Old age - Medical care

1963 HANDBOOK

on Hospital Insurance for the Aged through Social Security

[Revised May 1963]

[American Federation of Labor and Congress of Industrial Organizations. Department of Social Security.]

[Washington, 1963]

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

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FACTS AND FIGURES
ON
HOSPITAL INSURANCE FOR THE AGED
THROUGH SOCIAL SECURITY

as proposed in President Kennedy's program, incorporated in the Anderson-King bill (S. 880 and H. R. 3920), providing for payment for hospital services, home health services, and services in skilled nursing facilities for persons over 65, financed primarily through the Social Security and Railroad Retirement programs.

May, 1963 (Revised)
AFL-CIO
Department of Social Security

Nelson H. Cruikshank
Director

THE NEED FOR PROTECTION

Older people have
Higher medical expenses

Older people have
Lower incomes

Older people have
Less insurance

RESULT

Fear of large and unpredictable bills is a major source of anxiety to the aged and their children.

Costs of serious illness are a major catastrophe and cause of dependency in old age.

The aged live with illnesses that go untreated or do not receive adequate and timely care.

Older people NEED MORE MEDICAL CARE than younger people

People over 65 use three times as much hospital care as people under 65.

ANNUAL RATE PER 1,000 PEOPLE:
2800 days for the aged compared to
900 days for those under 65

Hospitalization is more frequent.

After age 65, 9 out of 10 persons are hospitalized at least once.
2 out of 3 are hospitalized 2 or more times.

Hospitalization lasts longer.

The average hospitalized person over 65 stays twice as long (14.9 days) as the average younger person (7.6 days).

Source: American Hospital Association
U.S. National Health Survey

Older people have HIGHER MEDICAL COSTS than younger people

Average yearly private spending for medical care of people over 65 is more than twice as much as that of the rest of the population.

Half the aged couples, where one or the other is hospitalized, have total medical bills of over $800 in one year.

Among the unmarried aged who are hospitalized, half have medical bills of over $700.

Source: Dept. of Health, Education, and Welfare

Hospital care is expensive and HOSPITAL COSTS ARE RISING

A hospitalized illness is the kind of emergency for which it is most difficult to budget. Paying for hospital care becomes an increasingly acute problem as hospital costs continue to rise.

The average expense per day of hospital care has gone up from $9.39 in 1946, to $23.12 in 1955, to **$34.98 in 1961**, and is continuing to rise.

Source: American Hospital Association

Older people are LESS ABLE TO PAY for medical care than younger people

They have less income

Two-person families with a head 65 or over have a median income of **$2530** a year—less than half that of younger two-person families ($5314). Aged persons living alone have a median income of **$1050** (compared to $2750 for people under 65 living alone.) Aged persons living with relatives have a median income of $500 a year.

They have fewer assets

More than three out of ten families with a head of 65 or over have either **no assets** that can be readily converted into cash, or **less than $100** in such assets; almost half have none or less than $1000.

They have less insurance protection

Only about **half the aged** have some hospitalization insurance compared to over **75% of younger people.** The insurance the aged have is usually expensive, limited, and restrictive, and frequently can be cancelled at the option of the insurance company or excludes pre-existing conditions.

Source: Department of Health, Education and Welfare and U.S. Census.

Older people have LESS HEALTH INSURANCE than younger people and the insurance they have is less adequate

About half the aged have some form of health insurance.

For those groups among the aged who have the most need for protection, the proportion with coverage is even lower

Only **33%** of the aged in families with **incomes less than $2,000** have hospitalization insurance

Only **30%** of the aged with **chronic disabilities** have hospital insurance

Only **32%** of the aged who are **75 and over** have hospital insurance

Older people have substantially less protection against hospital costs through insurance.

Three-fourths of the hospital bill is paid by insurance for 54% of those under 65, while only **30%** of those **over 65** have as much as three-fourths of their bill covered.

Source: Dept. of Health, Education, and Welfare

Health insurance that is now available to older individuals and that provides reasonable protection is EXTREMELY COSTLY

Comparatively comprehensive nongroup policies for the aged	Annual Cost Per Individual
Blue Cross plans covering 70 days of hospital care and auxiliary benefits on a service basis	$97-175
State-wide commercial insurance plans with basic hospitalization and surgical coverage plus major medical	
Connecticut 65	$204
Massachusetts 65	210
New York 65	228

Health insurance that is now available to older individuals at moderate cost provides only SEVERELY LIMITED PROTECTION

Typical nongroup policies available to the aged:

A. **Blue Cross hospital insurance** (approximately 4¼ million aged policyholders):

Annual premiums (per person) ***$51.60 - $174.60***

Three-fifths of the 54 Blue Cross contracts (excluding Blue Shield) have premiums of over $100 per person per year.

Three-fourths of the 20 Blue Cross-Blue Shield combined offerings have premiums of over $125 per person per year.

Common limitations:

1. Most plans (96%) exclude pre-existing conditions for at least 6 months.
2. More than half have dollar limits or coinsurance provisions on hospital room costs.
3. Only about half cover nursing home care or visiting nurse service.
4. More than ⅓ limit dollar allowances for ancillary hospital services.
5. Almost ¼ may exclude applicants on the basis of a statement of their health.

(cont.)

B. Health insurance protection offered by insurance companies (approximately 4¾ million aged policyholders):

Two specific policies cover more than half of the 4¾ million aged with commercial health insurance protection:

	Continental Casualty 65-Plus	Mutual of Omaha Senior Security Policy
Aged persons holding policies	1.2 million	1.25 million
Annual premiums (per person)	$78	$102
Percent of premiums paid out in benefits [1]	49	67
Benefits offered:		
Hospital room payments (per day)	$10 (31 days)	$10 (60 days)
Other hospital expenses	$100	$1,000 (with $100 deductible & 80% coinsurance)
Surgical expenses (per schedule)	$200 maximum	$225 maximum
Nursing home expenses (per day)	NONE	$5 (55 days)

[1] All nongroup medical expense policies, 1961.

PRESIDENT KENNEDY'S PROPOSAL (ANDERSON-KING BILL)

PEOPLE PROTECTED

18 million persons over 65 protected beginning January 1965

Coverage for present workers and their wives (or widows) when they reach 65

People Protected

Population aged 65 and over: ESTIMATES OF ELIGIBILITY FOR HOSPITAL INSURANCE UNDER THE ADMINISTRATION PLAN AS OF JANUARY 1965

(in millions)

TOTAL AGED PERSONS		**18.2**
Eligible under OASI	**15.1**	
Eligible under RR	**.5**	
Others eligible	**2.4**	
TOTAL PROTECTED UNDER SOCIAL SECURITY HOSPITAL INSURANCE PROPOSAL		**18.0**

(Almost all of the 200,000 not protected under this plan are Federal employees or retired Federal employees, protected under their own system.)

Distribution of Aged Persons, by State

State of Residence	Persons 65 and over[a]	As percent of all ages in State	As percent of all aged in U.S.
	(in thousands)		
Total	**16,560**	**9.2**	**100.0**
Alabama	261	8.0	1.6
Alaska	5	2.4	.03
Arizona	90	6.9	.5
Arkansas	194	10.9	1.2
California	1,376	8.8	8.3
Colorado	158	9.0	1.0
Connecticut	243	9.6	1.5
Delaware	36	8.0	.2
District of Columbia	69	9.1	.4
Florida	553	11.2	3.3

State of Residence	Persons 65 and over[a]	As percent of all ages in State	As percent of all aged in U.S.
	(in thousands)		
Georgia	291	7.4	1.8
Hawaii	29	4.6	.2
Idaho	58	8.7	.4
Illinois	975	9.7	5.9
Indiana	446	9.6	2.7
Iowa	328	11.9	2.0
Kansas	240	11.0	1.5
Kentucky	292	9.6	1.8
Louisiana	242	7.4	1.5
Maine	107	11.0	.6
Maryland	227	7.3	1.4
Massachusetts	572	11.1	3.5
Michigan	638	8.2	3.9
Minnesota	354	10.4	2.1
Mississippi	190	8.7	1.1
Missouri	503	11.7	3.0
Montana	65	9.7	.4

State of Residence	Persons 65 and over[a]	As percent of all ages in State	As percent of all aged in U.S.
	(in thousands)		
Nebraska	164	11.6	1.0
Nevada	18	6.4	.1
New Hampshire	68	11.2	.4
New Jersey	560	9.2	3.4
New Mexico	51	5.4	.3
New York	1,688	10.1	10.2
North Carolina	312	6.9	1.9
North Dakota	59	9.3	.4
Ohio	897	9.2	5.4
Oklahoma	249	10.7	1.5
Oregon	184	10.4	1.1
Pennsylvania	1,129	10.0	6.8
Rhode Island	90	10.4	.5
South Carolina	151	6.3	.9
South Dakota	72	10.5	.4
Tennessee	309	8.7	1.9
Texas	745	7.8	4.5

State of Residence	Persons 65 and over[a]	As percent of all ages in State	As percent of all aged in U.S.
	(In thousands)		
Utah	60	6.7	.4
Vermont	44	11.2	.3
Virginia	289	7.3	1.7
Washington	279	9.8	1.7
West Virginia	173	9.3	1.0
Wisconsin	403	10.2	2.4
Wyoming	26	7.8	.2

[a] As of April 1, 1960.
Source: U.S. Bureau of the Census.

PRESIDENT KENNEDY'S PROPOSAL (ANDERSON-KING BILL)

SERVICES COVERED

Hospital Care

Nursing Facility Care

Hospital Outpatient Diagnostic Services

Home Health Services

Services
covered

The Administration Plan would provide payment, in the case of each illness of an aged person, for:

1. **Hospital services** . . . the beneficiary may select one of three options:
   A. Hospital services for 90 days in each illness, subject to a deductible paid by the patient of $10 a day for up to 9 days (minimum deductible, $20; maximum, $90); or
   B. Hospital services for 45 days in each illness, at no cost to the patient; or
   C. Hospital services for 180 days in each illness at a maximum cost to the patient of 2½ times the average cost of one day of hospital care (this would be $92.50 during 1965-1966.)

2. **Skilled nursing home services** in facilities affiliated with hospitals, after transfer from a hospital, up to 180 days;

3. **Outpatient hospital diagnostic services**, as required, subject to $20 deductible amount for each diagnostic study;

4. **Home health services**, up to 240 visits during a calendar year; includes nursing care and therapy.

Effective dates of Provisions

HEALTH SERVICES

January 1, 1965	Inpatient hospital services Outpatient hospital diagnostic services Home health services
July 1, 1965	Skilled nursing facility services

FINANCING PROVISIONS

January 1, 1965	Increase taxable earnings base to $5,200, and Increase contribution rates by ¼ of one percent on employers, ¼ of one percent on employees, and 4/10 of one percent for self-employed

PRESIDENT KENNEDY'S PROPOSAL (ANDERSON-KING BILL)

FINANCING & ADMINISTRATION

The average wage-earner will pay about $1.00 per month through the Social Security system for Hospital Insurance Benefits for both himself and his wife (or widow) beginning at age 65.

Financing Provisions in the Proposal

1. Social security and railroad retirement **contribution rates would be increased** by ¼ of 1 percent each for employees and employers and 4/10 of 1 percent for self-employed persons.

2. **The taxable earnings base would be increased** from $4,800 to $5,200. Contribution income from the increased taxable earnings in excess of that required to pay the cost of increased cash benefits would be allocated to help pay for the hospital insurance benefits.

3. Appropriations from Federal **general revenues would pay for benefits for the aged people not insured** under social security or railroad retirement.

Present Social Security Tax and scheduled increases

Calendar Year	Employee	Employer	Self-Employed
1963-65	3 5/8 %	3 5/8 %	5.4%
1966-67	4 1/8 %	4 1/8 %	6.2%
1968 and after	4 5/8 %	4 5/8 %	6.9%

Proposed Social Security Tax with Hospital Insurance

1963-64	3 5/8 %	3 5/8 %	5.4%
1965	3 7/8 %	3 7/8 %	5.8%
1966-67	4 3/8 %	4 3/8 %	6.6%
1968 and after	4 7/8 %	4 7/8 %	7.3%

Proposed Increase in Weekly and Monthly Contributions of Wage Earners Covered under Social Security

Annual Wage*	Number of Wage Earners (millions)	% of Wage Earners	Contribution for Hospital Insurance	
			Weekly	Monthly
Less than $2400	29.4	43	Less than 12¢	Less than 50¢
$2400-4799	18.4	27	12¢–23¢	50¢–$1.00
$4800 and over	20.2	30	23¢–34¢	$1.00–$1.47

* 1961 earnings

Social Security Contribution Rate and Amount of Contributions for An Employee Under Present Law and Under the Proposal

	Contribution rate (percent of taxable earnings)	Yearly Earnings				
		$2400	$4800	$5200 or more *		
				Total	OASDI	Hospital Insurance
1965						
Under the proposal	3 7/8	$93.00	$186.00	$201.50	$183.82	$17.68
Under present law	3 5/8	87.00	174.00	174.00	174.00	——
Increase	1/4	6.00	12.00	27.50	9.82	17.68

* Workers with yearly earnings of over $4800 would receive higher old-age, survivors, and disability insurance benefits, in addition to hospital insurance protection. With an increase in the earnings base to $5200, the maximum worker's benefit would ultimately rise to $134 and the maximum family benefits to $268 (as compared to $127 and $254, respectively, under present law).

Increase in Monthly Benefits as a Result of Increase in Earnings Base

Increasing the earnings base from the present $4,800 to the proposed $5,200 would result in an increase in the amount of monthly cash benefits payable to workers who earn more than $4,800 a year, and to the eligible dependents and survivors of such workers. Because workers would be making contributions on the first $5,200 of their annual earnings, many workers would have, for purposes of computing social security benefits, a higher average monthly wage. (The average monthly wage is the base for determining benefit amounts.) Thus, the maximum monthly benefit payable to an individual worker, for example, would be increased from $127 to $134 per month. The maximum benefits payable to a worker and his family would be increased from $254 to $268 per month.

This increase in maximum family benefits would produce an immediate increase (January 1965) in benefits to some 170,000 families (about 700,000 persons) in which three or more members are receiving benefits and whose benefits are reduced because of the present $254 maximum limitation on the amount of benefits payable to a family.

The increase in the earnings base would produce an increase in contribution income which would be more than sufficient to cover the cost of the resultant higher cash benefits. The excess of increased income over increased cost would be allocated to help pay for hospital insurance benefits.

Estimated Income and Expenditures Under the Proposal[a] *(in millions)*

Social Security

Year	Income		Expenditures for Benefits and Administration	
	OASDI Trust Funds	Hospital Insurance Trust Fund	OASDI	Hospital Insurance
1965	$300	$1,430	$20	$1,040
1966	510	1,710	30	1,530

Federal General Revenues *(Benefit and administrative expenditures for people not eligible for Social Security or RR)*

Year	Gross Cost for Blanketed-In Group	Present Cost of MAA & OAA Met by Proposal (Offset to Gross Cost)	Additional Cost to General Treasury
1965	$220	$150[b]	$70
1966	290	200[b]	90

[a] Excludes contributions and expenditures for aged persons eligible only under Railroad Retirement.

[b] Somewhat greater amounts of State and local funds would also be offset.

Administration of the Hospital Insurance Proposal

A. Federal Agencies

1. For social security beneficiaries—Department of HEW.
2. For railroad retirement annuitants—Railroad Retirement Board.
3. For the uninsured—Department of HEW

B. State Agencies

1. Secretary of HEW would have authority to use State agencies to perform certain administrative functions:
   a. Determine whether providers meet conditions for participation;
   b. Furnish consultative services to providers for the purpose of assisting them to improve their services and administrative operations, and helping them to meet conditions for participation.
2. States could recommend that higher conditions should be established for providers within the State's jurisdiction; upon such recommendation, the Secretary could modify conditions in the State accordingly.

(cont.)

State Agencies (cont.)

3. Secretary would consult with States in formulating conditions for participation necessary for health and safety which he may establish. Consultation would provide additional assurance that local conditions would be taken into account.

C. Private Organizations

1. Groups of providers could designate the private organization of their choice to bill and receive payment from the social security system for services covered under the program.
2. Designated private organizations could, subject to approval of the Secretary, perform such further functions as determining the amount of payment due providers, auditing provider records to assure proper payment and assisting providers in the application of safeguards against unnecessary utilization.

D. Advisory Council

A Hospital Insurance Benefits Advisory Council would advise the Secretary on policy matters in connection with administration.

KERR-MILLS LIMITATIONS

- Two and a half years after enactment of Federal Kerr-Mills legislation, half the States had no Kerr-Mills MAA program at all

  By February 1963, only 25 states were paying MAA benefits

- Where there is a program

  Very few get benefits

  Humiliating poverty test is required

  Benefits are usually very meager

The Kerr-Mills MAA Program cannot meet the needs of the vast majority of the aged

As of February, 1963, less than 7 of every 1,000 aged persons in the United States were receiving any assistance under the Kerr-Mills (MAA) Program.

All but the poorest are left out. People who have more than minimum incomes get no benefits.

Benefits are frequently meager, spotty and uncertain. Half the states still pay no benefits at all. It is up to the state.

An aged person must pass a humiliating poverty test before he can get help. In many states his children, too, have their incomes and resources investigated before he can get help.

Limited state tax resources and high cost of good quality service have forced the use of facilities that endanger health and safety.

Kerr-Mills *can* function successfully as a supplement to the Anderson-King bill. With the main burden of health costs met by Social Security, it would become possible in all states to set up good medical assistance programs under Kerr-Mills to meet any remaining needs.

Status of program of Medical Assistance for the aged — March 1963

Programs operating ..... **28 jurisdictions**

25 States

Alabama	Kentucky	New Hampshire	South Carolina
Arkansas	Louisiana	New York	Tennessee
California	Maine	North Dakota	Utah
Connecticut	Maryland	Oklahoma	Vermont
Hawaii	Massachusetts	Oregon	Washington
Idaho	Michigan	Pennsylvania	West Virginia
Illinois			

Other jurisdictions

Guam Puerto Rico Virgin Islands

Programs to begin later ..... **5 jurisdictions**

New Jersey (effective 7/1/63)
South Dakota (effective on or after 7/1/63)
Wyoming (effective 7/1/63)
Virginia (effective 1/1/64)
District of Columbia (may be effective 7/1/63)

Need implementing legislation ..... **21 States**

1. Legislation pending or being drafted ..... 13 States

Arizona	Iowa	Missouri	North Carolina	Rhode Island
Colorado	Kansas	Nebraska	Ohio	(being drafted)
Indiana	Minnesota	Nevada		Wisconsin

2. Other States ..... 8 States

Alaska	Florida	Mississippi	New Mexico
Delaware	Georgia	Montana	Texas

Source: Bureau of Family Services, Department of Health, Education, and Welfare.

States With MAA Programs, By Amount of Payment, Number of Recipients, Average Payment—January 1963

State	Total Payments			Recipients	
	Amount (in thousands)	Cumulative Percent	Average Per Recipient	Number	Percent of Aged in State
Total	**$24,937**	—	**$214**	**116,672**	**1.1** [a]
N. Y.	9,641	38.7	302	31,929	1.8
Calif.	5,258	59.7	289	18,193	1.2
Mass.	3,679	74.5	165	22,343	3.9
Pa.	1,489	80.5	248	6,011	0.5
Mich.	1,421	86.2	332	4,283	0.7
Conn.	956	90.0	206	4,637	1.9
Ill.	248	91.0	410	604	0.1
Md.	223	91.9	34	6,574	2.8
Utah	214	92.7	136	1,576	2.3
Idaho	205	93.6	137	1,491	2.4
W.Va.	197	94.4	35	5,664	3.4
N. D.	178	95.1	203 [b]	875 [b]	1.4 [b]

State	Total Payments			Recipients	
	Amount (in thousands)	Cumulative Percent	Average Per Recipient	Number	Percent of Aged in State
Okla.	173	95.8	221	783	0.3
Wash.	157	96.4	183	856	0.3
S.C.	150	97.0	191	786	0.5
Ark.	145	97.6	76	1,923	0.9
La.	124	98.1	255	486	0.2
Me.	94	98.5	267	351	0.3
Hawaii	86	98.8	204	419	1.2
P.R.	74	99.1	34	2,196	1.7
Tenn.	67	99.4	62	1,084	0.3
Ala.	57	99.6	298	193	0.1
Ky.	33	99.7	14	2,306	0.8
Vt.	29	99.8	353	82	0.2
Ore.	26	99.9	69	375	0.2
N.H.	12	100.0	138	84	0.1
V.I.	2	100.0	4	483	16.1
Guam	[c]	100.0	3	85	8.5

[a] Based on States listed in this table. Proportion of total aged in U.S. is slightly under 0.7%.

[b] An unknown number of cash-only recipients is included, causing average vendor payment to be understated.

[c] Less than $500.

Operation of Kerr-Mills (MAA) Programs in the various states is uneven and uneconomical

Even the limited objective of this program, to provide medical care on the basis of need, is not being met. There is **no correlation between need and the distribution of funds.** In January 1963, 75% of total MAA funds were being spent in three rich industrial states (New York, California and Massachusetts), which together have only 21.9 percent of the Nation's older population.

Average expenditures per recipient ranged between $14.18 in Kentucky and $410.45 in Illinois.

Administrative costs are enormous. Due to restrictive eligibility requirements and coverage, expenditures for administration in fiscal year 1962 were as high as 67% of benefit costs in one state, and 124% in another.

ELIGIBILITY REQUIREMENTS

At least two-thirds, perhaps over three-fourths, of all aged persons meeting the income tests for MAA fail, nevertheless, to qualify for payment for care covered by the State plans.

1. **Cash Income Limits:** Half the existing programs provide an upper yearly income limit of $1,200 or $1,500 for MAA eligibility for an individual. About half do not provide MAA where yearly income exceeds $2,000 for a couple;
2. **Liquid Asset Limits:** About two-thirds of the MAA programs deny eligibility when liquid assets exceed $1,000 for an individual or $1,500 for a couple;
3. **Life Insurance Limits:** All but 1 of the 28 jurisdictions limit the value of life insurance eligible persons may hold; 4 disqualify persons with life insurance value over specified amounts—as low as $500 for a couple in two States;
4. **Relative's Responsibility:** Thirteen of the 28 jurisdictions make MAA payments only after specified relatives (sometimes including parents) are found unable to pay for medical care expenses which the applicants cannot meet from their own resources.

(cont.)

SCOPE OF MEDICAL CARE

1. **Limitations on Types of Care:** Federal law requires that at least two types of care (one institutional and one noninstitutional) must be covered. The only type of care common to all 28 programs now operating is inpatient hospital care. Only 4 States provide substantial coverage of 5 major types of services (hospital care, physicians' services, nursing home care, prescribed drugs and dental care)—but even these States do not cover all needed care;

2. **Limitations on Amount of Care:** Covered care is available in 8 States only in certain kinds or degree of illness, not whenever medically required; or for short periods—no more than 15 days of hospital care per year in 4 States, and no more than 15 days per stay in 4 other States. At least 8 States require deductible amounts to be paid before MAA is provided.

RECOVERY PROVISIONS

Ten of the 28 jurisdictions may, after finding an individual eligible for aid, recover MAA payments from recipient's estate.

SOCIAL INSURANCE

"Social insurance is to economic well-being what preventive medicine is to health. Social insurance seeks to prevent poverty from arising, while relief measures deal with poverty after it has become a fact. The underlying issue in the current debate is whether we shall forestall, so far as we can, the poverty which health costs create among the aged; or whether we shall wait for poverty to occur and minister only to those who have already exhausted their own resources."

ALANSON W. WILLCOX, *General Counsel*
U.S. Dept. of Health, Education. & Welfare

Principles of Social Insurance

1. The purpose of social insurance is to provide **basic protection** against those economic hazards which are sufficiently far-reaching as to require such protection for the good of society.

2. The protection is provided in a manner designed to preserve individual dignity and self-respect by making it a **self-help** program—i.e., benefits are an earned right based on work and contributions.

3. Social insurance is intended to serve society as a whole, so the program must have the **widest practicable coverage of the population.** Coverage of all those who work in covered employment eliminates adverse selection as a factor and avoids the need to use underwriting procedures which reduce the coverage of the poor risks. (Under many private employer insurance or pension programs, membership in the insurance plan is required, just as in social security, as a condition of employment.)

4. Both **social adequacy** of benefits and individual equity (i.e., a fair return for contributions) are important considerations in social insurance, while individual equity is generally governing in private insurance. (In

some private insurance, especially in negotiated plans, adequacy is a consideration.)

5. Social insurance **reinforces the incentives** to earn—by making benefits contingent upon work—and to save, since the omission of a means test makes it possible to have both the benefits and full value from personal savings.

Insurance Nature of Social Insurance

Insurance distributes the economic costs, resulting from the hazard insured against, over a group of people and over a period of time. It works by pooling relatively small, regular payments from a large number of persons subject to a serious hazard that for the individual is unpredictable (but is reasonably predictable in the aggregate), with payments from the pooled funds being made when the hazard strikes.

The nature of insurance can be summed up in four basic principles: (1) the loss should **not be a regularly recurring, budgetable event;** (2) the loss should be of **financial consequence** to the insured individual; (3) whether or when the loss occurs should, for practical purposes, be **beyond the control of the insured;** and (4) the loss should be of a **calculable amount.**

The loss insured against by social security is loss of earnings due to disability, death or retirement in old-age—events which threaten the financial security of the family. When earnings stop because of retirement, death or disability, insurance benefits are paid from the contributed funds to partially replace the income that has been lost. The cost of meeting

the risks is actuarially evaluated and contributions sufficient to cover these costs are provided for. Benefits are paid on a predetermined basis when and if the risks covered occur. The right to these insurance benefits is a legal right enforceable in the courts. These are the characteristics that make social insurance "insurance"; they are similar to the characteristics that make private voluntary insurance "insurance."

Differences Between Social and Private Insurance

Contractual relationships. Under private insurance a contract establishes premiums and benefits for the duration of the contract which can generally be changed only by agreement of both parties. Under social insurance the legal right to benefits (a legally enforceable right) and the contributions required are spelled out in a statute which can be amended. (Changes made over the years in the social insurance program have always improved protection; this ability to improve protection as needs change is considered one of the advantages of social insurance.)

Reserve requirements. Because the social insurance program is assured of full coverage into the future, it does not have to build up the kind of reserves a private insurance company needs to meet its obligations even if it is unable to attract new customers or it goes out of business. The obligations of private companies which go out of business do not, of course, extend to providing the full value of protection for the full term of the policy. The test of a sound social insurance program is whether it operates under a plan of financing which provides sufficient income to meet all obligations as they fall due.

Citations on the Nature of Social Insurance

- ***Encyclopaedia Britannica* article by Dr. J. Edward Hedges, Professor of Insurance at the University of Indiana:**

  ". . . The modern institution of insurance is divided into the two broad categories of voluntary or commercial insurance and compulsory or social insurance, both relying on the same basic principles . . .

  "The shift from an agricultural and handicraft economy to modern industrial society in the western world brought with it a new type of social insecurity for which social insurance was evolved as at least a partial solution. . . ."

- **The Supreme Court of the United States in the case of *Flemming v. Nestor, 1960:***

  ". . . The Social Security system may be accurately described as a form of social insurance, enacted pursuant to Congress' power to 'spend money in aid of the general welfare.' "

- **"Social Insurance In A Democracy," speech by Reinhard A. Hohaus, Vice President and Actuary, Metropolitan Life Insurance Company, 1942:**

  "The depression years brought about general agreement that changes in the social and economic structure of our country had made inadequate some of the old methods by which society attempted to meet its obligations, and that major innovations were needed. One of the results was the adoption of the social insurance approach for certain of the major hazards. While that approach was new to this country, it can hardly be considered as a change in basic philosophy . . ."

Soundness of the Social Security Trust Fund

The long-run financial position of the social security program is sound. The total income to the program over the years has exceeded its total outgo; at the end of 1962 the balance in the social security trust funds was $20.7 billion. Although outgo has been more than income in some years—for example, expenditures from the trust funds during 1962 were about $1.5 billion more than income—present estimates show that the combined trust funds will increase by $3.1 billion during the 5-year period 1963-1967.

Recent excesses of outgo over income were largely attributable to several past legislative changes which caused a relatively large but temporary increase in expenditures in the period immediately after their enactment. For example, in 1956, the law was changed to make it possible for women to begin receiving benefits at age 62. Since the benefits paid to women who choose to draw "early retirement" benefits are permanently reduced to take into account the longer period of time over which benefits will be paid, the payments to those women will be smaller in future years than they would have been under previous law. Thus, this change has no significant effect on long-run costs, although it did increase the immediate outgo of the system.

Federal Advisory Council Finds Social Security Trust Fund Solvent and Sound

Social Security financing is reviewed periodically by an Advisory Council composed of distinguished economists, private insurance actuaries, bankers, social insurance and financial experts, and representatives of management and labor. The most recent such review was in 1959. The Council declared the program sound and solvent:

"*The method of financing the old-age, survivors, and disability insurance program is sound, and, based on the best estimates available, the contribution schedule now in the law makes adequate provision for meeting both short-range and long-range costs.*"

The members of the 1959 Advisory Council were:

Elliott V. Bell, Chairman of the Executive Committee, McGraw-Hill Publishing Co., Inc.; Editor and Publisher, Business Week

J. Douglas Brown, Dean of the Faculty, Princeton University

Malcolm Bryan, President, Federal Reserve Bank of Atlanta

Arthur F. Burns, President, National Bureau of Economic Research, Inc.

Joseph W. Childs, deceased, formerly Vice President, United Rubber, Cork, Linoleum and Plastic Workers of America

Nelson H. Cruikshank, Director, Department of Social Security, American Federation of Labor and Congress of Industrial Organizations

(cont.)

Carl H. Fischer, Professor of Actuarial Mathematics and Insurance, University of Michigan

Reinhard A. Hohaus, Senior Vice President and Chief Actuary, Metropolitan Life Insurance Co.

Robert A. Hornby, President, Pacific Lighting Corp.

T. Norman Hurd, State Budget Director, State of New York

R. McAllister Lloyd, Chairman, Teachers Insurance and Annuity Association of America

Eric Peterson, deceased, formerly General Secretary-Treasurer, International Association of Machinists

Relation Between Hospital Insurance and Cash Benefits

Cash benefits can meet regular recurring expenses like food and rent but are ineffective in meeting health costs because health costs are not evenly distributed from month to month. Aged people may have no health costs for several years and then suddenly incur costs running into thousands of dollars. It would be impossible to provide for all aged beneficiaries an increase in cash benefits of such magnitude as to cover the catastrophic expenses of some beneficiaries as they occur. The only solution is to even out this expense over time and over all the aged through insurance.

QUESTIONS AND ANSWERS

Isn't the proposed program "SOCIALIZED MEDICINE," or at least a big step toward it?

NO. "Socialized Medicine" is a system where doctors work as employees of the government, and the government owns the medical facilities. Hospital insurance through Social Security is not socialized medicine in any way, shape, or form.

Under the hospital insurance program

The Government would not provide—a single medical service, but only provide basic hospital insurance for the aged.

Hospital and other services would be paid—in much the same way that **Blue Cross and other insurers now pay.**

The proposed law states specifically—that the Government would in no way control, regulate, or interfere with the practice of medicine or the administration or operation of participating hospitals.

"Socialized Medicine" is being used as a scare slogan. Hospital insurance through Social Security is no more like socialized medicine than are Blue Cross or other insurance plans that pay hospital or medical bills.

Isn't the program just an ENTERING WEDGE TO A BROAD GOVERNMENT HEALTH PROGRAM?

NONSENSE! Any extension of this program would have to be legislated by Congress.

Are we to assume that once they have voted the Social Security hospital insurance program into law, Congressmen and Senators will suddenly go hog-wild, lose all critical judgment, and begin to enact health legislation the American people neither need nor want?

The U.S. Government has assisted its citizens in meeting their health needs since 1789 with no bad results.

This hospital insurance for the aged program meets a very special need, that the American people cannot meet without a governmental program.

Won't this program result in all the problems and abuses found in the BRITISH SYSTEM?

There is no relationship between President Kennedy's proposed Hospital Insurance for the Aged through Social Security, and the British National Health Service.

In evaluating the Anderson-King bill, there is nothing that an assessment of experience under the British system can contribute. There is **no similarity** between the two programs.
In Britain, the government provides **medical and hospital care** to the entire population.

In the U.S., under the Kennedy proposal, the government would provide **basic hospital insurance** to a limited group with special needs.

The charge of the opposition that the Anderson-King bill should not be enacted because the British have had bad experience and are dissatisfied with their National Health Service is false and misleading both because

- The British, including all 3 political parties and the British Medical Association, support the Service, and because
- The British experience is not relevant to the Anderson-King bill.

Wouldn't this proposal interfere with the doctor-patient relationship, or with the FREE CHOICE OF DOCTOR?

NO. There would be no interference in the doctor-patient relationship. Every patient would have free choice—of the doctor and hospital or nursing home from which he received care.

The Government would not—provide care, offer any service, suggest any physician or facility.

The Government would—set up the means for paying for an aged person's hospital and related care by a small tax levied during his working years.

The opposition of some medical organizations to this proposal is a mystery. Doctors' bills are not involved.

Aren't ALL THE AGED NEEDING CARE GETTING IT now? Is anyone who really needs it ever denied care?

A great many older Americans are not getting the care they need when they need it.

Although it is rare that anyone in *critical* condition must go without care because he cannot afford it,

Study after study—shows that vast numbers of aged persons throughout the country cannot get the good quality care they need when they need it.

Many live with their symptoms—and don't get treatment, because of the expense of treatment, or because they are too proud to accept charity.

Many postpone hospitalization—until it can no longer be put off—when it may be too late.

Lack of money certainly stands in the way of getting needed care. But it is important to remember that the primary purpose of the proposed legislation is not to provide care, but to give the aged some protection against the worry of becoming destitute or dependent as a result of the costs of major illness.

Private insurance cannot extend basic coverage to many more of the aged.

As the former president of the national Blue Cross Association, the late Dr. Basil C. MacLean, put it:

> *"A lifetime's experience has led me at last to conclude that the costs of care of the aged cannot be met, unaided, by the mechanism of insurance or prepayment as they exist today. The aged simply cannot afford to buy from any of these the scope of care that is required, nor do the stern competitive realities permit any carrier, whether non-profit or commercial, to provide benefits which are adequate at a price which is feasible for any but a small proportion of the aged." (February 5, 1960)*

Blue Cross, which insures half of the aged who have any health insurance, has recognized that they can no longer subsidize the aged. The Blue Cross Plans now recommend that public funds be used to help pay for protection against the health costs of the aged.

AMA predictions that private insurance can be extended to substantial additional numbers of the aged ignore the fact that the millions of older people who are uninsured are the worst sales prospects—the bad health insurance risks with low incomes.

How about solving the problem through a TAX CREDIT TO BE USED TO BUY PRIVATE INSURANCE, as proposed by Congressman Bow?

This kind of proposed program would provide **no assured protection to anyone,** and would give the **least protection to those who need it most.**

The Bow bill would provide a gift of $150 for all aged, costing over $2½ billion a year to start, and more later as the aged population grows and as pressure mounts from insurance companies as well as insurance recipients. With no tie to a special tax paid by future beneficiaries, the program would not be conservatively based, as is Social Security.

Much of the cost of this expensive proposal would go into **high administrative** costs resulting from individual enrollments.

But most important, **insurance carriers would not be obligated to provide adequate insurance at reasonable cost.** The chronically ill, the disabled, and those in the oldest age groups either would not be able to buy any protection at all, or would be charged premiums vastly higher than they could afford—against which the $150 credit would be a mere drop in the bucket.

Shouldn't any government program BE LIMITED TO THE NEEDY? Why help millionaires?

A major goal of the Anderson-King bill is to pay benefits to all persons as a matter of right rather than force them through the indignity of first exhausting their resources and then proving their poverty.

The determination of who is "needy" requires an investigation of a person's income, his possessions, and his savings. Many states investigate the financial position of children and other relatives too.

When eligibility depends on a means test, aged people who get sick must often deplete their entire resources before receiving benefits. What is left for them when they do get well?

There are very few among the aged who are so wealthy they don't need the protection of Social Security hospital insurance.

3/10 of 1% of those eligible have incomes over $50,000
only 3% of those eligible have incomes over $10,000

We must prevent dependency—not just deal with it after it has arisen, and then only at the price of humiliation and deprivation for the aged person and his family.

Many situations require looking into a person's financial condition. WHY OBJECT TO THE MEANS TEST UNDER KERR-MILLS?

The Kerr-Mills test is not like qualifying for a bank loan: Proving to a bank that you can pay back a loan is vastly different from proving to a welfare worker, after a lifetime of independence, that you can't pay for the necessities of life. One is proof of ability; the other is proof of failure.

The Kerr-Mills means test is not like qualifying for Social Security benefits: The social security law requires that a person be substantially retired in order to receive full social security retirement benefits. To receive social security people are not asked how much money they have in the bank, what property or other possessions they have, or whether their children can support them. They must only show (until they are 72 years old) that their **earned income** does not exceed a specified amount so that they can be considered retired—not whether they are rich or poor. Retirement is a condition for pension payment from practically every private pension plan too. By contrast, a means test program required investigation of all income, assets, and personal needs, and effectively classifies eligible applicants as a drain on the community—a drain the community often resents.

Wouldn't this program COST TOO MUCH?

NO! This program costs pennies a day—contributed by workers and employers. Spread out over his working life a contribution of about $1 a month is no sacrifice to the individual.

The costs of health care in old age are going to be paid somehow. The question is whether they shall fall as sudden crushing burdens on old people or their families—with charitable help available after they have been reduced to dependency; or whether people shall be able to contribute during their working years toward paid-up hospital insurance when they retire.

The hospital insurance program would also cut down on public assistance payments that states and the federal government othewise have to make.

Does anyone seriously believe America's aged citizens should live with the spectre of a financial catastrophe when they can enjoy security with a few pennies a day contributed while they are working?

Would there be OVERUTILIZATION of services?

NO. There are three safeguards built into the program to prevent overutilization.

The attending doctor—certifies that the services are needed before any will be paid for. Only the doctor can decide when a patient should be hospitalized.

The institution itself—sets up a committee to sample review the need for care. After 21 days' continuous service it reviews all cases to determine if further treatment is required.

The types of services covered—outpatient, nursing home, diagnostic and other services are covered. There would be no financial incentive to use a higher cost service than that required.

There will naturally be an increase in the aged entering hospitals when this program is enacted. People will be able to get needed treatment which they have long put off. This is not overutilization. This is proper utilization.

Is the old-age, survivors, and disability insurance fund FINANCIALLY SOUND?

YES, the fund is sound and the method of financing it is sound.

Advisory Councils—composed of distinguished economists, private insurance actuaries, financial experts from management also watch over the fund. In 1959 such a council reported the financing sound and adequate.*

Congress reviews—carefully the methods followed in financing this federal program.

$18 billion—is presently in the old age survivors insurance trust fund and $2 billion in the disability fund. The funds are expected to increase to $45 billion by 1970.

This insurance program is in good working order. It has worked well for a quarter of a century, paying regular benefits to millions. It will continue to do so. Claims to the contrary are based on deliberate distortions of the facts and represent a cynical and callous attempt to undermine public confidence in Social Security.

* *See section on Financing*

Didn't the Supreme Court say that SOCIAL SECURITY IS NOT INSURANCE?

NO. A solicitor-general in the Eisenhower Administration said that. The Supreme Court held that he was wrong, and it is Supreme Court decisions, not statements by the Solicitor-General that constitute the law of the land. In its decision the court said

"***The Social Security system*** may be accurately described as a form of social insurance, enacted pursuant to Congress' power to 'spend money in aid of the general welfare.'

"**The 'right' to Social Security benefits** is in one sense 'earned' for the entire scheme rests on the legislative judgment that those who in their productive years were functioning members of the economy may justly call upon that economy, in their later years, for protection from 'the rigors of the poor house as well as from the haunting fear that such a lot awaits them when journey's end is near.' "

Why does Hospital Insurance for the Aged BELONG IN THE SOCIAL SECURITY SYSTEM?

The whole point of Social Security is to provide financial independence to people who have worked all their lives and don't want to be a burden on their relatives, or to depend on charity and means tests.

Cash benefits—now paid are barely enough to enable most older people to keep themselves housed, clothed and fed. They certainly are not adequate to meet the cost of expensive and unpredictable illnesses, nor are they large enough to pay high health insurance premiums.

Social Security—cannot provide financial independence without this additional program of basic hospital insurance.

The aims and ideals embodied in the Hospital Insurance program will help Social Security do the job it was designed to do . . . provide dignity and independence for America's aged citizens.

Is it right that PEOPLE WHO HAVE NOT CONTRIBUTED toward these benefits should be protected?

The alternative is to write off an entire generation of Americans just because they're over 65, and thus supposedly beyond help.

Improvements in social insurance—have traditionally been extended to individuals already covered. When disability benefits were added to Social Security, those already disabled were covered even though they themselves made no additional contributions.

The worker of today—is more secure when this precedent is maintained. He knows that if times change he too will receive benefits that are added to the program to keep it up to date.

Why provide THE PARTICULAR BENEFITS specified in the Administration's Hospital Insurance proposal?

Hospital care—is the most expensive. Payment for hospital care will provide the most relief where medical bills are highest.

Care in a nursing home and nursing care at the patient's home—is less expensive and can allow hospitals to discharge patients whose conditions are improved but who still need some treatment.

Outpatient diagnostic services—will encourage early diagnosis and make it unnecessary for patients to be admitted to hospitals for diagnostic purposes.

With this range of benefits patients can get the medical care they need according to their condition—not according to their means.

Wouldn't the Program RUIN PRIVATE INSURANCE?

On the contrary, private insurance would be benefited.

With basic protection assured under Social Security hospital insurance, aged persons could use what funds they have to supplement their coverage.

Supplementary insurance could be sold by private insurance plans to cover items not covered by Social Security hospital insurance, such as surgery, drugs, physician visits, and dental care.

Without the burden of insuring the high-cost aged, Blue Cross, Blue Shield, and commercial insurance carriers could hold down their rates and sell insurance to the working population more successfully.

Private health insurance would thrive with the enactment of Social Security Hospital Insurance, just as private life insurance was stimulated in its growth by the passage of the original Social Security Act 28 years ago.

Why shouldn't the program be FINANCED THROUGH GENERAL REVENUES rather than through a "regressive" Social Security Tax?

A payroll tax has great advantages

Earned right—to benefits is based on contributory system. This frees the beneficiary from the personal repugnance and social stigma of meeting a means test.

Better administration of the program—with funds coming regularly from a payroll tax rather than from an annual appropriation.

No alternative exists—to a federal payroll tax other than using state and federal general funds. States average 4 times as much revenue from sales taxes as from income taxes. What is more regressive than sales taxes?

Why can't unions take care of the health costs of the aged THROUGH COLLECTIVE BARGAINING?

The very best plans unions have been able to negotiate leave most retired workers inadequately protected.

Most plans have ***high eligibility requirements***—20 years of continuous employment at Swift, 15 at Jersey Standard—and these are among the best.

In most plans, even in those paid for in part by the retired workers, ***benefits are much lower*** for the retired than the active worker.

Union negotiated ***protection for a retired worker may disappear overnight*** as plants and departments shut down, during this period of rapid industrial change.

The worker who is ***disabled*** before he is 65 or who ***loses his job*** often finds himself without earnings, pension, or insurance. And if he ***dies***, his widow is usually left without protection from a negotiated plan.

And what about all the people who have never belonged to a union?

Can KERR-MILLS at least TAKE ADEQUATE CARE OF NEEDY and near-needy?

Kerr-Mills does not and can not adequately take care of the near-needy or even of many of the very needy.

Almost half the states still have no Kerr-Mills MAA program.

Strict means tests under many OAA programs exclude even some of the clearly very needy.

Some MAA programs also apply very tight means tests, again excluding many of the needy and provide for very limited services, covering as few as 10 hospital days a year. In some states, care is provided only in emergency or life-endangering illnesses.

It is not that states are callous. States simply cannot afford to finance broad medical assistance programs for the medically indigent. Result is that the number of aged receiving help under MAA is only a fraction of those who need help.

With the main burden of health costs met by Social Security, it would become possible in all states to set up good medical assistance programs to meet the needs of those who need help beyond the benefits provided by the basic Social Security Program.

Where is all the push coming from for the President's Hospital Insurance Program? Is there really PUBLIC SUPPORT for it?

The President's program of hospital insurance for the aged through Social Security has broad and enthusiastic support.

A. In June 1961 a nationwide Gallup Poll* showed 2 out of 3 persons interviewed (67%) favoring increase of the social security tax to pay for health insurance for aged:

Age Group	21-29	30-49	50+
Favored	63%	67%	69%
Opposed	30%	26%	24%
No Opinion	7%	7%	7%

(cont.)

*This was the only Gallup Poll to date that asked directly for an opinion on health insurance for the aged through Social Security. Subsequent Gallup Polls presented rather confused alternatives, but even with the choice unclear, a majority in both later polls (April and August 1962) favored the alternative specifically mentioning health insurance for the aged through Social Security. Other nationwide surveys of opinion, such as those taken by pollster Samuel Lubell, found overwhelming public support for the program incorporated in the Anderson-King bill.

B. Countless individuals, organizations, and publications throughout the nation support the principle of financing hospital insurance for the aged through Social Security. Among the most prominent of these are the following:

American Federation of Labor and Congress of Industrial Organizations and affiliated unions
American Nurses Association
American Public Health Association
American Public Welfare Association
Council of Golden Ring Clubs of Senior Citizens
Council of Jewish Federations and Welfare Funds
Family Service Association
Group Health Association of America
National Association of Social Workers
National Consumers League
National Council of the Churches of Christ in the USA
National Council of Jewish Women
National Council of Senior Citizens
National Farmers Union
National Federation of Settlement and Neighborhood Centers

(cont.)

National League of Senior Citizens
National Medical Association
Nationwide Insurance Companies
Railway Labor Executives' Association
Synagogue Council of America
White House Conference on Aging (1961)
Women's Division of Christian Service of Methodist Church's Board of Missions
YWCA National Board
More than thirty state governors (1960)
Outstanding Social Security, hospital, and medical experts
including
E. M. BLUESTONE, M.D., recipient of 1961 Distinguished Service Award of American Hospital Association
J. DOUGLAS BROWN, Dean of Faculty, Princeton University
DR. EVELINE M. BURNS, Professor of Social Work, New York School of Social Work, Columbia University
MICHAEL DE BAKEY, M.D., Professor of Surgery, Baylor University, and Recipient, Americal Medical Association Distinguished Service Award
FEDELE F. FAURI, Dean, School of Social Work, University of Michigan
MARION B. FOLSOM, Secretary of Health, Education and Welfare in the Eisenhower Administration
MSGR. RAYMOND J. GALLAGHER, Secretary, National Conference of Catholic Charities

(cont.)

SEYMOUR HARRIS, Littauer Professor of Political Economy, Harvard University

ARTHUR KORNBERG, M.D., and DICKINSON RICHARDS, M.D., Nobel prize winners in medicine

ARTHUR LARSON, Director, World Rule of Law Center, Under Secretary of Labor in Eisenhower Administration

HOWARD RUSK, M.D., New York University Medical Center

HERMAN M. SOMERS, Chairman, Political Science Department, Haverford College

BENJAMIN SPOCK, M.D., Professor of Child Development, Western Reserve University

PAUL DUDLEY WHITE, M.D., formerly personal physician to President Eisenhower

Business Week

Life Magazine

The New York Times

Saturday Evening Post

The Washington Post

WHAT YOU CAN DO TO HELP AMERICA'S AGED TO GET HOSPITAL PROTECTION

Write to your Congressman and Senators and those listed below and tell them to support H.R. 3920 and S. 880, hospital insurance for the aged through Social Security and Railroad Retirement.

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