FUTURE DIRECTIONS IN SOCIAL SECURITY

HEARINGS

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

FIRST SESSION

PART 2—WASHINGTON, D.C.

JANUARY 22, 1973

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

92-231 O WASHINGTON : 1973

For sale by the Superintendent of Documents
U.S. Government Printing Office, Washington, D.C. 20402
Price 50 cents domestic postpaid or 30 cents GPO Bookstore
Stock Number 5270-01802

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Part 1. Washington, D.C., January 15, 1973.
Part 2. Washington, D.C., January 22, 1973.
Part 3. Washington, D.C., January 23, 1973.

(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

WITNESS

APPENDIXES

FUTURE DIRECTIONS IN SOCIAL SECURITY

MONDAY, JANUARY 22, 1973

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 1224, Dirksen Building, Hon. Frank Church, chairman, presiding.

Present: Senators Church, Fong, Domenici, Gurney, Stafford, Beall, Muskie, Kennedy, and Chiles.

Also present: William E. Oriol, staff director; David Affeldt, chief counsel; Val Halamandaris, associate counsel; Kenneth Dameron, Jr., professional staff member; John Guy Miller, minority staff director; Robert M. M. Seto, minority counsel; Dorothy McCamman, consultant; Gerald Strickler, printing assistant; and Janet Neigh, assistant chief clerk.

OPENING STATEMENT BY FRANK CHURCH, CHAIRMAN

Senator CHURCH. The hearing will please come to order.

Today we enter the second day of the scheduled 3-day hearings having to do with the Social Security System, and our witness this morning is Mr. Nelson Cruikshank, who is the president of the National Council of Senior Citizens, a longtime friend of this committee, and an outstanding authority on the subject matter.

He was formerly the director of the Social Security office of the AFL–CIO, and a few weeks ago he was named man of the year by the National Consumers League.

He is a very distinguished authority in the field, and we are pleased to welcome him again to the committee.

First, we have some statements by members of the committee.

STATEMENT BY SENATOR EDWARD M. KENNEDY

Senator KENNEDY. In spite of our Nation's efforts to assure health care for the elderly, we are still covering less than half the costs of their health care.

Medicare's deductibles, coinsurance, and limitations leave these Americans to pay most of the bills.

In fact, as Nelson Cruikshank points out, medicare has evolved into a program of catastrophic insurance only, which offers little help with the day-to-day health care costs that eat so deeply into the meager income of the elderly.

It is a tribute to Mr. Cruikshank that he is visionary enough to see that Medicare's weakness is the fact that it only covers the elderly disabled, and makes no attempt to control costs and reform health care for all Americans.

The elderly are reaping the whirlwinds of inflation in health costs that result from our health care system being out of control for all Americans.

We can only bring this system under control by a national health insurance program that offers benefits to all Americans at the same time that it reforms the health care system.

These reforms must assure well-organized, high-quality care, as well as offering incentives and positive controls on costs.

Indeed, good health care for the elderly, at a cost they can afford, is tied inextricably to providing good health care at affordable cost to all Americans.

National health insurance is the only ultimate answer to the problems of the elderly.

The health security program, Senate bill No. 3, which I have introduced, and which Mr. Cruikshank endorses, is the only proposal before the Congress which couples comprehensive and universal coverage with comprehensive and universal reform of our health system.

This program should receive the highest priority from the 93d Congress, which should go down in history as the "Health Congress."

Senator CHURCH. Senator Fong, the ranking minority member of the committee is here this morning and we welcome his statement.

STATEMENT BY SENATOR HIRAM L. FONG

Senator FONG. It is a pleasure to join with our chairman, Senator Church, and other members of the committee in extending a warm welcome this morning to our witness, Mr. Nelson Cruikshank.

As president of the National Council of Senior Citizens, Mr. Cruikshank has been in a most favorable position to enlarge his already great expertise on the Social Security System.

His recognition as an authority in the field is well grounded.

His service for many years as director of the Department of Social Security of the AFL–CIO and as a member of the Social Security Advisory Council over a span of years extending from 1948 through 1964 have unquestionably given him valuable insights which will be helpful to the Committee on Aging as it looks at "Future Directions in Social Security."

I am particularly pleased that Mr. Cruikshank will give emphasis to health needs of older persons in his presentation.

No question looms larger in the minds of older persons save the one related to basic income needs.

Despite the progress made in financing health care services through Medicare, Medicaid, and other Federal programs, many problems still remain unsolved.

As Social Security Commissioner Robert M. Ball observed when he testified last Monday at the opening of these hearings, less than half of the medical care expenses of persons past 65 are taken care of now by Medicare.

He pointed out much of this discrepancy between Medicare benefits and actual expenditures results from necessary services which are not covered under the law at all.

The list is long. It includes costs of out-of-hospital drugs, hearing aids, dentures and related professional services, eyeglasses, and others.

As a step toward relieving some of this burden, I favor a restoration of the full deductibility of medical expenses for income tax purposes as prevailed prior to 1967.

I will shortly introduce a bill I have prepared to effect this restoration of full deductibility.

It will be of considerable help to the many older persons who are not now eligible for Medicaid and the broad supplement of services it now offers to those with lowest incomes.

In introducing this bill, I am fully aware that it will not meet all of the needs related to financing of health care services.

It will, however, be a step in the right direction as the Congress continues its deliberations on other improvements in health services for older Americans.

Another bill on which I now am working will provide for elimination of the Medicare requirement for 3 days of hospitalization prior to admission to a skilled nursing home.

My special interest here is to simplify procedures for persons who have serious stabilized illnesses, and possibly those needing skilled rehabilitation services, who might actually be better served through direct admission to a skilled nursing home.

When Medicare was adopted, the 3 days prior hospitalization requirement made good sense.

Not only was the Medicare emphasis almost exclusively on the acute-illness episode, but there was confusion as to definition of a skilled nursing home.

Among the changes in Medicare accomplished through passage of the Social Security Amendments of 1972 was language to clarify the definition of a skilled nursing home and establish conformity of definition under Medicare and Medicaid.

With this amendment, elimination of the 3-day waiting period becomes a much more valid concept than it was before.

Congressional intent, as set forth in the report on H.R. 1 by the Finance Committee, more than implies a broadening of the care concept for Medicare.

Two paragraphs from that report serve to illustrate the change:

> The types of services which would be covered under both medicare and medicaid would include those skilled services which are essential to the rehabilitation and recovery of the patient, and also those which are necessary to prevent deterioration of the patient's condition and sustain the patient's current capacities even when full recovery or medical improvement is not imminent.
>
> Since the principal aspect of covered care relates to the skilled services being rendered, the restorative potential of the patient is not controlling. Many patients who have no potential for rehabilitation require a level of care which is covered under the program. For example, a terminal cancer patient whose life expectancy is not more than a few months who requires palliative treatment, periodic "tapping" to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort is receiving care covered by this definition. Thus, the controlling factor in determining whether a person is receiving covered care is the skill and frequency involved and the supervision that the patient requires, rather than considerations such as diagnosis, type of condition, or degree of functional limitation.

That elimination of the 3-day hospital requirement makes sense is reinforced by two other paragraphs from the Finance Committee report:

> The recognition of a patient's need for skilled rehabilitative services as a basis for meeting the level of care requirement is intended to cover situations such as

the following: (1) non-ambulatory stroke patients who need daily skilled rehabilitative services such as speech therapy, but who do not necessarily need skilled nursing services, and (2) hip fracture patients who need daily physical therapy services after the fracture has healed to the weight-bearing stage.

These kinds of services, however, would be covered only if they can as a practical matter be provided only in the skilled nursing facility setting because other arrangements that could be made to provide the needed services (e.g., bringing the services to the patient in his place of residence or daily transportation to an outpatient facility) are not practical because of the patient's condition or from the standpoint of efficient delivery of the required services. In determining whether other arrangements would be practical, the coverage or noncoverage of the various alternatives under medicare or medicaid should not be taken into account—the issue is feasibility and not whether coverage is provided in one setting and not provided in another.

Unquestionably, much more will need to be done, particularly as related to the provision of adequate longtime medical care for persons suffering from serious chronic illness.

I am confident Mr. Cruikshank will address this problem in his testimony today.

Senator CHURCH. Senator Muskie has a statement.

STATEMENT BY SENATOR EDMUND S. MUSKIE

Senator MUSKIE. Mr. Chairman, the White House Conference on Aging, held over a year ago, brought some hope to all of us that improvements would be made in providing better health care for our Nation's older citizens. Indeed, the administration's rhetoric at the time of the Conference carried a promise of a better day for the elderly in health and other areas.

The recommendations of the Conference charted a course that could lead to the kind of life that our elderly need and deserve. And adequate health care should be a cornerstone of this decent life for the elderly. But we have had no clear signals from the administration since the White House Conference on Aging.

The administration's favorite word before the Conference—"action"—has suddenly disappeared from official pronouncements. Now we hear words about new plans and a new team. While we wait for clues on these new plans and what the new team has in mind, the elderly are suffering.

The Nation's senior citizens do not have time to wait any longer. They need better health care now.

The full effects of the indifference and inaction of this administration toward the health needs of our elderly may not be apparent to many of our fellow citizens.

It may even be true that most Americans think that Medicare and Medicaid have taken care of the old folks' health needs. The realities are otherwise.

The elderly are paying, out of their own pockets, almost as much for health care in 1973 as they did before Medicare was enacted in 1965. Rising medical costs are undermining Medicare and Medicaid, causing new restrictions and higher costs to participants in those programs.

Despite expressions of official concern, alternatives to institutionalization are not available to most older persons, especially in the area of home health services. Fragmentation of medical services is worsening, especially in inner-city and rural areas.

On January 15, the opening day of these hearings, our distinguished chairman, Senator Church, indicated that testimony would be invited on gaps in Medicare coverage, as well as other health-related issues.

Our chairman believes this is appropriate because, in his words, "Genuine security in old age is impossible without real protection against medical crises that even yet wipe out family savings." I concur completely in these comments.

I might point out, too, that the first witness to appear before the committee in these hearings, Commissioner Ball, cited health as the key area under Social Security deserving priority attention.

Today, Nelson Cruikshank, the dynamic and effective president of the National Council of Senior Citizens, will tell us more about what needs to be done to assure our elderly of decent health care.

The valuable testimony on health care that will result from this first round of hearings in this series will serve as the springboard for hearings and other inquiries by my Subcommittee on Health of the Elderly in 1973.

A major goal of these hearings and other subcommittee activities will be to make certain that a national health security program for all, when finally enacted into law, will include provisions meeting the real needs of older persons.

Yet another goal will be to stop the decline of health services for older Americans that has marked this administration's approach to Medicare and Medicaid and other health programs that serve the elderly.

We will be focusing on the barriers to adequate health care for the elderly and ways to remove them.

Mr. Chairman, I commend your fine leadership in scheduling these important hearings. They are providing the stimulus for what I hope will be productive hearings and other inquiries by my Health Subcommittee in 1973.

Senator CHURCH. We will now hear from Senator Stafford.

STATEMENT BY SENATOR ROBERT T. STAFFORD

Senator STAFFORD. Mr. Chairman, one of my constituents, Mr. Serse Ambrosini of Rutland, Vt., has written a petition to the U.S. Government through my office detailing many of the problems faced by a Social Security recipient. I endorse many of his points, especially the elimination of outside earnings limitations.

I thought the remarks of Mr. Ambrosini would be helpful to the members of this committee during the hearings on "Future Directions in Social Security."

I would like Mr. Ambrosini's petition placed in the record at this time, along with a letter to me from Mrs. Bernice Ryan, the president of the Rutland, Vt., chapter of the National Council of Senior Citizens, endorsing the ideas advocated by Mr. Ambrosini.

Senator CHURCH. If there are no objections, the material will be placed in the hearing appendix.[1]

Senator Beall has a statement.

[1] See appendix 2, p. 153.

STATEMENT BY SENATOR J. GLENN BEALL, JR.

Senator BEALL. Mr. Chairman, it is a great pleasure for me to assume a seat on the Senate Special Committee on Aging. As you know, I have served for the last 2 years as the ranking Republican member of the Labor and Public Welfare Committee's Subcommittee on Aging. From that vantage point, I have had an opportunity to help shape legislation effecting the programs conducted by HEW, NIH, the Action Agency, and so forth. This experience has served to further arouse my keen interest in the well-being of our Nation's 20 million senior citizens, and I am delighted to have an opportunity to serve on this distinguished committee.

Since its inception, the special committee has carried out numerous hearings and investigations which have served to provide the Senate with the information needed to tailor legislation to the needs of our older Americans. In addition, the activities of the committee have served as a catalyst, stimulating new initiatives and new approaches to solving the problems of the aging within the various departments and agencies of our Federal Government.

Mr. Chairman, I look forward to working with you and the other members of this committee as we seek to come to grips with the complex problems confronting our Nation's senior citizen.

Senator CHURCH. Please proceed, Mr. Cruikshank.

STATEMENT OF NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. CRUIKSHANK. Senator Church and members of the committee; thank you, Senator, for that very kind and generous introuction youd gave me.

I am very happy to be here and have the opportunity to present our views of the National Council of Senior Citizens on this very important subject to which you are directing the committee's attention.

You have already very generously, Senator Church, mentioned some of my credentials and background; and in my statement here, I have summarized some of my credentials. I have a prepared statement which I should like included in the record.

I would like to summarize in further detail some of my prepared text, and I would like to say that I do not mind being interrupted if any Senators have questions. Sometimes those who wish to inquire will out of courtesy wait until the end, but it does not bother me if somebody wants to interrupt while a question is fresh in his mind.

Senator CHURCH. Very good. We will proceed on that understanding.

Mr. CRUIKSHANK. Fine. No one has designated me to speak in any capacity other than that of my position as president of the National Council of Senior Citizens. While I cannot presume to go beyond that, I do believe that the interests of the membership of my organization are the same as those of most all the elderly. Furthermore, speaking for elderly citizens, I do not believe they are to be considered a group set apart from the rest of the population in the sense that their needs are to be met at the expense of meeting the needs of others. Of

course, each age group has its special problems and concerns. But in the larger sense, what is good for one group benefits all groups, and the proposals advanced to meet the needs of one must be weighed in terms of their effects on all the others.

You have asked me, Mr. Chairman, to speak on the problems of health, and then to go into what may be the future directions of our cash benefit programs in Social Security.

Medicare is making its contribution, and it is an important program, but we need something now better than Medicare. It has been almost 8 years since that was passed by the Congress, and we have learned something, we hope, from it, and also we believe that what we can evolve is something better than Medicare, that it should be applied to the entire population.

White House Conference on Aging

I cite in "A Platform for the Seventies," which was developed for the White House Conference on Aging, which concluded a little over a year ago—the platform developed by representatives of a number of national organizations, including the National Council of Senior Citizens—we said:

> The Nation will continue to fall short of a reasonable goal of income security so long as heavy and unpredictable health costs threaten fixed incomes.

By that, I meant to direct the attention of the administration, the Congress, and the public at large, to the fact that these matters of health and matters of income maintenance were irrevocably involved with each other, and that you really could not consider one without the other.

At the conclusion of that Conference, the White House Conference adopted in the income section a similar statement saying this Nation can never attain a reasonable goal of income security so long as heavy and unpredictable health costs threaten incomes of the aged.

In my prepared statement, I make reference to some of the studies that have already been done by this committee. It is our view that they are enormously helpful, they have helped direct the public's attention to these problems, and they have been backed up by our experience.

We read the work of this committee, and we checked it with the experiences of people with whom we visit, those who write us, as I am sure the Members of the Senate do, in their correspondence from constituents. I believe your experiences will coincide with ours—that these studies support that experience.

I proceed to review the history of Medicare, because it seems to me that this first great experiment, that this Government launched into something of an undertaking to help pay the expenses of a large segment of the population, now 7½ years ago, it is time we reviewed that experience and evaluated it.

Some of us that were involved in getting this legislation passed, including some members of this committee, may be tempted to be a bit wedded to it, and say that was our program, and it is a great success. But it seems to me we should not become wedded to a certain stage of an experimental program. Let us join with those who did not agree with the program when it was adopted and evaluate Medicare as objectively as we can. Let us see where it succeeded, where it has failed.

I point out the two areas in which I think it has succeeded:

1. Medicare has removed to a large degree the fear of the cost of an acute illness from 20 million older people in the United States. The figures that are given about the average costs and outlays of these older people are a little bit misleading sometimes. Surely it does pay only 42 percent of the total costs of the elderly, but it pays most of the costs of serious illnesses, and I think this is important to remember.

Senator MUSKIE. Mr. Cruikshank, do you have documentation that would spell that out specifically?

Mr. CRUIKSHANK. Yes, there is documentation, Senator Muskie.

The "Current Medical Survey," which is conducted by the Bureau of Health Insurance, includes the statistical study, and a study by interview of a sample of the population that is covered by Medicare. It shows that, while this overall coverage is relatively small, many of the large bills are taken care of to a much greater extent. The reason for this is because of the deductibles and the coinsurance. For example, a person who has only a $70 doctor bill in the course of a year has the $60 deductible taken out of it, and then he gets 80 percent of the remaining $10 paid. Thus, out of the $70 doctor bill in the course of a year, he would have only $8 covered by Medicare.

Senator MUSKIE. There are two points suggested by that. First, that a large portion of the usual medical costs of the elderly are not paid. Second, that Medicare would seem to be in fact only "catastrophic" medical insurance. Now, are those accurate impressions?

Mr. CRUIKSHANK. I think it can be said, with the deductibles and the coinsurance and all, that the Medicare program has somewhat moved in the direction of a catastrophic insurance program. This concerns us.

LINE BETWEEN SERIOUS AND NONSERIOUS ILLNESS

Senator FONG. Mr. Cruikshank, will you draw for us the line between a serious illness and one that is not a serious illness, as you see it?

Mr. CRUIKSHANK. That would be very difficult to do, Senator Fong.

Senator FONG. What would be the money cost?

Mr. CRUIKSHANK. Well, serious illness might be a $100 bill for persons living on Social Security with a $150 monthly benefit, whereas a serious illness for a person who has a good retirement program might be a $1,000 doctor bill. I think you mean serious in terms of its economic impact?

Senator FONG. Yes.

Now, could you confine that to days in the hospital, or the days a person is sick, or the extent of the medical care?

Mr. CRUIKSHANK. Yes, there again, even a 10-day stay in the hospital can be a catastrophic blow.

But Medicare would pay a larger percentage of his hospital bill than his doctor bill. Of his hospital bill, he would have to pay only the first $72, whereas his share of the doctor bill, which could be very large for a 10-day hospital stay, would be the first $60 plus 20 percent of the balance. That is, although Medicare would pay almost all the hospital costs, his share of physician expenses would be catastrophic if the person had a low income.

Senator FONG. Medicare has taken care of the needy to a very large extent as far as——

Mr. CRUIKSHANK. I think it has taken care to a very large extent of the needy elderly people, first with respect to their hospital bill, and, second, to a lesser extent with their doctor bill, and still a much lesser extent if it is a long-term care. After I make reference to medicare's success in meeting the operational problems, there are three areas in which Medicare has not been so successful.

No. 1 is in preventing a dangerously rapid increase in the cost of medical services.

No. 2, making the fundamental changes in the health delivery system necessary to improve the quality and availability of care.

No. 3, meeting the long-term care needs of the very old and the chronically ill.

You will note I said before that Medicare meets the large part of the costs of an acute illness, but when you get beyond that, and you get the chronically ill, the very old, the nursing home problems and all, Medicare has not done nearly so good a job. Now, if we look for the reasons for this, if we examine this experience we have had in Medicare, I think we will find a number of basic factors.

Much has been said about the failure of early Medicare planners to anticipate these medical cost increases. I submit that the mistakes that were made were not so much in the areas of utilization and the estimates of need but in the concept incorporated in the Medicare law that the limit to the liability of an insurance scheme could rest on the notion of "reasonable cost" and "reasonable charge." I think this is crucial, and, you are all very well aware, any insurance scheme has to have a limit to the liability that it is underwriting. But in Medicare, the Congress felt that they could establish that limit, by relying on the reasonable costs of hospital care, and the reasonable charge of the doctor services. Six years' experience has shown that many of the so-called reasonable costs under part A are simply cost-plus operations of an uncontrolled and unplanned hospital industry. The "reasonable charge" approach under part B opened the way for charges often having little relationship to past practices limited by customary charges; as it turned out, no one really knew what customary charges were. The result was in all too many instances "reasonable charge" in practice became all the charge the traffic would bear.

Many providers followed the long-established practice of considering the fact of a patient's being insured a factor in his ability to pay and proceeded to add charges above the allowable amounts. After the program had been in operation 2 years, the Social Security Administration finally got around to limiting the allowable amounts payable under Medicare, but the net result in all too many cases was a decrease in the proportion of the total cost of medical care covered by the program. To compound the problem, the decrease in the protection provided was accompanied by steadily rising costs of premiums.

PHYSICIAN "ASSIGNMENTS" DOWN

Senator MUSKIE. Mr. Cruikshank, you just made the statement that in all too many cases the net result was a decrease in the proportion of the total cost of medical care covered by the program. You said earlier that currently 42 percent of total covered medical cost was paid by Medicare.

What was the peak percentage of medical cost paid by Medicare? Do you have a figure?

Mr. CRUIKSHANK. The peak was somewhere up around 45 percent, I think.

It is also interesting, Senator Muskie, that the proportion of physicians who are taking "assignments"—that is, agreeing that the amount charged under Medicare will be the total charge for the patient—was once as high as 61 percent, but is now down to 49 percent.

Senator MUSKIE. It is down to 49 percent?

Mr. CRUIKSHANK. It is down to 49 percent.

On many of the larger bills, doctors will take "assignment" because they think there is a risk in getting paid at all. But on the smaller bills they will not take "assignment," and they often will add charges above the allowable amount of Medicare. The recipient is confused, he gets the impression Congress has cut back on the coverage of Medicare.

Well, Congress has not cut back at all. It is simply that the bills have gone above the amount determined under laws to be the "reasonable charge." The program then holds to the reasonable charge, but the proportion of the bill that is paid by Medicare has fallen, and people are getting the impression that the program has been cut back.

Senator CHURCH. Mr. Cruikshank, what can be done about this?

This, I think you have capsuled the situation very well. Do you treat this in your paper?

Mr. CRUIKSHANK. Later on I make suggestions to move to a negotiated fee schedule, and I will come back to that later on.

Senator CHURCH. Fine. You have it in your paper?

Mr. CRUIKSHANK. Yes, sir.

Senator FONG. Mr. Cruikshank, since we are on the question of 42 percent, 50 percent, could you give us, say, the highest percentage that is unpaid in a nonserious illness?

Mr. CRUIKSHANK. The highest of a nonserious, Senator? I do not know whether we could get that information in just that category, but I would be glad to supply you with what I can.

Senator FONG. Can you give us a figure for the highest percentage paid by the Government on serious illness?

I presume it exceeds 50 percent or 60 percent.

Mr. CRUIKSHANK. Well, we would have to establish some kind of an arbitrary figure to determine for the purposes of the question what was a "serious illness."

Senator FONG. You stated as a general proportion that most of the costs in serious illnesses are paid.

We would like to get an idea as to how many, what is the percentage that has been paid, the amount that has been paid in a serious illness—that is, of a $1,000 bill, how much does the Government pay?

Mr. CRUIKSHANK. Well, may I try to work that out and provide it for you later?

Senator FONG. If you could give us an idea, fine.

Mr. CRUIKSHANK. I would like to work that out, and perhaps discuss with others as to what level we consider as a serious illness.

(The following information was subsequently received for the record:)

Percent of Medical Expenses Paid Under Medicare

The percentage of medical expenses paid under Medicare is determined by the category of covered service utilized rather than such things as the amount of the health bill, days sick, or days hospitalized.

Medicare provides the most complete coverage for the expenses of hospitalization for an acute illness. A Social Security Administration study shows that in 1967, while Medicare covered 48 percent of the *mean* health charges per person, it paid 84 percent of these charges for hospital care.

However, it must be noted that days hospitalized is a poor index of percentage reimbursement because of the diminishing hospital reimbursement schedule. As a result, 85 percent of the charges for short-stay hospitals (average stay less than 30 days) were paid by Medicare, in contrast to 38 percent of the long-stay hospital charges.

In this connection it is also important to note that the record of hospital discharges for Medicare patients shows that only 6 percent of hospital stays are over 30 days and only about one percent are over 60 days.

More moderate coverage is provided for medical services, both inpatient and ambulatory. Because of the deductible and coinsurance amounts and the unfiled claims and disallowed charges paid by the patient, Medicare only pays 45 percent of this expense. In a year only about one-half of the Part B enrollees have bills greater than the deductible amount.

The amount of the medical bill is also a poor measure of the percentage paid by Medicare. Again it is more significant what type of service is provided.

The following table shows the percentage of combined medical and hospital expenses paid by Medicare for illustrative cases by amounts of medical charges (for physician and related professional services) and days of hospitalization (at $100 per day).

Medical charges	Days in hospital—					
	0	5	10	20	40	80
$50	0	77.8	88.4	94.0	97.0	93.9
$100	32	76.6	87.3	93.3	96.6	93.8
$200	56	77.1	86.7	92.7	96.2	93.7
$400	68	77.7	85.0	91.7	95.5	93.3
$800	74	78.5	84.4	90.0	94.2	92.7
$1,600	77	79.0	83.1	87.8	92.1	91.7

The table also illustrates:

the more extensive coverage of hospital charges vs. medical charges;

the more extensive coverage of hospitalization for 60 days or less vs. over 60 day stays;

the inadequacies of using dollar amounts, per se, as an index of Medicare coverage.

It should also be borne in mind that the medical expenses in the table are not total expenses for an illness in a typical case since it includes only *covered* expenses and does not include therefore such items as out-of-hospital drugs. If such items were included the percentages in the table in almost all cases would be smaller.

Mean charges per person for care in extended-care facilities and nursing homes are covered by Medicare to an even smaller extent—18 percent.

I think it is clear that any objective demarcation between serious illness and non-serious illness, for the purposes of discussing Medicare coverage, is not a very useful approach to the problem. Nevertheless, because of the very high coverage of short hospital stays and large medical charges, the *generalization* that Medicare covers a significantly higher proportion of the expenses incurred in serious illnesses appears to provide some meaningful measure of the extent to which the program is meeting its objectives.

Limit Medicare Liability

Mr. Cruikshank. I point out in my statement that in 1965 the public and the Congress relied mainly on two factors to limit the liability assumed by the Medicare program.

(1) Self-restraint on the part of the medical professions, and

(2) The controls exercised by the carriers and intermediaries.

Neither was completely lacking, but both proved woefully inadequate.

I am citing these well-known facts not in criticism of the program itself or even of the providers, many of whom have done a conscientious job of carrying out the basic purposes of the program. The most important lesson from this experience has been that health care problems have two components: financial and delivery. It is insufficient to provide simply a method of payment that will greatly increase the effective demand for a limited supply of health services. Measures must also be included to provide some control over the economic processes of the health care industry and to stimulate an increase in the supply of health services.

Senator MUSKIE. Mr. Cruikshank, may I ask a question here? It seems that, to allow the effective operation of the two factors you described which we relied on in 1965 to limit Medicare liability, we needed two things. First, we needed a will on the part of the carriers and the medical profession to bring costs under control. Second, we relied on their capacity to do so.

But there has been a failure to stop rising medical costs covered by Medicare.

Was this failure attributable to a lack of capacity, a lack of will, or, perhaps, a lack of leadership?

Mr. CRUIKSHANK. I think it was a combination of all three, Senator Muskie.

Carriers, I believe the record will show, misled all of us to some extent. When Medicare was finally being considered by the Congress, and this matter of the prevailing charges was brought up, they assured the Congress and the public that they had the information that would allow them to establish profiles of charges on most practicing physicians. After the program went into effect, they really abdicated that position. They said, in fact, they did not have such information.

PHYSICIAN FEES INCREASE

I recall specifically as a member of the Health Benefit Advisory Council questioning one of the representatives of one of the largest carriers, whether in establishing the prevailing charges he tried to find what past charges had been or visited doctors asking to see copies of the bills which they had presented. I asked him: "Did you go to doctors' offices and ask them for copies of bills that they had presented?" He replied, and I think very honestly, "We started to do this, but the doctors raised so much trouble, we backed off."

Although there are many doctors who did not increase their charges, there were too many who did. There was a great fear. The propaganda that had been carried on against Medicare, mainly by the American Medical Association, instigated a fear on the part of the physicians that the Government was going to establish some schedules, and many of them anticipating that raised their fees.

In response to a provision of H.R. 1, there is a study being conducted by Robert Nathan Associates of the reimbursement methods used by physicians under Medicare and the factor of the cost increases. I have seen the preliminary findings which indicate the big rise in fees took place just before Medicare went into effect. I think when that full study comes out, it will merit very careful consideration. It was

not just the operation of the economics of an increase in demand on the limited supply, but it was also highly psychological.

Some medical societies advised the physicians to hurry up and raise their fees, because they would likely not be able to do it later. Accordingly, many raised their fees. But it is very interesting, the big jump in doctors' fees took place before Medicare became effective. So there was the matter of the will, the matter of the capacity, the matter of the misunderstanding of the program.

Senator MUSKIE. Can you quantify the cost jump that took place so we can put it in perspective?

Mr. CRUIKSHANK. Yes, roughly. This will be documented more completely later. Roughly, doctors' fees had been going up a fraction above 2 percent per year for a period of years. During 1965 they went up by 5.8 percent and beginning in 1966 they went up between 6 and 7 percent a year.

There were many people who were ready to reach the conclusion that it was Medicare, because of its increased demand, that caused the price rise, but the fact that fees went up prior to the effective date of the program indicates there were other factors.

Senator MUSKIE. In other words, the medical profession was using preventive medicine.

Mr. CRUIKSHANK. Yes.

Senator GURNEY. Were those fees raised across the board, or did they apply only to Medicare treatment?

Mr. CRUIKSHANK. Most of them were across the board, because Medicare made some attempt, and the law provides, as you know, the law provides that the fees charged the Medicare patient cannot exceed the fees charged other patients.

Now, this is very difficult to enforce, and also let me say that just the fees do not give you all the picture.

You may have seen over the weekend in the newspapers that the American Medical Association is taking great exception to the fact that the phase III of the economic program does not exempt them, the physicians' fees. They complain they are being discriminated against.

The fee itself is not the sole controlling factor, and while these fees went up by 6 percent, the total charges went up more than that. You will find it was the common practice of physicians to charge $7 or $8 for an office visit. Now you have the same office visit, but it will be itemized, and there will be 10 or 12 things listed which he always did before as part of a routine office visit. And you will find the total charge comes in as $15, $17, or $18, so the thing to look at in the overall is the rise in physicians' incomes.

HOSPITAL COSTS INCREASE

Senator GURNEY. What about hospital costs, too; is there any comparative study, or do you know how hospital cost increases compare with increases in physician fees since 1965?

Mr. CRUIKSHANK. Hospital costs have gone up even faster than physicians' fees.

The average room charge for room service has gone up from $43 to $103 since 1965. There is one offsetting factor, the average stay has gone down.

The average stay has gone down a little which somewhat reduces the total bill.

Of course, that is $170, if you get an $85-a-day hospital charge.

Senator GURNEY. How do the increase of doctors' fees and hospital costs compare with the entire rise of inflation in the last 8 years?

Mr. CRUIKSHANK. It is the most rapidly rising factor in the Consumer Price Index by far.

Senator GURNEY. More than other factors?

Mr. CRUIKSHANK. Oh, yes. The factor of medical costs is far and away the largest. You can look at the report of the economic advisers. and the joint committee, which break the Consumer Price Index down; you see the medical cost increases are far higher than any other component of the Consumer Price Index.

Senator GURNEY. One other question, either in the study, or of your own testimony, is there any evidence as to what medical services and hospital services consist of now compared with 8 years ago?

Mr. CRUIKSHANK. There are studies on that, and it is an important factor. When you compare the medical services that are given in the hospital today, say one of our best, good, teaching hospitals, it is a better service generally speaking than you got 8 years ago.

Senator GURNEY. Which would be a factor.

Mr. CRUIKSHANK. Which would be a factor, yes.

It is a little bit like comparing the price of automobiles. Automobiles have gone up in price, but also, if you are getting an automobile with air conditioning, you do not quite compare that to an automobile that you bought maybe 10 years ago without air conditioning.

Also there are some factors that have improved quality care in our better hospitals.

Now, however, this has not occurred across the board, and it does not always relate directly to increased costs. For there are some hospitals where the price has gone up and the services have gone down.

CEILING IN FEES FOR MEDICARE

Senator KENNEDY. Mr. Cruikshank, I want to extend a word of welcome, and commend you for your testimony and your responsiveness to these questions.

Even if you were able to achieve what you have outlined here by getting some kind of a ceiling in fees for Medicare, would you not be concerned lest many of the doctors would avoid treating elderly people and would go into other areas not covered by the schedule?

Mr. CRUIKSHANK. I think this is a matter of concern, Senator Kennedy, but my feeling is that it is better to have it that way for probably a short time, so that the issue becomes clear to the public.

Today it is so confused, there are so many factors; the beneficiary gets a bill from his physician, he thinks that Medicare is going to cover 80 percent of that, and he finds it covers only 60, or maybe even 50 percent of it. The notation on the bill is simply: "Not covered by Medicare." We have tried to get the carriers to say: "Not covered, because beyond reasonable charges established by law," but they have refused to say this, and the administration has refused to require the carriers to say it.

I think it would be better that, if doctors do not want to care for patients at rates which have been established, under very generous

procedures, as "reasonable" and also wish to conceal their actions, they just pull out of the program.

I believe that if the charges were set in fair negotiations, in which the doctors fully participate, there might be an early but unsustained pullout. Doctors, I believe, would come back into the program and take care of their patients at a reasonable charge.

Senator KENNEDY. Obviously, that is not as desirable as if there were a general application of this throughout the whole——

Mr. CRUIKSHANK. No, indeed not.

Senator KENNEDY. You are going to outline the reasons a little later?

Mr. CRUIKSHANK. Yes, sir.

DOCTORS EXEMPT FROM PHASE III

Senator MUSKIE. Do you think that doctors should be exempted from phase III, Mr. Cruikshank?

Mr. CRUIKSHANK. No, I do not, because this is one of the two or three most rapidly rising components of the Consumer Price Index. The building construction is another that is rightfully not exempted. Of course, I do not think any of them should have been exempt at this time, because it is too early; but I think, if you are going to make exemptions, you certainly should not include in the exemptions those that have proven themselves as the most uncontrolled costs in the economy, and doctors' fees are certainly one of them.

Senator FONG. Are there many doctors that refuse to take Medicare patients?

Mr. CRUIKSHANK. Very few. We have had some letters from doctors and copies of notices posted in doctor's offices, saying they want no part of this "socialized medicine," but they are very much the exception. Most doctors have participated in the program.

There was a threat on the part of one State, which happens to be my native State of Ohio, where the medical profession threatened to go on strike, but they were advised by their asscoiation not to do so. However, it is indicative that the proportion of assigned bills is about the lowest in the State of Ohio, so that the attitude of the State society is reflected in the charges and the refusal to take assignment. But very few have refused to serve under Medicare.

You will note in my prepared statement that I refer to the second major shortfall of the Medicare program—its failure to make basic changes in the health delivery system. I point out that Medicare did not make these changes because the Congress directed that the system not be altered in any way. At the time, we who supported Medicare were in agreement with that position, which reflected, we believed, the popular conception that what was needed was a mechanism for paying bills.

The consciously accepted limitations of the program also apply to the third major area of the public's dissatisfaction with Medicare, namely the lack of provision for long-term care of the very old and chronically ill. Again, in 1965 we were attempting no more than to provide the elderly with the protection most people still in their working years enjoyed. Medicare was modeled on Blue Cross and Blue Shield, and these plans were also deficient in the area of long-term care. But here, too, public attitudes have changed.

The time has now come for applying the lessons learned from Medicare to the development of a program to meet the health needs of the entire Nation, not just the oldest and highest risk population group. The time has come for us to stop thinking primarily about insurance programs that simply meet costs incurred under our present system—or "nonsystem" as it is so frequently and deservedly labeled. The time has come for us to begin building a health care system that assures all Americans equal access to comprehensive and continuous health services of high quality at economical costs.

The statement also reflects our view that, although most of the changes improve Medicare, we have reservations about physician "peer review" groups: PSRO's—professional standards review organizations. These groups are supposed to monitor physician practices under Medicare, Medicaid, and other Federal medical programs with a view toward eliminating wasteful practices such as unneeded operations and prolonged hospital stays. Some people think this is analogous to making a fox the security officer for a henhouse. On the other hand, if the medical profession rises to its true professional responsibility, it just may work. We shall have to wait and see.

Consumers on PSRO's?

Senator Kennedy. Mr. Cruikshank, would you not agree with me that it would be helpful if we worked through the PSRO's, to give us more consumer cooperation?

Mr. Cruikshank. I would hope so, but this was specifically ruled out. If we did have some consumer input into this, it would seem to me there would be a chance to have more give and take, and also develop more responsibility.

I have had the privilege during the course of the last 35 years of sitting on a number of advisory councils, and also as a labor person in negotiations. It is always interesting to me, to observe both sides of the table, Senator. We labor people would go out and vigorously put forth our demands and present our views to the public. The management people would do the same thing. It is surprising how responsible you can get when sitting across the table from your counterparts; both sides tone down, both sides get more reasonable. I have seen this happen again and again. Whereas, when they act unilaterally, they always feel they can only represent the most extreme views of their constituents. I think this is true of any group in our society. I have seen it in labor, in management, and in the medical profession. At the very time when there is more consumer interest and more consumer representations in various fields, this PSRO arrangement shuts out the consumers; this is the major reason we have our reservations about it.

Senator Kennedy. I think you are probably aware that the various consumer-run programs in the neighborhood centers and the other programs evaluated by HEW showed them to be among the very best; it is clear that their track record in the health area has been commendable.

Mr. Cruikshank. That is true, sir, and I have worked with the American Hospital Association. I am chairman of their National Citizens Committee on Health Care, which is really a consumer representative group. You probably noticed in the papers recently

the American Hospital Association published the patients' bill of rights, which is a reflection of a consumer input to hospital administrations. But at the same time, when a group like the American Hospital Association is beginning in a little way to listen to consumers, we set up these PSRO's which place all of the responsibility on the group of providers.

Senator GURNEY. Mr. Cruikshank, if you are going to put—well, let us use the word "consumers"—or other people on the PSRO's, what would be your suggestion as to who should go on, and how they should be applied?

Mr. CRUIKSHANK. Well, I think that there is experience in the law today—for example, the Health Insurance Benefit Advisory Council, and other councils of this kind—the Congress has written provisions saying those who have the experience, who come from organizations that are representative; it does not seem to me the Government should allow organizations outside the Government actually to name them, but they should nominate them and present their credentials, which the appointing officer can review and determine that they do really represent a body of consumers. The Congress has written a number of provisions of this kind, and so I do not think it would be hard. It is not always easy to get real representatives of consumers, but I do think we have a body of experience that would be helpful in getting them.

Senator GURNEY. Could you specifically suggest in this case, what outside organizations should be named?

Mr. CRUIKSHANK. Yes, those that have had experience in the health area, like the American Public Health Association, nongovernmental private organizations, consumers organizations, like the Consumer Federation, organizations that have represented users of service. The labor organizations bring to this field a good body of experience, because they have been negotiating health plans for a long time, and they have had both good and bad experiences, and they would be in a position to help. Then I believe organizations like mine that represent citizens. Of course, if you get to a broad across-the-board position, you would not just want senior citizens, you would have to have broad citizen representation.

In Medicare, our organization represents seniors who are covered, and should have a specific role to play, but you would have to get to a broader base than just a senior organization for a national health program.

INSURANCE INDUSTRY REPRESENTED

Senator GURNEY. A lot of heat has been turned on insurance companies that offer health programs because of the high, rising costs of medical care. Due to their experience in monitoring these, would a representative of these carriers be represented?

Mr. CRUIKSHANK. Yes, if they are checked by others being present. The insurance industry has always been represented on the Health Insurance Benefit Advisory Council, and some of them have had valuable contributions to make, but the insurance industry has not had the experience in monitoring the services that sometimes they claim they have. Their experience is largely the experience of paying bills, and they are not inclined very often to question these bills.

I go back to my experience in the health field when I was with organized labor, from which I retired in 1965. We would find insurance carriers, when we would negotiate a health plan, often making the claim to the employer if it was a noncontributory plan they wanted to carry it, because they would say, "We get along fine with the doctors."

Well, this is just dandy, if you put in enough fat in the system so that nothing has to be questioned, and actually in many cases, the insurance carrier would write in the high enough retention fee in the bargaining agreement, so that there was not really much reason to question the bills. Very often a person not experienced with health administration would be given a set of vouchers from the insurance carrier, and the people would come in and make their claims, and they would just sign these vouchers, and there was no question and no review about it at all. There was enough fat in the system, so they did not have to question them, and this is one of the things that has escalated medical costs. Yet the fact that they do not quarrel with doctors about bills is a part of the carrier's appeal.

Now, they are beginning to move in the opposite directions. One insurance carrier, one of the biggest ones in the country, recently notified clients that if they had difficulty with doctors who were hiring lawyers to prosecute unpaid bills which were above the insured amounts, that they could apply to this company for legal aid. Well, the vice president of this company was called before the House of Delegates of the American Medical Association last June, and given what I will mildly call in this room a serious dressing down. He was told that he would have to withdraw that statement, which he abjectly did. They have now agreed they will not provide legal aid to people who feel they are overcharged, and who are subject to legal action for these bills.

This only illustrates that there are incentives in the present system that develop a cozy arrangement between the carriers and the doctors.

Blue Cross-Blue Shield Payment

Senator Gurney. I really thought if that was the case previously, it is changing now because of the rapidly rising costs.

I remember just last week talking to the executive director of Blue Cross-Blue Shield in Florida, and he was telling me how many doctors were complaining about the claims Blue Cross-Blue Shield has turned down, and I thought possibly the surveyors had increased very considerably in the last few months.

Mr. Cruikshank. While the distinction between Blue Cross-Blue Shield and commercial carriers is not as sharp as they would like to present sometimes, I think there is some distinction, and there have been some cases where Blue Cross-Blue Shield negotiated with reasonable effectiveness on the costs of the bills to be covered in the hospital, and Blue Shield has done a very little bit in this with respect to doctors' bills.

Under Blue Shield it is agreed that payment for the bill of low-income people shall be accepted as total remuneration. However, I must emphasize this usually applies only to low-income people, that is cases in which the doctor probably would not get paid otherwise. Those above this income level established by Blue Shield are subject to charge beyond the reasonable amount.

Although, there has been some movement in Blue Cross-Blue Shield, and even some commercial carriers, to put a brake on this escalation, their efforts obviously are far below what is needed to do the job as manifest by the unchecked rise in costs.

Senator CHURCH. Mr. Cruikshank, if you cover the latest statement in your paper, we will defer it at that time, but if you do not, however, I would like to ask this question.

REASONABLE CHARGES FOR HOSPITAL FEES

We have been discussing up until now the effort that is made in the Medicare program to establish a reasonable charge and to pay on that basis where doctors' fees are concerned, and you pointed up the weaknesses of the system, and they are everywhere inherent, of course, but is there any comparable effort in the Medicare system where hospital fees are concerned, to establish a reasonable charge for the same purpose, that is to hold down rising costs, rising charges?

I recall an excellent series of articles done by one of the Washington papers on hospital charges, and the racketeering that is going on in the large hospitals.

I remember the case of the pathologist laboratories, which are contracted, the services are normally contracted for, and the chief pathologist in each case will draw down an enormous profit, $150,000 in one case. I remember another case of a quarter of a million a year, still another, half million dollars a year being drawn by the chief pathologist, who paid very little attention, that was not even their full-time job, and they engage at salaries the people that actually did the work.

Now, if that kind of racketeering will be permitted in the major hospitals, it is no wonder charges have gone through the roof.

Mr. CRUIKSHANK. That is absolutely true, Senator Church, and this very fine bit of investigative reporting that was done in the Washington Post revealed what we had inklings of going on in a number of places. Of course, the fees of the radiologists and pathologists are set separately under Medicare, and so, they are allowed to make these charges. There was a big fight which emerged in the last days of the passage of the bill in 1965 and this provision was hastily conceived. As a result, it is liable to be among the most flagrantly abused provisions.

The Post article also pointed out the abuses in contracting for laboratory services, which, well you used the word "racket," and I think that word actually describes what is going on. There have been some attempts to correct this situation, which I do not deal with later, so I will speak on them here for a moment.

The Medicare law gives more control over hospital costs than it does the physicians' charges. This is possible because a set of conditions of participation were established in the very early days of the program, and then a contract is made with the hospital, and the method of determining the costs to a Medicare patient is rather thoroughly spelled out. While that does give them some control, and there has been some effective policing, it does not give them the power to control unnecessary expansions or unnecessary charges that enter into the thing, except in a very slight degree.

They can catch such things as overcharges with the use of field auditors. I remember seeing one of these auditor's reports where a carrier had people listed on the payroll at the legal minimum wage but were actually paying about 40 cents an hour less. This carrier even included Social Security payments at the amount that they were reporting in their books, but were not actually making the payments.

In this case the overcharges were caught and disallowed. The auditors do find such flagrant cases, but they have no way to control the basic forces which move up the hospital costs.

The Congress has given the administration the power to negotiate costs, with some incentive of reward to hospitals that hold them in a prospective payment basis, but there are only three or four such experiments underway. The hospitals have not been anxious to take up this offer that the Congress put in the bill, and it is a very inadequate kind of control.

Also in H.R. 1, there is some provision that there must be community planning. For example, they will not cover the cost of radium bomb treatments if they have purchased that kind of very expensive equipment, when there was already one in the community only being used a third of the time. Now, that is in H.R. 1, and we hope to be able to put the brakes on some unnecessary duplicated services, but it still does not run to the kind of basic health planning that is needed.

In the Medicaid section of H.R. 1 there is some movement backward, while we feel that on the whole the amendments made last summer by the Congress in the Medicare section moved forward.

National Health Security Program

Referring again to my prepared statement, I point out the only solution to this is to provide adequate health care not just for the elderly, but for all the population, and that we do not believe that the final solutions, even for the elderly, can be made separately. We have the firm conviction that the answer to this is a national health security program. Medicare has demonstrated that drastic reform of the system is needed, and we believe the basic principles of Senator Kennedy and Congresswoman Griffith's bill are the principles that will meet this need. I summarized the reasons for our convictions at some length which I will not repeat in their entirety. I give six reasons. One, that such a program provides really the economic leverage that is needed to correct the system. We must move on this, and I think the public, the same public saying in 1965, "Just pay the bills, but don't tamper with the system," is now saying, "Correct the system, and then find a way to pay the bills." I believe there has been a complete reversal of public attitude on this.

The second reason is the national health security gives more than lipservice to our now generally accepted premise that good health care is a right of every American. It guarantees this right through a single universal system.

Third, national health security removes barriers to timely care by eliminating deductibles and coinsurance and by assuring the patient of no billing by the doctor. These deductibles and coinsurance are designed to control utilization, but we believe they are the poorest way to control utilization, because they really only work for poor people who cannot afford to meet the deductibles and coinsurance.

Incidentally, the insurance industry itself has very ambivalent attitudes. The industry will argue for deductibles and for coinsurance as necessary means of controlling utilization, and then turn around and sell insurance that meets the deductibles and coinsurance.

Preliminary studies that the Social Security Administration has made shows that the deductible and coinsurance does not really control the utilization in an effective way. In addition, I cite here a similar finding made by the Blue Cross Association of America, saying that if the deductible and coinsurance is high enough to be effective, it has an adverse affect on the quality of care. If it is low enough not to bar people, then it does not do the job in controlling utilization. Clearly the conclusion is that it is the wrong method to use in the whole thing.

"Overutilization" by the Elderly?

Senator Kennedy. Mr. Cruikshank, just on one point here. As chairman of the Health Committee I have observed that one of the great myths in the whole discussion of health reform is the idea that the underprivileged overutilize health resources. I am interested in your experience with the elderly. For I have noticed in our travels over the country, in talking with people in neighborhood health centers, and the other health delivery systems that have been developed, that the first priority has always been an outreach program to reach out into the community to try to find the people who are sick and ill, to bring them in and make them aware of the availability of health services. The one group in our society which really overutilizes the health care services is the rich. In hospitals and clinics I have visited I have rarely found elderly patients wanting to wait for 3 or 4 hours with two or three children, when they could be home. I am interested in your reaction to the idea that there is overutilization by the elderly people. Do you think that is true?

Coinsurance and Deductibles To Control Utilization

This is a common myth that we have to have deductibles and coinsurance to keep people out. But as you and I know, the people they are keeping out are the people in the most need. Second, I wonder if you ever came across the problem of elderly people asking: Am I $16 sick, or am I $20 sick today? Because they know that that is what it will cost if they go into an outpatient clinic in any major city in the country. For they know that before they even get in there they will have to pay that basic charge of $15. And so surely they say to themselves, that pain in the stomach, or wherever, it's surely not worth $15; I will wait until tomorrow. What this does, of course, is just complicate further the illness, quite apart from the mental anguish it causes. So, first of all do you find there really is an overutilization by elderly people, and second, do you think that the question of coinsurance and deductible is in the minds of the elderly people whom you so ably represent, not a very real and troublesome feature?

Mr. Cruikshank. Yes, Senator; our experience runs exactly in that direction.

I do not know how the myth arose that it is fun to spend your time in a doctor's office, that it is the way to enjoy a free afternoon. And as you pointed out, these troublesome aspects of receiving health

care are particularly common in the less privileged areas of the country.

We do not need to go any further for an example of this than right here in Anacostia, the District of Columbia. Before one of these neighborhood health centers was established there, the 40,000 people living in Anacostia had only two physicians. This is despite the fact that the number of physicians per population for the whole District of Columbia is about the highest in the United States. But before the establishment of this clinic, people who lived in Anacostia and had to visit a doctor would be subjected to long waits in the doctor's office and the inconvenience of getting to and from the office.

The older people do not need any coinsurance or deductible to keep them from unnecessary physician visits; they do not go unless the care is needed.

The question you raised about coinsurance, deductibles, and "$15 sick" should never be a question, either from an economic or medical standpoint. Suppose a woman is only "$10 sick," but it is with a possible incipient cancer, which has not started to pain or burden her yet. She is a little worried but because of the deductibles and copayments she will wait and see. Can we afford, in any sense of the term, to discourage her from seeking a medical examination?

We should encourage health service utilization, not discourage it. The present health system is designed to respond with episodic care for critical or disabling conditions. This negative delivery of care is further promoted by deductibles and copayments, which tend to make people wait until they feel "bad enough." Studies indicate these insurance provisions are most effective in reducing the utilization of annual physical exams. Again I ask: Can we afford to discourage the highest health risk segment of our population from seeking medical examinations?

Instead we must begin to emphasize and practice positive health care by preventing health needs from beginning and providing early detection and intervention of problem areas.

Senator KENNEDY. Mr. Cruikshank, there is a $1 deductible in the Harvard program, which is a major community group program in Massachusetts.

It works quite well, it keeps away these few people who might just wander in and yet, it is not enough to deter people who are sick. But I could not agree more with your comment on the importance of eliminating the deductibles and coinsurance.

NATIONAL HEALTH SECURITY

Mr. CRUIKSHANK. No. 4, national health security is the only practical answer to the economic delivery of health services and control of skyrocketing costs. It does this by providing health care directly at the lowest possible cost, with no waste of health dollars on private insurance carriers as middlemen, and by using advance budgeting to assure effective controls on all health costs. Other proposals, in contrast, would perpetuate rising fees and would be a bonanza with the insurance industry. Anyone acquainted with the roll of commercial insurance in the health field, beginning as early as 1908 in State workmens compensation laws and continuing through the era of

negotiated health and welfare plans knows that commercial insurance has been a major barrier to positive health planning. It is easy to talk about a pluralistic approach to the problem and about building on the "existing foundations" of our present system; but this is an unsound and futile approach when one of the pillars of the existing foundation is the shakiest part of the whole structure.

This is an $80 billion industry, approaching $100 billion a year, which is unbudgeted and unplanned. The health security program approaches the problem by having a national budget for health, and then working on a regional service area budget so health delivery can be planned in a rational and economic manner.

No. 5, National health security assures public accountability. It would guarantee consumer representation at all levels of administration and would establish a local office in each community charged with responsibility for serving as the "ombudsman" for the consumer.

Senator KENNEDY. I think you talked a good deal about the costs, and I think that, as you pointed out, by 1980 the amount spent will be $200 million. We will be doubling or tripling the amount we spend on just health alone, if the present line just continues and if we do not have any kind of a ceiling on the amounts that are expended. I think your suggestion is the only way that you can really get a handle on these programs.

Mr. CRUIKSHANK. It is the only one we see, Senator.

Later in my statement, I begin to make some proposals about improving Medicare and Medicaid pending national health security.

ESSENTIAL REFORM OF MEDICARE AND MEDICAID

Now, being planners, we know it takes some time to get comprehensive and fundamental programs, such as this program through the Congress. The sponsors of the program recognize there will be a required tooling up period, and we realize that is true and the only practical approach. In view of those considerations, we are proposing considerations of essential reform of Medicare and Medicaid.

In essence, our plan would merge Medicare-Medicaid in a federally administered program covering all residents 65 and older, all other Social Security beneficiaries, and the adult categories receiving cash assistance. Such a merger is especially appropriate in view of the federalization of the adult categories under the new supplementary income assistance program.

Benefits now provided under Medicare would be expanded and payable without coinsurance or deductibles.

Skilled nursing home services—regardless of prior hospitalization—would be covered for up to 120 days and without limit if furnished in a nursing home owned by or affiliated with a hospital or comprehensive health service organization. All outpatient prescribed drugs would be covered if furnished through an approved health service organization; otherwise, coverage would be limited to drugs needed for maintenance therapy or especially costly drug therapy.

Under the proposed program, services would be covered only if performed by a qualified participating provider who would have to agree to accept the program payment as full payment for a given covered service. Participating physicians, who chose to be remunerated on a fee-for-service basis, would have their fees predetermined on a

negotiated basis. Institutional providers would be paid on a prospectively approved budget basis. Thus, the beneficiaries are assured that they will not be billed for any covered service; at the same time, cost controls are built into the system.

Predetermined Physicians' Fees

I should like to spell out in some detail what I have just referred to with respect to physicians' fees being predetermined on a negotiated basis.

The Medicare law part B provides for the payment of 80 percent of the physicians' reasonable charges in excess of the annual deductible amount. However, as physicians have steadily increased their charges year after year, the agency—Social Security Administration—has steadfastly refused to require the insurance carriers to notify beneficiaries that the amounts of their bills not reimbursed are a result of the charges being increased beyond the amount determined under provisions of the law as reasonable. The beneficiaries are left bewildered and confused and by the notations on their bills are led to believe that Medicare has progressively reduced its coverage. Of course, they blame the Congress for that, and they should not, because that is not what has happened.

We believe the reimbursement to physicians should be adequate and even generous, considering the value of the services performed and the investment in education that physicians have made. But we do not believe they should be exorbitant or unreasonable as so many of the charges now are.

We firmly believe that the time has come in the Medicare program to move beyond the complicated and confusing procedure now involved in determining reasonable charges on an individual doctor-by-doctor basis. In place of the present procedure, we believe that doctors should be reimbursed on the basis of established fee schedules. These schedules should be negotiated region by region or service area by service area. They should represent fair and adequate compensation to doctors. Both representatives of the beneficiaries and the medical profession, as well as the Government agency, would participate in the negotiations in which the fee schedules would be established. Those doctors who did not wish to particiapte in the program could withdraw entirely. Lists of participating physicians should be made public and doctors would be required to inform patients who are eligible for Medicare as to whether or not they are participating.

Under such an arrangement, doctors would know the rates under which they are to be paid for their services. Beneficiaries would know exactly what was covered under the program and the many inequities and causes of confusion existing in the present program would be removed.

Under our plan, incentives would be included for both providers and beneficiaries to choose comprehensive prepaid group practice with its emphasis on preventive care and reduction of institutional care.

The new program would provide for consumer representation and public accountability at all levels.

Such a program, we know, will be an expensive one, concentrating as it does on the high-risk groups. Without knowing the exact size of

the price tag, certain financing principles could be agreed on at the start.

Federal general revenues should finance 100 percent of the costs for beneficiaries other than those eligible for Social Security benefits. Social Security beneficiaries should not have to pay any premiums. Some portion of the cost of their coverage should be borne out of general revenues, with the remainder financed by a payroll tax. The payroll tax should be the same for employers and employees.

Senator CHURCH. Mr. Cruikshank, at that point, may we interrupt.

Last week, Commissioner Ball testified on the Social Security program in general, and he said that the present tax rate was sufficient to pay for the retirement features of Social Security. He said that it was for a long time to come, and I was surprised that the projection extended clear into the next century, year 2011.

ADDITIONAL FUNDING FROM GENERAL REVENUES

Before they forecast the need to make an adjustment in the rate of the tax, it is the year 2011, however, he stressed that any improvements in the Medicare program would call for additional funding, and he advocated that the additional funding come out of general revenues rather than an added increase in the rate of tax on the payroll tax.

How do you feel about that?

Mr. CRUIKSHANK. Well, I agree that the health care area is the most urgent, and the one where the need of Federal revenue financing will emerge most quickly.

I am sure as all of the Senators present are aware, there has been a great deal of discussion raised about the present increase in the rates. But none of the press stories I have seen indicate that the Social Security rate for the old-age survivors and disability program is less now than Congress contemplated 2 years ago.

The increase has come because of the increased cost coverage and protection, and prices that are covered by the health insurance programs. This will probably continue to be true for a time, particularly as we add increased protections, like eyeglasses, drugs, prosthetic devices, and long-term care which are so urgent. As we take on more of the problem, the need for Federal financing will emerge more dramatically and at an earlier stage in the health area than it will in the others.

However, as I will point out later in my statement, even with the recent increases in the cash benefits side, the system falls short of its total objectives and the public needs as we read it. As a result there will need to be some increased financing on that side, and we think as this protection is improved, it should also include provisions for general revenue financing.

Senator CHURCH. Thank you.

Mr. CRUIKSHANK. I cite in my statement the importance of the long-term care provisions, and note that the latest provision of the Kennedy-Griffiths bill, the provision for long-term care while not going perhaps as far as we would like to see it go, does go further than the earlier provisions that were introduced in the 92d Congress. This provision encourages meaningful experimentation in the long-term care area which is such a baffling and difficult problem to all of us,

one which Medicare just completely ducked because it said we cannot insure this kind of risk at this time, but we need to move to meet the problem.

Health Area Spending

Senator Kennedy. Mr. Cruikshank, just before you go into long-term care and the alternatives to institutionalization, is it not true that the health area is perhaps the only critical domestic need that we have which would not really require large additional financial resources to meet?

It is my understanding that the money is already being spent, but it is being spent inefficiently, and with a great deal of waste and inequity. If we were really able to do the kind of things which you have outlined here, surely the reduction of inefficiencies, and getting a handle on the escalation of costs would provide resources for expanded services? Unlike Medicare and Medicaid in the past, which increase demand without increasing supply, what we are really talking about is a total approach on the question of services, demand as well as supply. It will be a lot less costly for the future consumer to have the kind of reform which you have outlined.

It has always been clear to me that if we were doing the job needed in housing, or fighting crime, or rebuilding our cities, or depolluting the streams, additional resources would be needed. But in the health area, it has always appeared to me we are already expending the money; the tragedy has been that it is being spent inefficiently and wastefully. The kind of program which you have outlined here would make very significant savings.

I wonder if briefly, those that are opposed to this program are always talking about cost——

Mr. Cruikshank. Yes, that is true. A lot of money is being spent now, certainly not enough under the present system to meet the needs as we know them to exist. But we know some efficiencies that could be introduced now and there are changes in the quality and the type of approach to the problem that could save money such as the kind of thing that our consultant, Dr. Lionel Cosin, has done in Oxford. He has established day hospitals, a kind of in-and-out day-care center where people can come in part of the time and get the clinical services they need, and are receiving supplemental home health care. These facilities have reduced the need for acute and costly hospital and nursing home services.

With the same expenditures we are now making we could vastly improve the availability and quality of health services and attain the ideal of good health being a right, not a privilege, by the implementation of health resource planning and allocation. However, I do think that we need to be careful, particularly of health care on a money-saving argument as long as we are talking just about elderly people.

If we are talking about a national health security program for all of the population, the better the quality of medical care and the more preventative services provided, the lower will be the per unit cost of service delivered.

But this is not necessarily true, if you consider the elderly by themselves. For one thing, if you want a low-cost program for the elderly, the most economical thing to do is let them all die off at age 66. Now,

if you sustain their living and just postpone for 3 or 4 years the time when they are going to die, you are not going to save money. My point is, we should not be approaching health security by chunks of the population for the health system improvements can be maximized only by covering the whole population.

In my statement, I go into more detail in stressing the need and the importance of long-term care, and point out that it is the most lacking in all types of services in our present health system. It shows up more dramatically that a health care system that is run on a piecework for profit, fee-for-service basis can never be geared to meet this kind of problem, no matter how much tinkering and catching up that we do with it.

I conclude with the statement that our current long term care system is nothing short of a national scandal. We urge the Congress to move quickly to correct the abuses, stop the commercial exploitation of the elderly sick, and begin to provide some peace of mind for all those who dread the approach of the days when they may need long-term care.

Future Directions in Old-Age, Survivors, and Disability Insurance

I will now direct my remarks to the future directions in old-age, survivors, and disability insurance. I appreciate the opportunity you have given me to present my views on Social Security in general and not just on health services to economic security.

I shall touch on only a few essential points.

First, the benefit level. During nearly four decades since the enactment of our Social Security system, we have heard repeatedly of the benefit level as a "floor of protection." The debate has been waged, not around the concept of Social Security as the base of income security, but around varying views as to the positioning of the "floor." The concept of Social Security as merely a floor of protection is outdated; the time has come to reexamine the whole question of the level of benefits.

In discussing benefit levels, I shall refer to benefits payable to older people who are retired. But we must always keep in mind that our Social Security system is far more than a system to pay retirement benefits. It is essentially a program designed to provide economic security for the family, the family as a unit. Some 22 percent of the more than 28 million current beneficiaries are younger disabled workers and their wives and fatherless children and widowed mothers. The National Council of Senior Citizens, in urging higher retirement benefits, has also pressed for like increases in protection for younger members of the family.

Social Security benefits are now, and I believe will continue to be, the measure of this Nation's regard for its older population. For most retirees today, Social Security benefits are the major source of income; for many, the exclusive source. This fact has been pointed out repeatedly by your committee, which has done such an outstanding job of documenting the income position of the elderly through its annual reports and its extensive study of the "Economics of Aging: Toward a Full Share in Abundance."

I now refer to the recent Social Security amendments and improvements, with which you are all familiar, showing how the increases over the last 5 or 6 years, particularly the 20-percent increase was adopted by incorporating Senator Church's amendment, which most of you were cosponsors into the debt ceiling bill. This brought about a substantial increase in benefits, which the elderly, and many younger people benefit from very greatly. While we have definite evidence that today's retired population is primarily dependent upon Social Security benefits, all projections realistically based on present trends indicate that the situation will not change markedly in the future. We do not wish to seem ungrateful to a Congress that has done tremendously, that has enacted substantial increases, but we just have to point out that even with these increases, many retired elderly are still below the poverty level. Projections made by your committee show that this will not change in the future, and that private pensions will not really cover this. I hasten to make clear that I am aware of the need of the private pensions and appreciate their present value to many retired people. But I have also seen—especially in my long years as director of the Social Security Department of the AFL–CIO—false claims about future growth used as an excuse for rejecting badly needed increases in the level of Social Security benefits.

To assure that most retirees of the future—and especially low-wage workers—will receive private pensions would require Federal regulations so stringent as to be rejected out of hand. And I might say that I think if the private pensions were to be built up to where they meet the needs, Congress would have to make so many requirements, that it might just as well expand the Social Security system and do the job in one fell swoop. Furthermore, I do not think the stringent controls and mandatory provisions that are necessary to make private pensions adequate would be acceptable to many that are affected by them, particularly the employers that have the private pensions in operation.

Adequacy of Protection

In the area of adequacy of protection, we can learn from foreign experience. In some areas, benefits have improved in relation to wages. Of course, many foreign wages are not as high as ours, though some in West Germany and Sweden and other countries approach them but the proportion of the wage recoverable by the benefit system in some of the countries of the free world are above those in this country.

Congress took a giant step forward in adopting the 1972 amendments to provide automatic adjustment of benefits to increases in the cost of living. Also the amount of the covered wage under the recently passed law is based on a wage level, which more nearly reflects the standard of living than the living cost level. We think these are sound principles and are important future directions for Social Security.

Financing: Payroll Tax

Next, I touch on the matter of financing, and I will conclude my testimony with these brief remarks, and they are brief, not because my views on this subject are uncertain or brief, but because I know you will be exploring financing in depth tomorrow, and because I hope to have a future opportunity to expand these remarks.

I firmly support the payroll tax as the primary method of financing the Social Security system. For more than a quarter of a century, I was privileged to represent trade unionists in their efforts to achieve economic security. I speak then from this experience when I say that, over the years since the introduction of Social Security, workers have shown a commendable willingness to pay Social Security taxes. In no small part, this willingness stems from a recognition that taxes paid out of earnings will entitle them to continue to share in productivity after their working years are over. They look forward to their future Social Security benefits as an earned right. I do not know of any government system that approaches the amount of wide acceptance, particularly among working people, and also among others that the Social Security system has attained.

There have been claims, as I have read in a recent Brookings report, authored by one of the men who will be with you tomorrow, that this faith the workers have in the Social Security system arises largely out of the fact that they are so dumb they do not understand the system is not insurance, and instead have been sold a big bill of goods.

I, as a representative of the workers, for one thing rather resent this. I think they do understand the system, I would say even better than some of those at the Brookings Institution. The workers know the basic purposes of the system, they know the principles under which it operates, and being less selective about Supreme Court decisions, they do understand that it is essentially an insurance system—a social insurance system.

It is a matter worthy of note, you never use the word insurance alone, it is fire insurance, life insurance, indemnity insurance, automobile insurance. Each insurance has its special approach and method of adaptation to the need. When people say Social Security is an insurance, it is not any insurance in the abstract: it is not fire insurance, not life insurance, it is social insurance. As a Supreme Court decision pointed out, social insurance has a separate definable function to perform, and working people, the Brookings Institution withstanding, I think understand this pretty well and they accept it.

We believe as I stated nearly 3 years ago when I had the privilege of writing a paper for this committee, that the time will soon be reached, if it is not already here, when it will be difficult to levy a further regressive tax to pay Social Security benefits.

Progressive Nature of Benefits

As an aside, I would point out while we speak of this tax as regressive, and it is, that its regressive nature, is to a considerable extent counterbalanced by the progressive nature of the benefits. Many current newspaper articles point out that a $100,000 a year man pays the same tax now as the $10,800 a year man. But they usually fail to mention that they will also receive about the same benefits. But the $10,800 a year man, retiring some years in the future will get as a primary benefit, 43 percent of his wage, while the $100,000 a year man will get a benefit of less than 5 percent of his earnings.

If the $10,800 a year man has a wife who receives retirement benefits, they will get some 64 percent of his wage in benefits, whereas the $100,000 a year man and his wife will get a benefit of less than 8 percent of his past earnings. So there is a very great degree of progressivity in the benefit side of the structure.

Senator CHURCH. Is it not true, Mr. Cruikshank, at the lower levels, it is even more dramatic, that is, one getting the very lowest, paid on the lowest wage, something close to the minimum wage, will get even a higher percentage of return?

Mr. CRUIKSHANK. That is true, the primary insurance amount at age 65, for a person with an average wage of $100 a month gets a primary insurance benefit under the law just passed this summer of 109 percent of his average wage; this is part of the reason we call it social insurance. It is a program designed to meet a part of the social need, and lift the lower wage people up, and the higher wage earners have not objected to the fact they get a smaller proportion of their past earnings in benefits, recognizing the need to meet the lower average.

I went on to say in the report I prepared for this committee 3 years ago, "There is sound justification for financing through general revenues that part of Social Security costs which is equivalent to prior service credits. Workers already close to retirement age when the system was first started, or when coverage was extended to their employment, received full benefits even though the contributions they and their employers paid would finance only a small part of the benefit. While this was sound public policy and kept many old people off relief, it did mean that these benefits had to be financed from future contributions. There is no justification for expecting presently covered workers to pay for this 'accrued liability'—estimated in the long run to amount to one-third of the total cost of the program—through a regressive payroll tax. A far fairer method would be to finance this share from general revenue sources to which all taxpayers contribute and through a more progressive tax structure."

I stand on this position today—that the best way of financing our Social Security system is to introduce general revenues in combination with a higher wage base, thus preserving the essential value of earned rights and at the same time lessening the regressivity of the tax.

There are various ways of introducing general revenues as a share in the costs of the cash benefits of our Social Security system, just as general revenues now share in the costs of Medicare. There are also ways to predetermine the share and to commit a specified amount so that the share—and perhaps even more important, the level of benefits—can be predetermined in advance of congressional action. There are ways of assuring that these financing methods preserve the value of the payroll tax and the contributory nature of Social Security, which have been so valuable in assuring entitlement to benefits as a right.

"INDIVIDUAL EQUITY" AND "SOCIAL ADEQUACY"

Over the years we have heard much about Social Security as a compromise between "individual equity" and "social adequacy." I prefer to think of this, not as a "compromise," which implies a sacrifice through concession, but as a melding or optimum blend.

The Social Security system is clearly a blend of these two essential ingredients, and it is because of the blend that the system has earned such great public acceptance. This is a major reason why we cannot evaluate the financing of the system without relation to benefits.

It is important to emphasize that we must look at the whole system, not as my friends at Brookings, who look at one segment at a time. It is like a three-legged piece of furniture. You cannot say one leg is

too short; the other legs may be too long. You have to look at the whole, the financing, the tax structure, and the benefit structure as a unit in order to make valuable judgments about the system.

The 92d Congress is to be complimented for the major improvements enacted in 1972 which were consistent with the basic principles of the time-tested Social Security system—moved further in the direction of social adequacy without weakening the equity of the program.

I refer specifically to the new supplemental security income program, providing a floor of income for all aged, blind, and disabled individuals, to be financed out of general revenues. The Congress, by resisting pressure for an undue increase in the minimum benefit that is financed out of contributions, preserved the principle of wage-related benefits. On this point, I would again refer to the working paper I prepared for your committee. Under the heading, "Social Security Costs Which Workers Should Not Be Expected to Bear", I said:

> Workers should not be expected to pay higher Social Security taxes in order to pay a high minimum benefit to people who barely meet eligibility qualifications because their lifetime work has been in noncovered employment.

In these amendments passed last year, the Congress recognized the lifetime contributions made by low-wage workers through the provision for higher minimum benefits for workers with long years of coverage. This provision reintroduced a principle in the original act that benefits should be graduated by length of coverage and further recognized the greater presumptive need of the lifetime contributor with low wages. In conclusion, then, I urge that the Senate Committee on Aging, in exploring our future directions in Social Security, give full attention to improvements that build on the essential principles of our very successful social insurance program.

That concludes my statement, gentlemen, and I thank you very much for your interest.

Senator CHURCH. Mr. Cruikshank, let me express the appreciation of the committee for a splendid presentation, and we are particularly grateful for your recommendations concerning ways to improve the Medicare program, and the Social Security program in general, and I want to take this opportunity also to extend to you my personal appreciation for the counsel that you gave to me and to other Members of the Senate in our efforts to improve the Social Security system last year.

I think that last year was a high water mark for Social Security that compares with the original establishment of the system, and the passage of Medicare, and we made great progress toward improving the system last year, and we want to build on that accomplishment, and your suggestions will be most helpful.

I would like to mention that Senator Lawton Chiles, is the newest member of the committee, and was present through most of the hearing today. He will be chairing the committee for a time tomorrow, because of my need to be elsewhere.

I would like to recognize the presence of Senator Beall.

Senator Fong, you may have some questions.

Senator FONG. I just want to thank Mr. Cruikshank for his very fine statement. I want to welcome Senator Chiles and also Senator Beall who is a ranking minority member on the Senate Subcommittee on Aging.

Better Health Care for Our Nation's Elderly

Senator Muskie. I would like to read to Mr. Cruikshank four paragraphs of the statement I made earlier and ask for his comments:

It seems to me, Mr. Chairman, that the White House Conference on Aging, which was held over a year ago, brought some hope to all of us that improvements would be made in providing better health care for our Nation's older citizens.

Indeed, the administration's rhetoric at the time of the Conference carried a promise of a better day for the elderly in health and other areas.

The recommendations of the Conference charted a course that could lead to the kind of life that our elderly need and deserve. And adequate health care should be a cornerstone of this decent life for the elderly.

But we have had no clear signals from the administration since the White House Conference on Aging. The administration's favorite word before the Conference—action—has suddenly disappeared from official pronouncements. Now we hear words about new plans and a new team.

I wondered whether your hearing was more sensitive than mine, whether you have been hearing something I have been missing in this respect?

Mr. Cruikshank. No, Senator; I am afraid we are on the same wavelength, and it is not very encouraging.

We were encouraged when on the first day of December 1971, the President appeared before the 3,400 delegates that came to the White House Conference from all over the country, and announced that certain programs would be liberalized, and promised more funds in certain areas, like housing, food for the elderly, and employment opportunities. There seems to have been a reversal of the position.

I was challenged by Secretary Richardson just the other day when I made that point, and I said it was documented unfortunately, but adequately, in the President's veto message of the Older Americans Act, which had unanimous support of this body. All the Older Americans Act really did was implement some of the promises that were made at the conclusion of the White House Conference, but it was vetoed at a time when the Congress was not in a position to override that veto.

I understand it has been reintroduced, and believe that it will have the same bipartisan support that it had in the last Congress. I would hope if it runs into another veto, the veto could be overridden, and I hope then that the appropriations would not be impounded.

There does seem to be a reversal of the field here, and the evidence is unfortunately quite established, particularly in that veto message.

Self-Reliance on the Part of Senior Citizens

Senator Muskie. Is it your view that a great exertion of the commendable quality of self-reliance on the part of senior citizens could deal adequately with these problems you have outlined this morning?

Mr. Cruikshank. The generation that I represent has had about 70 years of self-reliance, but we also do not feel that there is anything that is more American than self-reliance in group action. Our social Security System is not one of these despised Government programs as such, it is a program of self-help, and a program of self-protection where we use the machinery of Government. There is nothing that withdraws any bit of our self-reliance about our deciding as a group of people who are citizens of the United States to use the machinery of their Government to help each other.

In my mind this is as American as barn raising, or any other kind of collective action that is characteristic of our life, our people, our attitudes, and our sense of independence and pride.

Senator MUSKIE. I do not think it could have been said better.

Let me ask one more specific question, and then I will yield.

We have been trying to get some statistical perspective on the achievements and the weaknesses of the Social Security system and Medicare.

Now, is it true that the elderly are paying out of their own pockets almost as much for health care today as they were before Medicare was enacted in 1965?

Mr. CRUIKSHANK. That is true. It comes within a few dollars of being the same in the average amount. However, I think again, we have to say that the acute illness, about which I propose to give some further information to Senator Fong is better taken care of. In cases of a big bill, the thing that could just crush an older person, Medicare has relieved the older population of a major part of this burden. The averages you cite are correct, but such averages do not give the whole picture.

Senator MUSKIE. Is it your view that your interim plan which you have discussed this morning would keep those costs from going significantly higher, or must we do more, and if so, what else more can this Congress do?

Mr. CRUIKSHANK. As an interim plan, we devised the suggestions with the hope of containing these costs, and we believe that they would work and are responsible. Even if these were all adopted, they would not solve the fundamental problem of restructuring the health care system which we think is so necessary, not only to provide health care to all of the citizens of the country, but to also contain the costs, and put the health care system on a rational, workable, budgeted basis.

Senator MUSKIE. Thank you, Mr. Cruikshank, and may I join my colleagues in commending you for your work and your testimony this morning.

Mr. CRUIKSHANK. Thank you, Mr. Chairman, it was a pleasure and honor to be before your committee.

Senator CHURCH. Mr. Cruikshank, before you leave us, there may be other questions.

Senator DOMENICI. I have none.

MALDISTRIBUTION OF HEALTH PERSONNEL

Senator BEALL. I have just one specific question that does not bear on the total statement, but with the section of your testimony where you were talking about the refinements and improvements in Medicare. You talked about negotiating fees with doctors. Whether region by region or service area by service area. It seems to me that one of the big problems we have in the whole medical area is the maldistribution of health personnel, and I think we have done something in that regard with Senator Kennedy's legislation that the Labor and Public Welfare Committee worked on in the last Congress. I am particularly pleased that this health manpower legislation included the physician shortage scholarship program approved by me. While this program was funded at the $2 million level by the Congress, the funds were in the HEW bill which was vetoed.

I was visited by a group of Appalachian doctors a month or so ago, and they pointed out that we tend to perpetuate this imbalance through our Government supervised fee schedules.

These doctors further stated that they were from a county in Appalachia that had a doctor population ratio of one doctor for every 4,000 people, and an orthopedic surgeon told me that comparing himself with a doctor in Baltimore, with whom he went to school all the way to the point where they went out to practice, that this doctor today gets 50 percent more for a hip operation than he did, and Yet the Appalachian is working a lot harder, almost to the point of exhaustion, because of the number of patients he sees.

My point is, if we continue to pay doctors on a service-area-by-service-area basis do not we perpetuate the situation that leads to further maldistribution?

Mr. CRUIKSHANK. Standing alone, I would say you would, if that were the only proposal.

There are, as I am sure you realize, a number of factors that determine the distribution of doctors. Your doctor friend in western Maryland probably is concerned not only with the fact that his colleague in Baltimore gets a higher fee for the same procedure, but he is probably also concerned about the cultural and educational possibilities for his family in the deprived area, although there are compensating reasons to live in western Maryland, as I could appreciate, but he is also concerned about perhaps the lack of facilities. There is nothing in the Appalachian area that gives him the tools and the kind of workshop that he would have in Johns Hopkins, and he is concerned about this.

Now, there again, the national health security bill, deals not just with this one facet, but provides other incentives for physicians to move into the less privileged areas. I think we have to move on a broader front than just the fee schedule.

NEGOTIATED FEE SCHEDULE

Senator BEALL. I am not denying we have to move on a broader front. I think some progress is being made in opening up opportunities for doctors to have a better opportunity to practice their profession in better facilities. The point I want to make, however, is that I think we tend to perpetuate this inequity if we do not recognize that a doctor is a doctor, wherever he is. If he has the same skill, he ought to be paid at the same rate for his services, giving allowance of course, for higher costs of living.

Mr. CRUIKSHANK. A negotiated fee schedule would give the doctor an opportunity to do this. The negotiated fee schedule would not necessarily incorporate just the prevailing schedule, which might reflect a very low income on the part of the clientele.

Senator BEALL. That is the problem, of course.

If you are dealing with rich people, you are now paid more, but if you are dealing with poor people, you are paid less, because of the clientele you have.

I am not sure that is fair. Why should a doctor who treats rich people for the same thing be paid more than the doctor who treats poor people.

Why should he not be paid the same thing, because he is treating the same illnesses.

Mr. CRUIKSHANK. If I understand you, you are suggesting a universal fee schedule.

Senator BEALL. I am suggesting there ought to be more universality than there is.

Mr. CRUIKSHANK. I would agree, but I think there would be room within the negotiated fee schedules to do this. If you did it under the provisions of the health security bill, you would not be depending solely on the resources of that service area, such as the western Maryland area, to pay for the services in that area, as you now are, and that is why they get lower fees. There would be a transfer under the national health security bill from some of the more affluent areas to the less affluent areas, which would permit an upward level of the payment for services.

As it is now, just on a piecework basis, the doctor charges what he thinks he can collect. Lots of times, he just does not get paid in poor areas even if he charges it. Some people are too poor to pay, and that is not fair either.

Senator BEALL. I am talking about where the Government describes the fee that he will be paid.

Mr. CRUIKSHANK. The Government serves as a referee, and consumers, and physicians would negotiate the fee. Now, I agree it is inadequate, if you do it, as I am proposing, just under Medicare, but I am only proposing it as an interim step. The ultimate solution is a national program, which would permit a fee schedule negotiated with the Government operating as a kind of referee or umpire, and which would permit the transfer of financial resources to the impoverished areas from the more affluent areas. It would move in the direction of correcting these things which you cite.

Senator BEALL. I think it should be pointed out the impoverished areas are not just the low-populated areas, the impoverished areas are also the inner cities.

Senator CHURCH. Mr. Cruikshank, I would like to touch on a couple of points that did not come up in the course of your testimony, but I think we would benefit from your own views on these two subjects.

THE NURSING HOME PROGRAM

The first has to do with the nursing home program. You said in your statement that it was a kind of national scandal, but I recall that in July 1971, President Nixon announced his eight-point plan to eliminate substandard nursing homes, and it was done with considerable fanfare.

In your view has the program been successful, has there been substantial improvement, or are things about the same?

Mr. CRUIKSHANK. Well, Senator, I do not think it was successful in terms of meeting the needs. The main need was not getting rid of substandard nursing homes, although they should have been gotten rid of a long time ago, and never have been allowed to exist in the first place. The main need is to get more quality care, not just to close down the bad ones. Now, not many bad ones have been closed down, I have not heard of any. Also there has been a withdrawal of support for enlarging the services of an expanded nursing home program, and there has been no support for moving into an area where the need for nursing homes could be lessened by better home health services, and by establishing day care centers for the elderly.

These are the needs. These are the needs the White House Conference very eloquently underscored, and there has been no movement in that direction whatsoever.

Senator CHURCH. One final point on the Social Security program, I do not think that was touched upon in your statement, I do not recall that we have questioned you on this point.

SOCIAL SECURITY AND THE WORKING WIFE

Some criticized Social Security for failing to fairly treat the working wife, that is to say the criticism is that a working wife will pay into the system along with the working husband, but will benefit from that payment, possibly not any more than a nonworking wife who pays nothing into the system, and I think it was Carl Rowan the other day who proposed in one of his columns, this might be rectified by allowing the working wife a tax credit on the joint income tax that the husband and the wife filed for the amount she pays into Social Security.

What is your reaction to this general criticism, and what specifically do you think of the Rowan proposal?

Mr. CRUIKSHANK. Yes, Senator, Mr. Rowan is completely in error in some of his assertions. Specifically when he says the retirement benefit will be the same for a family when both husband and wife work as it would be if only one works.

If you will recall, in my paper, I pointed out that the Social Security system is designed as a family security system. The nonworking wife gets a benefit equivalent to a half of her husband's benefit, the primary insured benefit, recognizing both the family need for this additional payment, and recognizing also that a housekeeper who may have been kept out of the labor market by her family responsibilities is also contributing to the economy, although not contributing in such a way that lends to accounting and tax payments in the same way that a working wife on a payroll would. Now, the working wife, as you know, has some advantage. She has the choice when she reaches retirement age of taking her benefit, the benefit as the wife—half the primary insured amount—or her own, based on her own wage, whichever is the highest. This is a move in the direction of equity, as well as family protection.

If we begin to divide the Social Security system into compartments, relating just to individual family members, we would reduce a great deal of the protection that it provides.

Take for example, the young working man in his thirties, who has only been under the system maybe 5 or 6 years, and therefore has not contributed as much, he has a wife and two children, in the example which Commissioner Ball presented to you the other day, and yet he has under the Social Security system the protection of what is the equivalent of term life insurance with a present value of $89,480. Now, he has not contributed anything like the amount that it would take to purchase term insurance for his wife and children for $89,480, and if you thought in terms of just equity, he is getting an unfair amount. But I think the public has asked, and the Congress has responded over the years to a system that provides protection to the family as a family unit, even recognizing that in some instances, it is not 100 percent of the direction of individual equities.

Senator CHURCH. Well, I think that the testimony both today and last week has been very helpful to this committee, particularly in having emphasized the Social Security concept, with respect to its derivations, with regard to the social aspects that are oftentimes overlooked, and that this has been very helpful.

Senator Kennedy has a question.

Senator KENNEDY. Just a couple of questions, Mr. Cruikshank.

I reiterate my welcome to you, Mr. Cruikshank, and commend you for this splendid statement.

You bring an extraordinary knowledge and understanding of this whole area of health care since you are one of the architects of the Health Security Act, which reflects, to a great extent, your knowledge, concern, and awareness of the problem. I think this has probably already been mentioned here, but it is important that all of this committee understand it, and I want to thank you for your comments.

STUDY OF LONG-TERM CARE FOR THE ELDERLY

There is one other thing which you talked about here this morning, that is, the importance of the development of a study of the total system of long-term care for elderly.

That is specifically authorized in the Health Secruity Act, as you are well aware.

I am just wondering whether we should not consider perhaps the wisdom of having legislation on this immeditely, and moving ahead on it.

I hope we will get health security in this Congress, but for such a review, do you think it would be worthwhile for us to consider legislation authorizing this particular study, and perhaps the support of different pilot programs in this area right away?

Mr. CRUIKSHANK. I believe it would, and I do not think it would retard the whole health security movement. In fact, I believe it would move it forward because we could demonstrate that this is workable, and that what so many have considerd a stumbling block, I believe we can remove.

It is not going to be easy, but I think there is enough ability and practicability in this country to deliver care in these related areas. Long-term care is closely related to expanded home health services and homemaker services. We should move forward on the whole broad front and I do not think we ought to wait.

Senator KENNEDY. Would you help us and make some suggestions in terms of drafting legislation and work with us in its development?

Mr. CRUIKSHANK. My colleagues and I would be very glad to work with you.

Senator KENNEDY. It would be most helpful and valuable to us. You mentioned Dr. Cosin in Great Britain as a man who had done so much and been so imaginative. I had the opportunity to hear him in our Health Committee, and also to visit with him in England this week is truly extraordinary.

WHITE HOUSE CONFERENCE RECOMMENDATIONS

Finally, on the question of where we are really going as a country, and as a Congress as well, I suppose you are somewhat perplexed,

as you explained in responding to Senator Msukie's inquiries, as I, and I am sure others have been, at the lack of response in the White House Conference recommendations. As you are well aware, we heard in the Aging Committee of the Labor Committee, Dr. Fleming indicate to us shortly after the White House Conference that the administration was asking various aging organizations all over the country, private and voluntary organizations as well as State bodies, for their comments on the White House Conference. This seems to me to be just another study on a study since the recommendations were quite clear and I thought compelling. Yet they set an elaborate time system for the various groups and organizations to respond to the advantages and disadvantages of the study.

I asked Dr. Fleming if the administration itself was going to give us a reaction to the specific recommendations, which ones they thought of value, and which ones they thought were not, and their reasons, but those studies and reactions have still not been forthcoming.

I know that the Committee on Aging, the Labor Committee, and I do not know if they have ever been forthcoming to you, but they have not been to us.

Administration's Approach on Health Insurance

The second area which is of great interest to me, and I am sure to you, is the administration's approach on health insurance. As you are well aware, they introduced their own program some time ago, and it had some rather serious gaps in terms of total coverage. Some of these gaps you have outlined here; approximately 40 million Americans would not be covered for a wide range of different services, depending on income. It set widely varying standards and had very little in terms of cost control. These were the reactions of the Senate and Congress, and now HEW has effectively canned the whole administration health security approach. When Mr. Weinberger appeared before the Labor Committee the other day, he was asked when we could expect administration approach on these various points. He said he was unprepared to give us any information on what was going to happen. I think this record on these two subjects help to demonstrate why it is so important, why we must continue to move quickly to consider the kinds of proposals that you have mentioned here today. Because I do not see any real counter-proposals on the horizon, and I think that as we continue to study this, and these other proposals begin to fall by the wayside, the logic and the reason and the fairness of the proposals which you have outlined come through even more clearly.

Mr. Cruikshank. Thank you, Senator, there is a final meeting of the White House Conference on the Aging Board scheduled for March 5 and 6. It seems to many of us to have been a lot of wheel spinning on this.

Some of us wonder why we need to have another meeting. The Executive Committee, of which I am a member, met with Mr. Fleming recently, and we said we did not want to wait until that March meeting, to have a chance to give our interim comments to the President so we met with Secretary Richardson just last week and got a pretty negative response.

We pointed out that many of President Nixon's promises were not being fulfilled, and we just wanted to know what was happening on these promises which appeared so glowing a year ago last December, and now meeting vetoes in places where the Congress had responded, and with bipartisan support. The Congress, I am sure, thought all they were doing was fulfilling the pledges of the White House Conference.

Earlier the administration had a position on the health matters, and I raised the question personnally with Secretary Richardson, nearly 3 years ago now, on the plan, and complained about the reliance on commercial insurance. He assured me I had not seen all of the plan, that when the whole administration proposal came in, it would include proposals to establish standards for the insurance industry. I waited and waited for these, and then finally they came out. What the standards did was to refer the matter back to the States, which, of course, means no standards at all, and that is exactly where it rests now.

Senator KENNEDY. When he appeared before our Health Committee, he indicated there would be strong Federal standards, because the insurance industry had failed to measure up adequately in this area. But, as you pointed out, by the time it got to the House of Representatives, it was to be just State standards, and then finally it was to be no standards at all.

Mr. CRUIKSHANK. I read Mr. Richardson's 67-page final report, and I must say it read to me like a long explanation of why he had not done a better job as Secretary, blaming all the shortcomings on the Congress. In the health section, I was particularly interested to read that even the proposals that had been espoused by the administration inadequate as we felt they were, have been abandoned. The administration proposes a catastrophic insurance with one system of medical care for the well-to-do, another system for the intermediate, and another for the indigent and unemployed. This takes us back to where we were 10 years ago.

Senator KENNEDY. I want to thank you again, Mr. Cruikshank, for your comments.

Senator CHURCH. Thank you, Senator Kennedy. Are there any other questions on the part of the committee?

I would like to close by including for the record an excellent article that appeared in the New York Times. It seems to be a very well balanced assessment, it was written by Mr. Dale, and he reaches the conclusion that Social Security at its worth is not a bad deal, and that it is even good for the young worker with 40 years of paycheck deductions ahead of him.

I think this is a good summary statement of the present state of the Social Security system, and without objection, it will be included in the record at this point.

[The article follows:]

THE SECURITY OF SOCIAL SECURITY

[The New York Times Magazine, Jan. 14, 1973, by Edwin L. Dale, Jr.*]

WASHINGTON. A funny thing happened to your taxes on the way to 1973. Congress passed the biggest Federal increase since the Korean war (and that one was temporary), and hardly anybody peeped except a few intellectuals. This was happening at the time of the "taxpayers' revolt" at Federal, state and local levels.

*Edwin L. Dale, Jr., a member of the Washington bureau of the Times, specializes in economic news.

It was at the time when even George Wallace was appealing to a sense of frustration in the middle and lower-middle classes, telling them the tax system was unfair. It was an election year.

And yet Congress passed—*with scarcely a dissenting vote*—and President Nixon signed two bills that will raise the taxes of working middle-class Americans by $164 in 1973 and another $70 in 1974. They will raise the taxes of working lower-middle-class and poor Americans (the working poor have been practically eliminated from the Federal income tax, in a reform for which Congress and the first Nixon Administration got far too little credit) by some lesser amount, depending on their earnings, but the increase will be real. The two bills will raise the tax on the working rich by the same amount as on the middle class, and of course they will hardly feel it, proportionately.

Before anyone wonders whether he has missed some important news development, or has been somehow bamboozled, it is best to explain the mystery. The paradox is resolved in two words: Social Security.

Social Security is a wonderland of semantics. A tax becomes an "insurance premium," for example. The very words "social" and "security" are as slippery as can be. As semanticists have long known, when a vague or misleading phrase comes to have a popular acceptance or understanding, all kinds of irrational behavior can take place. But let it be said at once that this article is not designed in any way as an attack on the Social Security system. It is not even a criticism of the way the system is now financed, though an increasingly powerful case is being made that the financing is wrong and regressive (a long word for "soak the poor"). Rather, it is an effort to describe and assess the almost breathtaking things that have been happening in Social Security, of which the most breathtaking has just been described: a $7-billion tax increase enacted in 1972 with scarcely a voice of protest.

I remember well a sense of pleasure and satisfaction at seeing the first (minuscule) Social Security deduction on my first paycheck. The last thing I was thinking about was retirement, but I was made both conscious of it and slightly comfortable about it. I *still* feel good about my Social Security deduction, despite its big increases. After reading countless thousands of words on the subject—and becoming aware that no ironclad conclusion is possible—I believe that on balance, Social Security is a "good deal" for me and for nearly all working Americans. As we shall note later, there is no dispute that Social Security has been an extremely good deal for those already retired.

The ever-controversial economist Milton Friedman, while conceding that the retired have had a very good deal, has argued that "the benefits promised younger workers are much smaller than the equivalent of the taxes paid on their wages." But the equally prominent economist Paul Samuelson says the exact opposite: "Everyone who reaches retirement age is given benefit privileges that far exceed anything he had paid in."

In the real world, Samuelson seems much closer to the truth. Certainly his view has been right up to now. And Friedman's arguments are based on a set of assumptions, including the debatable one that the worker is really paying the employer's part of the Social Security tax. They are also based on law that has since been substantially altered. There are endless arguments, too, about possible alternative yields on investments, if employers and employees were to invest Social Security money elsewhere, but in the end these arguments are not conclusive, even assuming this were a realistic possibility.

To repeat, I am persuaded that Social Security at the worst is not a bad deal, and is safe, even for the young worker with 40 years of paycheck deductions ahead of him. It is not a bad deal, either, for the doctors and salesmen and other self-employed who tend to do the most squawking. Unless the world blows up, or the country goes bankrupt, it is highly likely that current workers will get back from Social Security more than they paid in if they live only a few years past their retirement age, and a great deal more if they live a long life.

If the world blows up, or the country goes bankrupt (whatever that may mean), alternative investments will not be worth much, either. One of the saddest financial stories I know is that of a fine young Englishman who went to Argentina 25 years ago, when that was a comparatively prosperous and stable country, and invested his savings in an annuity policy. He is now broke, in a savings sense, because of that country's irresponsible Government and consequent raging inflation, while American Social Security recipients—hardly affluent, to be sure—have more than kept up with the rise in the cost of living.

But back to taxes. As is generally recognized, a worker's Social Security tax is a specified percentage (5.85 per cent in 1973, the highest yet) of all his earnings up to a "wage base" or maximum covered earnings ($10,800 in 1973, also the highest yet, rising to $12,000 in 1974). Both the percentage and, more rapidly,

the wage base have risen over the years through successive acts of Congress. The results are striking. The following figures show the Social Security tax paid and to be paid by a worker whose earnings have always been at or above the wage base (each figure matched, of course, by the employers' payment):

1950	$45.00
1955	84.00
1960	144.00
1965	174.00
1967	290.40
1969	374.40
1971	405.60
1972	468.00
1973	631.80
1974	702.00

The increase is far greater, proportionately, than in any other tax. Even a state sales tax that was 1 cent in 1950 and is now 7 cents has not risen as much. The Federal income tax—measured as the tax collected on a given amount of income—has actually declined, and quite substantially. The comparison is not quite fair, because the huge increase in maximum Social Security taxes reflects both rising tax rates and a rising wage base. But taking tax rates alone, the increase since 1950 has been from 1.5 per cent to 5.85 per cent.

Social Security taxes (including the employers' equal share) will bring in an estimated $63.4-billion this calendar year—far more, for example, than the corporate profits tax. For literally millions of workers, Social Security taxes are now larger than Federal income taxes. And they will keep going up, as we shall see, without any further action by Congress—particularly for the better paid—though the rise may be much less rapid in the future than it has been since 1965.

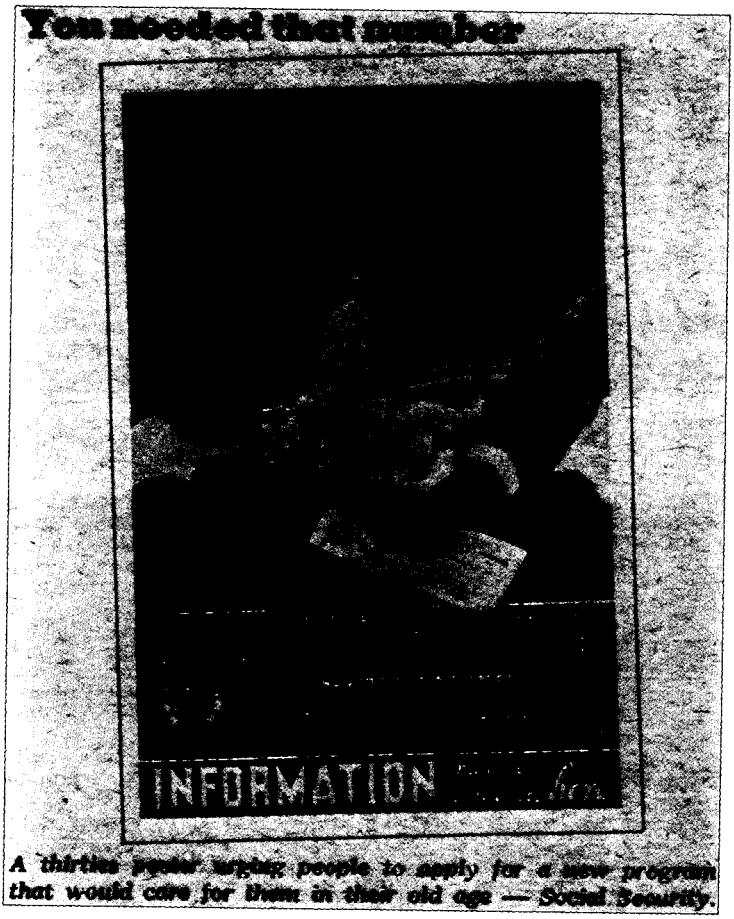
What has all this money bought? The answer comes in two parts, and the description of the first can well begin with a small episode in the recent election. John Chafee, campaigning for the Senate in Rhode Island, visited a jewelry factory and asked the workers, mainly women, what they were interested in. Many said they would like to be able to retire on Social Security with full benefits at age 55. He thought for a moment and then commented that such an idea would be very costly—both in terms of lost taxes and a big increase in the total benefit payments. The reply came back: "Let the young pay for it."

That, of course, is precisely what has been happening. The explosion in Social Security tax rates, wage base and hence tax collections from the younger working people has financed a huge increase in cash benefits for those already retired, plus the highly important addition in 1965 of Medicare for the aged (the tax for which, technically separate but collected as part of the Social Security tax, is included in all these figures).

At the beginning—the nineteen-thirties—when no one dreamed that inflation would be a way of life (even the relatively moderate inflation averaging 2.5 per cent a year that we have had over the past quarter century), the idea was to relate the Social Security pension to the wage while working. That is still theoretically the case for workers now working, but it is not true for the pensioners. Each pensioner *started* with a Social Security monthly benefit calculated on the basis of his or her covered wages while working. In theory, the benefit was to remain the same for as long as he or she lived, as would be the case with a private annuity. But, in fact, about every two years Congress has simply added a percentage increase to the existing benefit schedule—with the biggest of all, 20 per cent, enacted in 1972. A couple retired early in 1965, for example, with the maximum benefit then payable of $184.50 a month is now getting $339.30 a month, more than enough of an increase to preserve the real value of the pension in the face of rising prices. This couple has paid in nothing extra, and any insurance company that offered a contract like that would go broke in a year.

There is no intention here to claim that these successive benefit increases were "wrong." It would have been far worse, in a moral sense, to keep the aged on a fixed Social Security income while prices rose, and the benefits are not all that lucrative in the first place. But the fact is that in dollar terms those already retired have had a huge bonanza from the Social Security system, as measured by what they paid in—especially when Medicare is considered in addition. The bonanza has been paid for by rising tax collections from those working, not only higher Social Security tax rates but the regular rise in the total of wages subject to the tax. What all this says is a simple truth, often obscured by the semantics of "social insurance," "trust fund" and the like: The income earners pay for the income of the aged. Congress recognized that principle more explicitly last year in several ways:

All pretense of an "actuarial" trust fund for Social Security was abandoned and Congress provided that from now on benefits would be financed exactly by each year's Social Security tax income from wage earners. The present fund of about $20-billion will remain as a sort of cushion but it will grow no further as an actuarial system would have to. The system is now pure "pay-as-you-go."



A thirties poster urging people to apply for a new program that would care for them in their old age — Social Security.

For the first time, Congress recognized in setting present and future Social Security tax schedules that, in the real world, average wage rates rise each year. The old tax schedules had been based on the assumption of unchanging wage rates, though they did assume a growing labor force. The result was that tax rates were higher than they needed to be, and the trust fund ran a surplus and grew almost every year. Now that the assumption has been changed and made more realistic, the scheduled tax rates for the next five years and longer will rise much less than they would have, despite the huge 1972 benefit increase and despite other costly improvements, such as a higher minimum benefit for those who have worked for many years at very low wages.

Most important, the "escalation" principle was introduced into Social Security for the first time. From now on, it will not take an act of Congress to raise benefits when prices rise. Benefits will automatically be adjusted upward when the consumer price index rises by 3 per cent. And to pay for this, there will be an equally automatic increase in the taxable wage base (not the tax rate). It is a straightforward recognition that the young—in this case, the better-paid young—will pay for "justice" for the aged. The

escalation provision simply regularizes what has been happening anyway on a slightly haphazard basis in the biennial benefit increases enacted by Congress. It guarantees a further bonanza for the already retired—again, measuring their dollar benefits against what they paid in.

So part of the answer to what higher Social Security taxes have bought is a dollar windfall for the aged. But there is also something of a plus for the working man. Although we have seen that the principle of Social Security benefits being related to wages is partly a myth (benefits are far higher for those already retired than the principle would imply), it is not entirely so. Every increase in the wage base does in fact raise the future amount that the middle- and higher-income worker will receive as a starting benefit, and he will have the benefit of escalation after that.

On relatively conservative assumptions about inflation, the worker now in his mid-30's earning $12,000 or more a year, and whose future earnings rise at least as much as the general wage level, can count on a starting monthly benefit on retirement of more than $1,500. That will be in dollars of about the year 2000, of course, which will not be worth today's dollars. But still, the wage-base increase (though not the tax-rate increase) is "buying" a better pension for those with good incomes. And with escalation now established in law, Social Security is an even better retirement deal. In fact, the more inflation there is after retirement, the more the retired "beat the system," in the sense that they will get a benefit far higher than their payments and working earnings would have entitled them. The then-young will pay.

Is anything wrong, then? To dispose of one tenaciously held myth first, there is nothing wrong with the "soundness" of the system. No one's benefits—present or future—are in jeopardy. If the day comes when the United States Government cannot pay its contractual obligations, a lot more people than the retired will feel that the world has come to an end. The Social Security "trust fund" is a convenient financial accounting device, but in fact it is largely meaningless. The obligations to pensioners, like the interest payments on Government bonds, would be paid if the trust fund disappeared tomorrow. Social Security payments will stop only on the day that the U.S. Government stops paying its bills.

I recognize that it is very difficult to persuade some people of this fact. There are criers of doom who bombard us with figures seeking to demonstrate the "unsound" condition of the trust fund, the Social Security system's "unfunded liabilities" and the like. But they overlook the fact that, in the real world, the Social Security benefit is a straighforward obligation of the United States Government, regardless of how it is financed. Some day, part of it may be financed by regular income taxes, as many now urge. But the benefit payment will remain an obligation. Perhaps the best analogy is compensation benefits for veterans with war-connected disabilities. These are paid out of general revenues, and they are paid every year even if the budget is running huge deficits. If necessary, the Government will borrow the money to pay its obligations, as it now often does with no disaster for the economy.

Up to now, of course, benefits have been financed solely out of Social Security taxes, and they will continue to be unless there are fundamental changes in the law. Because these collections rose faster than benefits, the "trust fund" gradually built up, though the principal will grow no more. It is "invested" in special Treasury bonds and earns interest each year—interest which does have the effect of reducing slightly the level of taxes that have to be paid by those at work to finance any year's level of benefits to the retired. But all of this is really just bookkeeping. The tax money is collected by the same Internal Revenue Service that collects all other taxes, and the benefits are paid by the same Treasury that pays all other Government bills.

The trust fund has helped preserve the idea of the "separateness" of Social Security and the principle of "insurance"—the semantic confusion that has so far helped to make Social Security tax increases acceptable as they apparently were even in 1972. But in the end, the "insurance" is only the insurance that the U.S. Government pays its obligations, and that is pretty good insurance. It will remain good insurance even if some day there is a revolt by the young against the rising Social Security tax. In that event, the contracted-for-benefits will be paid from some other revenue.

What about the level of benefits to the aged? Even with automatic escalation and even granting, as we must, that the retired are doing well in terms of dollars collected vs. dollars paid in, a case can be made that benefits "should" be higher. The average Social Security benefit today for a retired couple is only $271 a month.

But that is a pure question of "national priorities," and is beyond the scope of this article. With the present tendency of total Federal spending to outrun

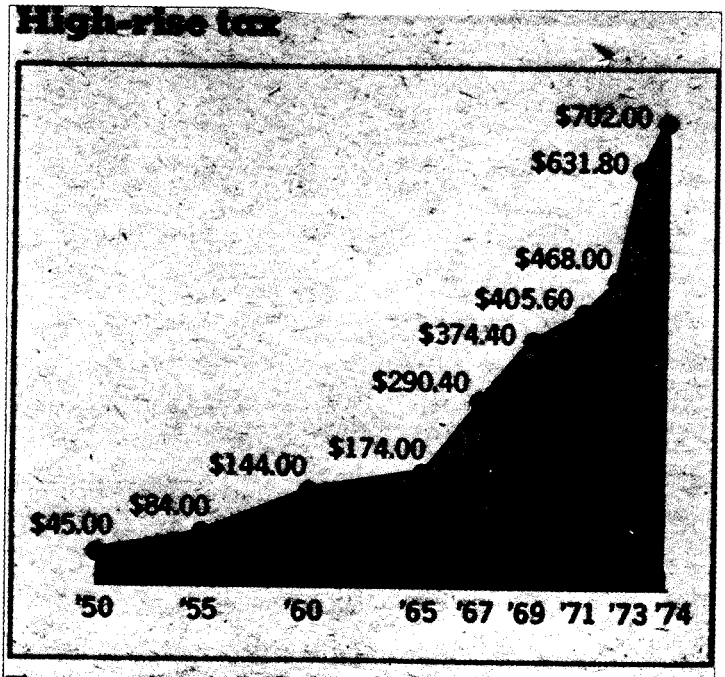
revenues, it should be obvious that any decision to increase the benefit level of the aged will require an exactly corresponding tax increase on those who are working, or a reduction in some other Federal expenditure. Apart from the fact that the young are not in love with tax increases (even though, so far, they have swallowed the Social Security tax increases with remarkable equanimity), many people feel that there are higher priorities for new Federal funds than cash benefits to the aged: services, food and cash for poor children, for example.

Some people even prefer more spending on defense. The point here is not to make a choice but simply to point out that the "Social Security system" can no longer disguise that a choice must be made, especially now that it is entirely pay-as-you-go. The choice is whether to raise taxes on the young at all and, if so, what to spend the money on. The answer is not necessarily higher cash benefits for the aged.

But finally, there is probably the most serious question of all: Is the Social Security tax system fair?

Most liberals who have looked into the matter think the system is unfair—a soak-the-poor system. If the Social Security tax is viewed solely as a tax, they are right, even after the wage base rises to $12,000 in 1974. The worker with any amount of income from $12,000 down will pay 5.85 per cent of his income in Social Security tax while the executive with an income of, say, $40,000 will pay less than 1.8 per cent. Even for the majority with incomes of $12,000 or less the tax is directly "proportional," not progressive as the income tax is with higher rates on higher incomes.

A Brookings Institution research report by John A. Brittain, published in late 1972, makes this point powerfully. It argues for calling a tax by its right name—not an "insurance contribution"—and making it at least as progressive as the income tax. One idea of Mr. Brittain's, for example, would be to give exemptions and deductions on the Social Security tax so that it would work out to be progressive, and the lower-income workers would pay a lower rate than the middle class and the rich. The result, of course, would be either a higher Social Security tax scale for the better-off or, more likely, an increase in the regular income tax.



The curve of an individual worker's maximum annual Social Security payments. Increases have been far greater, proportionately, than those of any other tax.

The other side of the argument is that the Social Security tax is still—even after discarding the myths—different from regular taxes. It does "buy in" to a system of retirement benefits that will be a good deal for both poor and rich. Given the increasing improvement in minimum benefits, the system is better for the poor than for the rich, once retirement is reached; those with very low wages and sporadic work experience already receive a starting benefit much higher than their wage earnings alone would justify. In this sense the system is quite progressive. Except for those who had received the lowest pay, the starting benefits reflect what is paid in, and we all do, after all, pay in the same percentage of our covered earnings. Put another way, while it is true that Social Security taxes are a higher proportion of total earnings for the lower-paid than for the higher-paid, so are Social Security benefits after retirement. The rich man's benefit after retirement, like his taxes while working, is small proportionate to his large earnings—though the increase in the wage base will increase his benefits along with his taxes. And not only do we all (except the lowest-paid) get a benefit proportionate to what we paid in, from now on we will also escalate together once we start receiving benefits.

It seems fair to say that, despite all that has been happening to Social Security, the "insurance" principle still does have validity, from the point of view of the individual worker. The young do pay for the old, but the young will have their day.

Could the younger taxpayers "revolt"—at the sheer amount of the tax, if not at its supposed "unfairness"? That is possible, of course, but there is little sign of it so far. What is more, it now appears that the days of very steep increases in Social Security tax rates are behind us, certainly for the years immediately ahead. While the wage base will gradually creep higher under the escalation principle, this will affect only the better paid, will not cause much of a tax increase in any one year and will have the advantage of increasing the starting benefit upon retirement for these people.

In any case, there is no present indication that Congress will change the basic Social Security financing—a separate and equal-percentage Social Security tax. It may be that the lack of complaining so far among the great mass of us is based on some confusion about Social Security, but after all, we are likely to get a pretty good deal when we are older. Perhaps we were right not to have protested much at what happened to our taxes in 1972.

What if You Die the Day Before Your Social Security Payments Are To Start?

Social Security is not solely a retirement system. There are benefits for survivors no matter at what age a worker may die, and there are benefits for disability, again regardless of age. All as a matter of right, with no means test.

For example, take the case of a man who has paid Social Security taxes all his life and dies this year, at the age of 64, just before he is ready to start collecting his pension.

Has he lost everything? If he is single without dependents, yes—as would be the case with some private annuities or company pensions. But if he has a widow, there is a different answer. If this man had been paying the maximum Social Security tax during his working life, and his wife is 62, she will promptly start receiving $206 a month and will receive it for as long as she lives. Her life expectancy, incidentally, is 17 years, meaning probable total benefits of about $42,000, or far more than the man paid in.

In this sense, the younger workers have the best deal of all. In the case of a well-paid young man now 30 who dies in five years, leaving a wife and two children, 3 and 5 years old, the surviving family will receive a starting monthly benefit of $717, which will escalate with inflation. On a conservative estimate of inflation, this family will have received $189,000 from Social Security by the time the youngest child is out of college at the age of 22.—E. L. D. Jr.

Senator Church. I thank you, Mr. Cruikshank, for your fine testimony, and the hearing is adjourned.

Tomorrow morning at 10 we will take up the third session of these hearings.

[Whereupon, the hearing was recessed at 12:25 p.m.]

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL FROM WITNESS

ITEM 1. PREPARED STATEMENT OF NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, Members of the Senate Special Committee on Aging, my name is Nelson H. Cruikshank.

I deeply appreciate the opportunity to present my observations on the operation of our major social insurance programs. The very fact that these hearings are not directed to a specific legislative proposal gives us the opportunity to attempt a broad, overall view of the purposes of the various programs and arrive at some measure of their effectiveness in meeting their objectives.

No one has designated me to speak in any capacity other than that of my position as President of the National Council of Senior Citizens. While I cannot presume to go beyond that, I do believe that the interests of the membership of my organization are the same as those of most all the elderly. Furthermore, while speaking for elderly citizens I do not believe they are to be considered a group set apart from the rest of the population in the sense that their needs are to be met at the expense of meeting the needs of others. Of course each age group has its special problems and concerns. But in the larger sense, what is good for one group benefits all groups and the proposals advanced to meet the needs of one must be weighed in terms of their affects on all the others.

My statement today also draws upon experience in various capacities. I served as Director of the Social Security Department of the AFL–CIO during the long years of evolution of Medicare. The AFL–CIO, representing working people and their families, was a wholehearted supporter of proposals for social security financing of health costs for the aged—those most in need of protection and least able to obtain it privately.

With the enactment of Medicare in 1965, I was appointed to the Health Insurance Benefits Advisory Council, the Council charged with advising the Secretary of Health, Education, and Welfare in the operation of Medicare. I was reappointed in 1968 and have just completed this second term. I still serve on the Physician Reimbursement Method Study Committee, which is a Committee of the Council. And, finally, as President of the National Council of Senior Citizens, whose three million members have day-to-day experience with Medicare, I believe I am in a position to reflect their feelings about the operation of this program. The National Council of Senior Citizens was born out of the long struggle for Medicare. We were originally established in July 1961 as the National Council of Senior Citizens for Health Care through Social Security. Our beloved first President was the Honorable Aime J. Forand, sponsor of the legislative proposals from which Medicare evolved.

A Better Life For All Americans

Over the years, the National Council has greatly expanded its concern. Our goal is to improve life for all Americans, including the elderly, and we want to be sure that the better life for the elderly is in harmony with the total national interest. The National Council is a wholehearted supporter of National Health Security for the total population. Medicare has relieved much of older peoples' heavy medical costs, lessening the need to seek help from family or public welfare in meeting crushing medical bills. Our members now want the same relief for their own children and grandchildren in the years ahead.

Early in our history, too, we extended our goals far beyond health care and have placed special emphasis on improvements in cash Social Security benefits. I think I can safely claim that the recent improvements in Social Security benefits are due in large part to the efforts of our organization. But we have never lost sight of the essential importance of adequate protection against health costs in the struggle for economic security.

In "A Platform for the Seventies", developed for the White House Conference on Aging by representatives of a number of national organizations, including the National Council of Senior Citizens, we said:

"The Nation will continue to fall short of a reasonable goal of income security so long as heavy and unpredictable health costs threaten fixed incomes." [1]

That the Platform's philosophy helped to guide the deliberations of the delegates would seem clear from the introduction to the recommendation on Meeting Health Needs that was adopted by the Income Section of the Conference. I quote:

"This Nation can never attain a reasonable goal of income security so long as heavy and unpredictable health costs threaten incomes of the aged." [2]

It is appropriate, therefore, that as your Committee embarks on its study of Future Directions in Social Security, early attention be directed to health care barriers that must be overcome if our older population is to achieve meaningful economic security.

Medicare in Perspective

This Committee, in its valuable two-year study of the "Economics of Aging: Toward a Full Share in Abundance." examined the strengths and weaknesses of Medicare and reported:

"Two points clearly emerge from the testimony of expert witnesses. First, it is not enough for the government to provide only a financing mechanism for health costs; there is an attendant responsibility for assuring the delivery of high quality and effective services.

"And second, there are serious problems built in from the start if the focus of the health care system is on the aged—the highest risk group; as one witness put it: 'This is the logic for writing automobile insurance for people only when they are intoxicated.' " [3]

I would like to go back in history and explore with you in greater detail the valuable lessons we have learned from Medicare.

It is important, I believe, to recognize that Medicare is an experiment, by definition, "a test or trial; a tentative procedure . . . an operation for the purpose . . . of testing a principle." Inherent in such testing is the discovery of both successes and failures. The disclosure of weaknesses or mistaken ideas in such a testing of principle can be just as valuable—sometimes even more valuable—than the proving of success.

What has Medicare accomplished and where has it fallen short?

It has succeeded brilliantly in these major areas:

(1) Most of the 20 million older Americans have been relieved of the major burden of medical care expense and the dread fear of financial catastrophe resulting from an *acute* illness. We often hear that Medicare covers only 42 percent, more or less, of the total medical costs of the aged group, including costs of long-term care and drugs. We hear less often of the individual with staggering hospital bills, virtually all of which are reimbursed by Medicare, saving the old person and his family from resort to charity.

(2) It has for the most part overcome the administrative complexities that could have thwarted the main objectives of the program. However, it must be noted that the procedures still seem unnecessarily complex to the ordinary beneficiary.

Clearly, these are significant achievements of the Medicare program.

However, Medicare has not been successful in these respects:

(1) Preventing a dangerously rapid increase in the cost of medical services.

(2) Making the fundamental changes in the health delivery system necessary to improve the quality and availability of care.

(3) Meeting the long-term care needs of the very old and the chronically ill.

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[1] "Guiding Principles: Income," *A Platform for the Seventies,* National Council of Senior Citizens (November 1971), p. 2.

[2] *Income: Recommended for Action,* White House Conference on Aging (1971), p. 7.

[3] U.S. Senate Committee on Aging, *Economics of Aging,* December 31, 1970, p. 16.

What Caused These Shortcomings?

Many complex interpretations have been offered to account for these shortcomings, but I suggest the shortcomings may be explained largely by a few basic factors. First, with respect to the rising costs: Much has been said about the failure of early Medicare planners to anticipate these increases.

I submit that the mistakes that were made were not so much in the areas of utilization and the estimates of need, but in the concept incorporated in the Medicare law that the limit to the liability of an insurance scheme could rest on the notion of "reasonable cost" and "reasonable charge." Six years experience has shown that many of the so-called "reasonable costs" under Part A are simply cost-plus operations of an uncontrolled and unplanned hospital industry. The "reasonable charge" approach under Part B opened the way for charges often having little relationship to past practices limited by customer charges; as it turned out, no one really knew what customary charges were. The result was in all too many instances, "reasonable charge" in practice became all the charge the traffic would bear.

Many providers followed the long established practice of considering the fact of a patient's being insured a factor in his ability to pay and proceeded to add charges above the allowable amounts. After the program had been in operation two years, the Social Security Administration finally got around to limiting the allowable amounts payable under Medicare, but the net result in all too many cases was a decrease in the proportion of the total cost of medical care covered by the program. To compound the problem, the decrease in the protection provided was accompanied by steadily rising costs of premiums.

In 1965, the public and the Congress relied mainly on two factors to limit the liability assumed by the Medicare program:

(1) Self restraint on the part of the medical professions. (2) The controls exercised by the carriers and intermediaries.

Neither was completely lacking, but both proved woefully inadequate.

I'm citing these well-known facts not in criticism of the program itself or even of the providers, many of whom have done a conscientious job of carrying out the basic purposes of the program. The most important lesson from this experience has been that health care problems have two components: Financial and deliverv.

It is insufficient to provide simply a method of payment that will greatly increase the effective demand for a limited supply of health services. Measures must also be included to provide some control over the economic processes of the health care industry and to stimulate an increase in the supply of health services.

The second major short-fall of the Medicare program has been its failure to make basic changes in the health delivery system. It is hardly fair to refer to this as a "failure" because the program never attempted to alter the system. In fact, the law specifically forbade it to do so.

When Medicare was being formulated all of us—proponents of the plan and our representatives in Congress—were constantly assuring the medical profession, the hospitals and, indeed, the public, that we were not altering the system in any way. We were simply providing a method of payment for health services within the existing system. I'm convinced the public as well as health care providers wanted, even demanded, such assurances in 1965. But times have changed. Public opinion has changed.

In the light of our present experience, not only with Medicare, but with Medicaid, and with a multitude of private health insurance schemes, the public is now convinced that there must be some major alterations in our health care system.

Reversal of Public Demands

The demands of the public in the 1970's in this respect are just the reverse of what they were in the early 1960's. This change in attitude has been prompted by such factors as inflationary increases in the cost of health care, fragmented health care delivery, and uncoordinated development of health facilities.

The consciously accepted limitations of the program also apply to the third major area of the public dissatisfaction with Medicare, namely, the lack of provision for long-term care of the very old and chronically ill. Again, in 1965 we were attempting no more than to provide the elderly with the protection most people still in their working years enjoyed. Medicare was modeled on Blue Cross and Blue Shield, and these plans were also deficient in the area of long-term care. But here too, public attitudes have changed.

The time has now come for applying the lessons learned from Medicare to the development of a program to meet the health needs of the entire Nation, not just the oldest and highest risk population group. The time has come for us to stop thinking primarily about insurance programs that simply meet costs incurred under our present system or "nonsystem," as it is so frequently and deservedly labeled.

The time has come for us to begin building a health care system that assures all Americans equal access to comprehensive and continuous health services of high quality at economical costs.

Medicare and Medicaid Today

Before presenting our recommendations for a reformed health security system, let me briefly mention some 1972 amendments of particular significance to the Medicare and Medicaid programs.

In the future, the premium for Medicare Part B (physician) insurance can be increased only in the event of an increase in cash social security benefit and by no more than the percentage raise in benefits since the last premium adjustment. The premium, scheduled to rise to $6.30 a month next July, is more than double the $3 paid by Part B enrollees when Medicare got underway in 1966.

This amendment, while an improvement, fails to come to grips with the basic problem: beneficiaries living on small incomes cannot afford to pay health insurance premiums that are necessarily large because of the heavy incidence of their illness. These costs should be prepaid through payroll taxes during the working years and shared by the *total* population through general revenue financing.

The recent amendments authorize the Secretary of HEW to establish, by diagnosis, minimum periods after hospitalization during which a patient would be presumed to be eligible for extended care or home health benefits. Thus, both the patient and the facility will have badly needed protection against retroactive denial of Medicare payments, These are clearly steps in the right direction.

Another new provision establishes physician "peer review" groups to monitor doctor practices under Medicare, Medicaid and other Federal medical programs, with a view toward eliminating wasteful practices such as unneeded operations. We have our reservations about this provision. Some people think we may be making the fox the security officer for the hen house. On the other hand, if the medical profession rises to its true professional responsibility, it just may work. We shall have to wait and see.

The coverage of Medicare is significantly expanded to include disabled Social Security beneficiaries under age 65 after they have been entitled to disability benefits for two years. The extension of coverage to the disabled has long been urged by the National Council and similar organizations. We would have preferred to see Medicare coverage provided at an earlier stage of the disability when rehabilitative medical services might be most effective. But this extension of coverage is clearly a significant improvement in the protection of the program.

Of even more far-reaching significance is the provision of Medicare protection against the costs of hemodialysis and kidney transplantation for almost all Americans, regardless of age, afflicted with severe and costly kidney disease. This protection against catastrophic costs is indeed a step in our progress forward toward national health security. Indeed, it might be said that we now have national health insurance for one disease!

1972 Amendments Weaken Medicaid

Unfortunately, the 1972 amendments which improved Medicare seriously weakened Medicaid. These amendments eliminated the requirement that a State must show that it is making efforts in the direction of broadening the scope of services in its Medicaid programs and liberalizing requirements for medical assistance. Co-payments and deductibles are permitted or required through the following provisions:

(1) States which cover the medically indigent would be required to impose monthly premium charges, graduated by income.

(2) States could, at their option, require payment by the medically indigent of nominal deductibles and nominal copayment amounts which would not have to vary by level of income.

(3) With respect to recipients of cash assistance, nominal deductible and copayment requirements, which are prohibited for the six mandatory services required under Federal law—in-patient hospital services, out-patient hospital

services, other X-ray and laboratory services, skilled nursing home services, physicians' services, and home health services—would be permitted with respect to optional Medicaid services, such as prescribed drugs, hearing aids, etc.

In brief, the 1972 amendments moved us forward in some respect; backward in others.

The Solution Is National Health Security

The Medicare Amendments of 1972 while on balance improvements failed to get at the heart of the problem. The program continues to meet costs incurred under present payment methods, doing nothing to achieve the orderly and effective reorganization of the health care system that would assure universal access to comprehensive health services at economical cost. Coverage is extended beyond the aged. but only to even higher risk groups of the disabled and severe kidney cases.

If we are to heed the lessons of Medicare, much more drastic reform is needed. Reform along the lines proposed by Senator Kennedy and Congresswoman Griffiths in S. 3 and H.R. 22. I would like to identify the reasons why we are convinced that National Health Security, and only National Health Security, can solve the health crisis our country faces.

First, National Health Security provides the leverage, the financial muscle, needed for basic change. Other proposals accept the inevitability of the present non-system and merely pour in more health dollars without disturbing the status quo.

Second, National Health Security gives more than lip service to our now generally accepted premise that good health care is a right of every American. It *guarantees* this right through a single universal system, without using a means test and with the same benefits for all, rich and poor alike. In contrast, other proposals perpetuate invidious distinctions in health care based on income, and even so, may fall far short of universal coverage.

Third, National Health Security removes barriers to timely care by eliminating deductibles and coinsurance and by assuring the patient of no billing by the doctor. I stress the importance of no billing by the doctor because older people who have found Medicare such a boon have also known the bane of uncontrolled medical bills from doctors unwilling to take assignment. Other proposals rely heavily on deductibles and coinsurance, made no more palatable in actual practice by the euphemism of "cost sharing", thus inevitably causing the patient to postpone needed care.

And here, with reference to so-called "cost sharing", may I quote from a 1971 survey of the Blue Cross Association and National Association of Blue Shield plans which found:

"If the coinsurance or deductible is small enough not to create any financial hardship, then the two provisions are nothing more than administrative nuisances and will hardly act as a control on utilization." [4]

I consider this a finding of great significance: insofar as coinsurance and deductibles are effective, they deprive the very people the system should be designed to help. It is the poor, not the well-to-do who will go without health care, thus increasing inequities and aggravating the health problems of all but the most fortunate.

Fourth, National Health Security is the only practical answer to the economic delivery of health services and control of skyrocketing costs. It does this by providing health care *directly* at the lowest possible cost, with no waste of health dollars on private insurance carriers as middlemen, and by using advance budgeting to assure effective controls on all health costs. Other proposals, in contrast, would perpetuate rising fees and would be a bonanza for the insurance industry!

Anyone acquainted with the role of commercial insurance in the health field beginning as early as 1908 in State Workmens Compensation laws, and continuing through the era of negotiated health and welfare plans, knows that commercial insurance has been a major barrier to positive health planning. It is easy to talk about a pluralistic approach to the problem and about building on the existing foundations of our present system. But this is an unsound and futile approach when one of the pillars of the existing foundation is the shakiest part of the whole structure.

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[4] *The Effect of Deductibles, Coinsurance and Copayment on Utilization of Health Care Services, Opinions and Impressions from Blue Cross and Blue Shield Plans,* Blue Cross Association and National Association of Blue Shield Plans, mimeograph (September 3, 1971), p. 11.

Fifth, National Health Security assures public accountability. It would guarantee consumer representation at all levels of administration and would establish a local office in each community charged with responsibility for serving as the "ombudsman" for the consumer. The countless pleas we receive from our members on this score were echoed by an outstanding expert in hearings before this Committee, when he said:

"I would say that our American medical care system is characterized by the fact that there is no identifiable point of public accountability. To whom can the older patient go and say 'I don't like what's going on; who is going to do something about it'." [5]

On the point of public accountability and consumer representation, other proposals are ominously silent.

In summary, the Kennedy-Griffiths proposals is a bold, imaginative, far-reaching program. The Nation's health needs require this kind of action. Halfway attempts to patch up the existing way of doing things will not do the job.

Improving Medicare-Medicaid Pending National Health Security

Mr. Chairman, I trust my remarks thus far have made clear that the National Council of Senior Citizens has strong reasons for believing that National Health Security is the only answer to the health crisis with which we are faced. But the National Council is also realistic enough to recognize that the Congress may have to take some time to develop such a comprehensive health care program for the total population.

Members of the National Council, indeed, older people in general, are used to waiting. We well remember that historic date of May 20, 1962, when President Kennedy addressed our membership at Madison Square Garden. To an audience hoping for early enactment of Medicare, there was disappointment in his promise that the King-Anderson bill would be passed, "This year or, as inevitably as the tide rolls in, next year." Now in 1973 we firmly believe that the time has arrived for National Health Security, but we are also prepared to wait for the tide.

Even were National Health Security to be enacted immediately, the sponsors of the proposal have cautiously recognized that a period of several years would still be required for tooling up. Improvements in Medicare-Medicaid are urgently needed now and cannot await the reform of the total health system. These improvements must be more than patchwork, and we firmly believe that their shape should be formed by the shape of the Nation's future health care system.

We therefore offer for your consideration the essentials of a reformed Medicare-Medicaid system which, if not actually paving the way for National Health Security, would at least assure that we do not continue on divergent paths. We are cautious about any claims of "paving the way" or "providing valuable experience" because we clearly recognize that a health program limited to only part of the population, and indeed the most vulnerable part, cannot possibly have the financial leverage for reform and restructuring which is basic to National Health Security.

In essence, our plan would merge Medicare-Medicaid in a federally administered program covering all residents 65 and older, all other Social Security beneficiaries, and the adult categories receiving cash assistance. Such a merger is especially appropriate in view of the federalization of the adult categories under the new Supplementary Income Assistance program.

Benefits now provided under Medicare would be expanded and payable without coinsurance or deductibles. Skilled nursing home services, regardless of prior hospitalization, would be covered for up to 120 days and without limit if furnished in a nursing home owned by or affiliated with a hospital or comprehensive health service organization. All outpatient prescribed drugs would be covered if furnished through an approved health service organization, otherwise coverage would be limited to drugs needed for maintenance therapy or, especially, costly drug therapy.

Under the proposed program, services would be covered only if performed by a qualified participating provider who would have to agree to accept the program payment as full payment for a given covered service. Participating physicians who chose to be remunerated on a fee-for-service basis would have their fees predetermined on a negotiated basis. Institutional providers would be paid on a prospectively approved budget basis. Thus, the beneficiaries are assured that they will not be billed for any covered service. At the same time, cost controls are built into the system.

[5] Testimony of S. J. Axelrod, M.D., Director of the Bureau of Public Health Economics, University of Michigan; pp. 132–3 of report cited in footnote 1.

I should like to spell out in some detail what I have just referred to with respect to physicians' fees being predetermined on a negotiated basis.

The Medicare Law Part B provides for the payment of 80 percent of the physicians' reasonable charges in excess of the annual deductible amount.

However, as physicians have steadily increased their charges year after year, the Agency (Social Security Administration) has steadfastly refused to require the insurance carriers to notify beneficiaries that the amounts of their bills not reimbursed are a result of the charges being increased beyond the amount determined under provisions of the law as "reasonable." The beneficiaries are left bewildered and confused and by the notations on their bills are led to believe that Medicare has progressively reduced its coverage.

We believe the reimbursement to physicians should be adequate and even generous, considering the value of the services performed and the investment in education that physicians have made. But we don't believe they should be exhorbitant or unreasonable as so many of the charges now are.

We firmly believe that the time has come in the Medicare program to move beyond the complicated and confusing procedure now involved in determining reasonable charges on an individual doctor-by-doctor basis. In place of the present procedure, we believe that doctors should be reimbursed on the basis of established fee schedules. These schedules should be negotiated region by region or service area by service area. They should represent fair and adequate compensation to doctors. Both representatives of the beneficiaries and the medical profession as well as the government agency should participate in the negotiations in which the fee schedules would be established. Those doctors who did not wish to participate in the program could withdraw entirely. Lists of participating physicians should be made public and doctors should be required to inform patients who are eligible for Medicare as to whether or not they are participating.

Under such an arrangement, doctors would know the rates under which they are to be paid for their services. Beneficiaries would know exactly what was covered under the program and the many inequities and causes of confusion existing in the present program would be removed.

Under our plan incentives would be included for both providers and beneficiaries to choose comprehensive prepaid group practice with its emphasis on preventive care and reduction of institutional care.

The new program would provide for consumer representation and public accountability at all levels. Such a program, we know, will be an expensive one, concentrating as it does on the high risk groups. Without knowing the exact size of the price tag, certain financing principles can be agreed on at the start.

Federal general revenues should finance 100 percent of the costs for beneficiaries other than those eligible for social security benefits. Social Security beneficiaries should not have to pay any premiums. Some portion of the cost of their coverage should be borne out of general revenues, with the remainder financed by a payroll tax. The payroll tax should be the same for employers and employees.

These, in brief, are the principles for reforming Medicare-Medicaid that the National Council of Senior Citizens advocates. The National Council, from its day-to-day knowledge of the problems that older people encounter with these programs, as well as from experience in trying to fill gaps in protections, through our non-profit health insurance plan, is well qualified to speak to the problem and the principles for solution. Nothing short of National Health Security for the total population can have the financial leverage needed to restructure the nation's health care system. We believe, however, that our proposal deserves consideration as a first step in reform.

Long-Term Care and Alternatives to Institutionalization

As I have said, the National Council of Senior Citizens believes that optimum health care for the elderly can be achieved only if fully integrated with care for for our population of all ages. Nevertheless, we are fully aware of the necessity of directing special attention to the extraordinary health needs of the aged because of the framework in which their illnesses occur—inadequate income, forced retirement with loss of identity, poor housing, lack of mobility and social isolation.

We are also especially aware of what this Committee referred to in its earlier report as the need for "Translating Health Care Into Social Care". May I quote only a few paragraphs to provide a frame of reference?

"Too many older people are living out meaningless days in institutions simply because there are no alternative arrangements for more appropriate care. This nation lacks the home care and homemaker services that would permit the

frail older person to live independently at home. It lacks neighborhood centers and programs of day care that make it more feasible for three generations to live together. It lacks alternatives to nursing homes and mental hospitals for the older person who needs sheltered care." [6]

Your report cites the pioneering efforts of Dr. Lionell Cosin at Oxford Hospital in England, whom we proudly claim as a Consultant to the National Council of Senior Citizens, in developing day care and readmission as an alternative to lifetime commitment to institutional care. And it goes on to say:

"We use billions in tax dollars to maintain the aged in institutions instead of financing programs that would enable them to live in their own homes in much more comfortable and satisfying surroundings." [7]

The National Council of Senior Citizens, as a wholehearted supporter of National Health Security, nevertheless considered the original proposal as introduced in the last Congress deficient with respect to its provisions for long term care and especially for the personal or social care that can be so much more beneficial than medical care. We are delighted to see that the bill introduced in the 93rd Congress includes a provision for maintenance and long term care.

A new section would give the Board authority to make grants for pilot projects to test the feasibility of home maintenance care for chronically ill or disabled people. Home maintenance services would include homemaker services, home maintenance, laundry services, meals on wheels, assistance with transportation and shopping, and such other services as the Board deemed appropriate. If experience under these projects proved that home maintenance services reduced the need for institutional care (hospital, skilled nursing home) and could be administered in such a way as to effectively control inappropriate or unnecessary utilization, the Board would be authorized to recommend expansion of these services to the entire population.

The absence of a program of coordinated, continuous and comprehensive health and social services—for the aged and those persons suffering from long-term chronic illness—is a grave national problem for which a solution must be found.

The lack of such a program has produced fragmented and uneven care and services; hardship and deprivation; inefficiencies and spiraling costs and a shortage of proper facilities truly capable of providing the differing levels and kinds of care and services required by this growing segment of the population.

Present public programs for long-term health care are divided among medical facilities construction programs, housing programs, public assistance programs and programs specifically for the aged. Each, however, is addressed to only a facet of the problem. There is no coordination with respect to various kinds and levels of care required by different persons or the relative need for facilities of several types. And the availability of such care and services is distributed very unevenly among geographical areas.

Existing medical care and related institutional programs are not in themselves efficient and effective mechanisms for dealing with all long-term care problems. This fact, coupled with the shortage of appropriate facilities, has resulted in much improper and wasteful use of acute care facilities.

The Congress, and specifically the Special Committee on Aging, should call on the Secretary of Health, Education, and Welfare to develop a program of coordinated, continuous, comprehensive health and social services for the aged and other persons suffering from chronic illness, which will include a uniform benefit package guaranteeing the full range of services needed for ambulatory, home, and institutional care. High priority should be given to the development and financing of the non-medical services that would make it possible for the chronically ill to live independently; thus saving countless dollars now spent on institutional care as well as providing a more satisfying life for the individual.

The Secretary of Health, Education, and Welfare, together with the Secretary of Housing and Urban Development should be directed by Congress to conduct a joint study of the extent of the need for appropriate facilities of various kinds required by the program and of equitable means of meeting both capital and operating costs of such additional facilities.

We believe it should be possible for the Secretaries to develop, and transmit to Congress within the next two years, a consistent and coordinated program to meet the long-term care needs of all older Americans.

Mr. Chairman, we believe that legislative proposals to get this program underway should be enacted as quickly as possible. Some work in this area has already

[6] Pages 18–19 of report cited in footnote 1.
[7] Ibid, p. 19.

been undertaken and further studies can be initiated immediately, without waiting for final enactment of National Health Security. Our hope is that the long-term care program which is developed can be meshed quickly and easily into the National Health Security program.

Our current long-term care system is nothing short of a national scandal. We urge the Congress to move quickly to correct the abuses, stop the commercial exploitation of the elderly sick and begin to provide some peace of mind for all those who dred the approach of the days when they may need long-term care.

The achievements of modern scientific medicine have unquestionably been responsible for adding years to our lives. When the Congress moves forcefully to meet the problems of long-term care, it will have enabled this great nation to meet its responsibility to add life to the extra years which medical science has given us.

Future Directions in OSADI

I appreciate the opportunity you have given me to present my views on Social Security in general, and not just on Health Services to Economic Security. I shall touch on only a few essential points.

During nearly four decades since the enactment of our Social Security system, we have heard repeatedly of the benefit level as a "floor of protection." The debate has been waged, not around the concept of Social Security as the base of income security, but around varying views as to the positioning of the "floor." The concept of Social Security as merely a floor or protection is outdated; the time has come to re-examine the whole question of the level of benefits.

In discussing benefit levels, I shall refer to benefits payable to older people who are retired. But we must always keep in mind that our Social Security system is far more than a system to pay retirement benefits. It is essentially a program designed to provide economic security for the family. Some 22 percent of the more than 28 million current beneficiaries are younger, disabled workers and their wives and fatherless children and widowed mothers. The National Council of Senior Citizens, in urging higher retirement benefits, has also pressed for like increases in protection for younger members of the family.

Social security benefits are now, and I believe will continue to be, the measure of this Nation's regard for its older population.

For more retirees today, Social Security benefits are the major source of income; for many, the exclusive source. This fact has been pointed out repeatedly by your Committee, which has done such an outstanding job of documenting the income position of the elderly through its annual reports and its extensive study of the "Economics of Aging: Toward a Full Share in Abundance."

The recent increases in Social Security benefits, legislated by the Congress despite opposition of the Administration, have significantly improved the protection of the system. For example, the average benefit is now $273 for a retired couple, both receiving benefits, and $156 for an aged widow, nearly double the average of $144 for the couple and more than double the $75 paid to widows at the end of 1967.

Significant as this improvement is, these benefits fall far short of the income goal set by the White House Conference on Aging when it recommended, as the minimum standard of income adequacy, the intermediate budget of the Bureau of Labor Statistics. Based on figures then available, this intermediate budget would have cost a couple $375 a month in the spring of 1970; its estimated cost at the end of 1972 had risen to $412 a month. Of the non-institutionalized aged population at the beginning of 1973, more than half—5.9 million of the single persons and 4.6 million of the married—had total incomes below this BLS standard. For beneficiaries long on the rolls, the Social Security benefit, despite increases, now purchases a smaller proportion of this budget than it did when they first started to receive benefits. For example, the average couple that came on the rolls at the end of 1950 recieved benefits that amounted to half the cost of the retired couple's monthly budget—$74.30 in relation to $149.17.

Today, due to increases prices and adjustment of the budget to allow for higher living standards, the budget would cost $412 a month and the same couple would receive a benefit that had been raised to $179.60, or slightly more than two-fifths of the budget amount.

While we have definite evidence that today's retired population is primarily dependent upon Social Security benefits, all projections realistically based on present trends indicate that the situation will not change markedly in the future. Great optimism about the future income situation of the elderly rests primarily on what I consider to be unreasonably optimistic claims for the growth of private pensions.

I hasten to make clear that I am aware of the need for private pensions and appreciate their present value to many retired people. But I have also seen, especially in my long years as Director of the Social Security Department of the AFL–CIO, false claims about future growth used as an excuse for rejecting badly needed increases in the level of Social Security benefits.

I need not detail the findings of the Senate's Labor Committee on the illusionary protection of private pension plans today. But I would point out that the overriding resistance to the reasonable reform measures reported out by that Committee make all too clear that we cannot base our hopes for great improvement in the income position of the average retiree on his private pension expectations.

To *assure* that most retirees of the future, and especially low wage workers, will receive private pensions would required Federal regulations so stringent as to be rejected out of hand. If all of tomorrow's retired population is to be assured of adequate income in old age, such an assurance must come from our basic Social Security system.

It is time, therefore, that we come to grips with the question of the level of income intended for future generations of the elderly and the part Social Security benefits should play in achieving this level.

In this respect, we have much to learn from the trend abroad in recognizing that the adequacy of income in retirement should be measured in terms of the amount of pre-retirement income replaced. The trend there has been toward establishing earnings replacement levels between 60 and 80 percent of variously defined measures of pre-retirement earnings. In contrast, as a result of our most recent Social Security amendments, the retirement benefit for men retiring at at age 65 amounts to about three-fourths of average monthly earnings of $200, just under 60 percent at $400, and drops to below half for workers qualifying in the future with an average monthly wage of $700. (And in assessing these figures, we must remember that more than half of all men starting to draw benefits are under age 65 and receive a reduced benefit.) There has also been a trend abroad to increase the ceiling on contributions and creditable earnings to take into account the total earnings of all except the very higherst earners. Furthermore, most foreign systems now base benefits on earnings during the period just prior to retirement, rather than on earnings over the working lifetime.

This Nation took a giant step forward in adopting the 1972 amendment to provide automatic adjustment of benefits to increases in the cost of living. An important future direction for Social Security, one also endorsed by the White House Conference on Aging, is acceptance of the concept of measuring income adequacy in terms of rising national standards of living, not just rising prices. In this respect, we have much to learn from the experience of other countries, notably West Germany and Sweden, in adjusting pension benefits to rising wage levels, thus allowing retirees to share in economic growth.

Nearly three years ago, I prepared for this Committee a working paper on, "The Stake of Today's Workers in Retirement Security." This was at a time when the label of expansionists was used for proponents of an updated and improved benefit level under Social Security. While Congressional action in the years since then have significantly raised the benefit level, I would like to repeat what I said then in my letter of transmittal:

"It will be clear to all who read by working paper that I am obviously among the 'expansionists'. I take this position without apology. I take it because the gap between the needs of retired people and their economic resources, including their Social Security benefits, is expanding. I take it because the economy of this Nation is expanding. I take it because the standard of living is expanding. I take it because I wholeheartedly believe that in an expanding economy, facted with an expanding need, Social Security should not be the only program area that is not expanding, left wedded to an outdated concept of a minimum 'floor of protection'." [8]

Financing—A More Equitable Basis for Sharing Costs

I will conclude my testimony with a few brief remarks on the financing of Social Security—brief, not because my views on this subject are uncertain, but because I know you will be exploring financing in depth tomorrow and because I hope to have a future opportunity to expand these remarks.

[8] U.S. Senate Special Committee on Aging, *The Stake of Today's Workers in Retirement Security,* prepared as a working paper in conjunction with the overall study of "Economics of Aging: Toward a Full Share in Abundance" (April 1970), p. 3.

I firmly support the payroll tax as the primary method of financing the Social Security system. For more than a quarter of a century, I was privileged to represent trade unionists in their efforts to achieve economic security. I speak then from this experience when I say that, over the years since the introduction of Social Security workers have shown a commendable willingness to pay Social Security taxes. In no small part, this willingness stems from a recognition that taxes paid out of earnings will entitle them to continue to share in productivity after their working years are over. They look forward to their future Social Security benefits as an *earned* right. They take pride in participation in a sound social insurance system.

It is the economists, not the workers, who haggle over whether this is a contractual right and whether the insurance analogy has been oversold. And the average worker may not be too concerned about the regressive nature of the tax, a regressivity offset to a considerable degree by a benefit formula that replaces a higher proportion of earnings for those at low wage levels.

But it is the workers as well as the economists who are increasingly concerned about the heavy burden of payroll taxes. In the working paper I prepared for this Committee early in 1970, I said:

"The time will soon be reached—if it is not already here—when it will be difficult to levy a regressive tax on low-paid workers at the higher rates needed to finance benefit improvements. The regressive nature of the Social Security tax can be relieved in two ways: by a higher wage base—raised substanitally more than through past actions—and by use of general revenues. A combination of the two methods would be best. Serious consideration must therefore be given to the use of general revenues as a more equitable basis for sharing these costs.

"There is sound justification for financing through general revenues that part of Social Security costs which is equivalent to prior service credits. Workers already close to retirement age when the system was first started, or when coverage was extended to their employment, received full benefits even though the contributions they and their employers paid would finance only a small part of the benefit. While this was sound public policy and kept many old people off relief, it did mean that these benefits had to be financed from future contributions. There is no justification for expecting presently covered workers to pay for this 'accrued liability'—estimated in the long run to amount to one-third of the total cost of the program—through a regressive payroll tax. A far fairer method would be to finance this share from general revenue sources to which all taxpayers contribute and through a more progressive tax structure." [9]

I stand on this position today—that the best way of financing our Social Security system is to introduce general revenues in combination with a higher wage base, thus preserving the essential value of earned rights and at the same time lessening the regressivity of the tax.

There are various ways of introducing general revenues as a share in the costs of the cash benefits of our Social Security system, just as general revenues now share in the costs of Medicare. There are also ways to predetermine the share and to commit a specified amount so that the share, and perhaps even more important the level of benefits, can be predetermined in advance of Congressional action. There are ways of assuring that these financing methods preserve the value of the payroll tax and the contributory nature of Social Security, which have been so valuable in assuring entitlement to benefits as a right.

Over the years we have heard much about Social Security as a *compromise* between individual equity and social adequacy. I prefer to think of this, not as a "compromise," which implies a sacrifice through concession, but as a melding or optimum blend. The Social Security system is clearly a blend of these two essential ingredients, and it is because of the blend that the system has earned such great public acceptance. This is a major reason why we cannot evaluate the financing of the system without relation to benefits.

The 92d Congress is to be complimented for the major improvements enacted in 1972 which were consistent with the basic principles of the time-tested Social Security system—moved further in the direction of social adequacy without weakening the equity of the program.

I refer specifically to the new Supplemental Security Income program, providing a floor of income for all aged, blind and disabled individuals, to be financed out of general revenues. The Congress, by resisting pressures for an undue increase in the minimum benefit that is financed out of contributions,

[9] Ibid, p. 10.

preserved the principle of wage-related benefits. On this point I would again refer to the working paper I prepared for your Committee. Under the heading, "Social Security Costs Which Workers Should Not Be Expected to Bear," I said:

"Workers should not be expected to pay higher Social Security taxes in order to pay a high minimum benefit to people who barely meet eligibility qualifications because their lifetime work has been in non-covered employment." [10]

In these amendments passed last year, the Congress recognized the lifetime contributions made by low-wage workers through the provision for higher minimum benefits for workers with long years of coverage. This provision reintroduced a principle in the original act that benefits should be graduated by length of coverage and lifetime contributor with low wages.

In conclusion, then, I urge that the Senate Committee on Aging, in exploring our Future Directions in Social Security, give full attention to improvements that build on the essential principles of our very successful social insurance program.

ITEM 2. SUPPLEMENTAL STATEMENT BY NELSON CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, ON MEDICARE ASPECTS OF THE BUDGET MESSAGE OF THE PRESIDENT

Subsequent to my appearance before the Senate Committee on Aging in connection with the hearings on Future Directions in Social Security, on January 22, the President's budget message was submitted to the Congress.

We were shocked to learn that rather than improving the Medicare program along lines proposed by the White House Conference on Aging, the message proposed extensive cutbacks in the existing program.

Under the guise of reducing what is termed unnecessary utilization of hospital services, the President proposes that the present deductible of $72 per day in hospital insurance be increased to the actual first day charge. In addition each medicare patient would be required to pay a "co-insurance" amount equal to 10 percent of his hospital charge. The administration claims that will "save" $345 million in fiscal 74.

In addition, the budget message proposes to cut back the Supplemental Medical Insurance program by increasing the initial deductible to $85 from its present $60 and to increase the percentage amount of subsequent cost to the beneficiary from 20 to 25 percent. This proposal is presented as a "saving" of $171 million in fiscal 74.

Thus a total of $516 million additional burden is to be placed on the backs of the elderly sick people in the fiscal year. In the staff briefing on the budget other obscure amounts were included bringing the total to nearly $850 million.

The striking part of this proposal is that it is a paper saving for the President's budget—not a saving for the people who pay the costs as *no proposal is offered to reduce the one percent payroll tax* (increased from 0.65 percent last year) for hospital insurance nor the $6.30 per month SMI premiums collected from beneficiaries. The monies collected in these accounts are thus to be used to effect a *paper* reduction in the President's budget deficit.

Thus under the budget proposal the elderly sick and the working people would be the victims of a double edged assault—increases in taxes and premium accompanied by reductions in health protection.

This is an outrageous and unconscionable proposal which we trust the Congress will never find acceptable.

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[10] Ibid, p. 10.

Appendix 2

SOCIAL SECURITY—A PETITION

ITEM 1. PETITION FROM THEMISTOCLES S. AMBROSINI, RUTLAND, VERMONT, SUBMITTED BY SENATOR ROBERT T. STAFFORD*

RUTLAND, VT., *September 27, 1972.*

A PETITION

HON. Senator GEORGE AIKEN, Senator ROBERT STAFFORD,
U.S. Senate.
Congressman RICHARD MALLARY,
U.S. Congress,
Washington, D.C.

MY DEAR SENATOR AIKEN; SENATOR STAFFORD; CONGRESSMAN MALLARY: As one of your constituents, allow me to petition our Government, through you, for a redress of grievances under the Social Security Act, and Medicare, as well as for a redress of grievances covering hospitals and nursing home charges, and doctors', and dentists' fees.

SOCIAL SECURITY

Since my retirement on July 31st., 1970, I have experienced that the Social Security pension which accrued to me, and to my wife, is so regulated as to represent a threat to my constitutional rights as a free citizen; an invasion of my privacy; an affront to my honesty, and a danger to my health.

From the very first day that the Social Security Act was promulgated, my employers and I contributed regularly to the System which was to provide me, and my wife with a government pension at age 65. But, after having contributed taxes to it for thirty-five years, I have learned as a retiree that our Government does not look upon Social Security as an accrued pension, due and payable in full at age 65 without earnings restrictions of any kind.

Recently, I received a NOTICE from the Department of Health, Education, and Welfare, Social Security Administration, reminding me that their records showed that I earned more than $1,680.00 in 1971, and that, therefore, I was required to file a report of my earnings with the Social Security Administration. "Unless we get your report in 30 days," I was advised, "we will have to assume our records are correct and *stop* your current benefits in order to recover the overpayments." The NOTICE continued: "Please furnish your reasons for not reporting on time on a separate sheet of paper so that we can decide whether the additional penalties will apply in your case."

The Annual Report I was ordered to file, contained the following questions:

(1) Were you an employee in 1971?
(2) Were you self-employed in 1971?
(3) Earnings estimate for 1972.

With regard to question #2, there was the following warning:

"Whoever makes a false statement in connection with this Report is liable to a fine or imprisonment or both."

The NOTICE continues:

"As a self-employed person . . . Count all time you spend at the place of business or elsewhere, in any activity relating to the business. This includes time spent in planning and managing as well as doing physical work."

"More than 45 hours of service in a month are considered substantial unless you give evidence establishing that the services were, in fact, not substantial."

"If the time devoted to the business amounts to 45 hours or less in a month, the services in that month would usually not be substantial. However, as little as 15 hours of service in a month could be substantial if they involved the management of a sizable business or were spent in a highly skilled occupation."

*See statement, p. 99.

And the instructions, and the regulations rattle on, sufficient to drive insane any 62- or 65-year-old retiree who is honest, and wishes to comply with all the tenets of the law, no matter how much he believes that they are unjust, and impossible to comply with.

What can a financial consultant like me, for instance, do with instructions such as these? Since my retirement, I have not earned one penny from my profession, although time and again I have worked on propositions that did not succeed. But, one of these days, I could be offered to act as a financial advisor to a small firm for a retainer of say $500.00 a month, or I could be offered a directorship in a bank or a company at a fee of $500.00 a month. While these activities would be a tremendous boost to my morale, and an incentive to apply my abilities to other worthwhile endeavors, I could not accept them, because they would cancel out the social security pension for my wife and for myself. I should be working for nothing.

It is human nature to crave for security, and social security pension represents security notwithstanding its pittance. But, this sense of security is attained at the price of freedom of action; freedom to do what one wishes to do with his time, and skills without having to give an account to anybody but the Internal Revenue Bureau for the payment of taxes on additional earnings. The honest 62- or 65-year old retiree finds himself in an economic straight jacket, bruntly forced into demeaning idleness after a dignified lifetime of work, and a lifetime of paying social security taxes that supposedly were to guarantee him a monthly pension at retirement without any earnings restrictions.

Our Government talks as though it were doling out welfare, and not pensions fully paid for by the pensionee, and his employers. What kind of security does this Social Security System represent for the average American pensionee? Contrast our system with systems prevailing in Western Europe! An English pensionee, or an Italian pensionee, for instance, receives his pension without any strings attached. His doctors,, dentists,, hospitals,, and medicine bills are fully paid by their Governments without any questions asked. If so inclined, the Western European pensionee is free to carve out for himself a new career, and permitted to continue his contributions to society as a producer, and as a tax-payer, without loss of his government pension.

Social Security "benefits" as referred to by official sources, is a misnomer. They are not "benefits," but a "pension" fully paid for by the pensionee, and his employers. This statement is confirmed by the fact that an employer who pays a private pension, deducts there from 50% of the social security pension accrued to his retired employee, not concerned in the least if his retired employee collects his social security pension or not. The employer reasons that, having paid 50% of the tax cost, he is entitled to recover 50% of the social security pension which must be paid to his employee when the latter retires.

It follows that, if through dire economic necessity as it is in most of the cases, or for the sake of keeping his sanity, or of not dying before his time from forced idleness, a pensionee secures another job or earns on his own an average of $100.00 a week before taxes, he and his wife lose their social security pensions for the year. But, the pensionee will be deducted 50% of his social security pension from his private pension just the same.

Let us remember that a private pension seldom reaches 40% of a pensionee's earnings during his last years of work. If to this, is added the Social Security pension, A pensionee finds himself to have to live with about 70% of his previous income. Thus, the pensionee is forced to reduce his standard of living at a time when he and his wife require more living conforts than when they were younger, stronger, and better able to undergo privations.

For the sake of illustration, let us see what average earnings of $100.00 a week, would mean for a pensionee before he reaches the age of 72:

Earnings for the year	$5, 200
Less: Social security, Federal, State, and city taxes	1, 000
Net earnings	4, 000
Lost as a consequence of these earnings:	
Social security pension for himself	2, 400
For his wife	1, 200
Net of taxes	3, 600

Moreover, the pensionee lost $1,200.00 a year which his employer deducted from his private pension.

Do we call this arrangement social justice?

PRIVATE PENSIONS

Should a private employer forbid his retired employee from entering into a gainful employment of any kind under penalty that he would lose his private pension, the law would intervene to protect the retired employee's constitutional rights. Yet, the Social Security Act as at present applied, does exactly that. It is:

(1) a confiscation of the individual's pension for which both he and his employers paid during his active life;

(2) an invasion of the constitutional rights of the individual as a free citizen;

(3) unsocial in that it deprives society of the contributions which pensionees could continue to make to our country by imparting their skills to the younger generation;

(4) inhuman for, while it punishes a pensionee of 62 or 65 for working for more than $1,680.00 a year, it lifts its punishment after a pensionee reaches the age of 72. This prejudice of age must have been inserted in the Act by evil forces who prevailed upon our legislators, who were unaware of the untold miseries that this disparity of treatment was bound to work upon millions of pensionees, and of the havoc that it was bound to work upon our country, and its economy.

If it is illegal to refuse a job to a person because of age, why should it not be illegal to place earnings restrictions on pensionees of 62 or 65, but not on pensionees of 72 and over? What is the reason for this prejudice of age? If a person of 62 or 65 has earned his right to a social security pension, it should not be at the sacrifice of his right as a free citizen to seek other gainful employment even to the extent of carving out for himself a new career at $100,000.00 a year, without thereby losing his right to a social security pension for which he paid, and which has fully accrued to him.

In its report of the month, dated August 4th., 1972, Research Institute Recommendations reporting on Social Security to-day, comments:

"The hardy creatures who continue to work past their 72nd birthdays have the best of two worlds: They can collect their salaries and their benefits as well, because there are no earnings restrictions on pensionees who are 72 and older."

Why should not the same rule apply to pensionees of 62 or 65, who worked for forty years and longer, and who paid Social Security taxes since the System was inaugurated? Most pensionees of 62 or 65 will never reach the age of 72, condemned as they are by this unjust and, I believe, unconstitutional Act to live a life of privations, and of denials. They are denied to pursue their trades or professions, or to employ their skills, and their talents, lest the extra meager earnings deprive them of the Social Security pensions. And, come to think of it, is it not too late even for a pensionee of 62 to begin "to enjoy the best of two worlds" ?

(5) disastrously uneconomic for:

(a) it forces many pensionees on welfare because by no stretch of the imagination is the pittance of the existing Social Security pension sufficient to meet the needs of a senior citizen, and of his wife;

(b) it forces hundreds of thousands of pensionees to live abroad where the cost of living is cheaper to the detriment of our domestic economy, and of our balance-of-payments as social security pensions remitted abroad amount to about 1 billion dollars a year;

(c) it deprives the domestic economy of the contributions of millions of pensionees as producers, tax-payers, and consumers;

(d) as all unjust laws, the Social Security Act is being defied daily by untold numbers of employers who hire pensionees on Social Security pensions, and pay them in cash to avoid to have to register them on their books as employees. Employers find it advantageous, because pensionees have no choice but to accept a much lower scale of pay to the detriment of labor in general, and at a non-indifferent loss to the U.S. Treasury, and to the Social Security System itself, of evaded taxes on earnings of thousands upon thousands of pensionees.

MEDICARE

As part of the present set-up, Medicare has become a tool which enriches hospitals, doctors, and insurance companies. Let me explain with a personal illustration:

For my 72-year-old wife, and for myself, 67 years old, I pay $150.00 a year for additional hospital and medical insurance under Medicare. Moreover, I am forced to carry major hospital insurance with my former employer because Medicare coverage is limited, at an extra cost of $123.60 a year. So, I spend a total of $273.60 a year for extra hospital and medical coverage. During 1971, I spent:

Doctors' bills for:	
My wife	$155.00
Myself	135.00
Total	290.00
Medicines for:	
My wife	42.46
Myself	0
Total	42.46
Expenses:	
Insurances	273.60
Doctors	290.00
Medicines	42.46
Grand total	606.06

Of this amount, Medicare re-imbursed me only $105.60 instead of $152.00, that is, 80% of $190.00, after the deductible of twice $50.00 for my wife and for myself.

Much to my distress, New Hampshire-Vermont Physician Service, Two Pillsbury Street, Concord, N.H. 03301, has been scaling down practically every fee charged to my wife, and to me by our doctors on the plea that Medicare pays for 80% of a "reasonable charge" for the services. But, who is to judge what are "reasonable charges"?

On December 28th., 1971, my doctors began a diagnostic examination of my condition which ended early in February, 1972. My doctors charged me $35.00 for their first examination as a new patient for a complete diagnostic history and examination. N.H.-Vermont Physician Service sent me its statement that Medicare allowed only $15.00 (!) for said visit, and it re-imbursed me $12.00 instead of $28.00, that is, 80% of $35.00. Moreover, even though my doctors advised N.H.-Vermont Physician Service that their subsequent fees were part and parcel of their diagnostic examination which began on December 28th., 1971, Medicare deducted from said fees the $50.00 deductible for 1972, even though it had already deducted $50.00 from my medical expenses for 1971!

On April 11th., 1972, my doctors charged my wife $15.00 for a visit. N.H.-Vermont Physician Service recognized only $8.00 as allowable towards the $50.00 deductible.

My doctors' bills which I always submit to N.H.-Vermont Physician Service, bear the following legend:

"All fees are patterned to the relative value scale established by the Vermont State Medical Society and the Vermont State Society of Internal Medicine."

It would seem unreasonable, therefore, that Medicare should leave to the pensionee the burden of haggling over fees with his doctors, first, because of his incompetence to discuss medical fees; second, because of the fear that his doctors whom he trusts as professional men, might suggest that he find himself other doctors. The very fact that my doctors go on record that their fees are patterned to the value scale established by the Vermont State Medical Societies, it would seem proper to suggest that Medicare called for a conference with all the Medical Societies in our country, and come to an iron-clad agreement as to the amount of fees that any and all doctors should charge Society Security pensionees.

But, allow me to add that the above measure would be a palliative, and not a solution to the despairing situation of pensionees who more and more require the services of doctors, and hospitals, and who depend in whole or in part upon their Social Security pensions, and Medicare to meet their daily needs with a sense of dignity, and security.

When I retired, I counted upon our country, that our government leaders keep on reminding us is the most affluent country in the world, to have a Social Security pension, and a Medicare Service for its pensionees worthy of the names. Services which would assist pensionees to make of their declining years, the golden years,

and not the dreaded years which regulations covering Social Security, and Medicare have made.

Why should our country not be able to pay to its pensionees pensions without any earnings restrictions alike Western European countries? Why should our country treat our pensionees as though it were doling out welfare to them instead of a monthly pension, and a Medicare service for which they, and their employers paid?

On the basis of the foregoing exposition, permit me to petition our Government, through you, for amendments to the Social Security Act, and to Medicare, as follows:

(1) Social Security is a pension fully paid for by the pensionee, and his employers, and not "benefits". Accordingly, this pension must be paid in full to every pensionee upon reaching the age of 65, free of all earnings restrictions. Pensionees must not be made to wait till the age of 72 to regain their dignity as free citizens;

(2) Private employers must be forbidden to deduct 50% of the Social Security pension which accrued to their retired employees from the private pensions they pay to them. The Social Security tax which an employer pays on behalf of his employees, must be considered as part and parcel of his employees' compensation. Is it not odd that an employer should recapture his Social Security tax payments which the law requires him to pay for each and every one of his employees, by claiming 50% of the Social Security pension which accrued to his retired employees?

(3) Medicare services must be broadened to include full payment of doctors', dentists', and medicine bills, whether incurred in or out of a hospital. All hospitals', and nursing homes' charges must also be paid in full, without any deductions or restrictions whatsoever. Let us remember that pensionees paid for these services in the form of social security taxes, and that they continue to pay premiums for additional hospital and medical insurance.

Thus amended, the Social Security Act, and Medicare, would become a blessing for over twenty-six million pensionees, and a blessing for our country, and its economy. Most of these pensionees would continue to make their contributions to the economy as producers, earners, tax-payers, and consumers, free of all earnings restrictions, and of anxieties. Relief, and welfare rolls would drop dramatically; hospitals would be less crowded with indigent senior citizens crushed spiritually, and physically by the weight of their economic insecurity. It can well be reasoned that the additional cost of these absolutely necessary amendments to the Social Security Act, and to Medicare, would be recovered by our Government.

Hospitals' and Nursing Homes' Charges; Doctors' and Dentists' Fees

It has been my personal observation that hospital, and nursing home charges; that doctors', and dentists' fees have been increasing by leaps and bounds ever since hospital, and medical insurances were inaugurated.

When in 1930, I entered St. John's Hospital in Brooklyn, N.Y., for a hernia operation, I paid $7.00 a day for a beautiful semi-private room, and $100.00 for the operation. In the course of forty-two years, hospital, and nursing home charges have gone up about 1000%; doctors', and dentists' fees have gone up about 700%!

Since actuarian tables confirm that the rate of hospitalization remains more or less constant throughout the years, it is alleged that insurance companies have found it to their advantage to encourage hospitals, nursing homes, and doctors, to keep on increasing their charges, and their fees. For, it enables insurance companies to justify their constant demands for increases in premiums on medical, and hospital insurances. While insurance companies are satisfied to pay more and more for the constant percentage of hospital, and nursing home cases, they collect ever increasing premiums on *100%* of their insured customers. The underwriting of life, hospital, and medical insurance policies, represents the greatest source of ever increasing profits for insurance companies.

A NEW FEDERAL LAW

Hospital, and nursing home rates, as well as doctors., and dentists' fees, must be regulated like the rest of the economy. We have left these services unregulated for too long with the consequence that their charges, and their fees have run wild. Who would have ever thought that a week's stay in a hospital can run close to one thousand dollars, not including doctors' fees? The cost of hospitalization, of

nursing homes, of medicines; of doctors, and of dentists, constitute too large a portion of the inflation from which our country suffers. It is alleged that in our country to-day many doctors, and dentists become millionaires long before their retirements. Who pays for all these excesses?

Before the advent of Medicaid in New York City, Clinic patients were treated gratis by doctors who gave their services free once or twice a week. After Medicaid required that its clinic patients pay a fee, hospitals found themselves with a flow of funds which by law they could not appropriate. It is alleged that these hospitals decided to divide these fees among their doctors who heretofore had given their services free. A friend doctor of mine in New York City found himself receiving from $1,000.00 to $1,500.00 monthly for clinic services that he would gladly have continued to give free.

I would suggest, therefore, that a Congressional Committee be organized to investigate hospital, and nursing home charges, as well as doctors', and dentists' fees to the end that a bargaining procedure be enforced after the model of the bargaining system which prevails in private industry. Bargaining teams should consist of consumers representatives' as the employers, and of hospital superintendents', of doctors', and of dentists' representatives as the employees. The bargaining teams would be under the supervision of a government agency which would not include doctors, dentists, hospital, nursing home, and insurance people, to avoid the possibility of conflict of interest such as we now have between insurance companies, hospitals, and medical societies. Hospitals, and nursing homes; doctors, and dentists, should no longer be allowed to increase their charges, and their fees at will without the consent of an authority greater than theirs.

To overcome the shortage of doctors, and dentists artificially created throughout the years by the American Medical Association as it is alleged, I would suggest further that Congress appropriate the necessary funds to build new medical colleges throughout the country to provide for additional 10,000 doctors, and 10,000 new dentists a year, and to staff these medical schools with professors from other countries to make up for the lack of teachers in our country.

While looking forward to the receipt of your kind reply, I keep myself at your complete disposal, ready to testify at any Congressional hearings which may be organized for the purpose.

Respectfully submitted.

THEMISTOCLES S. AMBROSINI.

ITEM 2. LETTER TO SENATOR STAFFORD IN SUPPORT OF PETITION OF THEMISTOCLES S. AMBROSINI, NOVEMBER 27, 1972

RUTLAND, VT., *November 27, 1972.*

Senator ROBERT T. STAFFORD,
U.S. Senate,
Washington, D.C.

MY DEAR SENATOR STAFFORD: Further to my petition of September 27th, 1972, to the Congress of the United States, through you, for a redress of grievances under the Social Security Act, and for a redress of grievances under Medicare, and ancillary medical services, and to my Addition #1 of October 12th to said Petition, I now enclose a folder containing 416* signatures of Vermont citizens in support of my said petition.

On the basis of polls' criteria, we believe that this sample poll is a mandate to you from all the workers of our State to take up in earnest the fight for:

(1) removal of the earnings limitation;

(2) prohibition of the deduction of 50% of the s.s. pension which accrues to retirees by their employers who grant private pensions as part and parcel of the compensation they pay to their employees;

(3) free and complete medical services on the type of the British National Insurance service at least for senior citizens under Medicare.

The November 14th., 1972 issue of The New York Times carried an article, British Restructuring Health Service, by Richard Eder from London as per excerpts below:

". . . The (National Health) service's principle of universal tax-supported care has become almost as unquestioned in the minds of the 55 million Britons as Magna Carta."

*Letter accompanied by 416 signatures in support of petition of September 27, 1972, retained in committee files.

"Mr. and Mrs. Macaulay, both retired, make a social-security payment—part of it for the health program—of a bit less than $2.—out of their pension of $50.—a week. When they have to buy a prescription drug, it costs only 50 cents. What they get, above all, is freedom from the fear that what remains of their lives will be wrecked by doctors' bills."

"The right to that freedom is universally accepted here. To talk with British health experts is to get a recitation of the great shortcomings in the Health service, but they—and the Government—are out to reform it, not reverse it, *and their attitude toward the lack of such a program in the United States is politely incredulous.*"

"Even the British Medical Association, a conservative equivalent of the American body, is mainly at work not to denounce the system, but to get the benefit of its almost free drugs extended to the minority of patients—roughly 3 percent—who still use private doctors all or part of the time . . ."

"Britain spends about 5.9 percent of national income on medical care, as against 8 percent in the United States. . ."

"What kind of service does the money provide . . ."

"The figure for infant mortality for England and Wales is 17.9 per thousand live births—better than the United States rate (19.8 per thousand) . . . British male life expectancy is 69.1 years . . . Female life expectancy . . 75.1 years. Both rates are better than in the United States, where men can expect at birth to live 67.3 and women to 74.4."

"It is widely agreed that the Briton gets superior hospital treatment and first rate care for acute illness and major surgery. Frank Honigsbaum, an American medical writer who has studied the British system for a number of years and subjects it, despite generally favorable enthusiasm, to some sharp criticism, says:

"The only thing comparable in our country to a very general Standard of British hospital service are the best American teaching hospitals. If I were hit by a car in Cornwall or Newcastle, I'd have not the slightest hesitation in being entrusted to the local hospital. In parts of Georgia, I'd be terrified."

". . . And one of the overwhelming advantages that independent analysts such as Mr. Honigsbaum see in the National Health Service, despite all its problem, is that it has built the framework around which British society can decide rationally what it wants to spend on medicine and where it wants to spend it."

In the November 1972 issue of Newsweek, there appeared the following letters to the Editor:

FIRST LETTER

"The British Rx.

"The British are not the only ones who benefit from Britain's National Insurance Service. While vacationing in London last year, I suffered a heart attack. As an emergency case, I qualified for N. H. S. My hospital stay did not cost me one penny. Medical attention, pharmaceuticals, lab tests, and therapy were rendered free of charge.

"I have only the highest praise for the treatment I received. The dedication, professionalism, concern, and the gentleness administered by all involved can only be viewed in U.S.T.V."

(Signed) MARVIN V. RUSSOTA, *New Haven, Conn.*

SECOND LETTER

"Bravo! for the National Health Service operating in Great Britain. After becoming seriously ill in Wales last fall, I panicked at the throught of the potential financial disaster. However, this worry was alleviated after the first home visit by a physician. After fifteen more home visits, five house calls by a nurse, some twenty-odd lab tests of various types, five chest X-rays, one consultation with a specialist, and ten prescriptions, my treatment was completed. Total cost $5.00 All for prescribed drugs. Quality of care? I have never received better."

(Signed) DON KEMP, *Douglas, Alaska.*

The Report of the Committee on Finance, United States Senate, to accompany H.R. 1, to amend the Social Security Act, and for other purposes, a tome of 1282 pages, amounts to a medley of provisions ranging from welfare to child care which have nothing in common with Social Security. Social Security is an insurance annuity fully paid for through taxation by the respective beneficiary, and his employers during his entire active life. It is a base upon which the senior citizen can build retirement protection for himself, his wife, and other dependents by continuing to work for wages for the time that he can. By so doing, he prac-

tically pays a second time for his social security pension by continuing to pay taxes on his earnings, and by otherwise contributing to the national economy as a substantial consumer.

By commingling the various services, Social Security trust funds are not being used exclusively for the benefit of American workers who contributed to it for a lifetime, and who have reached retirement age. These funds are used also to finance for instance the extension of social security benefits to new groups of people not at present covered, and who until now did not contribute to the Social Security trust fund. We believe that such coverage should be provided by the government directly in the same way that the government should provide for welfare programs, and other social services. In the present situation, Congress treats Social Security pensionees on the same level of people who are on welfare.

We believe that to divert Social Security trust funds for purposes other than for those for which they were collected through taxation, is illegal and unconstitutional. When a worker reaches the age of 65, he should not be called upon to make any more sacrifices other than to continue to pay his income taxes on any new earnings or income he may have. He should not be denied his s.s. pension, and full and free medical services, irrespective of his continued earnings. With the assurance of a s.s. pension, a senior worker could go on to a second job that might give greater rein to creative impulses, or focus more on community services.

The time has arrived for our Government to take care of the American senior worker, and to stop squandering our youth, our blood, and our substance for alien people who scorn us, and who want us to get out of their hair. If we keep strong at home, we shall never have to fear about dangers from abroad. Our Government's first priority should be its senior workers who gave a lifetime of work to our Country, paying taxes, s.s. taxes, and supporting our country in every way possible. Our Government is ready to pour another $7,500,000,000.00 of American workers' taxes into Vietnam, this time to rebuild what it wants only destroyed, but our Government is not willing to give to its senior workers what they paid for during a lifetime of work, and of paying taxes: a s.s. pension without any earnings limitation, and a completely free medical service.

We read that it is estimated that the cost of eliminating the limitation would be equivalent to a 5% across-the-board benefit increase. But, this reasoning makes no sense, for the ones who would benefit from the lifting of the limitation would be the ones who would continue to work, and to pay taxes so that in fact they would be paying twice for their social security pensions: once, during their active lives like all other s.s. pensionees who through illness or through choice do not continue to work, and collect their monthly s.s. pensions; and, the second time, as taxpayers on their new earnings. The reasoning that the lifting of the limitation would cost our government money flies in the face of facts, and of sound economics. The Government cannot escape the charge that, in effect, it is robbing senior workers of their pensions for the crime of continuing to work, and contributing their skills, their time, their energies, and their taxes, to build America.

In my personal case, my wife and I have been deprived since October 1st, 1972, of our monthly pensions totaling $385.20 for the high crime of having worked from January 2nd to June 12th, 1971, which enabled me to pay *additional* income taxes of $3,557.00, including $399.00 for s. s. taxes. In other words, we are now being taxed additionally $385.20 monthly until the Social Security Administration decides that it has re-imbursed itself of the "overpayments" made to us. I was also advised that I may be subject to other penalties. We say that it is taxation without representation; a confiscation of what rightfully belongs to me, and to my wife.

As I cannot afford to initiate a suit to have the provision of the limitation declared unconstitutional, may I ask you as one of your constituents, and in the name of the 416 citizens of our State who have signed my Petition, if you would initiate such a suit so that the U.S. Supreme Court can rule on the constitutionality or not of the limitation. In the name of your fellow-Vermonters, and on behalf of all American senior workers, we call on you to take up the cudgels, and lead the good fight to redeem the honor of our Country from the gross injustice that it has perpetrated upon its most deserving citizens.

In the second section of The New York Times, dated November 8th, 1972, there appeared an article, The South Asians: City Mysterious Immigrants." India Abroad is a foreign community-journal, published in New York City, of which Mrs. Kusum Lai Mohan, a former Newsweek researcher, is the Editor, and her husband, Mr. Anend Mohan, who teaches political sciences at Queens College, is the Associate Editor, Mr. Mohan reports on a recent poll taken by his paper among his countrymen here as follows:

"One of the main reasons (that half the Indians here planned to go home one day, while one third were undecided) *is the dread of living in this country as old people. They will be forgotten and neglected here.* But in the Indian culture, old age is venerated."

What about it, our dear Senator Stafford? Is it not about time that our Government take a leaf from the Indian culture, and give the American senior worker at least his just due, and respect his dignity as a free man by lifting the limitation, and granting full and free medical services such as Great Britain does? May we suggest that you enter the above-mentioned article in the New York Times by Richard Eder, in full; the above-quoted two letters, and the above quotation from India Abroad, into the Congressional Record to awaken the conscience of all the members of Congress to what ought to be their first priority: The veneration of the American senior worker, the very soul of America!

Assuring you of our full support, and cooperation in this just fight for all American senior workers, and for our Country, four hundred and sixteen fellow-Vermonters join me in extending to you our anticipated thanks for the good fight that you will want to initiate for this just and sacred cause.

Respectfully,

THEMISTOCLES S. AMBROSINI.

ITEM 3. LETTER TO SENATOR STAFFORD FROM MRS. BERNICE RYAN, RUTLAND, VERMONT, IN SUPPORT OF PETITION OF THEMISTOCLES S. AMBROSINI

NATIONAL COUNCIL OF SENIOR CITIZENS,
RUTLAND, VT. CHAPTER,
October 26, 1972.

Senator ROBERT T. STAFFORD,
U.S. Senate,
Washington, D.C.

Our Dear Senator Stafford: Our neighbor and friend, Mr. T. Serse Ambrosini, spoke to our Group last evening on Social Security, Medicare, and on the cost of ancillary medical services.

Mr. Ambrosini took occasion to read to us your letter to him of October 3rd in response to his petition of September 27th., 1972, to the Congress of the United States through you, Senator Aiken, and Congressman Mallary for a redress of grievances under the Social Security Act, and Medicare, as well as for a redress of grievances regarding the cost of ancillary medical services.

We are grateful to you for your assurances to Mr. Ambrosini that his petition will receive your utmost attention by you during the coming month, because we are in full agreement with Mr. Ambrosini's petition for:

(1) the complete lifting of the earnings limitation from Social Security pensions;

(2) the broadening of Medicare's services to include full payment of doctors', dentists', and medicine bills, as well as payment in full of all hospitals', and nursing homes' charges without any deductions or restrictions whatsoever;

(3) the enacting of legislation to regulate hospitals', and nursing homes' rates; to regulate the cost of drugs and medicines, and to regulate doctors', and dentists' fees, in the same way as the rest of the economy is regulated.

Concerned as we are with the welfare, and the well being of senior citizens, we can confirm Mr. Ambrosini's statement that existing regulations have made the declining years of senior citizens the dreaded years, and not the golden years of life.

As American citizens who gave a lifetime of work to our Country, paying taxes, and social security taxes, we must insist that, as a pension fully paid for by the pensionees and their employers, social security pensions be paid in full to them at the age of 65 without any earnings limitations whatsoever, and that Medicare services be rendered free of any and all charges. For the existing monstrous regulations have made prisoners of senior citizens who have not reached the age of 72 with police looking over their shoulders to spy whether they work or not.

Being in daily contact with the realities of life as they affect senior citizens, we can confirm that by depriving senior citizens of the dignity of work as they choose; and of the freedom to earn as much as their skills, ambition, and strength permit them, our government is forcing millions of them (1) to swell the welfare rolls, (2) to crowd hospitals' beds, broken in bodies, and in spirit.

As Mr. Ambrosini explained, the earnings limitation does not make any economic or moral sense. It is a burden upon our country, and an unbearable burden upon 26 million senior citizens. It deprives our country of the contributions which 26 million senior workers could continue to make to our economy as producers, tax-payers, and consumers. It serves to enlarge the welfare rolls, and to crowd our hospitals throughout the nation.

Both you, Senator Aiken, and Congressman Mallary wrote to Mr. Ambrosini that Congress will never approve the lifting of the earnings limitation, that is, not until the senior citizen reaches the age of 72. Are we to surmise that this earnings limitation at the expense of senior workers was placed to create a huge bureaucracy just to police it, to create sinecure jobs for political hacks as a reward for their assistance to members of Congress to retain their seats during election campaigns?

As your constituents, we urge you to take up the challenge, and lead the members of Congress back to their solemn sense of duty to our Country, and to its senior workers by lifting the earnings limitation, and by broadening Medicare services as advocated by Mr. Ambrosini's petition.

While awaiting the pleasure of your reassuring reply, we extend to you the sentiments of our highest esteem.

Respectfully,

(Mrs.) BERNICE RYAN, *President.*

Appendix 3

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1: LETTER FROM ALFRED PARKER, EXECUTIVE DIRECTOR, TAX FOUNDATION, INC., NEW YORK, IN RESPONSE TO SENATOR CHURCH, JANUARY 15, 1973

TAX FOUNDATION INC.,
New York, N.Y., January 15, 1973.

Hon. FRANK CHURCH,
Chairman, Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR SENATOR: This is in response to your letter of January 8 which unfortunately did not reach us until last Friday.

You asked for suggestions on issues that should be considered either at hearings or in special studies in connection with the overall inquiry which the Senate Special Committee on Aging will conduct on "Future Directions in Social Security." A few issues which might be considered are the following:

1. There is, of course, the basic issue whether the provision for the really needy is "adequate" and that the aid is going only where it is "justified." Aspects of this issue are that the aged should be provided for without undue burdens on the taxpayers and without creating depressants on the economy through the level of taxation required.

2. The benefits under Social Security are one of the largest single items excluded from adjusted gross income. This is a substantial total and this exclusion provides different economic benefits to different people, depending upon their levels of income.

3. Another issue is the extent to which we wish to provide incentives to people to either continue or discontinue useful activity when they reach retirement age. One of the general aspects of this issue is the provision of freedom and opportunity for each person to do his best with a minimum of distortion of his incentives either through a benefit level or through a tax level.

4. Another issue involves the treatment where two workers (husband and wife) have participated, but the benefit provided is no more than for another couple where there was only one wage earner.

These are the first suggestions of issues that occur to us. Perhaps as your inquiry develops or you hold hearings, we may have other suggestions to make. We appreciate the opportunity to contribute to the progress of your study on this very important subject.

Sincerely,

ALFRED PARKER,
Executive Director.

ITEM 2. LET'S GIVE TAX CREDIT FOR SOCIAL SECURITY LEVY, ARTICLE BY CARL T. ROWAN

LET'S GIVE TAX CREDIT FOR SOCIAL SECURITY LEVY

[Washington Star and Daily News, Jan. 21, 1973, by Carl Rowan]

Rep. Wilbur Mills, D-Ark., the king of the congressional road when it comes to tax laws, has pledged that the 93d Congress is going to review every single one of those exclusions, exemptions and preferences otherwise known as "tax shelters" and "tax loopholes."

Bravo! But don't expect too much, They'll plug the holes in Swiss cheese with moondust before they seal off all those legal openings that allow some Americans to escape the grasping fingers of Uncle Sam's revenooers.

First they'll threaten to deny deductions for the interest on home mortgage payments, and maybe even for real estate taxes. This will create such an uproar from millions of moderate-income home owners that someone will quickly say, "That's one 'loophole' we'll keep."

That will make it seem fair, then, to keep those fast-depreciation regulations that have made real estate one of the juiciest of the get-rich-by-minimizing-income-taxes operations.

The truth is that when Mills and Co. conclude their survey, this Congress will still embrace the notion that $10,000 made by investing money ought to be taxed at a lower rate than $10,000 made by the sweat of some man's brow.

This society is steeped in the notion that what makes the economy run is people with money risking it in oil exploration, housing developments, ore extraction, cattle breeding and myriad new business enterprises, and not the brawn or even the brains of laborers.

If economic philosophy were not enough to prevent this, accept the reality that most of the powerful men in both houses of Congress have vested financial interests in a lot of those tax shelters.

What chance is there, then, for something closer to justice for the average working Joe in this country? Not much, because our tax laws have long been proof that the smart operators can fool enough of the people enough of the time to have things go their way indefinitely.

If Working Joe had enough savvy and enough zip, he'd be raising hell right now about the fact that his Social Security deductions are 35 percent higher than last year. But he's so enthralled with President Nixon's pledge of "no tax increase" that he can't feel that long arm from Washington reaching deeper into his hip pocket,

They taxed only the first $9,000 of Working Joe's pay, at a rate of 5.2 percent, last year. This year they'll tax $10,800 at 5.8 percent—and next year the tax will apply to the first $12,000 of Joe's earnings.

I have written before that this is a regressive tax where the guy earning 120,000 bucks a year will pay the same $632 this year that the struggling earner of $12,000 will pay

What is worse—and little realized by the average American—is that in millions of poor and moderate income families the wife works; both pay the full Social Security tax, but the ultimate benefits on retirement will be the same as if only one spouse had worked.

Let me put it another way. Joe Smith earns $15,000 a year. Nice, but not enough with two kids in college. So his wife works, earning $11,000 per year. They will pay a whopping $1,264 in Social Security taxes this year.

Sam Fullbull earns $100,000 a year (plus $30,000 worth of nontaxable fringe benefits) and wouldn't think of allowing his wife to work. His family pays $632 in Social Security taxes.

On retirement, the Fullbulls will get the same Social Security benefits as the Smiths.

Now, since I know the Congress is not going to wipe out all of the loopholes that are so beneficial to the Fullbulls, but are mostly out of reach of the Smiths, I propose this simple change in the law to provide at least a pretense at justice.

Where husband and wife both work, as in the case of the Smiths, with a combined income of less than $42,500 a year (that's a congressman's salary), let's allow a full income tax credit for the Social Security payment of the second spouse.

It wouldn't hurt the Social Security program, where the reserve already is $50 billion and moving toward $74 billion by 1977. The shameful truth is that this regressive tax is now being used to finance non-Social Security programs that ought to be financed through the fairer income tax.

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