

HEALTH SECURITY FOR THE AGED

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HEALTH SECURITY FOR THE AGED

I. THE PROBLEM

The care of older people in the population is a problem that is not new. A number of years ago most families had one or more elderly relatives living with them. These older people for the most part had little or no income, but helped around the house so that they could contribute something for the food, lodging, and care which they received. They expected to live out their lives with their children and grandchildren. The offspring, in turn, were taught that it was their responsibility to care for their elders.

Although this responsibility is still extent, and legally enforced in many instances, cultural changes and alterations of family mores have resulted in a greater percentage of older people living by themselves. This has increased their living costs so that they must be more self-sufficient.

An obvious contributor to the problem is the rapid increase in the number of elderly "over 65 years" people in proportion to other age groups. Persons aged 65 and over now number about 17 $\frac{1}{4}$ million. The following figures indicate that by 1970 over 10% of the population will be in the elderly group:

Population of U.S. - Over 65 Years of Age
(Including Armed Forces Overseas)

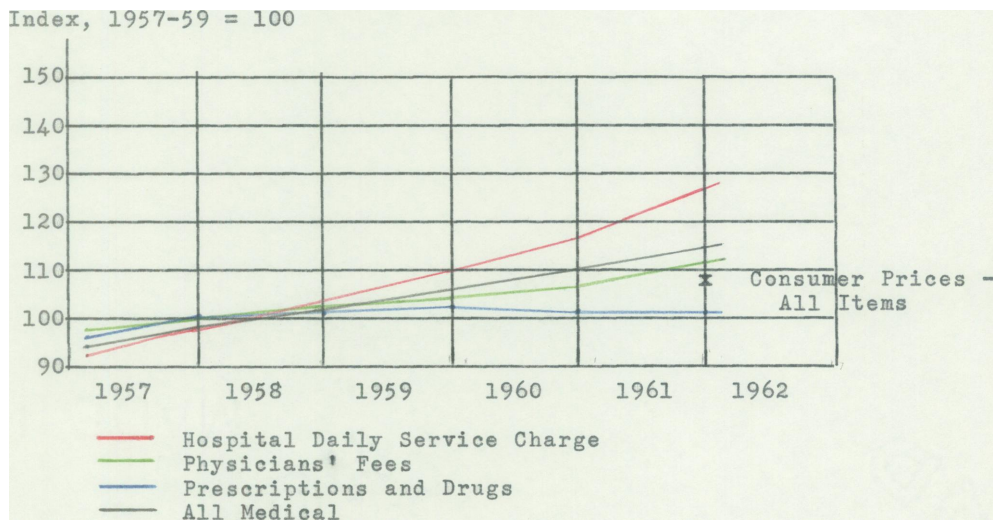
<u>Period</u>	<u>Millions</u>	<u>% of Total Population</u>
1940	9.0	6.8%
1950	12.3	8.1
1960	16.7	9.2

Source: U.S. Dept. of Commerce, Bureau of the Census; Current Population Reports, Population Estimates and Series P-25.

This rapid expansion of the elderly population is due to better hospital care, improved medical and surgical techniques, and rapid advances in drug therapy. The result is that there are not only more people to care for but the care costs much more.

It has been recognized for some time that medical care prices have increased more than other costs to the public. The following graph indicates that total medical care prices went from an index of 100 (1957-59) to 115 in early 1962. During the same period the Consumer Price index went to 108 --- about 50% of the medical care increase.

Medical Care Prices



Source: U.S. Dept. of Labor, Bureau of Labor Statistics; Price Indexes for Selected Items and Groups

Note that not all segments of the medical care package increased proportionately. Hospital charges and physician fees have increased considerably whereas prescriptions and drugs have stayed approximately level.

Another facet of the problem is the growing independence of the older population group. With better health and more elderly couples, the married oldsters wish to carry on an independent existence within their own home, apartment, trailer or cooperative living group. Seventy percent now maintain independent living arrangements. This independent existence costs far more than living under the same roof with their children.

The younger generation, too, has encouraged independence for their elders. Homes no longer house the large family groups of former years. The patriarch no longer exists. Children are more reluctant to assume the burden of direct care for their elders. The elderly do though, in many cases, receive some financial assistance from their children while maintaining separate living accommodations, and when they are finally unable to care for themselves, they are placed in a rest home.

Older people, by becoming more independent, are also more reluctant to accept offerings from their children. Many have Social Security benefits and modest savings or

retirement incomes. They can get by with the routine expenses but a catastrophic illness can leave them penniless with less than enough to maintain themselves. The net result is that there are many millions of elderly people in this country who do not and cannot live a peaceful life free from the worries of impending serious illness.

During the past few years, federal, state, and local governments, and private groups, have taken increasing interest in this problem. Much legislation has been proposed; some has passed. Private insurance companies have developed many new plans to take care of the over 65 group. The problem, however, is far from solved. John F. Kennedy, while still a Senator in 1960, stated:

The 65 year old existing on an income of \$72 a month -- average Social Security check -- who is faced with large medical bills cannot wait for further studies. The disabled wage earner who has already exhausted his savings cannot wait for a study. I believe, under the circumstances, Congress must take the initiative and exercise the necessary leadership.

Studies still continue and some action is now taking place. The following is an attempt to outline some of the legislative background for health care to the aged, recent plans advanced by private companies, and some analysis of ability of the older people to pay for health care.

II. LEGISLATION

A review of the federal legislation concerning health care indicates that there is a progressive increase in interest on the part of officials and the public concerning the necessity for care of both indigent patients and those that can afford limited medical assistance. In recent years, accent has been on aid to the elderly.

The first piece of health legislation passed was a public medical care bill for indigent patients in 1798. During the last century, both state and local governments began to care for the mentally ill and those with acute communicable diseases as well as chronic conditions such as tuberculosis. Prior to World War I, the various states began to pass workman's compensation laws which provided for disability and chronic illness payments. After World War I, the Federal Government provided extensive care for veterans who were unable to pay.

In 1921, the Shepard-Towner Act was passed providing for grant-in-aid programs which provided medical and social services for needy mothers and children. In 1933, the Federal Emergency Relief Administration began to provide limited medical, dental, and nursing services to recipients who could prove a need.

The Social Security Act of 1935 provided federal grants for general public health. Although previous laws had included some aid to elderly needy, this was the beginning of specific legislation which recognized the needs of those over 65. Various subsequent amendments to the Social Security Act have considerably expanded federal public health expenditures for the elderly. ¹

The original concept of the Social Security Act was quite simple in that it included old age retirement benefits and cash refunds. Subsequent changes have provided benefits for dependents of retired workers and for survivors of deceased workers. Benefit levels were increased and eligibility age was reduced from 65 to 62 for various categories of benefits to women. Disability benefits were also added for all age groups.

The result has been a planned progressive increase in compulsory contributions in order to keep the program on a sound actuarial basis. The following table shows the past and scheduled financing provisions:

PAST AND FUTURE FINANCING PROVISIONS

<u>Period</u>	<u>Maximum Taxable Earnings Base</u>	<u>Combined Employer - Employee Tax Rate</u>
1937-49	\$3,000	2%
1950	3,000	3
1951-53	3,600	3
1954	3,600	4
1955-56	4,200	4
1957-58	4,200	4½
1959	4,800	5
1960-61	4,800	6
1962	4,800	6½
1963-65	4,800	7½
1966-67	4,800	8½
1968 and after	4,800	9½

Source: Health Education and Welfare
Indicators, September 1961

After World War II, the V.A. again expanded its medical care program and built many large new hospitals. Broadened Social Security benefits were passed through 1943 and 1950 amendments.

In 1960, the Kerr-Mills Act (Public Law 86-778), another amendment to the Social Security Act, was passed enabling individual states to provide health care to old age recipients who could demonstrate a financial need for this type of help.

In those states which have adopted implementing legislation, the Act meets at least part of the costs of medical care for the aged who do not need cash old-age assistance payments but whose incomes are insufficient (under eligibility conditions determined by the states) to meet their medical costs. ² Most states participating in M.A.A. (Medical Assistance for the Aged) have now set up income limits on persons eligible for benefit. Examples are: Louisiana, \$3,000 a year; Illinois, Massachusetts, New York, \$1,800 a year; Maryland, South Carolina, Tennessee, less than \$1,200. ³

The bill makes clear that States may determine eligibility for medical assistance to the aged on a basis more liberal than for O.A.A. (Old Age Assistance). It was estimated that in the first year of operation Federal Funds would amount to \$60 million, and state and local funds to nearly \$56 million. In April, 1962 total M.A.A. assistance for that month was \$21,393,000. ⁴ Although there is criticism that the program is not being implemented fast enough the expenditures are as high as anticipated. The

reason may be that some states have progressed more rapidly than expected and others have done nothing to implement the program.

A number of other legislative proposals have come before the U. S. Congress in recent years, but because of their controversial nature, have not passed. These forms of legislation take two basic positions; one is typified by the Forand Bill, H.R. 4700, which was introduced in the House of Representatives in February of 1959. This Bill would have provided hospital, surgical, and nursing home care for those eligible for old age pensions by amending the Social Security Act and adding 1/4% to the combined employer-employee contribution. This Bill had the support of labor and the liberal Democrats. The Republican Administration, and most business and industry, and the American Medical Association, opposed the Forand Bill on the basis that it was a departure from the original Social Security Act ideals in that it provided services rather than cash remuneration from prior contributions. Proponents of the Forand Bill contend that over 50% of the aged population could not afford medical treatment nor could they afford to pay for private insurance. The opposition claimed that compulsory participation in a medical health

plan was alien to the rights of the American people.

The National Association of Manufacturers contended that "The problem is not to provide care for the aged but rather to provide assistance to those who need it. The Bill (Forand) would invade another area of free choice by providing a service rather than a cash benefit." ⁵

The Forand Bill was subsequently defeated. In the meantime, the Republican Administration had proposed a "Medicare Program for the Aged". This was submitted by Health, Education and Welfare Secretary Fleming in May 1960. It typifies the second opposing position. This plan would have provided for hospitalization, nursing home, medical, dental and drug subsidies to approximately 12 million people over 65 years of age with low incomes. This would include approximately 70% of those over the age of 65. In contrast to the Forand Bill, the program would be voluntary. It would include those on public assistance and those with a maximum annual income of \$2500 (\$3800 per couple). Those coming under the maximum income would pay a \$24 annual fee and would be subject to \$250 deductible plus 20% of the total cost of the annual individual health assistance. Public assistance rolls would presumably receive a 100% subsidy.

The Administration at that time contended that this proposal was more encompassing than the Forand Bill because it covered all needy elderly individuals rather than just those participating in OASDI. The opponents, however, stated that the proposal discriminated against many elderly people who could not afford a catastrophic illness.

This proposal from H. E. W. Secretary Fleming was, however, an admission on the part of a Republican Administration of government responsibility to provide extensive health care for the aged. On the other hand, many legislators contend that it was just a political move to prevent passage of the Forand Bill.

In 1960, at the time the Kerr-Mills Bill was under consideration, two other plans were advanced -- the Javits and the Anderson-Kennedy plans. Both of these would have been supplements to the Kerr-Mills Bill. The Javits plan was a voluntary one in which moderate income individuals could choose among three plans for short term illness, long term illness, or optional private insurance. Costs would be financed on a sliding scale by federal and state governments. Participants would pay an enrollment fee equal to 10% or more of the estimated cost of his benefit plan. There was no tie-in with Social Security.

The Anderson-Kennedy plan would have provided for hospital, nursing home, home health, and diagnostic service to all Social Security beneficiaries after they reached the age of 68. Benefits would be financed by a 1/4% increase each in payroll taxes on employers and employees, and 3/8% for self-employed.

The Anderson-Kennedy and Javits plans again emphasize the basic difference between two opposing viewpoints -- one requesting compulsory health coverage under Social Security and the other proposing voluntary coverage through private companies. The result was that the Kerr-Mills Bill passed without either of the above additions. ⁶

Another proposal, and this was submitted by a Democratic Administration in 1961, was the King-Anderson Bill (S909, HR 4222). This proposal was a more modest approach to the old age program but was similar to the Forand Bill in that it was non-voluntary and was tied to OASDI. It would have provided certain health care benefits for those over 65 who are eligible for Social Security. It would cover a limited amount of hospitalization and some nursing home care, home health services, and outpatient diagnostic services. The patient would be required to pay \$10 a day for the first nine days of hospitalization with a minimum of \$20, and \$20 for each complete diagnostic test.

The King-Anderson Bill would have provided for compulsory old age health benefits to all OASDI participants and presumably would supplement the provisions of the Kerr-Mills law which provides only for health services to the needy. The administration of the King-Anderson Bill would "rest with the Secretary of Health, Education and Welfare. Considerable reliance would be placed upon the States to assure that local conditions would be taken into account." ⁷

The King-Anderson Bill was defeated in the Senate at the 1962 session of Congress because of firm opposition from private insurance companies, other business enterprises, the A.M.A., and also because of the Southern coalition and internal dissention in the Democratic Congress.

As a result of the increased interest in health care for the aged, and because of conflicting viewpoints regarding proposed legislation, President Eisenhower, in January of 1961, had called a White House conference for the aging. The purpose of the conference was to obtain opposing views and see if there was any program that could resolve the conflicts. ⁸

Examples of topics covered were: Impact of Inflation on Retired People ⁹; Income Maintenance and Financing. ¹⁰ Scores of other topics were discussed and an effort was made

to obtain the opinion of all groups. No problems were solved but the opposing views were made a matter of record and the airing helped to better define the problem.

III. PRIVATE INSURANCE COVERAGE

The aroused public interest in care for the aged and the increasing possibility of legislation to provide broad Social Security health coverage for older people has spurred the private sector to offer more comprehensive health plans at a lower cost. The private companies and the non-profit group insurers* are realizing that the onus is on them. They have to demonstrate that they are capable of creating plans that will meet the need and that they are able to sell the older people on the necessity of insurance coverage. Their failure to satisfy the older population needs will result in medical care through the government by default.

That they have had some success in recent years is evidenced by two surveys which were conducted by the Census Bureau. They show the following percent of persons over 65 to have had some sort of health insurance.

<u>Survey #1</u>		<u>Survey #2</u>	
March 1952	26%	Mid-1953	31%
Sept. 1956	37%	Mid-1958	43%

* Blue Cross and Blue Shield are group plans established as non-profit medical-service corporations under state laws. Both are largely controlled by the providers of service - the Blue Shield by state or local societies and Blue Cross by local hospitals. Other interests are increasing however.¹¹

In the second half of 1959 the National Health Survey found that 46% of those over 65 had some type of health insurance. ¹² It is now estimated that over 53% are covered. These figures indicate that private health insurance for aged has doubled in the past ten years.

These figures can be misleading because those people who are covered vary widely in the scope and adequacy of the coverage which they possess. Some policies cover as little as \$5 daily for hospital benefits and others go as high as \$25 or more daily plus full surgical coverage and major medical protection. During the period July 1958 - June 1960, a survey indicated that 51% of hospital discharge cases had some portion of the bill paid by insurance companies. Three-fourths or more of the hospital bill was paid in only 30% of the cases. It can be seen that even though over 50% of the older population possesses coverage there is definitely a need for additional protection in this group.

What about the other half who have no coverage? Is there any hope that the number insured will continue to increase as it has during the past ten years? The following results of a survey of OASI beneficiaries offer some clues:

Table 32.--Reasons for no hospitalization insurance: Percent of aged OASI beneficiaries who did not have insurance, 1957	
Reason	Percent
Aged beneficiaries never insured-----	100
Could not afford it-----	41
Never thought about it-----	30
Not interested-----	18
Refused by insurance company-----	9
Other reasons-----	2
Insured at one time, policy dropped-----	100
Could not afford it-----	39
Group policy could not be converted at retirement-----	29
Not interested-----	14
Canceled by insurance company or terminated at death of husband-----	13
Other reasons-----	5
Source: Bureau of Old Age and Survivors Insurance, Social Security Administration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.	

It is interesting to note that 30% of those who had never been insured had never even thought about it. About 68% of those interviewed had never been insured. The aged population in 1957 was about 15 million and of these about 60% (9 million) were uninsured. Thus, about 1.8 million or 12% of the elderly population had never even thought of obtaining health insurance. This group presents a fertile field for the insurance companies. It's also probable that many of those who say "Could not afford it" or "Not interested" have never been approached in an effort to sell them on the benefits that can be derived from adequate insurance coverage.

There is, of course, a sizable percentage (14%)¹³ of the population covered under the Old Age Assistance program of the federal government. This assistance is also supplemented by local and state governmental help. Under Public Law 86-778 (Kerr-Mills) an increasing number of additional aged are being included for care under standards set by their individual states and approved by the Department of Health, Education and Welfare. Others are taken care of through veteran's facilities. These figures then indicate that over two-thirds of the population over 65 do have some form of coverage. There is an additional

group, maybe 5%, who can afford whatever hospital care they will need. Thus, between 25-30% of the aged population represent a sales challenge to the insurance companies.

Blue Cross, Blue Shield and the private companies have been very active in the past five years and have developed plans to enable the older people to acquire protection at the lowest possible cost.

One method is to set up mass enrollment programs whereby insurance is offered to all persons 65 years of age and older regardless of present or past condition of health. No physical is necessary. The enrollments are scheduled annually or semi-annually and are limited to two weeks or a month. The limited time period assures that most enrollees do not have a current acute medical condition. The coverages, which are guaranteed renewable, include hospital, surgical, and nursing home benefits. Many also include major medical provisions up to \$5,000.

One of the big drawbacks of health insurance coverage used to be that most policies automatically expired when the policyholder reached 65. Another disadvantage was that many policies could be canceled by the company on any anniversary date. After one major illness the company could decide that the person was a poor risk and cancel the insurance.

Now, however, many companies write policies that are guaranteed renewable for life and cannot be canceled except by the policyholder. Following is a statement from one such policy:

The policy is guaranteed renewable and coverage will continue on each adult for life. While coverage is properly in force the company:

- . cannot change the premium rate for your policy unless it changes the table of premium rates for all policies in the same class
- . cannot refuse to accept premiums paid when due
- . cannot place any restrictive rider on the policy
- . cannot reduce the benefits.¹⁴

There are also plans available which provide for guaranteed-renewable lifetime hospital-surgical expenses fully paid-up at the age of 65. Eight different companies¹⁵ now provide this type of coverage. Somewhat larger premiums are charged during the early years so that a reserve is created, which carries the policy through the later years. Although this type of coverage does not help the aged at the present time, the insurance companies have shown considerable foresight in this type of planning. People are paying for their older years when they are best able to afford it. Every policyholder will also be a person opposed to non-voluntary assistance under OASDI.

The aged can now also be enrolled through associations or groups of retired persons. One example is the American Association of Retired Persons. This plan includes benefits for hospital and nursing home care, surgery, and physician's services in home or office. As another example, on July 1, 1961, retired employees of the United States Government became eligible for health insurance on a group basis. Approximately 70% of Federal Civil Service retirees have acquired this protection. 16

Another innovation was a plan initiated by Connecticut insurance companies to permit them to join together to provide comprehensive major medical insurance for the state's senior citizens. The plan covers health care expenses up to \$10,000. It is open for enrollment regardless of past or present health status. Cost ranges from \$84 to \$204 per year. The advantage of the Connecticut 65 Plan is that it enables the insurance companies to join their experience and thus cut down on individual losses. They are also committed to administer the coverage in such a manner that any excess of premiums over the losses, expenses and a risk charge will be used by the association for the benefit of the people insured. The Connecticut plan is important because it partially obviates an

important disadvantage of private plans - high cost due to poor experience on limited numbers covered.

With the many plans now available from the Blue Cross, Blue Shield, and private companies and an aggressive selling program on their part, it is conceivable that they can cover a sufficient number of people in time to stem the tide of feeling that the Federal Government should cover all elderly people under OASDI provisions.

Even though the private insurance companies have been working diligently over the past few years in order to devise satisfactory plans to economically and profitably insure the older population, there is one factor working against them. It's the very concept that they are attempting to promote - "voluntary membership". Voluntary membership is a very worthwhile goal but there are many millions of people in this country who don't wish to plan their budget to cover health insurance even if they can afford it.

The rapid growth of health insurance in the working class has had a powerful impetus from union negotiated health plans. Garbarino¹⁷ states:

All in all, it seems conservative to say that a substantial portion of the customers of the health insurance movement have been recruited as a result of the operations of negotiated plans and that most of these were unlikely to have been recruited in any other way.

Our older population has no union to negotiate plans for them. There are, however, groups such as the Retired Peoples Association which have formulated plans but they do not have the same hold over the older people as do the unions. Also, they reach only a small percentage of the older group.

The insurance companies may have a difficult time then in obtaining "voluntary" coverage for the group not now insured.

IV. ABILITY TO PAY

One of the issues about which considerable controversy centers is the ability of the older people to finance their own health care. One viewpoint is that the vast majority of older people have incomes that barely permit them to maintain a minimum standard of living and that they cannot afford to pay normal health care needs or insurance premiums let alone the costs of a catastrophic illness. The other argument states that most older people can and are paying for some health insurance and that those who cannot pay are in the minority and can be taken care of by present legislation.

The available facts are confusing and lend themselves to distortion so that both sides can make a plausible case for their views.

In 1956 the National Opinion Research Center conducted a survey to determine cash income and median income for persons over 65. Following are the results:

Percentage Distribution of Cash Income and Median Income in 1956, for Persons Aged 65 and Over with Income, by Sex

<u>Income</u>	<u>Total</u>	<u>Per Cent</u>	
		<u>Men</u>	<u>Women</u>
\$ 1- 499	13.0	8.0	20.5
500- 999	24.3	16.6	35.9
1,000-1,999	26.1	25.6	26.8
2,000-2,999	13.5	17.5	7.4
3,000-3,999	8.2	10.6	4.4
4,000-4,999	5.5	7.5	2.3
5,000-5,999	3.3	4.9	0.8
6,000-6,999	1.6	2.4	0.4
7,000-9,999	2.6	3.9	0.6
10,000-and over	2.1	3.1	0.6
Median Income	\$1,300	\$1,935	\$880

Source: Health Information Foundation - Research Series 10 - Financial Resources of the Aging, by Ethel Shanas, Ph.D., page 4

This survey excludes women living with husbands because the low income of women receiving OASDI would considerably lower the median and distort the figures. Another survey gives the income of husband-wife families:

Percentage Distribution of Husband-Wife Families
with Head Aged 65 and Over, by Total Money
Income in 1956

<u>Income of husband and wife</u>	<u>Per Cent</u>
Under \$2,000	43.8
\$2,000-3,999	31.4
\$4,000-5,999	14.0
\$6,000-and over	10.9

Source: Ibid

The figures from the first chart are probably somewhat higher than the true figures as a result of the methods of tabulation. The median figures were \$1,935 annually for men and \$880 for women. The Census Bureau for the year 1960 reports a median income of \$1,698 for men with income, and a median income of \$821 for women with income. The two figures are not far apart. Now, how much of this is required for health care?

Medical care for persons over 65 in 1957-58 averaged \$177 per year.¹⁸ This is approximately twice the expenditures by those under 65. The \$177 outlay amounts to about 13% of the median income of the older age group and compares to an outlay of about 5½% of the income of the younger population group. The question is, "Can the older population foot the bill?"

The question is difficult to answer because of the varied costs of living for the elderly. The cost of a "modest but adequate" level of living for a retired elderly couple renting a home has been estimated by the Bureau of Labor Statistics to range from \$2,390 to \$3,110 for 20 large cities in the autumn of 1959.¹⁹ These figures would suggest that about 50% of the population over 65 cannot afford health care.

The Labor statistic figures, however, do not make allowances for any savings that result from home ownership. In early 1960, almost two-thirds of the nonfarm families headed by a person 65 and over owned their homes, with more than four-fifths of the homes clear of mortgage debt. Among OASI beneficiaries studies in 1957, about 66% of those married and 34% of those nonmarried owned their homes.²⁰ Most of them were mortgage free. Home ownership means a considerable savings but higher taxes, upkeep, and utilities offset some of this.

Another factor bearing on the ability to pay is the amount of assets of the older age group. An OASDI survey in 1957 made a rough comparison of the assets owned by the aged in 1951 and in 1957. The median net worth of the retired worker, with wife entitled, increased from \$5,610 to \$9,616. These figures do not include cash surrender value of life insurance policies. Discounting cost of living changes and appreciation, it appears that the older group is much better off from the standpoint of assets. Although assets are not generally considered a source for living expenses and health care, they should be considered because most people do accumulate assets to take care of themselves in their older years.

It was mentioned earlier that the median cost of health care for those over 65 was \$177 annually. The actual cost to any one individual may vary from no cost to thousands of dollars. It's, therefore, not possible to determine whether the older person can afford to pay for health care from his income and assets, because it is impossible to predict the cost annually to each individual. A better avenue of approach would be to determine whether the majority can pay for adequate health insurance.

A review of available plans indicates that a typical plan ²¹ to cover most expenses should include the following: Hospital Daily Indemnity of \$20 per day for a period of 60 days for each accident or sickness, miscellaneous hospital expenses of \$200, and surgical expense of \$200. A \$50 deductible is subtracted from the total covered expenses. The annual cost of this coverage for males varies from \$84.84 at the age of 60 to \$172.44 at the age of 80.

This policy does not cover all costs and it, therefore, seems reasonable to expect that the cost of the insurance plus the additional costs and the \$50 deductible would place the individual annual median cost close to the \$177 figure.

The data available do not tell whether the majority can afford this expenditure. We know that over half of the older people are covered by either Blue Cross or some form of private insurance and the income analyses suggest that approximately 50% of the older group cannot afford the outlay necessary for insurance. Of this 50%, 14% receive OAA and a number of others receive veterans assistance and other forms of help. As estimated earlier, there is a group of 25% to 30% who are "in-between" and about which little is known. They have no insurance and probably have no recourse to state or federal assistance. It would be interesting to determine the income of this group and find

out whether they have the ability to pay. If so, are they willing to continue their self-insurance or do they want federal assistance under OASDI? If not, what type of aid most interests them. A survey of this segment of the older population would go far toward determining the ability of the older group to pay.

V. DISCUSSION

As with most controversial issues action has been slow in coming for assistance to the aged. There is a need for additional means of financing health care; both sides agree to this. The controversy lies in the method of providing the financing. Should it be on a voluntary basis handled by private means or should government action make coverage mandatory so that older people will be assured of adequate care resulting from their participation during their wage earning years?

The large increase in voluntary health coverage during recent years and the passage and current implementation of the Kerr-Mills Act indicate that the voluntary proponents have a strong case. On the other hand, implementation of the Kerr-Mills Act has been subject to criticism. In 24 States, there are now Kerr-Mills programs of medical assistance for the aged, but only 88,000 aged persons (one half of 1% of the aged population) received help under this program in March, 1962. Five States - New York, Massachusetts, California, Michigan, and West Virginia - accounted for 83% of all recipients and for 90% of all Medical Assistance Act (Kerr-Mills) payments. ²²

The slow action on the part of some States to implement the Kerr-Mills Act points up another problem - the unwillingness of many States to allocate State funds to take care of those who cannot afford to pay medical bills. Many States have been slow in providing assistance under OAA but are required by federal law to provide some assistance. MAA provisions (Kerr-Mills) are voluntary on the part of the States with the Federal Government paying from 50% to 80% depending on the State's per capita income. Individuals who are recipients of OAA are not eligible to participate in the MAA program at the same time. There is no limit on the number who can participate in the MAA provisions other than that their income and resources may be insufficient to meet medical costs. The Kerr-Mills Act could conceivably provide assistance to all older people who are in need of care. The implementation, however, is up to each individual State.

Those who advocate health benefits under Social Security do not seem to be so concerned with the needy and the indigent as they are with mass of people who are already receiving a limited regular income. They contend that a catastrophic illness can reduce this person to indigent status and force him to pass a "need test" even though he may have made modest provisions for his old age. The contention is that the older person is in a defenseless

position and is at the mercy of whatever chronic or debilitating sickness should hit him. Those who would protect this individual want him to live his years past 65 with the feeling that whatever illness befalls him will be paid for from money which he has contributed during his years of peak earning. He will not be accepting charity. The services provided to him would be a social service of the government and not subject to profit of the private sector.

Those opposed to this view say that everyone in this country has a right to decide where and how he will spend his earnings - and Social Security benefits should be paid as a cash dividend. Care under a government health program would deprive him of his right to decide on the type of care he wanted. The quality of medical care would deteriorate they say. Waste and inefficiency would more than offset any savings resulting from handling by the "non-profit" Federal Government.

The views are not being reconciled and the fight goes on with the prospect of heated discussions in the 1963 session of Congress.

The American Medical Association (Clinical Session) in a recent meeting asserted "renewed vigor in strengthening existing Kerr-Mills programs and in working for passage of implementing legislation in States without such programs."²³

Insurance companies are bringing out new plans at a rapid pace and the Blue Cross and Blue Shield have both recently released improved plans for "Senior Citizens".

On the other hand the Administration is girding itself for a renewed effort to pass legislation which will provide care under Social Security.

The outcome of the two conflicting views will be determined not by the Administration but by the success of those who wish the voluntary form of participation. Their failure will result in a centralized form of old age health insurance.

VI. SUMMARY

An attempt has been made to give some insight into the current status of medical care for the aged. The problem was stated in an all too superficial manner. There are so many ramifications in the supplying of medical care to 17 million aged with an infinite diversity of needs that a volume could be written on this one aspect alone.

The brief legislative background is by no means complete but it does state broadly the measures taken to date by federal and state agencies for the care of those over 65. Also, of current importance, the two polar views for a solution to the old age medical care problem have been delineated; one, legislation to provide medical care through the social security concept and, two, voluntary medical insurance coverage with supplementary legislation to provide care at a state or local level for those in need.

The extent to which private insurance companies and non-profit group plans have satisfied the need has been discussed. Here again, a thorough analysis would involve a lengthy treatise and considerable original research to adequately define just how many elderly are covered and the true extent of their coverage. Only rough guideposts are now available.

Ability to pay is the subject that has probably attracted more political comment than any other aspect of the problem and about this the least is known. Metropolitan studies of old persons' living costs have been made by the Census Bureau. Most of the people surveyed in metropolitan areas rent apartments but studies show that 70% of the older group own their own homes. Statistics based only on metropolitan areas are therefore biased on one important point and probably on many others because there is a considerable difference in the mode of existence between city, suburban and rural people. Studies should be conducted to determine specific income disposal patterns for the elderly in random areas of the country. This information, when compared with income and assets which are fairly well defined, would give a much more accurate picture of ability to pay and would dispel some of the uncertainty surrounding this problem.

Finally, we should take a close look at the attitude of the people in the United States for a solution because the problem will probably be solved politically on the basis of the desires of the majority. In recent decades, people have begun to think more and more that medical care is a right which should be granted to them by the Federal Government. Somers says:

There is today a broad consensus that people should receive the medical care they need. This concept of medical care as a "right" has now become a part of our political vocabulary. This new public attitude stems partly from the growing health consciousness of the American people, increasing familiarity with the new medical potential and a changing socio-economic climate in post-war America.²⁴

Recent elections in this country tend to confirm that the majority do want additional social legislation or at least are not satisfied with the present methods for handling the problem. President Aime J. Forand, (former Congressman) of the National Council of Senior Citizens stated that on the basis of 33 holdover Senators who supported "Medicare" in the unsuccessful vote of July 17, 1962 and the election of at least 18 Senate candidates who backed the President's program, "the new 'Medicare Bill' to be submitted by the President early next year is certain of speedy Senate passage."²⁵

Debate on the subject may go on for many more years. There are obvious advantages to this type of public controversy. The private sector is spurred to further action and the government is stimulated to develop better plans for the ultimate solution for the care of the aged. Time will tell which view will predominate.

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