Old age - Medical care

NO GRAVIS

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MAJOR LEGISLATIVE PROPOSALS FOR FINANCING PERSONAL HEALTH SERVICES FOR THE AGED, 1939-1961

Many and varied proposals have been made over the years for Federal legislation to provide health insurance, to stimulate the spread of voluntary health insurance, or to support State medical care programs. The various proposals which have been made in bills introduced in the Congress since the late 1930's and which relate to the aged are summarized below.

The following discussion of these proposals is not limited to those specifically designed to provide insurance against the cost of hospitalization, or hospital and nursing home care, for the beneficiaries of old-age, survivors, and disability insurance. It is limited, however, to approaches that could be used for this purpose. It omits, therefore, proposals in which the primary basis for selecting the population group is not only unrelated to age but is one which is likely to encompass only a few aged people or a specified limited group of aged persons, such as retired Federal employees. Thus excluded are such proposals as exemptions or credits on Federal income taxes for amounts paid as health insurance premiums, or special programs for farm families or migrant workers, and for temporarily unemployed persons.

Also omitted, although they may affect substantial numbers of aged persons, are proposals related to the public assistance system. The Federal Government has shared in medical care expenditures under the old-age assistance program since its beginning in 1935. At first, it would share only if the payments were included in the monthly payments to the assistance recipient. However, in 1950 Federal sharing in vendor payments to providers of medical services was authorized. Prior to 1956, Federal participation in medical care costs was available only to the extent that such costs fell within the Federal maximum on the monthly assistance payment. In 1956, separate Federal sharing in the State's total expenditures for medical vendor payments, up to a stated maximum per recipient, was instituted. In 1958, the basis of Federal sharing in State expenditures was changed to include the provision for medical care costs with other items in assistance payments within a new averaging matching formula. The Social Security Amendments of 1960, in addition to authorizing the new medical assistance for the aged program, provided for increased Federal sharing in vendor payments in order to assist the States in improving or establishing medical care programs for old-age assistance recipients. The maximum on this Federal sharing in vendor payments was increased in 1961.

Some proposals express their coverage in terms of "low income families" or "medically indigent" persons wherever found in the total population. Most aged persons could come within the scope of such programs if broadly defined, so the proposals are included. The discussion does not include, however, the medical assistance for the aged program enacted by the 86th Congress, since this is an operating program rather than a proposal. Under the medical assistance for the aged program, States can receive Federal funds to help pay the costs of medical services for persons aged 65 and over who are not recipients of public assistance but whose income and resources are determined by the State to be insufficient to meet such costs. States may choose among a broad scope of medical services, but they must include both institutional and noninstitutional services.

Also included are those proposals specifically designed for all aged persons or for old-age, survivors, and disability insurance beneficiaries and those that have such comprehensive coverage that these groups are included.

A. Health Insurance for OASDI Beneficiaries

The first bill embodying a proposal for hospitalization benefits for beneficiaries under Title II of the Social Security Act was introduced into Congress in 1952. With minor variations, similar proposals have been introduced in each of the Congresses since then. However, as interest in health care for the aged increased, the variations between the proposals for financing health insurance through the old-age, survivors, and disability insurance system became more significant and bills incorporating modifications from those introduced earlier became more numerous.

1. Proposals Before the 82nd Through 85th Congress

The essential features of the proposals advanced between 1952 and 1957 are as follows: Persons eligible for insurance benefits, whether currently drawing benefits or not, would be insured for up to 60 days in a year for semiprivate room care in short-term hospitals. The hospital benefit would be a service benefit and would include those services, drugs and supplies which the hospital customarily furnishes its bed patients. The Forand bill (H.R. 9467) in 1957 also proposed to pay the costs of skilled nursing home care for patients transferred from the hospital (up to a total period, including the hospital stay, of not more than 120 days in a year) and of surgical services provided in a hospital (or, in case of emergency or minor surgery, in the outpatient department of a hospital or in a doctor's office).

Hospitals would be paid on a cost-incurred basis or on a reasonably equivalent basis. The methods of paying the hospital varied with the administrative arrangements suggested in the various bills. Under the early proposals where the Federal Government was to use State agencies as its agent, the State agency would either pay hospitals within the State for the care rendered eligible persons or would utilize private nonprofit health insurance plans to negotiate with and pay the hospitals. Under more recent proposals national administration has been proposed, with the Secretary of HEW given authority to negotiate agreements directly with hospitals or to use the services of such agencies as Blue Cross.

Benefits would be financed through the social security payroll tax paid compulsorily by covered employees, their employers, and the self-employed. The amount of the additional payroll tax would, of course, depend on the exact benefits proposed. The level premium cost of the Forand proposal for hospitalization, nursing home and surgical benefits was first estimated at one-half of 1 percent of covered payrolls, and taxes were set at that level.

The earliest proposals contemplated that the program would utilize the States, and preferably the State public health agencies, as administrative agents. Only in a State which did not effect an agreement to administer the program would the overall administrative functions be performed federally. (Necessary regulations relating to the program in general and determinations as to an individual's insured status would, of course, be made at the Federal level). As a result of the post-1952 development of national Blue Cross contracts and the implementation of Medicare, the later proposals contemplated national administration of the hospitalization benefits.

The following bills have embodied this proposal:

Year	Congress	Session	Bill Number	Sponsor
1952.....	82d.....	2d.....	S.3001	Murray.
1952.....	82d.....	2d.....	H.R. 7484.....	Dingell.
1952.....	82d.....	2d.....	H.R. 7485.....	Celler.
1953.....	83d.....	1st.....	H.R. 8.....	Dingell.
1953.....	83d.....	1st.....	H.R. 390.....	Celler
1953.....	83d.....	1st.....	S. 1966 1/....	Murray, Humphrey, and Lehman.
1955.....	84th....	1st.....	H.R. 638.....	Celler.
1955.....	84th....	1st.....	H.R. 2384.....	Dingell.
1956.....	84th....	2d.....	H.R. 9868.....	Dingell.
1956.....	84th....	2d.....	H.R. 9980.....	Metcalf.
1957.....	85th....	1st.....	H.R. 1092.....	Celler.
1957.....	85th....	1st.....	H.R. 4765.....	Dingell.
1957.....	85th....	1st.....	H.R. 9448.....	Roberts.
1957.....	85th....	1st.....	H.R. 9467 2/..	Forand

1/ Includes provisions permitting States to extend hospitalization coverage to noninsured aged persons.

2/ Includes nursing home benefits and surgery.

Hearings before the House Committee on Ways and Means on all titles of the Social Security Act, in June 1958, included testimony on H.R. 9467.

2. Bills Introduced During the 86th Congress

The bills introduced during the first session of the 86th Congress followed much the same pattern as those introduced in earlier Congresses. However, those introduced during the 2nd session show a wider variety in both coverage and in benefits provided.

Essentially, the tendency in the later proposals was to concentrate upon the aged or upon a retired or presumed retired group of the aged old-age and survivors insurance beneficiaries rather than all beneficiaries. Indeed, as the issue came to be viewed more explicitly as a problem of the aged, several bills provided for the extension of coverage to all retired aged, irrespective of whether they were eligible for old-age and survivors insurance benefits. Under these proposals, benefits for old-age and survivors insurance eligibles were to be financed by an increase in the payroll tax, while those for persons not eligible for old-age and survivors insurance were to be paid for from general revenues.

Under all proposals the basic benefit was hospitalization, with individual variations in the duration of the benefit and the use of a deductible which must be paid by the beneficiary. Aside from this base benefit, the proposals varied in their inclusion of skilled nursing home services, outpatient diagnostic services, home health services, physicians' services, and assistance in the purchase of drugs.

The unifying feature of all bills was that benefits for old-age, survivors, and disability insurance beneficiaries were to be financed through an increase in the payroll tax. All proposals called for Federal administration and administrative responsibility; some provided for a delegation of certain administrative functions to either State agencies or to voluntary, nonprofit health insurance plans.

The following bills introduced during the 86th Congress would provide health benefits for certain old-age, survivors, and disability insurance beneficiaries:

Bill No.	Sponsors	Persons Covered	Benefits
H.R. 4700 H.R. 10816 H.R. 11093 S. 881 1/	Forand Harmon Gilbert Morse	All OASDI eligibles, except disability insurance beneficiaries	a) Hospitalization up to 60 days; b) Skilled nursing home services following and associated with hospitalization up to 120 days less days of hospitalization; c) Surgical services
S. 1151 2/	Humphrey	Same as H.R. 4700	Same as H.R. 4700, except omits surgical services
H.R. 412	Roberts	All OASDI eligibles	Hospitalization up to 60 days.
S. 2915 H.R. 12255	Kennedy and Hart Gallagher	All OASDI eligibles	a) Hospitalization up to 90 days; b) Skilled nursing home care (following hospitalization), and c) Home nursing services (following hospital or nursing home stay), with overall 120 day combined care limit on a, b, & c: 1 day of a, 1½ days of b, or 2 days of c, equals 1 combined care day; d) Diagnostic outpatient hospital services.
H.R. 12418	Metcalf	a) OASI eligibles aged 68 or over b) All noneligibles 68 or over (except railroad retirement or Federal civil service retirement eligibles	a) Hospitalization up to 365 days, with initial 3 day deductible, and additional 3 day deductible after 24 days b) Skilled nursing home care (after and associated with hospitalization) up to 180 days c) Visiting nurse services up to 365 days d) For OASI eligibles, $4 a month additional cash benefit if elected in lieu of a, b, and c, above.
Amendment 6-30-60-B to H.R. 12580	Anderson, Humphrey, and McCarthy	OASI eligibles aged 68 or over	a) Hospitalization up to 365 days, with $75 initial deductible and $75 additional deductible after 24 days, b) Skilled nursing home care (after hospitalization) up to 180 days; c) Visiting nurse services up to 365 visits.

Bill No.	Sponsors	Persons Covered	Benefits
Amendment 8-17-60A to H.R. 12580	Anderson, Kennedy, Humphrey, Douglas, Gore, McNamara, McCarthy, Hartke, Randolph, and Engle	OASI eligibles aged 68 and over	a) Hospitalization up to 120 days after an initial $75 deductible; b) Skilled nursing home services (after hospitalization) up to 240 days; c) Home health services up to 365 visits; d) Outpatient hospital diagnostic services.
S. 3503 3/	McNamara, Kennedy, Clark, Randolph, Symington, Humphrey, Williams of New Jersey, Magnuson, McGee, Young of Ohio, Douglas, Gruening, Long of Hawaii, Murray, Hart, Morse, Hennings, Jackson, Pastore, McCarthy, Bartlett, Engle, Green, and Mansfield	a) Retired OASI eligibles aged 65 (62 for women) and over. Retired when earnings less than $2,000 in preceding year or $100 in each of preceding 3 months, or if aged 72 or over. b) All other aged persons meeting same requirements as OASI eligibles, except railroad retirement and Federal civil service retirement eligibles.	a) Hospitalization up to 90 days; b) Skilled nursing home services up to 180 days; and c) Home health services up to 240 days, with overall limit of 90 service units, and 1 day of a, 2 of b, or 2 1/3 of c equal 1 service unit; d) Diagnostic outpatient services, and e) Very expensive prescribed drugs, per Secretary's regulations.
S. 3763	Gore and Yarborough	Same as S. 3503	a) Hospitalization up to 60 days; b) Skilled nursing service up to 120 days; c) Home health services up to 180 days; and d) Medical services up to 25 home or

Bill No.	Sponsors	Persons Covered	Benefits
			office visits, with an overall limit of 60 service units, and with 1 day of a, 2 of b, 3 of c, or 2 home or 4 office visits equal to 1 service unit. e) Surgical services; f) Diagnostic outpatient services, and g) Specified prescribed drugs, per Secretary's regulations.

1/ Amendment 6-27-60-F to H.R. 12580 is identical.
2/ Amendment 6-28-60-G to H.R. 12580 is identical
3/ Amendment 6-24-60-C to H.R. 12580 is similar.

Hearings were held on H.R. 4700 by the Committee on Ways and Means in July 1959. Medical care for the aged also was the primary issue discussed during hearings before the Senate Committee on Finance in June 1960, on the Social Security Amendments of 1960 (H.R. 12580), which provided for the medical assistance for the aged program and for increased Federal participation in medical vendor payments under the old-age assistance program. Likewise, medical care for the aged was a major element in the hearings before the Senate Subcommittee on Problems of the Aged and Aging throughout the session. Hearings specifically related to health needs of the aged and aging were held in April 1960.

3. Proposals Introduced During the 87th Congress, 1st Session

During the first session of the 87th Congress, the primary new measure introduced was the Administration sponsored King-Anderson Bill, under which certain hospitalization, skilled nursing home, home health, and outpatient hospital diagnostic benefits would be provided for persons entitled to old-age and survivors insurance or railroad retirement benefits and aged 65 or over. The identical bills which were introduced are as follows:

Bill No.	Sponsors
S. 909	Anderson, Douglas, Hartke, McCarthy, Humphrey, Jackson, Long of Hawaii, Randolph, Engle, Magnuson, Pell, Burdick, Neuberger, Morse, Long of Missouri, Moss, and Pastore
H.R. 4222	King
H.R. 4309	Dingell
H.R. 4313	Karsten
H.R. 4314	Machrowicz
H.R. 4315	Green
H.R. 4316	Ullman
H.R. 4447	McFall
H.R. 4534	Pucinski
H.R. 4921	O'Neill
H.R. 7793	Santangelo

Several proposals from earlier Congresses were resubmitted. The following bills, identical to the Forand Bill (H.R. 4700 in the 86th Congress) were introduced:

Bill No.	Sponsor
H.R. 94	Holland
H.R. 676	Gilbert
H.R. 1765	Dulski
H.R. 4168	St. Germain

H.R. 2762, introduced by Representative Gilbert, provides for the same benefits as did the Forand Bill, but extends the scope of those eligible for benefits to encompass all persons eligible for old-age, survivors, and disability insurance benefits, including persons eligible for disability insurance benefits.

The McNamara Bill from the 86th Congress was reintroduced with minor changes in both the Senate and the House of Representatives, as follows:

Bill No.	Sponsor
S. 65	McNamara
H.R. 2407	Dingell
H.R. 2518	Rabaut

Representative Roberts reintroduced, as H.R. 2443, a proposal for hospitalization benefits for all persons eligible for old-age, survivors and disability insurance benefits identical to H.R. 412 which he had introduced during the 86th Congress. The bill proposed during the 86th Congress by the then-Senator Kennedy (S. 2915) was reintroduced as H.R. 195 by Representative Ashley.

Representatives Kowalski and Halpern introduced bills (H.R. 3448 and H.R. 4111 respectively) which would extend hospitalization, skilled nursing home, and surgical benefits identical with those in the Forand bill (H.R. 4700, 86th Congress) to aged persons. In addition, under H.R. 4111 diagnostic outpatient services would be provided. In essence, these bills would provide for extending health insurance benefits to all persons entitled to old-age, survivors and disability insurance benefits and to all persons who would be entitled if their earnings prior to January 1, 1962 from railroad or Federal civil service employment were counted as covered earnings, and automatically, to all persons attaining retirement age (65 for men, 62 for women when bills were introduced), before January 1, 1964. For health insurance benefits under the old-age, survivors and disability insurance program for future beneficiaries, there would be a new test for insured status, with a person insured if he had one quarter of coverage for each two of the quarters elapsing after December 31, 1961, or if later, the year in which he became 21 and the year in which he reached retirement age (or died, if earlier), and six quarters of coverage. Earnings from employment by the railroads or as a Federal civilian employee would be counted in determining quarters of coverage. Special provisions are included for States to enter agreements to extend benefits to their employees. The program would be financed by an increase in the payroll tax of 1/4 percent each on employers and employees (3/8 percent for self-employed) and an increase in the earnings base to $6,000 and making such increase applicable to Federal civilian and railroad employment. Self employed persons not presently covered by the old-age, survivors and disability insurance system might elect to become eligible for health insurance benefits by an irrevocable decision to pay the taxes associated with the health insurance benefit.

Hearings were held by the Committee on Ways and Means during July and August, 1961 on the Administration's health insurance for the aged proposal, H.R. 4222.

B. Federal Grants for State Programs of Health Insurance for the Aged.

During the 86th Congress, several proposals were advanced for programs of Federal grants to the States to help finance health insurance programs for aged persons. The proposals all provided that coverage for eligible aged individuals under the program depended upon their electing such coverage, and established or authorized enrollment fees to be paid by the individual. They all also provided for State administration, either directly or through contracts with insurance carriers.

1. The Javits Proposal 1/

This proposal would authorize Federal grants to participating States which extend health insurance to persons aged 65 or over and their spouses, either through an insurance carrier set up by the State for the purpose or by private commercial, prepayment or nonprofit insurance carriers under contract with the State. A choice between service and idemnity benefits must be offered. Physicians' home and office visits and other ambulatory treatment must constitute one third of the premium cost. The substitution of skilled nursing home care for care of equal cost in hospitals must be permitted. As a minimum, the health insurance shall insure against the cost of 21 days a year of hospital care or equivalent nursing home care, physicians' services up to 12 home or office visits per year, the first $100 of ambulatory, diagnostic, laboratory and X-ray services a year, and visiting nurse services for not less than 24 visits a year.

The program would be financed by individual contributions, State moneys, and Federal appropriations from general revenue. Individual contribution schedules were to be established by each State, with contributions based upon the income of the subscriber and with a maximum of the total premium cost if this were less than $13 a month. The Federal portion of the Federal-State share of the program would range between 33 1/3 and 75 percent of the premium cost up to $13 a month per capita less the individual contributions.

Bills embodying this approach were:

Bill No.	Sponsors
S.3350	Javits, Cooper, Case of New Jersey, Scott, Fong, Aiken, Keating and Prouty
Amendment 6-27-60-H to H.R. 12580	Javits, Cooper, Scott, Fong, Aiken, Keating and Prouty
H.R. 11661 1/	Weiss
H.R. 11677 1/	Lindsay
H.R. 11683 1/	Pirnie
H.R. 11685 1/	Riehlman
H.R. 11702 1/	Dwyer
H.R. 11820 1/	Glenn
H.R. 13020 2/	Lindsay

1/ Identical to S.3350
2/ Identical to Amendment 6-27-60-H to H.R. 12580

1/ This discussion relates to Amendment 6-27-60-H to H.R. 12580, rather than the earlier S. 3350. These differ in that the earlier bill established no minimum benefit and contained an individual contribution schedule ranging from nothing for persons with incomes under $500 in the preceding year to $13 a month (or the cost of the policy, if less) for those with incomes of $3,600 or over.

2. The 1960 Administration Proposal

As embodied in S. 3784, introduced by Senator Saltonstall, the proposal would authorize Federal grants to the States to assist them in establishing health insurance programs for persons electing to participate who were aged 65 and over and who did not pay an income tax in the preceding year or whose adjusted gross income, plus old-age and survivors insurance benefits and railroad retirement and veterans pensions, in the preceding year did not exceed $2,500 ($3,800 for a couple).

Benefits would be provided in any year after an eligible person had incurred medical expenses of $250 ($400 for a couple). The insurance program would then pay 80 percent (100 percent for old age assistance recipients) of the cost of hospital care up to 180 days, skilled nursing home care, organized home-care services, surgical procedures, laboratory and X-ray services (up to $200), physicians' services, dental services, prescribed drugs (up to $350), private duty nurses, and physical restoration services. For old age assistance recipients, the initial $250 would be paid by the public assistance program.

An eligible person so electing could receive 50 percent up to a maximum of $60 a year of a private major medical insurance policy in place of the benefits under the government program.

The program would be financed by individual enrollment fees, and Federal and State funds. Persons participating in the government benefits (except old age assistance recipients, would pay a $24 annual enrollment fee. The Federal share of government costs would be 50 percent on the average, ranging from 33 1/3 to 66 2/3 percent depending upon the relative per capita income of the State.

3. The Javits - Saltonstall Amendment

Amendment 8-20-60-A to H.R. 12580, sponsored by Senators Javits, Cooper, Scott, Aiken, Fong, Keating, Kuchel, Prouty and Saltonstall, blended the earlier Javits proposal with the Administration proposal. Under this program, the Federal Government would provide grants to the States to help pay for health services for all persons aged 65 and over who did not pay an income tax or whose income, including old-age and survivors insurance benefits, railroad retirement and veterans pensions did not exceed $3,000 ($4,500 for couples) in the preceding year and who elected to participate.

The States were required to offer each participant a choice of 1) a diagnostic and short-term illness plan providing as a minimum, 21 days of hospitalization or equivalent skilled nursing home services, 12 physicians' visits in home or office, diagnostic laboratory and X-ray services up to $100, and organized home health care services for up to

24 days; or 2) a long-term illness benefit plan providing as a minimum after a deductible of $250, 80 percent of the costs of 120 days of hospital care, up to a year of skilled nursing home and home health services, and inpatient surgical services; or 3) an optional private insurance benefit plan providing 50 percent of the cost of a private insurance policy up to a maximum of $60 a year. In addition, the Federal Government would share in the cost of improved programs of the first two types up to a maximum per capita cost of $128 a year.

To be eligible for benefits of the first two types, the individual was required to pay the fee established by the State in a schedule related to participants' income. This fee may not be less than 10 percent of the estimated full per capita cost of the benefits provided under the program. The Federal share of the government costs of the program would range from 33 1/3 to 66 2/3 percent, depending upon the relative per capita income in the State.

4. The Gubser Proposal

In H.R. 12272, Representative Gubser proposed a system of Federal grants to the States to provide for voluntary health insurance for persons aged 65 and over who pay a $5 enrollment fee and whose net taxable income in the preceding year did not exceed $4,900 ($6,200 for couple). 2/ The States must contract, subject to the approval of the Secretary of Health, Education and Welfare, with private insurance companies for service benefit plans, idemnity benefit plans, employee organization plans, group practice prepayment plans and individual practice prepayment plans. The Federal grant to the States operating the program would be a specified amount per participating individual, the amount based upon the individual's income and ranging from $5 a month for persons with net taxable incomes of $2500 or below the previous year ($3800 for couples) to $3 a month for persons with net taxable incomes between $3,700 and $4,900 the previous taxable year ($5,100 to $6,400 for couples).

During the 87th Congress, 1st Session the Javits - Saltonstall Amendment was reintroduced by Senator Javits and by two Representatives. The bills embodying the proposal are as follows:

Bill No.	Sponsors
S. 937	Javits, Cooper, Scott, Aiken, Fong, Cotton, Keating, Prouty, Saltonstall and Kuchel.

2/ H.R. 12670 is a reintroduction of H.R. 12272 correcting technical errors and making some minor substantive changes.

Amendment 6-22-61-B to H.R. 6027	Javits, Cooper, Scott, Aiken, Fong, Cotton, Keating, Prouty, Saltonstall, and Kuchel
H.R. 4731	Curtis of Massachusetts
H.R. 4766	Stafford

Representative Gubser has also reintroduced his earlier bill as H.R. 6181.

C. Other Federally Operated Health Insurance

Various proposals have been made over the years for national health insurance operated by the Federal Government. These include a proposal for voluntary insurance, one which combines compulsory coverage for workers with low earnings with voluntary coverage for others, and a proposal for compulsory hospital insurance for persons covered by old-age, survivors, and disability insurance.

1. National Voluntary Health Insurance

As proposed by Senator Hunt in 1950 in S. 2940 (81st Cong. 2d sess.), any individual who, with his dependents, had an annual income of $5,000 per year or less, who applied for the insurance, and who paid the prescribed premiums would be covered along with his dependents.

The benefits contemplated included medical, surgical, and dental services regardless of location; home nursing care; hospital care and related services for up to 60 days per person per year; such auxiliary services as laboratory tests, X-ray, diagnosis or treatment, optometrists' services, appliances, unusually expensive drugs, and so forth.

The program would be administered by a National Health Insurance Board with the Surgeon General as chairman and four additional appointive members, within a proposed Cabinet-level Department of Health.

Insured persons would be free to select and change physicians, dentists, hospitals, and so forth.

It was proposed that a Personal Health Insurance Account be created in the U. S. Treasury. All premiums, as set by the National Health Insurance Board, would be paid into this account. Reserves in the account could be invested in the same manner as those of the Federal old-age and survivors trust fund. Congress was authorized to appropriate additional money to the account when needed to carry out the program. No participation by State or local governments or private organizations is indicated in this proposal.

Payments to the providers of medical care benefits were to be made directly from the personal health insurance account under regulations promulgated by the National Health Insurance Board.

2. National Health Insurance Combining Compulsory and Voluntary Coverage

In 1938, Congressman Treadway introduced this proposal in H.R. 9847 (75th Cong.,2d sess.). Compulsory coverage was proposed for almost all employees (including dependents) earning $1,800 per year or less (agricultural employees excepted), with voluntary coverage for all other persons.

The proposed benefits included almost all physicians' services; hospital services up to 10 consecutive weeks per illness per person; "necessary" drugs and laboratory and diagnostic services. Services for diagnosis and treatment of any disability or disease for which public care was available "free" or "at nominal charges" or for which some agency or other person was required to pay would not be included.

Each employee covered compulsorily would contribute 2 percent of his remuneration, but not less than 35 cents per week nor more than 70 cents per week or $36 per year. His employer would contribute 1 percent of such employee's remuneration, but not less than 20 cents per week nor more than 35 cents per week or $18 per year.

All voluntarily covered persons would make sufficient contributions, as determined by Federal authorities, to pay benefit and administrative costs for such persons.

Moneys would become part of a "health insurance fund" operated by a "Health Insurance Commission" set up as a public corporation to administer the plan.

The Commission could pay physicians on a salary, a capitation, or a fee-for-service basis, except that, if fees were paid, maximum amounts, based on the number of patients, would be set and fees prorated accordingly.

Workers in any industry having a private medical services insurance plan would be excepted from compulsory coverage if the private benefits were at least equal to those under the public plan.

3. Compulsory Hospitalization Insurance for Persons Covered by OASDI

The Eliot and Green bills (1942-45) included provisions for a federally operated program of hospitalization insurance through an expansion of the coverage and benefits of the old-age, survivors, and disability insurance system.

Almost all employed and self-employed persons would have been covered by OASDI, and they and their dependents insured for up to 30 days of hospital care. (Government employees could be covered by special arrangements.)

The hospital insurance would be financed through payroll taxes, applying to the same portion of earnings taxed for purposes of cash benefits.

Administration was to be entirely through the Social Security Board. The Board would pay hospitals directly for the costs of hospital care or might accept and pay claims from insured individuals who had received

care. Participating hospitals would be approved by the Board with respect to care offered.

The proposal was introduced by Congressman Eliot in 1942 (H.R. 7534) and by Senator Green in 1943 (S.281) and 1945 (S.1188).

D. National Compulsory Insurance With State Operations

A series of proposals for a national compulsory system of health benefits was introduced by Senators Wagner and Murray and Congressman Dingell during the period 1943-61. These proposals provided for the setting up of a separate account in the U.S. Treasury and for payments to this account computed as a percent of the taxable earnings of insured persons.

The compulsory coverage of the proposals included almost all employees and self-employed in private pursuits, Federal civilian employees and annuitants, and persons entitled to OASDI benefits, and their dependents. Groups not compulsorily covered, such as recipients of public assistance, the unemployed, and certain persons in temporary employment (and their dependents) could be insured for any periods for which payments were made by or for them or for which guarantees of payment were made by any local, State, or Federal agency.

The benefits proposed included almost all physicians', dental, and home nursing services; hospital services for periods up to 60 days per beneficiary per year; prescribed auxiliary services and appliances and usually expensive drugs. All benefits except general practitioner and dental services would be available only by referral or prescription.

Since the Wagner-Murray-Dingell proposal was introduced as a health rather than a tax measure, the exact methods of raising Federal revenues to finance the benefits were not specified in the bill itself. However, the bill was so drafted as to make it clear that revenues would come, in the main, from payroll taxes.

The proposals contemplated administration by the States as agents. Any State could assume responsibility for administering the specified benefits within its boundaries by submitting to the National Insurance Board a plan which complied with listed provisions in the bill. The National Insurance Board could itself administer the program in States without approved plans.

Federal authorities would divide funds among the States on the basis of population, availability of health resources, and differing costs of services in various areas. State administrative agencies would contract with providers of care and fix rates of payments for services; State agencies would pay providers' bills or might utilize local health region officials or nonprofit voluntary prepayment plans as agents for

making such payments. Physicians would select the manner in which they would be reimbursed, whether by fee-for-service, capitation, or salary.

This proposal was included in the following bills:

Year	Congress	Session	Bill Number	Sponsors
1943.....	78th	1st	S.1161 1/	Wagner and Murray.
1943.....	78th	1st	H.R. 2861 1/	Dingell.
1945.....	79th	1st	H.R. 395	Dingell.
1945.....	79th	1st	S.1050	Wagner and Murray.
1945.....	79th	1st	S.1606	Wagner and Murray.
1945.....	79th	1st	H.R. 4730	Dingell.
1947.....	80th	1st	S.1320	Wagner, Murray Pepper, Chavez, Taylor, and McGrath
1947.....	80th	1st	H.R. 3548	Dingell.
1947.....	80th	1st	H.R. 3579	Celler
1949.....	81st	1st	S.5	Wagner, Murray, Pepper, Chavez, Taylor, and McGrath
1949.....	81st	1st	H.R. 345	Celler.
1949.....	81st	1st	H.R. 783	Dingell.
1949.....	81st	1st	S. 1679	Wagner, Murray, Pepper, Chavez, Taylor, McGrath Thomas, and Humphrey.
1949.....	81st	1st	H.R. 4312	Biemiller.
1949.....	81st	1st	H.R. 4313	Dingell.
1950.....	81st	2d	H.R. 6766	Bosone.
1951.....	82d	1st	H.R. 27	Celler.
1951.....	82d	1st	H.R. 54	Dingell.
1953.....	83d	1st	H.R. 1817	Dingell.
1955.....	84th	1st	H.R. 95	Dingell.
1957.....	85th	1st	S.844	Murray.
1957.....	85th	1st	H.R. 3764	Dingell.
1959.....	86th	1st	H.R. 4498	Dingell.
1959.....	86th	1st	S.1056	Murray.
1961.....	87th	1st	H.R. 4413	Dingell.

1/ These 1943 bills called for Federal administration rather than a State plan.

There were hearings on S. 1606 in April-July 1946; on S. 1320 in May-July 1947 and January, February, May, and June, 1948; on S. 1679 in May and June 1949; and on H.R. 4312 and H.R. 4313 in July 1949.

E. Other Federal Grants For State Health Programs

These earlier proposals for Federal grants to State-operated medical care programs lay out only broad outlines of the type of program envisaged, leaving to the States the specific provisions.

1. The Wagner Proposal of 1939

The coverage of the Wagner proposal of 1939 was in terms of all persons included in benefits of those State plans approved by the Social Security Board "for extending and improving medical care"; persons living in rural areas and those in greatest need were specifically mentioned. Similarly, the benefits contemplated were to be determined by the States in plans approved by the Social Security Board and could include "all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability."

State funds were to be provided according to a variable matching formula, but no Federal matching was allowed for so much of the State expenditure as was in excess of $20 a year per individual eligible for medical care.

The method of paying the providers of services was left to the State.

This proposal was included in S. 1620 (76th Cong., 1st sess.) introduced by Senator Wagner in 1939. There were hearings on this bill in the period April to July 1939.

2. The Capper Bills (1939-41)

The Capper bills were designed to foster State programs of medical care for lower income workers with coverage, for most of them, on a compulsory basis. The population groups to be covered were to be determined by the State, with workers' contributions related to their income and with Federal financial participation limited to persons with lower earnings.

Minimum benefits to be provided in approved State plans were specified. Details differed in various versions of the proposal but, in general, these included general practitioners' services in the home, office, and hospital, most dental services, home nursing care, maternity care, and, if prescribed,hospital and specialists' and laboratory services and care.

Contributions would be made to a health insurance fund in each State by the Federal and State Governments, by compulsorily covered workers and their employers and by other workers requesting voluntary coverage. While details differed, each of the bills introduced by Senator Capper (S. 658 in 1939; S. 3660 in 1940; and S. 429 in 1941) provided that the amounts of workers' contributions would vary directly with their incomes, with compensating increases for the lowest income workers from either employer or State-Federal contributions.

The method of paying the providers of care would be determined by the States or by local areas within the States.

3. The Taft Bills (1946-49)

Another proposal in which Federal grants would be used for State-operated programs was embodied in the Taft bills of 1946-49. In these proposals it was recognized that the State-operated programs might utilize voluntary health insurance in the provision of service.

The Taft proposals would have covered all those families and individuals in the State unable to pay the whole cost of needed medical and dental services.

Federal grants would be made to each State, on the basis of State population, to carry out surveys of existing medical, hospital, and dental services and to formulate "in detail" a 5-year plan for extending such services to persons unable to pay. The Federal share was to be matched by each State.

Federal matching grants for carrying out approved State plans would be made on a variable matching basis, varying between 33 1/3 and 75 percent inversely with each State's per capita income.

Total contributions from the State and from local governments could not be less than their expenditures for medical services to the covered groups prior to initiating the program and not less than the difference between the Federal grant and the cost of the approved State plan. Contributions from private institutions were allowed.

Collection of part of the costs of services from those patients or their families able to pay part of such costs could be provided for in the State plan.

Each State might choose any one (or a combination) of several ways to provide and to pay for services to eligible recipients. Use of nonprofit prepayment plans as insurers or agents and the reimbursement of local governments and private, nonprofit organizations for services rendered to eligible recipients were mentioned.

This proposal was embodied in the following bills:

Year	Congress	Session	Bill No.	Sponsors
1946.....	79th	2d	S. 2143	Taft, Smith of New Jersey, and Ball.
1947.....	80th	1st	S. 545	Taft, Smith of New Jersey, Ball, and Donnell.
1949.....	81st	1st	S.1581	Taft, Smith of New Jersey, and Donnell.

There were hearings on S. 545 in May, June, and July 1947 and January, February, May, and June 1948. Hearings on S. 1581 were held in May and June 1949.

4. The Lodge Bills (1940-49)

This proposal restricted the subsidization to certain high-cost drugs and medical services and would not have covered hospitalization costs.

The population group affected was described in terms of "such persons as may require 'X-ray services, laboratory diagnostic services, respirators, and the drugs useful in treating or preventing the listed diseases' and such other infectious or chronic diseases as the Surgeon General may from time to time prescribe."

Federal grants to each State would constitute one-half of all funds spent under the State's plan. Conditions under which recipients would pay for part of these services, while not mentioned in the proposal, could presumably be specified in State plans and could include use of voluntary health insurance plans.

Senator Lodge introduced the proposal in 1940 (S.3630), 1947 (S.678), and 1949 (S. 1106). There were hearings on S. 678 in April 1948 and on S. 1106 in May and June 1949.

F. Federal Subsidies to Private Carriers

In recognition of the problem to low-income groups, including the aged, of financing their own voluntary health insurance premiums, there have been a variety of proposals whose aim is to provide a form of Federal subsidy for either part of their premiums or the excessive cost of the care they will require, or both.

The purpose of these proposals is to make possible the inclusion under voluntary health insurance of groups inadequately represented in the existing enrollment without excessive financial burdens on those with low incomes and without either a differential premium on high cost risks or higher premium rates for the entire enrollment.

1. Flanders-Ives Proposal

This proposal, incorporated in a series of bills introduced during the period 1949-55, would have built on existing nonprofit plans subsidizing them from Federal funds indirectly through State plans.

Among its more important features were (1) scaling of premiums to income; (2) encouragement of expansion of coverage and improvement in

the scope of benefits by subsidizing premiums of low-income families and losses incurred from above average risks; (3) recognition of the fact that existing prepayment plans vary widely in the scope of the benefits they provide--the program was designed to be adaptable to the existing level of voluntary health insurance benefits; (4) costs reflecting local scales of payment to hospitals and providers of services; (5) State operation and control of the program; (6) development of health service areas.

The bill did not attempt to secure uniformity of prepaid protection throughout the Nation, or even within a given State, leaving the scope of benefits to be determined locally in relation to those locally available.

Any resident of a State having an approved State plan would be eligible for participation. Eligible persons could request payroll deductions for premiums. Premiums could be paid on behalf of welfare clients.

The bill spelled out a rather complete list of personal health services which might be provided including hospital room and board, services of physicians, dentists, nurses, and other auxiliary personnel, and related drugs, appliances, and ambulance service.

The regional health authority was to determine for its locality which of the benefits spelled out above might be included in contracts with prepayment plans in their local area. The regional health authority and each local prepayment plan would then enter into a contract for specific benefits selected from among these. The premiums established under these contracts were to be determined by the relationship of the benefits afforded to a so-called cost norm, priced to provide fairly complete coverage of physicians' services and 30 days of hospital care per person per year.

Financing the costs of the benefits agreed on would involve funds from three sources--subscriber premiums which would be related to family income as well as benefits insured; State and local subsidies to bring actual premium income up to an "allowed cost"; and Federal grants to the States, varying according to the State's per capita income, to share one-third to three-fourths of the subsidies paid to the prepayment plans.

Under the Flanders-Ives proposal, the local prepayment plan could provide either service benefits or cash idemnification of the claimant.

The following bills embodied this proposal:

Year	Congress	Session	Bill No.	Sponsors
1949.....	81st	1st	S. 1970	Flanders and Ives.
1949.....	81st	1st	H.R. 4918 through H.R. 4924	Case of New Jersey, Fulton, Hale, Herter, Javits, Morton, and Nixon.
1949.....	81st	1st	H.R. 5087	Auchincloss.
1951.....	82d	1st	H.R. 146	Auchincloss.
1953.....	83d	1st	S. 1153	Flanders and Ives.
1953.....	83d	1st	H.R. 3582	Hale
1953.....	83d	1st	H.R. 3586	Javits.
1953.....	83d	1st	H.R. 4128	Scott.
1955.....	84th	1st	S.434	Case of New Jersey, Flanders, and Ives.
1955.....	84th	1st	H.R. 481	Scott

Hearings held in June 1949 included testimony on S.1970; hearings were held on H. R. 4918 and other identical bills in July 1949.

2. Hill-Aiken Proposal

These bills (1949-53) were intended to provide voluntary health insurance for persons unable to pay part or all of the usual premium. Each State was to establish a State agency which would administer the means test. It would collect the portion of the premium from persons able to pay part of the cost, and pay the insurance plan the entire premium with respect to all such insured persons. The State agency would reimburse the plan for payments made to hospitals, etc., for care of persons certified as eligible for State payment (i.e., unable to pay any of the cost).

The plan contemplated service benefits covering 60 days of hospital care per year; surgical, obstetrical and medical services in the hospital; and diagnostic and outpatient services in hospitals or diagnostic clinics.

Of the public outlays for low income groups paying none of their costs or only part of their premiums, the Federal Government would provide from one-third to three-fourths (depending on the State's financial ability) and States and localities would share equally the remainder.

It was specifically provided that persons eligible for State payment were to be issued "membership cards," indistinguishable from those of regular members.

This proposal was introduced in the following bills:

Year	Congress	Session	Bill No.	Sponsors
1949.....	81st	1st	S. 1456	Hill, O'Connor, Withers, Aiken, and Morse.
1951.....	82d	1st	S. 2171	Hill and Aiken.
1953.....	83d	1st	S. 93	Hill and Aiken

Hearings were held on S. 1456 in May and June 1949.

3. The Smathers Proposal

In 1960, during the 86th Congress, Senator Smathers introduced a bill (S. 3646) which would provide tax credits for any life insurance company to the extent of the company's net losses from approved health insurance policies issued persons aged 65 and over. Life insurance companies (as defined in the Internal Revenue Code), including companies issuing noncancellable or guaranteed renewable health insurance policies under Section 802 of the Code, would be eligible to receive the credit for their losses on policies submitted to the Secretary of Health, Education, and Welfare and approved by him. To be approved, the contract would be required to provide insurance against the total cost of not less than 60 days of hospital care a year, not less than 120 days of nursing home care per year, and the total cost of drugs above $50 a year. In addition, the policy premium could not be greater than $72 a year. The policy also could not impose unreasonable standards for filing and proving claims, waiting periods, loss of insurability, or any limitation unreasonably restricting the right to benefits.

(In addition, the bill provided for increased medical care income tax deductions for aged persons and altered the formula for Federal sharing in vendor payments for medical care under the old-age assistance program.)

G. Reinsurance, Pooling, and Regulation

These proposals were designed to encourage the growth of voluntary health insurance without requiring any permanent form of Federal subsidy or tax. They therefore held Federal subsidization to a minimum, involving only direct Federal expenditures for costs of administration and for sums needed to launch the proposed reinsurance corporation. They were intended

to encourage expansion of the availability of voluntary insurance coverage (1) through legislation waiving the antitrust laws so as to permit insurance carriers to pool their resources in developing policies and methods for extending insurance to substandard health risks, (2) through Federal participation in the reinsurance, and (3) through Federal regulation of interstate insurance.

1. Reinsurance and Pooling

Existing antitrust laws constitute a barrier to collective efforts of groups of private insurance carriers who might wish to pool their experience and technical know-how and their financial resources in the development of new policies to cover unusual risks.

A bill whose purpose was "to encourage the extension and improvement of voluntary health prepayment plans or policies" was introduced in the 2d session of the 84th Congress. It authorized the Secretary of Health, Education, and Welfare, after consultation with the Federal Trade Commission and approval by the Attorney General, to approve voluntary agreements between certain private insurance organizations to make available new or improved types of insurance coverage. 1/

While the population groups affected were not spelled out, proponents of the proposal believed carriers might be more willing to experiment with coverage of substandard risks such as the aged or those with disabling conditions if they were able to take collective action to develop such policies. Experiments in coverage of rural and low income families might also have been undertaken.

Improvements in benefits could have been tried, such as the sale of more noncancellable policies, extension of existing benefits, major medical expense policies, and the like.

No Federal funds were involved in this proposal. The insurance carriers would fix their own premiums.

1/ Also the 1957 proposal applied only to nonprofit plans and to the smaller commercial companies (defined as companies paying out less than 1 percent of all health insurance benefits or having less than 0.5 percent of the assets of all health insurance companies and plans in the United States).

The following congressional bills embodied this proposal:

Year	Congress	Session	Bill No.	Sponsors
1956.....	84th	2d	H.R. 12153	Priest.
1956.....	84th	2d	H.R. 12140	Thompson.
1956.....	84th	2d	S. 4172	Hill and Smith.
1957.....	85th	1st	H.R. 489	Thompson.
1957.....	85th	1st	S. 1750	Hill and Smith.
1957.....	85th	1st	H.R. 6506	Harris.
1957.....	85th	1st	H.R. 6507	Wolverton.

2. Federal Reinsurance Corporation

These proposals contemplated the formation of a federally operated reinsurance fund to which the Federal Government would make an initial contribution and to which insurance carriers would contribute a small percentage of their premium income. The fund would provide partial idemnification to the companies for extraordinary losses experienced under those health insurance contracts which were reinsured.

As first roughly outlined in a proposal made by Mr. Harold Stassen in 1950 the reinsurance fund would have repaid insurance carriers for a portion of any hospitalization claims exceeding a maximum such as $1,000 and for medical-surgical bills above a certain maximum. Bills actually introduced in Congress have taken three forms.

(a) The 1950 Wolverton reinsurance proposal.--Congressman Wolverton's proposal embodied the Stassen suggestions with some additional features. It contemplated a Federal Health Reinsurance Corporation. Nonprofit organizations could reinsure their health service contracts with this corporation for a premium if these contracts met some specific criteria as to population groups covered and benefits offered. Separate funds to reinsure hospitalization and medical care were to be established. The reinsurance could be invoked and the corporation become liable for 66 2/3 percent of each claim in excess of $1,000 for any 12-month period for any one individual.

Subscription charges for the contracts were to be related to subscribers' incomes, to encourage participation of low income families.

The benefits contemplated were as follows: Six months of hospital care per year with the subscriber himself to pay 5 percent or $1 a day whichever was less as coinsurance; 95 percent of physicians' charges in hospitalized cases; 12 visits with a doctor in his office or at home with the subscriber paying out-of-pocket 25 percent. The scale of

charges to be paid by the insurer was to be fixed; the doctors were to agree not to make an additional charge of more than the 25 percent the subscriber was to pay directly. The plan did not cover the first visit to the doctor.

The sources of financing the reinsurance corporation proposed were $50 million from Federal general revenues divided equally into the hospital and the medical care funds, and 2 percent of gross premiums received for health service contracts.

The following bills embodied this proposal:

Year	Congress	Session	Bill No.	Sponsors
1950.....	81st	2d	H.R. 8746	Wolverton.
1954.....	83d	2d	H.R. 6949	Wolverton.
1955.....	84th	1st	H.R. 400	Wolverton.
1955.....	84th	1st	H.R. 401	Wolverton.

(b) The 1954 administration proposal.--The administration's proposal for reinsurance departed from the earlier concept of repaying insurance carriers a portion of an individual's claims and dealt with a carrier's average losses which resulted when the plan paid out more than it received in premiums. Both nonprofit and commercial insurance companies could participate.

Encouragement of underwriting major medical expense was anticipated as well as broadening of basic benefits, noncancelable insurance, etc. The 1954 proposal would have established a reinsurance fund which would pay 75 percent of a plan's losses on reinsured contracts that exceeded the premium income of the contracts less 87.5 percent of the administrative expenses predetermined for the contract. The Federal Government would lend the fund $25 million which would eventually be refunded from reinsurance premiums. Premiums of unspecified size (but 2 percent of reinsured premium income was discussed) would be paid by the carriers to the fund.

The 1954 administration proposal was introduced in the following bills:

Year	Congress	Session	Bill No.	Sponsors
1954.....	83d	2d	H.R. 8356	Wolverton
1954.....	83d	2d	S. 3114	Ives, Flanders, Purtell, Cooper, Upton, Ferguson, Bush, and Saltonstall.
1955.....	84th	1st	H.R. 2533	Wolverton.

There were hearings on H. R. 8356 in March, April, and May 1954 and on S. 3114 in April 1954. The House Committee on Interstate and Foreign Commerce reported out H. R. 8356, but it failed to carry and was referred back to the committee, which took no further action.

(c) The 1955 administration proposal.--A revised version of the reinsurance proposal of the 83d Congress was included as title I of an omnibus health bill introduced in 1955. The reinsurance fund was divided into four parts and each separate fund was to receive an initial $25 million in Federal money to launch it. The four funds dealt with: (1) plans for low and average income families, (2) major medical expense contracts, (3) plans specifically designed for rural areas, and (4) certain other plans.

Other features, including the terms of the reinsurance premiums and the claims formula, were the same as in the earlier administration proposal.

A type of contract providing a wide range of benefits but with co-insurance features was included for low income families.

Under the 1955 proposal, the Federal Government would contribute up to $100 million which would eventually be paid back. Participating insurance companies were to pay the fund an unspecified percentage of their premium income as reinsurance premiums.

The following bills embodied the proposal:

Year	Congress	Session	Bill No.	Title or part of bill	Sponsor
1955.....	84th	1st	H.R. 3458	Title I	Priest.
1955.....	84th	1st	H.R. 3720	Title I	Wolverton.
1955.....	84th	1st	S. 886	Title I	Smith and others.
1957.....	85th	1st	S. 1750	---	Hill and Smith.
1957.....	85th	1st	H.R. 6506	---	Harris.
1957.....	85th	1st	H.R. 6507	---	Wolverton.

3. Federal Regulation

In 1956 and 1957 three bills were introduced in the House of Representatives whose purpose was to encourage improvements in available voluntary health insurance policies, and thus indirectly to promote the spread of such protection. The method proposed was to prohibit the issuance of health insurance policies which could be canceled after a stated period for any reason other than nonpayment of premiums. The prohibition would apply to insurers engaged in interstate business.

Though applicable both to group and individual policies, the prohibition would be most meaningful in relation to individually purchased policies. Such policies are frequently the only ones older persons, rural residents, widows and the self-employed can purchase.

Bills introduced in sessions of the U. S. Congress were as follows:

Year	Congress	Session	Bill No.	Sponsors
1956.....	84th	2d	H.R. 8216	Christopher.
1957.....	85th	1st	H.R. 116	Christopher.
1957.....	85th	1st	H.R. 5041	Rhodes.
1957.....	85th	1st	H.R. 7087	Christopher.