide medical care to their elderly citizens who were receiving cash assistance under the welfare provisions of the Social Security Act, that is, federally subsidized old age assistance.

First, the definition of assistance was broadened to include payments for medical care, or other remedial care, made directly to suppliers of such services. However, these vendor payments had to be made within existing maximums on federal participation, which at that time were on an individual-case basis.

In 1956 the federal share of medical-care costs in all categories of aid was increased by establishing separate federal matching for medical care payments, over and above the cash assistance grant. Recipients of aid to the blind, aid to the disabled, and aid to dependent children were included in the program, as well as recipients of old age assistance. All of these recipients had to meet the state definition of "needy" and to pass through an investigation.

In 1958 the basis for federal sharing in state expenditures was changed to a general averaging formula which included both vendor and money payments. This averaging made it possible to share with the states in larger medical expenditures in individual cases, provided the maximum average was not exceeded.

By 1960 four fifths of the states had medical vendor provisions in their federally aided public assistance programs, and many of them provided for some items of medical care in money payments to recipients. Nevertheless, even with expanded federal and state effort, the need was so great that the majority of the states were able to provide for only limited medical care, financing one or more services, but not the broad scope of services needed by most elderly people.

Kerr-Mills Medical Assistance for the Aged

The increasing need of the aged for medical care and its ever mounting cost resulted in further amendment to the Social Security Act in 1960. Under the Kerr-Mills legislation, a new category of public assistance--Medical Assistance for the Aged (MAA)-- was established,

and additional funds were made available for vendor payments for medical care under existing old age assistance programs. Under the latter provision, the federal government contributes to state expenditures for medical care within a maximum expenditure of \$15 average per aged recipient per month.

For Medical Assistance for the Aged, the federal government shares with states in the total cost of the program without limitation on either the individual payment or total state expenditures. The amount of federal participation ranges from 50 to 80 percent of state expenditures for medical care of aged persons eligible for the program, the higher percentages going to states with low per-capita income.

Potential services. States may make available a broad range of medical services:

- (1) physicians' care, dental services, private duty nursing, physical therapy and related services; (2) inpatient hospital, outpatient hospital or clinic, skilled nursing home, and home health care; (3) laboratory, X-ray, diagnostic, screening, and preventive services; (4) prescribed drugs and appliances including eyeglasses, dentures, and prosthetic devices; and (5) any other medical or remedial care recognized under state law.

The states determine the kinds and extent of services for which costs will be assumed and the conditions of eligibility for such services.

Federal restrictions. Relatively few conditions are imposed by the federal government:

- (1) The state must include some institutional and some noninstitutional care; (2) a durational residence requirement is not permitted; (3) no charge, such as an enrollment fee or premium is permitted as a condition of eligibility; (4) a lien may not be placed against the property of any individual on account of medical assistance under the program, and recovery from his estate cannot be made except after the death of the surviving spouse, if any; and (5) disclosure of information concerning the applicants and recipients is restricted to purposes directly connected with administration of the program.

1964 eligibility.¹ In most states with MAA programs, persons otherwise eligible can receive help only after health insurance or such other potential resource has been utilized. The income resources on which eligibility is determined are only slightly higher than the standard used for old age assistance.

1. "Determining Financial Eligibility for Medical Assistance for the Aged," Welfare in Review 2: 8-15, June 1964

Most states use a specified amount of income in determining financial eligibility. This figure represents the money considered necessary for living expenses, and anything beyond that amount is evaluated against the probable cost of medical care needed. The most liberal annual income permitted by a state is \$2,000 for a single person; the most common is \$1,500--an amount approximating the highest for essential maintenance costs under a state old age assistance program.

All the states take into account the availability of other personal property to meet medical care costs. In most states there are dollar limits on the amount that may be held without affecting eligibility.

All states exempt real property used as a home, but some require that equity in a home not exceed a stated amount. One state does not allow holding of other real property, and others require it to be income--producing or utilized to apply to medical care costs.

Extent of coverage. Despite the expansion of medical care for the aged under the Kerr-Mills program and the various state public assistance programs, the extent to which the states are reaching the total group of medically indigent aged is still limited. For example, more than two fifths of the total aged population reside in states which do not have an MAA program in operation. In February 1964, 30 states and four other jurisdictions had going programs. By June 1964 three additional state legislatures had voted to implement the program.

MAA in California

California is one of the states in which the effect of the Kerr-Mills program was to reduce local expenditures for medical care of the indigent aged. Prior to 1957, county government in California bore the entire expense for care of the medically indigent. The kind of care received by the poor and, indeed, whether or not they could get anything but treatment in an emergency, depended very much in which county they happened to be living. In some counties medical care was very good, and in others it was all but lacking.

The Public Assistance Medical Care program (PAMC), begun in 1957 and paid for almost entirely by the federal and state governments, relieved the counties of providing all except hospital services to recipients of old age security, aid to the blind, aid to the disabled, and aid to needy children. Implementation

of the Kerr-Mills program, effective January 1962, relieved them of financing hospitalization or nursing home care to anyone 65 years of age or over.

The Kerr-Mills MAA program in California provides care in hospitals and nursing homes and subsequent outpatient services, including all those available to old age assistance recipients under the PAMC program. At present the latter furnishes physicians' services, some surgery, radio-therapy, podiatry, chiropractic, drugs (as contained in a state formulary), limited medical supplies, ancillary services, including laboratory, diagnostic X-ray, physical therapy, home nursing visits, complete dental services, eye refractions and glasses, and inpatient and outpatient rehabilitation services. As of February 1, 1965, financial difficulties compelled the State Welfare Department to place restrictions on eye and dental care, modify the drug formulary, and limit the selection of patients for rehabilitation services.

Persons seeking care under MAA must be 65 years of age or older; be a California resident (no duration required); have an average monthly income that does not exceed the cost of his medical care plus personal and incidental expenses, home upkeep and maintenance, and payment on certain debts, all according to the standards set for recipients of old age assistance; does not own personal property and nonutilized real property with a combined value in excess of \$1,200 (couple maximum \$2,000); does not have utilized real property (other than a home) with an assessed valuation, less all encumbrances of record, in excess of \$5,000; is not a recipient of old age assistance; is not a patient in an institution for tuberculosis or mental disease and not in an institution as a result of a diagnosis of tuberculosis or psychosis; is not an inmate of a public institution except as a patient. All applicants for care must be investigated by the county welfare department.

Since there is no ceiling on federal sharing for medical assistance for the aged, California, like many other states, immediately transferred to this program as many aged persons on other public assistance programs as could qualify. This resulted in considerable savings to the county treasuries, estimated "conservatively" by the California County Supervisors Association as a net savings of \$12 million per year. (County News, May 1963, p. 4)

Kerr-Mills in California, however, has begun to reach some portion of the aged for whom Congress intended the program. Since the last quarter of 1963, around 45 percent of the applications approved for aid have been from persons who were not receiving other public assistance.

The "Voluntary" Approach

This approach to providing medical services to the aged assumes that the private sector of the economy can carry out the task for all except those

receiving public assistance. Some persons who hold this view would also cover the public assistance recipient under voluntary health insurance, with the federal or state government paying the premiums. As early as 1946 Senator Robert Taft introduced a bill to provide \$230 million for grants to the states to help finance comprehensive medical insurance for the medically indigent.

In 1954 Representative Wolverton introduced a bill, with the support of President Eisenhower, that would have provided federal funds to reinsure certain experimental forms of private health insurance. The theory was that insurance carriers would become more enterprising in their coverage and benefits, if protected by reinsurance. Hearings were held by both Senate and House committees. The House Committee on Interstate and Foreign Commerce reported the bill out, but it failed to carry and was referred back to committee. No further action was taken. In 1955 the Wolverton bill was again introduced, this time in more detailed form and with the amount of federal funds appreciably increased. In 1956 and 1957 bills with similar purposes, but in some instances limited to smaller insurers, were introduced but not acted upon.

In 1956 and 1957 several bills were proposed that would have permitted insurers, by providing an exemption from antitrust laws, to pool their resources and to engage in joint research. The purpose was to encourage the broadening and further extension of private health insurance, with some emphasis on the aged population. No action was taken.

In 1960 Senator Javits proposed a bill by which the federal government would provide money to the states to assist them to provide voluntary health insurance for aged persons and would permit certain alternate choices for covered persons.

Extent of Private Insurance

Private insurance for the aged is undoubtedly growing. Whether it will grow fast enough, or whether the benefits will be sufficiently adequate at a low enough cost, to take care of the increasing number of aged persons is another question. The aged at present have a two-fold choice: a low-cost policy with little coverage, or a high-cost policy sufficiently comprehensive to cover most of their risks.

About half the persons aged 65 and over have some hospital insurance. The figure for those in this group who are no longer working however, is only 38 percent. The insurance is usually expensive, limited, and restrictive, and frequently excludes preexisting conditions or can be cancelled at the option of the insurance company. Furthermore, protection is uneven, with those needing the most having the least. Only one third of the aged in families with incomes of less than \$2,000 have hospital insurance, only 30 percent of those with chronic disabilities, and only 32 percent of the aged 75 and over.

Only 30 percent of those 65 or over have as much as 75 percent of their hospital bill paid through insurance, compared with 54 percent of the younger people.

Health insurance does not meet more than one fourteenth of the total cost for all the aged.

The typical commercial insurance policies cover elderly persons at annual premiums of \$78 to \$102 and provide hospital-room payments of \$10 per day for 31 days or \$5 per day for 60 days. Nursing home benefits are totally excluded or are limited to \$5 for 55 days.

Individual Blue-Cross policies--generally accepted as the best available protection at the lowest cost--charge an annual premium of \$112 to \$148 per person. But 96 percent of these policies exclude pre-existing conditions for at least six months; more than half have dollar limits or co-insurance on hospital room costs; only half cover nursing home care or visiting-nurse service; more than one third limit dollar allowances for related hospital services; and almost a quarter of the plans may exclude applicants on the basis of health.

The New 65-Plus Plans

Spurred by the increasing interest in some form of federal provision for health care of the aged, the private health insurance organizations in recent years have taken steps to make more adequate coverage available. Thus, groups of insurance companies have been offering so-called "state 65 plus" plans which provide basic hospitalization and surgical coverage. Cost of such a plan plus major medical is \$210 a year in Massachusetts, \$228 in New York, and \$252 in Connecticut. All plans call for the patient to pay the first \$100 of expense, plus 20 percent of the remainder.

"Western 65" offered in California, will pay up to \$20 per day for 180 days of hospital confinement, plus 80 percent (after \$100 deductible) of hospital

charges for services and supplies, surgical radiological or hospital services, and doctors' visits in and out of the hospital. It also pays 80 percent of convalescent hospital care up to \$10 per day for a maximum of 90 days per year, if incurred within five days after hospitalization; and 80 percent of the cost of a special registered nurse up to \$20 per day, but not to exceed \$1,000 per calendar year. The premium for this policy is \$276 per year.

'Western 65' also offers a simple hospital expense plan, at \$132 a year, that provides up to \$20 per day for 31 days for hospital room and board charges, and up to \$200 for hospital services and supplies. Lifetime maximum benefits for both types of policy are \$10,000.

New Blue Cross-Blue Shield Plans

With the approval of the American Medical Association and the American Hospital Association, Blue Cross-Blue Shield early in 1962 decided upon an open enrollment program for aged persons which would provide hospital care, nursing home and visiting nurse benefits, surgical and in-hospital medical services, to be offered in a uniform national contract at a uniform national rate of \$10 to \$12 per month. The possibility of a government subsidy was considered.¹

After several months of intensive effort, both organizations came to the conclusion that nationally uniform contracts at uniform rates could not be offered because of the difference between such contracts and those currently offered by the individual plans. Cooperative relationships among the plans were apparently not strong enough to support national underwriting of a uniform program, and in some areas, the necessary cooperation of hospitals and medical societies could not be obtained. The idea of a nationally uniform program--with uniform benefits, rates, and terms of enrollment--was therefore dropped.

Blue Cross and Blue Shield and their member plans then decided that each plan would develop one or more nongroup contracts which would meet as closely as possible certain standards to be set up by the governing boards of the two associations. Between October 1, 1962 and January 28, 1963 nongroup initial enrollment coverage for older persons was offered by 73 of the 77 Blue Cross plans and 67 of the 70 Blue Shield plans. Twenty-three of the Blue Cross plans and 14 of the Blue Shield plans had not previously made such enrollment available to the aged.

1. Blue Cross and American Hospital Association, Financing Health Care of the Aged, 1962, Part 2, pp. 16-30.

An analysis of the plans, made by the research division of the Social Security Administration, showed a wide variation from plan to plan in benefits, premium costs, and terms of enrollment. A small proportion of the plans offered virtually the same contracts as had previously been made available; a few offered new contracts with reduced benefits; the great majority, however, offered new contracts providing more comprehensive benefits than formerly, and generally at much higher rates than under former contracts of the same nature. The average (median) subscription rate for the combined Blue Cross-Blue Shield coverage under the plans offered was \$146 annually for a single person.

None of the coverages provides complete protection against hospital, surgical, and in-hospital medical service costs. As regards hospital coverage, the contracts offered have deductibles or require co-insurance payments; some provide a room allowance substantially below the cost of semiprivate accommodations; all have limits on the days of hospital care.

Almost half of the contracts do not cover nursing-home care and those that do, cover only a small part of the total nursing-home expenses. The contracts do not cover physicians' visits in the office or home. They provide no coverage of dental services, drugs outside of the hospital, eyeglasses, appliances, or special nursing in the hospital.

The author of this analysis states that even the best of the combined Blue Cross-Blue Shield plans offered would cover no more than 40 to 50 percent of the average total medical costs of aged persons, and many would cover a smaller proportion. The subscription rates must be evaluated in this light, he says. An annual charge of \$150 or \$180 for a single person and \$300 or \$360 for a couple--the general range of rates for the comparatively broader benefit packages--is substantial in relation to the incomes of most aged persons.¹

The Blues in California

Blue Cross-Blue Shield hospital nongroup initial enrollment contracts offered to older people in California during the fall of 1962 and early 1963 provided 70 days of hospital care per year for general illness, 30 days for mental illness, 30 days for tuberculosis care, at \$18 per day or 80 percent of costs (whichever was greater); provided for nursing home benefits and

1. U.S. Department of Health, Education and Welfare. Social Security Administration. Division of Research and Statistics, Blue Cross-Blue Shield Nongroup Coverage for Older People; by Louis S. Reed. 36p plus tables (Research Report No. 4, 1963) p. 7.

visiting nurse benefits; paid a limited amount for ancillary hospital services; and allowed 31 days of physician's services in the hospital.

Two days of nursing home care was allowed for every unused day of hospital care, with the daily benefit amount not to exceed 80 percent of the charge up to \$8 per day (or a maximum of \$6.40) to participating nursing homes. The nursing home benefit was available only after discharge from the hospital and only within 14 days of discharge, and not until the member was enrolled for six months.

Visiting nurse benefits were allowed at the rate of two visits for each day of unused hospital care at \$3 a visit, after six months' enrollment.

During the enrollment period no health examination was necessary, but no benefit was available for a pre-existing condition until after six months' enrollment. Service benefits under these contracts were available only to single persons or a couple with income to \$6,000 a year.

Cost per year was \$189.60 for a single person and \$379.20 for a couple.

WHO ARE THE AGED?

Can our aged citizens afford to pay for all but the most inadequate private insurance? What's their income, where does it come from, what are their assets?

Their Age and Marital Condition

First of all, persons 65 years of age and over, number nearly 18 million, more than 9 percent of the population. This proportion is expected to increase only slightly in the next decade. Nevertheless, by 1970 there will be 20 million persons aged 65 and over. On the average they will be older than the present age group, with the highest relative increases in the oldest age brackets--75 and over.

Of the 17.5 million aged, nearly 1.5 million live on farms; more than 16 million in urban centers. More than 12.5 million receive Social Security benefits. About 2.3 million are war veterans. Some 10,000 are over 100 years old.

About half of all aged persons are married and living with a spouse. But nearly forty percent are widowed and the majority of these are women, almost half of them aged 75 and over. Almost one out of four elderly persons lives alone or in a lodging house. One out of 25 is in an institution.

Their Income in 1962

The Department of Health, Education, and Welfare estimates that half the eight million older single persons had income of less than \$1,130 in 1962. Forty-four percent had incomes of less than \$1,000 in that year.

Of the five million older couples, one half had total income less than \$2,875 in 1962. Nearly 3 out of 10 had income under \$2,000.

Benefits under OASDI were almost the sole source of cash income for almost one fifth of the couples and more than one third of the single persons. Old age assistance was an important supplementary source of income for one in 12 of the married couples and one in 6 of the single persons. The proportion receiving assistance was almost three times as large for nonbeneficiaries as for beneficiaries of old age insurance.

Earnings still account for a good share of the income of the total aged population, especially those in the younger group. Earnings in 1962 accounted for 32 percent of the total money income of all persons aged 65 and over and their spouses. Old age insurance accounted for 30 percent and other public retirement programs 10 percent. Interest, rent, and dividends were 15 percent of total aggregate income; public assistance 5 percent; private pensions 3 percent; and other sources (including 1 percent from relatives) 4 percent.

The following table compares the source of income for married couples and for single persons, aged 65 and more:¹

<u>Source of Income</u>	<u>Married Couples</u>	<u>Single Persons</u>
Number reporting (000)	5,443	8,612
Percent with income from: ²		
Earnings	55	24
OASDI	79	62
Other public pensions	12	7
Private group pensions	16	5
Veterans benefits	14	8
Interest, dividends, rents	63	48
Private annuities	4	3
Unemployment insurance	3	1
Public assistance	8	17
Contributions by relatives	3	5

1. Lenore A. Epstein, "Income of the Aged in 1962," Social Security Bulletin 27, March 1964, p. 6
2. Percentages add up to more than 100 because total income is frequently from several sources.

The receipt of public assistance is definitely related to age. In October 1962, for example, public assistance payments were being made to 6.3 percent of the persons 65-69 years of age; 11.0 percent of those in the 70-74 group; 17.9 percent of the persons aged 75-79; 23.3 percent of those aged 80-84; and 30.1 percent of the persons aged 85 and over.¹ Almost 40 percent of the persons receiving old age assistance are also receiving old age insurance. In the older groups are persons who were never covered by Social Security or who were covered so short a time that their benefits are minimal.

Assets

What assets do older people have besides income? They are somewhat more likely than younger persons to have some savings, but in most cases these are not readily convertible to cash. The 1960 survey of consumer finances, conducted by the University of Michigan Survey Research Center for the Federal Reserve Board, found among spending units with heads aged 65 and over, 30 percent had no liquid assets, and 20 percent had liquid assets valued at less than \$1,000.

Equity in a home is by far the most common asset of the aged. Ownership of a home was reported by 64 percent of the older spending-unit heads, and more than 80 percent were clear of mortgage debt. More than half the home owners reported the value of a home as less than \$10,000.

Health Conditions

Health problems are a major concern of the aged population since advancing age is accompanied by a decline in health and physical capacity. They utilize health facilities and medical services more than younger persons. They use a greater volume of physicians' services and are admitted to hospitals more often and stay longer. They are primary users of nursing home and other long-term care facilities and receive a greater amount of home care, part of which is provided by nurses. They need and use more drugs. As a group, they are prone to chronic illness and as a result are likely to be partially or completely limited in activity.

Older persons are twice as likely as those under 65 to be chronically ill. Data from the National Health Survey show that about four out of five have one or more chronic conditions, as contrasted with two out of five younger persons.

1. "Age Variations in Public Assistance Recipients," Welfare in Review 2: 19, June 1964.

The incidence of chronic illness increases with age; the number of persons with one or more chronic conditions increases from 74 out of 100 persons in the age group 65-74 to 84 out of every 100 persons aged 75 and over.¹

Similarly the extent of disability due to chronic illness increases with age. Over half the aged persons with one or more chronic conditions have some limitation of activity, whereas among younger persons with chronic illness, only one out of five has any limitation of activity. Among persons aged 75 or over with some chronic condition, partial or major limitation of activity occurs in two out of three cases.

Although chronic illness is the major health problem of the aged, the incidence of acute illness among older persons, particularly respiratory conditions, is not insignificant. In many cases, acute illnesses may be the immediate cause of death for older persons with chronic conditions. Accidents, too, cause a considerable amount of disability. About one out of every four aged persons was injured in 1959, about two thirds of them in accidents occurring in the home.

Persons 65 years of age and over require two and a half times as much hospital care as do people under 65. Thus the annual hospitalization rate per 1,000 people was 2,800 days for the aged but 900 days for younger people.

Moreover, hospitalization is more frequent. Ninety percent of all older persons are hospitalized at least once, while two out of three are hospitalized two or more times. The average older person is incapacitated five weeks of the year and spends two of these in bed.

THE GREAT DEBATE

While medical advances have prolonged the life span, health problems among the elderly are often complex and their treatment costly. Even when older people are relatively prosperous, they find it difficult to pay for their medical expenses. The United States is the only industrial nation in the world that has no public health insurance system. Perhaps the rapid growth of sickness insurance in the private sector of the economy--brought about chiefly as a fringe benefit in employee-employer agreements--will eventually take care of the working population in this country. The unskilled workers who are not covered by agreements,

1. The National Health Survey data on health conditions of the aged are based on household interviews and exclude persons in nursing homes, homes for the aged, and long stay hospitals, as well as persons whose illness resulted in death during the survey year. For these reasons, the data present a more favorable picture of the health situation than is actually the case.

the unemployed, and the nonworkers like the aged, however, still have a problem that must be solved.

As we have seen, the debate about the best approach to this problem has been raging for many years.

The AMA Opposition

The most formidable opponent of providing medical care to the aged through Social Security has been the American Medical Association. 'AMA to Finance 'War' Against U.S. Medical Care,' the San Francisco Chronicle declared June 29, 1961:

The leaders of organized medicine voted a multimillion-dollar dues increase, created a special public relations high command within the AMA and urged doctors to lobby directly with their Congressmen starting right now.

'Wives of Doctors Battle Care Plan--Join AMA Fight on Social Security Help for the Aged,' the New York Times reported March 18, 1962:

Mrs. Burton Kintner of Elkhart, Indiana, is one of hundreds of doctors' wives in Indiana who wrote letters to their Congressmen this week.

The burden of their message was that passage of the Administration King-Anderson bill...would be a blow to the private practice of medicine.

Mrs. Kintner did not stop with letter writing....Next month she will begin ringing doorbells to ask friends and neighbors to vote against Congressmen who favor what she and the American Medical Association consider to be a step toward "socialized medicine."

Mrs. Kintner's efforts are being duplicated by physicians and wives throughout the country. The campaign has been organized by the new political-action arm of the AMA....It plans to pour time and money into a concerted drive to defeat proponents of the King-Anderson bill in 1962.

The AMA has consistently opposed any extension of Social Security always using the same kind of argument. Because of AMA opposition, the proposal to incorporate disability insurance in the Social Security Act remained in committee for a good many years. When the provision finally reached Congress in 1952, the AMA House of Delegates criticized the Truman Administration for using the bill as "a flagrant attempt to railroad socialized medicine into existence." According to the San Francisco Chronicle of June 13, 1952, the bill was said to be an entering wedge for socialized medicine by providing benefits for those insured workers who became permanently and totally disabled.

Leading officials of the AMA have frequently opposed many measures as "socialistic" that are today accepted practices and programs. They called elimination of the means test in the crippled children's programs a "socialistic" regulation. Federal grants for maternal and child welfare programs were decried as "unsound policy, wasteful and extravagant, unproductive of results and tending to promote communism."

Although there is no record of the House of Delegates opposing the Social Security Act itself, statements by responsible officials before congressional committees and in the official journal leave no doubt about the organization's opposition. Dr. Morris Fishbein, editor of the Journal, wrote in the December 30, 1939 issue:

All forms of security, compulsory security, even against old age and unemployment, represent a beginning invasion by the state into the personal life of the individual, represent a taking away of individual responsibility, a weakening of the national caliber, a definite step toward either communism or totalitarianism.

Again in 1949 a resolution adopted by the House of Delegates, and sent to all members of Congress, opposed extension of Social Security to physicians and surgeons, saying in part:

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 governmental control over the lives and fortunes of the people.

Today, the AMA supports voluntary health insurance, believing that it can solve the problem of medical care for the aged. In December 1949, however, the Journal of the American Hospital Association said editorially:

It is a sad fact that through the Nineteen Thirties and the early Nineteen Forties, the Medical Association did not believe in voluntary sickness insurance and did almost everything possible to prevent its development.

The last paragraph is quoted to show that even the American Medical Association can change. Indeed, there is a growing number of physicians in the organization who are beginning to voice strong opposition to official policies regarding Social Security.

The Weakness of Voluntary Insurance

A frequent point against Medicare is that it is not necessary. The advance of insurance is one facet of this argument. What kind of insurance do the aged have?

At the end of 1962 slightly more than half the persons 65 and over had some type of sickness insurance, chiefly hospitalization. The proportion of persons with insurance declined with age: from 59 percent at age 65-72 to 44 percent at 73 and over.

Of the total aged persons discharged from short stay hospitals during 1958-60, 49 percent had no part of the hospital paid by insurance, 9 percent had less than half the bill paid, and only 30 percent had three-fourths or more paid. Comparable data for younger persons showed 30 percent with no part of the bill paid, and 54 percent with three-fourths or more paid.

The overall achievements of voluntary health insurance have been spectacular. It has made better medical care available for more people in the U.S.A. than ever before. About two-thirds of our population now have some form of health insurance --a remarkable record for a private program.

One major factor that is frequently overlooked by advocates of voluntary health insurance for the aged is that group insurance, for those who have it, usually ends when the individual leaves the group--whether because he is unemployed, retires, or moves. The very individuals who are economically most likely to need sickness benefits in their old age, moreover, are the least likely to take out insurance during their working years because they are in low-income, low-education, unskilled groups. As a result they must depend on services provided by tax funds during their later years. (The Social Security Administration has estimated that the principal reason for one third of the applications for old age assistance is exhaustion of funds because of medical expense.) People in the higher socio-economic groups who can afford adequate insurance therefore pay not only for their own insurance but, through taxes, for the medical care of persons with no insurance.

One of the problems facing further extension of health insurance to the aged is that 90 percent have no connection with the labor market. In a period when income is the lowest in their adult lives, it is difficult for them to pay insurance premiums.

Insurance companies, to be solvent, must charge a price that is commensurate with the large costs involved. Thus a great proportion of the old are entirely excluded or their coverage is most inadequate. The commercial carriers have been in a position to offer lower premiums because they pick off the better risks through experience rating. This is in contrast to the nonprofit plans like Blue Cross-Blue Shield or prepaid comprehensive group plans, which usually use community rating.

Higher costs are now leading nonprofit plans to abandon community rating, thus discriminating against the aged, the chronically ill, and other "poor risks." Members of such groups who are already covered may be priced out of the market by rising rates. If the community rate must be raised because of the high cost of covering the aged, moreover, many younger people will no longer afford insurance. If the voluntary programs were taken out of the high-cost area of covering the aged, they might do a better job of covering the under-65 group at a lower rate. It might even improve the chances for greater profit to the commercial carriers.

An article in Business Week (December 5, 1964) pointed out that private plans may fare better with Medicare than they do now. Soaring costs have kept many plans in the red and put some flatly in trouble.

Continental Casualty, which aims for a 1 to 3 percent profit on its Golden-65 program lost money on it in 1963 and had to raise premiums as much as 36 percent....Nonprofit New York-65 is some \$3 million in the hole after two years in business and has asked for a rate increase....¹ Connecticut-65 won one rate hike late in 1963 but now, with almost no improvement in its claims experience, is asking for another. Massachusetts-65... now expects to ask for higher premiums sometime next year....

1. New York State Insurance Superintendent granted a rate increase averaging 21 percent, beginning February 1, 1965.

Kerr-Mills Medical Assistance for the Aged

This program now falls far short of meeting the needs of the aged. The range and standard of benefits are left to the states to determine, and benefits are limited to low-income persons who can meet a state-determined means test. Moreover, many aged persons who have managed to live independently all their lives are horrified at the idea of being investigated by a welfare worker. The mere idea of applying for charity can be a psychic shock.

A subcommittee of the Senate Special Committee on Aging reported in 1963 that evidence available after three years of Kerr-Mills operations "demonstrated that the congressional intent has not and will not be realized."

In its report, "Medical Assistance for the Aged, The Kerr-Mills Program, 1960-1963," the subcommittee said: "We find the Kerr-Mills Program of medical assistance for the aged still suffers from these major defects:

1. After three years it is still not a national program and there is no reason to expect that it will become one in the foreseeable future. Although all 50 state legislatures have met since this program was enacted into law three years ago, only 28 states and four other jurisdictions now have the program in operation.
2. Stringent eligibility tests, "lien type" recovery provisions and responsible relative provisions have severely limited participation in those jurisdictions where the program

is in operation. In July of 1963, only 148,000 people received MAA assistance or less than 1 percent of the nation's older citizens.

3. The duration, levels and types of benefits vary widely from state to state. Except for those four states having comprehensive programs (Hawaii, Massachusetts, New York and North Dakota) benefits are nominal, nonexistent or inadequate.
4. Administrative costs of MAA remain too high in most jurisdictions. In Tennessee, for example, administrative costs totaled 59 percent, while in four states, they exceeded 25 percent of benefits.
5. The distribution of federal matching funds under MAA has been grossly disproportionate, with a few wealthy states best able to finance their phase of the program getting the lion's share of the funds. Five states, California, New York, Massachusetts, Michigan and Pennsylvania, for example, received 88 percent of all federal MAA funds distributed from the start of the program through December 31, 1962, although those five states have only 32 percent of the nation's elderly people. New York alone, with 10 percent of the nation's elderly, received 42 percent of this total.
6. The congressional intent to extend assistance to a new type of medically indigent person through MAA has been frustrated by the practice of several states in transferring nearly 100,000 persons already on other welfare programs, mainly OAA, to the Kerr-Mills program. The states have done this to take advantage of the higher matching grants provisions of Kerr-Mills, saving millions of dollars in state costs, but diverting money meant for other purposes.
7. The welfare aspect of the Kerr-Mills MAA program, including cumbersome investigations of eligibility, plus the requirement in most states that resources of an older person must be depleted to a point of near-dependency, have further reduced participation.

The Social Insurance Advocate

The chief value of the social insurance approach to medical care for the aged is that it enables a person to contribute over his entire lifetime of productive labor to a paid-up health policy for his retirement. This is the same principle that underlay the enactment of old age and survivors insurance and then disability insurance. Under these programs, both employees and employers contribute over the working years to provide certain benefits to the insured individual who can no longer work.

The old age insurance program established in 1935 was a relatively simple one, designed primarily to pay old age benefits to eligible workers when they retired at or after age 65. A national system was adopted by Congress, rather than a state system, because the actuaries were convinced that the great mobility of American workers made old age insurance on a state basis unsound. Benefits for the survivors of deceased insured workers were added in 1939.

In 1956, under the Eisenhower Administration, monthly benefits were made available to disabled insured workers aged 50 to 65. Disability was defined very strictly, however. In order to be considered disabled, a worker must be unable to engage in any substantial activity because of a medically determinable physical or mental impairment which is expected to result in death or to be of long-continued and indefinite duration. In 1960 disability benefits were extended to insured workers irrespective of age.

Four states--California, New Jersey, New York, and Rhode Island--and the Railroad Retirement Act now provide temporary disability insurance to covered workers. The disability insurance program is coordinated with unemployment insurance in all but New York, where it is a separate program.

The Question of Compulsion

Attack has been leveled on the compulsory aspect of Medicare as well as of the existing social insurance programs. Despite the fact that compulsion is embodied in countless laws in order to protect our society, the compulsory feature is attacked as un-American. Persons favoring social insurance can see nothing un-American in the principle that people shall be compelled to save so that they do not become a burden on their families and the local charities, so that they can meet the needs of their old age with the self-respect which comes from being entitled to benefits because they have paid for them out of their own earnings.

Congress applied the principle of compulsion to old age insurance because it concluded that if the system were made voluntary many people would not contribute to a pension fund over their working lifetime, and in the end the taxpayer would have to take care of them through public assistance. It was held to be more in the interest of society to require everyone during their working years to pay a small premium that would protect them and their families against the insecurities of old age and death.

The principle of compulsion was not new with the 74th Congress. A law requiring prepaid hospital care for seamen was passed under the administration of John Adams, second President of the United States. Compulsory contributions of 20 cents a month (later increased to 40 cents) from the seamen were used to build hospitals and pay physicians for their medical care.

Equity of Including Noncontributors

Another feature of Medicare that has been attacked is that during the first years benefits would be received by persons who have not contributed because the system did not exist when they were earning a living. As younger people would be buying their own insurance for later years, however, it is difficult to see how anybody would lose. Those who are already too old to have been contributing to an insurance plan would benefit of course. Eventually everyone receiving benefits would have paid his share through Social Security taxes during his working years.

Seymour Harris, the Harvard economist, points out that this criticism has also been leveled against the whole Social Security program but, in his opinion, it is proper to provide the present aged with benefits because resultant losses to the Social Security fund can be recouped later. "With per capita incomes doubling about every 20 years," Dr. Harris says, "The costs of the recovery of X dollars diverted to the present old would be reduced as average dollar incomes continued to rise."¹

Cost of the Program

One argument against Medicare that has some merit is that of underestimated costs. The administration estimate is a current cost of 1/2 of 1 percent of payroll, or about one billion dollars a year, while the private insurance carriers estimate the cost at twice that sum, and as much as four billion dollars by 1983. The private insurance figure is obtained by increasing the hospital costs per person per year by about 20 percent (for example \$96 in 1963 for those aged 65-69 and \$117 in 1983), and a rise of eligible OASDI population from 14.25 million in 1962 to 24 million in 1983.

This calculation does not take into account, however, that this rise in costs would be equal to a smaller percentage of total payroll in 1983 than in 1963.

1. Seymour Harris, The Economics of American Medicine The Macmillan Company: New York 1964 p. 23

If total employee compensation rises as much in the next 20 years as it did in the past 20, Professor Harris declares, then the percentage of hospital costs, as estimated by the insurance actuaries, to employee compensation, would be 14 percent less in 1983 than in 1963. He bases this improvement on the assumption that hospital costs would rise only 20 percent in the 20 years, an increase reflecting a tendency of hospital costs to rise more than wages.¹ He made no allowance for an increase of benefits associated with higher prices and wage rates.

It should be pointed out in connection with costs of Medicare that expenditures under the Kerr-Mills program for fiscal 1963-64 amounted to about 460 million dollars and will undoubtedly increase with time. A member of the House Ways and Means Committee, who had voted for Kerr-Mills in opposition to the Social Security approach, before he retired called Kerr-Mills "the most socialistic legislation ever to pass Congress." He contended that a self-financed federal insurance system must be devised to replace it before it becomes "a bottomless pit" for general Treasury funds.²

As to costs, it should also be pointed out that a governmental insurance plan would be much cheaper than the voluntary plans since covering all people under the existing Social Security program would make unnecessary the acquisition and selling costs that voluntary insurance has to pay for. The government would have no additional cost in collecting these premiums because they would be added into the regular Social Security schedule.

Other Criticism of Medicare

Undoubtedly the major reason for failure to pass the King-Anderson bill has been the opposition of organized medicine. But the 1964 version of the bill did not win the enthusiastic support of those seeking larger government intervention. The benefits were largely restricted to costly inpatient services. Lack of provision for noninstitutional physicians' services overlooked the importance of preventive medicine, particularly for chronic illness. The omission of payments for expensive medicines--a great burden to most of our aged population--was also a shortcoming. The deletion of physicians' services was of course a compromise designed to soften AMA opposition, a compromise that did not work.

1. Harris, op.cit. p. 349.

2. Representative Burr P. Harrison, Democrat, Virginia. Quoted in the New York Times, April 15, 1962.

The Case for Medicare

Despite criticism from all sources, provision of medical services to elderly persons through the social insurance mechanism seems the most logical and efficient approach to the problem. Only by the wildest stretch of the imagination could it be termed socialistic--certainly no more socialistic than compulsory spreading through social insurance of the costs of unemployment, old age and death; and, for that matter, no more socialistic than free schools, special tariffs, price supports, cost-plus government contracts, or enforcement by government of private fair-trade agreements.

Provision of medical services to the aged through social insurance, moreover, would relieve the private sector of the economy of a program which is certain to end in substantial losses if any attempt is made to provide adequate service. The difficulties of the commercial carriers have already been mentioned. A number of Blue Cross plans are also paying out a great deal more than they take in on services to the aged, necessitating a rise in their community rates.

Blue Cross and the American Hospital Association have both admitted that government assistance is necessary to implement their plans for aged care. In presenting these plans to the public in January 1962, the policy adopted by the member plans said:¹

We recognize that many retired aged persons will need government assistance to enable them to purchase this health protection through the voluntary nonprofit prepayment system.

Blue Cross is now fighting a losing battle to retain its share of the hospital insurance market, according to the Wall Street Journal.²

Blue Cross has enjoyed wide support from medical and public groups, because it protected nearly everyone, bad risk as well as good, at a single community rate....Younger and healthier people, in effect, thus subsidized insurance for those more prone to illness.

But now the Blue plans not only are raising rates sharply but also are restricting coverage and seeking to model their insurance more along lines of profit-oriented commercial firms.

1. Blue Cross Association, American Hospital Association, Financing Health Care of the Aged, Pt. 2 (1962), p. 29.

2. Wall Street Journal, June 5, 1964, p. 1.

"If such trends continue," the Wall Street Journal declares, "many observers worry that Blue Cross and Blue Shield no longer will meet the health insurance needs of vast numbers of people with modest incomes."

"Either Blue Cross is strengthened or take the problem to the Government," the newspaper quotes Walter J. McNerney, president of the National Blue Cross Association, as saying.

Hospital costs have been mounting rapidly and will continue to rise. Social insurance is the only mechanism that can effectively spread the risk of illness and the cost of high hospital bills. First, because it covers the entire working population; and thereby balances losses at a cost per person lower than any private partial program. Second, because it extends over the entire working life of the individual and thereby accumulates enough funds to cover the cost of future hospital care.

The eventual costs of the program may be high, but they are high only when considered by themselves. Looked at in relation to a Gross National Product of more than 615 billion dollars estimated for 1964, they are very small indeed.

THE OUTLOOK FOR MEDICARE

President Johnson's huge majority in the 1964 election has been interpreted as an endorsement of Medicare. His strong stand on provision of health care for the elderly through Social Security augurs favorable action in the 89th Congress. Work on a bill was begun by the House Ways and Means Committee January 27, and Chairman Wilbur D. Mills has set March 15 as the target date for a health care bill. The Administration program for the aged is along the same lines as the King-Anderson bill but financed by a payroll tax which would be placed in a trust fund for health care separated from the OASDI fund.

The benefits provided in the new King-Anderson bill (HR 1 and S 1) are: (1) hospital care up to 60 days in a benefit period, with a deductible amounting to the national average cost of one day of care; (2) 60 days of post-hospital care in a convalescent facility in a benefit period; (3) home health visits (such as visiting nurse) up to 240 in a calendar year; (4) outpatient hospital diagnostic services. A deductible equal to one-half of the hospital deductible would be charged for each 30-day period in which such services are furnished.

The benefit period referred to in (1) and (2) would begin with the first day the patient receives hospital care and end after the close of a 90-day period during which he was not a patient in either a hospital or post-hospital facility. The 90 days need not be consecutive but must fall within a period of not more than 180 consecutive days.

Nonprofit associations of private insurers would be authorized, through exemption from federal and state anti-trust laws, to develop **health** benefit plans covering costs, including those for physicians' services, not met by the government program.

Republicans in Congress are proposing an alternative voluntary program, most of it financed by general revenues instead of a payroll tax. The program would include some physicians' care and drugs as well as hospital and nursing home care. Citizens reaching the age of 65 would be able to purchase Blue Cross-Blue Shield or commercial insurance, paying all or none of the cost, depending on income. Participation would be limited to individuals with an annual income of not more than \$3,000 or couples with an income of \$6,000. Participation would be voluntary for all persons 65 or over not on the old age assistance rolls. All participants would have to pay from \$10 to \$120 a year, according to income. The federal government would pay 50 percent of state administrative costs and 60 to 80 percent of other costs, depending on the state's per capita income. Presumably the various states would have to enact the program, as under the Kerr-Mills legislation.

The program is backed by the American Medical Association, which is still pursuing a determined fight on Medicare through Social Security.

The American public, however, appears to favor Medicare. The Gallup Poll in December 1964 asked the following question of a sample of the nation's adults, including both young and old:

Congress has considered a compulsory medical insurance program covering hospital and nursing home care for the elderly. This medical care program would be financed out of increased Social Security taxes. In general, do you approve or disapprove of this program?

Approval was voiced by 63 percent of the respondents, disapproval by 28 percent, and no opinion by 9 percent.