BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

PART 8—WASHINGTON, D.C.

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TUESDAY, MARCH 12, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY OF THE
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 5110, Dirksen Office Building, Hon. Edmund S. Muskie, chairman, presiding.

Present: Senators Muskie, Hartke, Chiles, Fong, and Pell.

Also present: William E. Oriol, staff director; Elizabeth Heidbreder, professional staff member; John Guy Miller, minority staff director; Margaret Fayé, minority professional staff member; Patricia Oriol, chief clerk; Gerald Strickler, printing assistant; Joan Merrigan, clerk; and Dorothy McCamman and Herman Brotman, consultants.

OPENING STATEMENT BY SENATOR EDMUND S. MUSKIE, CHAIRMAN

Senator MUSKIE. The subcommittee will be in order.

This hearing continues the inquiry of the subcommittee into barriers to health care for older Americans, a series we began 1 year ago this month with hearings on the administration's Medicare cutback proposal, and have continued in other hearings last year in Washington and around the country.

Today and tomorrow we will hear testimony on the administration's national health insurance proposal—the comprehensive health insurance plan. Before we hear from our witnesses today, I would like to make some brief points about national health insurance and the elderly.

First, I note with pleasure that every concerned group in the Nation has recognized the need for enacting a program of national health insurance. The defects of our health care system, for all citizens, are so severe that they can only be solved by a nationwide plan which insures every American access to sound health care. The public, health professionals, the administration, and Congress all agree that national health insurance is a top priority for America.

Second, I would like to note that agreeing on an adequate national health insurance plan will be a difficult and complicated process. Cooperation and a willingness to reason, by all parties involved, will be essential for the process to be successful. I am gratified that the administration has exhibited the necessary spirit of cooperation. I hope it continues.

Third, I believe it critical for us to keep in mind, as we consider the various national health insurance plans which have been proposed, that they must be judged by their effectiveness in dealing with the entire range of problems which beset health care in America. The health care needs of the elderly, with whom this subcommittee is primarily concerned, and of all other groups in America, will only be satisfied when we insure that benefits are adequate to cover individual health needs; that health costs are financed equitably; that costs are kept under control; and that all the health services our people need are actually available to all our citizens, regardless of geographic location or economic status, in well-planned, rational, institutional, and organizational form.

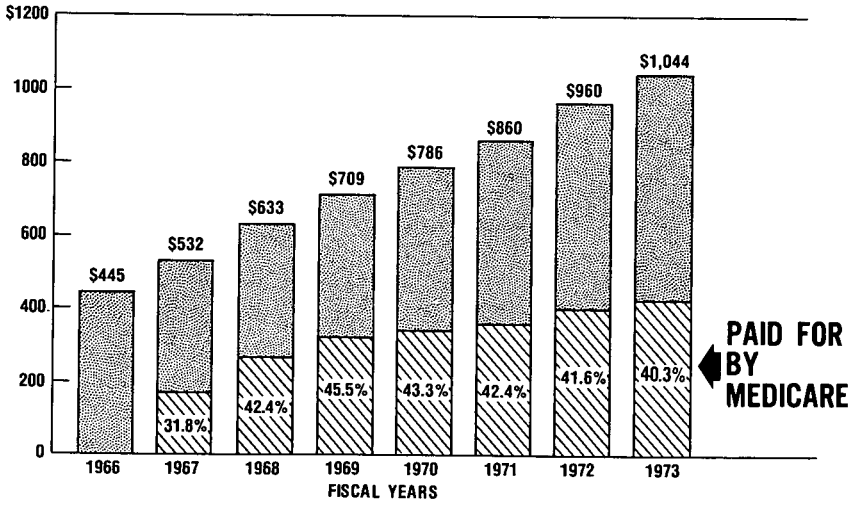
We cannot immediately legislate the total reform of our health system which should be our ultimate goal. But we should keep that ideal goal in mind, and aim to achieve it in the near future.

The fourth and final point I wish to make goes to the immediate concern of these hearings: The effect on the elderly of the administration's health insurance proposal. In our consideration of national health insurance, we must hold firm to a basic premise that we will not accept cutbacks in health care for the elderly.

Regretfully, examination of the administration's proposal reveals that it violates this standard. The administration's proposal on balance would actually lessen the health care coverage which our elderly now receive under Medicare. These cutbacks come in the form of new deductible and coinsurance charges which would force the elderly to pay more out-of-pocket costs for health care now covered by Medicare.

CHART 1.

MEDICAL CARE BILL PER AGED PERSON AND PROPORTION COVERED BY MEDICARE, FY 1966-1973



Source: Social Security Administration

The administration's proposal does include some improvements for the elderly—proposed coverage of outpatient drugs, improved mental health coverage, and catastrophic coverage. But the cutbacks included in the plan make it inadequate to meet the health needs of older Americans.

To set the framework for our examination of the administration's health insurance plan as it affects the elderly, I had charts prepared to analyze the new administration proposals, and I turn to them now.

Chart 1 illustrates how the total per capita medical bill for the aged has mounted since the beginning of Medicare while there has been a downward trend in the proportion that is paid by Medicare in recent years. The proportion that is covered by Medicare hit a peak of 45.5 percent in 1969; by 1973 this had dropped to 40.3 percent.

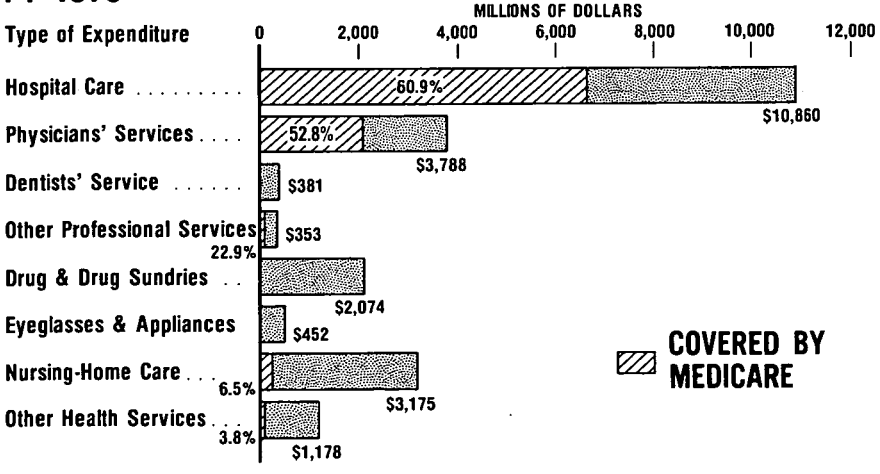
I might add that this slide downward to 40 percent is new information. It has just been acknowledged by the Department of Health, Education, and Welfare.

In other words, the Medicare program now covers only two-fifths of the health care costs of the aged. The amount not covered—$620 per person per year—is substantially more than the average per person bill of $445 in fiscal year 1966, before Medicare was in effect. Medicare beneficiaries write us letter after letter of the burden of these increased medical costs, and asking how they can hope to pay medical bills even with increases in Social Security benefits. So, even as it exists today, Medicare needs to be improved.

Turning to chart 2, this gives some information on what kinds of health costs the elderly incur. The chart shows that more money is spent on hospital care for the aged than any other type of health care. Of the total expenditure of more than $22 billion for the elderly in

CHART 2.

AMOUNT OF HEALTH CARE EXPENDITURES FOR THE AGED, BY TYPE, AND PROPORTION COVERED BY MEDICARE, FY 1973



Source: Social Security Administration

1973, $10.9 billion was spent on hospital care. Physicians' services were next with almost $4 billion followed by a total of $3.2 billion for nursing home care.

When we look at the proportion of each service which was covered by Medicare, we see that hospitalization was 60.9 percent covered and physicians' services 52.8 percent covered.

Nursing home care, which was the third largest expenditure, had only a miniscule 6.5 percent covered by Medicare. By far the biggest share of Federal support for long-term care is provided by Medicaid.

The bars on the chart which do not have any cross-hatching are those services which are not covered at all by Medicare. They are dentists' services, prescription drugs, eyeglasses, and appliances. Of these three services, the biggest expenditure by the elderly was more than $2 billion for prescription drugs. Alternatives to institutionalization such as home care are not even listed separately, but are included in the "other" professional services of which Medicare pays only 25 percent.

So this chart illustrates two points. First, that hospital care has a dominant role in the health care delivery system for the aged—and that dominance must be taken into account when we consider changing Medicare. Second, the chart shows how Medicare must be expanded—into areas like home health, nursing home care and drugs—to cover adequately the elderly's health expenses.

Turning to chart 3, it shows how out-of-pocket charges have increased since Medicare was started. Hospital insurance deductible and coinsurance charges have risen 110 percent, and the monthly premium charge under part B medical insurance has risen 123 percent.

CHART 3.

MEDICAL CHARGES SOAR

	1966	1974	PERCENT INCREASE
HOSPITAL INSURANCE			
DEDUCTIBLE	$40	$84	110%
CO-INSURANCE			
HOSPITAL			
1st-60th DAY	NONE	NONE	—
61st-90th DAY	$10 DAILY	$21 DAILY	110%
LIFETIME RESERVE DAYS	$20	$42	110%
NURSING HOME/EXTENDED CARE			
1st- 20th DAY	NONE	NONE	—
21st-100th DAY	$5 DAILY	$10.50 DAILY	110%
MEDICAL INSURANCE			
PREMIUM	$3.00	$6.70*	123⅓%
DEDUCTIBLE	$50.00	$60.00	20%
CO-INSURANCE	20%	20%	—

* Increase scheduled for July 1974.

These increasing charges under Medicare are one reason why it covers only 40 percent of per capita health bills for the aged. These charges impose a severe burden on older people and I am convinced that it is time that this upward trend be halted. To this end, I introduced legislation in the last session of the Congress which would have frozen the hospital deductible and coinsurance at the 1973 rates. This proposal was adopted by the Senate as a part of the amendments to H.R. 3153 but was referred to committee by the House. The $84 deductible rate, and coinsurance increases subsequently went into effect January 1, 1974, thus increasing the upward trend.

In chart 4, we see how the President's proposal to combine parts A and B of Medicare and impose a 20 percent coinsurance charge would affect costs for hospital stays. This chart assumes an average cost of $110 for hospital charges per day.

It also assumes for illustrative purposes that there were no other coinsurance or deductible charges prior to hospitalization.

Medicare now imposes a deductible of $84 but no coinsurance charges until after 60 days of hospitalization in a benefit period. This is shown by the straight line at the $84 level at the bottom of the chart.

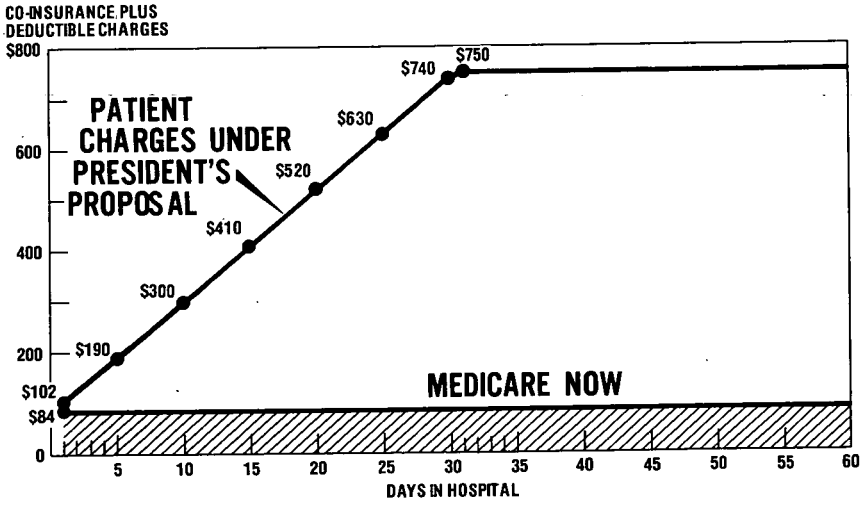
Under the President's proposal, there would be a $100 deductible, and 20 percent coinsurance charge after the deductible is satisfied, beginning on the very first day and $22 for each succeeding day until the maximum charge of $750 is reached. The maximum would be reached on the 31st day.

This proposal, it can be seen, will certainly increase costs for patients with short-term hospital stays over the current Medicare program. Medicare, as we saw in chart 2, covers a larger proportion of hospital

CHART 4.

PRESIDENT'S PROPOSAL INCREASES HOSPITAL COSTS FOR MEDICARE PATIENTS

BASED ON $110 HOSPITAL CHARGES PER DAY

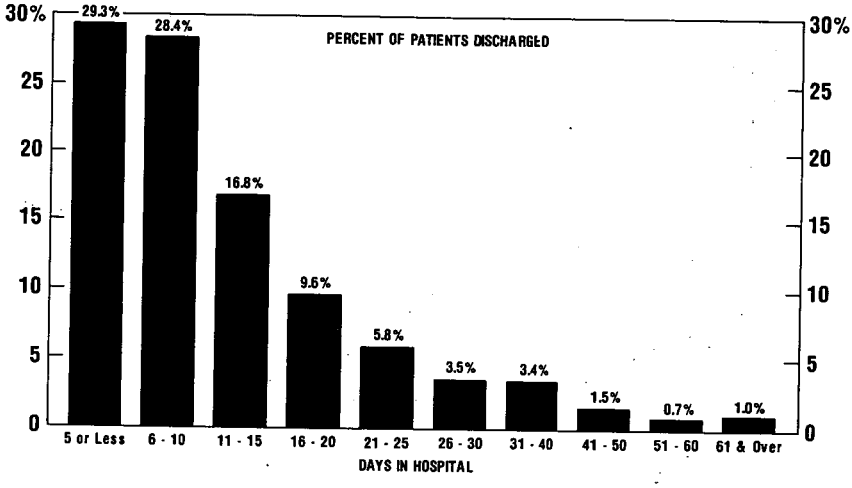


expenditures than any other type of care, but this proportion is likely to drop under this proposal because most hospital stays under Medicare are short term.

According to the American Hospital Association, the average hospital stay for persons over age 65 was about 12 days in 1973. In our illustration, the 12-day stay would cost $344 under the President's proposal compared to the present charge of $84.

CHART 5.

LENGTH OF STAY OF MEDICARE HOSPITAL PATIENTS, 1971



Source: Social Security Administration

Turning to chart 5, this has a distribution of hospital stays in 1971 which illustrates how few patients have long hospital stays. Only 1 percent of the patients had stays of longer than 60 days. It is only this 1 percent which now pays coinsurance for hospitalization covered by Medicare. Under the President's proposal, everyone hospitalized would have to pay coinsurance charges unless they had already incurred $750 in cost-sharing charges in the same year.

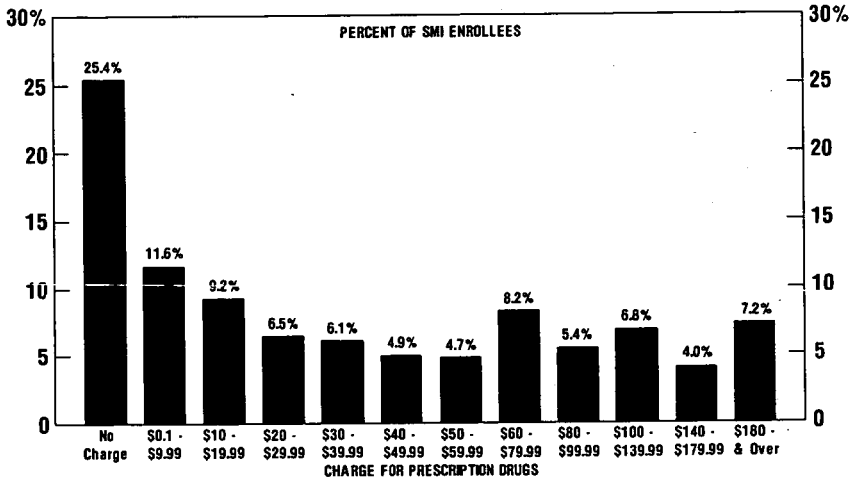
Chart 6 gives us some information to help evaluate the value of the administration's proposed coverage of out-patient prescription drug costs above a $50 deductible. This chart shows the results of a survey of supplementary medical insurance enrollees—those with Medicare part B insurance—and their charges for prescription drugs in 1971, the latest figures available.

About 25 percent had no charges for drugs. A total of almost 40 percent had drug costs, but of less than $50—so the coverage of drugs with a $50 deductible would not help them. Another 18.3 percent had charges of between $50 and $100—so less than half their drug costs would be covered. Although because of rising costs there have been

some changes in the distribution of drug charges since these figures were collected, they indicate that under the administration plan many of the aged would still have to pay for all of their drug costs or a good portion of their drug costs.

CHART 6.

AVERAGE ANNUAL CHARGE PER SMI* ENROLLEE FOR PRESCRIPTION DRUGS, 1971



*Supplementary Medical Insurance — Part B Medicare

Source: Social Security Administration

CHART 7.

MEDICARE HOME HEALTH COSTS INCREASE— BENEFITS DECREASE

	PRESENT LAW	PRESIDENT'S PROPOSAL
HOME HEALTH BENEFITS		
HOSPITAL INSURANCE		
DEDUCTIBLE	0	
CO-INSURANCE	0	
VISITS COVERED	100	
		DEDUCTIBLE $100
		CO-INSURANCE 20%
		VISITS COVERED 100
MEDICAL INSURANCE		
DEDUCTIBLE	$ 60	
CO-INSURANCE	0	
VISITS COVERED	100	

The drug benefit under the proposal would at least add something to Medicare coverage. But the proposed home health benefit would reduce the current home health benefit and impose coinsurance charges, and this is illustrated in chart 7.

Further Reduction of Home Visits

The number of home health visits now authorized under Medicare is 100 under part A and 100 under part B, for a total of 200 per year. The administration plan would reduce this number and it would apply a new coinsurance charge of 20 percent to home health visits. Thus, a home health benefit—which is inadequate now—would be further reduced.

In his message transmitting his proposal to Congress, the President said that he did not "consider our current approach to long-term care desirable because it can lead to overemphasis on institutional as opposed to home care." I agree, and I have introduced legislation to increase the number of home health visits allowed under Medicare, and to make other liberalizations in the home health benefit. It seems contradictory for the administration to agree in principle with the need for home care, but to propose a cutback in home health benefits.

Many of the problems with the administration proposal, illustrated by these charts, can be traced back to the principle of cost-sharing—meaning increased out-of-pocket costs. When we began our series of hearings a little over 1 year ago, I asked this question in my opening statement: "How can many of our elderly realistically expect to receive adequate medical care, in the face of these Medicare cutbacks?"

The cutbacks to which I referred would have resulted from administration proposals to raise the costs of Medicare to almost 21 million older Americans.

It came as no surprise, to me at least, when the administration could not find anyone in either House of Congress to make a serious effort to advance that cost-sharing legislation.

In fact, the Senate took a step later in the year which indicated its concern about the high cost of Medicare to participants in that program by voting in favor of my proposal to hold the line on the increase in the Medicare hospital deductible and coinsurance charges.

The Senate vote, I firmly believe, was a clear signal to the effect that the relentless rise in the costs of Medicare to the consumer must be stopped, before this essential program becomes too expensive to help the people it was meant to serve.

And yet, the administration has again come forward with a proposal which raises objections very similar to those expressed last year.

The difference is that now the Medicare cost-sharing is tied to the plan described by President Nixon as his comprehensive health insurance program, meant to serve all age groups, not just older persons.

Once again, these provisions are described as "improvements."

Once again, there is talk of cost-sharing.

Once again, we are told that less is more.

The President's comprehensive health insurance program deserves serious congressional scrutiny and debate. These 2 days of testimony before the Subcommittee on Health of the Elderly will begin that process.

Senator Frank Church, who is chairman of the full committee, has submitted a statement which I will be delighted to include in the record at this point.

PREPARED STATEMENT OF SENATOR FRANK CHURCH

Mr. Chairman and members of the Subcommittee on Health of the Elderly, I will take just a few moments to comment on the timeliness and importance of these hearings.

It seems to me that the subcommittee has acted promptly and wisely to provide a forum for discussion of the President's proposed comprehensive health insurance plan and its potential impact upon health care for the elderly.

The President's proposal, made on February 6, is significant for several reasons; for example, it offers some protection against catastrophic illness, and it clearly recognizes that there are major deficiencies in the present health care systems. These and other features of the administration plan—as they affect all age groups—should receive careful congressional consideration and extensive debate.

To the Committee on Aging and in particular this Subcommittee on Health, however, it already is apparent that early attention should be given to those provisions of the President's program that have direct meaning for older Americans.

These hearings provide the opportunity for that kind of dialog.

One issue which, I hope, will receive particular attention is the administration's proposal, once again, to increase cost-sharing for older persons now covered by Medicare.

Today, Medicare beneficiaries pay an $84 deductible before hospital charges are paid by the program. There is no coinsurance charge until after 60 days of hospitalization.

The administration's proposal would require a $100 deductible and 20-percent coinsurance for all covered hospital services.

INCREASE OF 20 PERCENT ON INSURANCE

Nor is that all. The monthly premium now paid for supplementary medical insurance would increase by about 20 percent, from $6.30 to $7.50. Home health visits would be cut from the present authorized 200 visits to 100 visits per year with no liberalization of the present stringent requirements to qualify for home health benefits.

Drugs are supposed to be included, but we have no details as to whether the proposed coverage of drugs would equal the legislation which I have sponsored and which has already passed the Senate. We do know that there would be a steep $50 deductible before any prescriptions are paid for.

Finally, it is certainly meritorious that the administration's plan would cover hospital stays without limit for those who require lengthy hospitalization. I have sponsored, and the Senate has passed, legisla-

tion which would improve the Medicare program substantially in this regard by increasing the lifetime reserve and reducing coinsurance charges.

Action to help long-term patients is to be welcomed, but too much emphasis is placed in the proposal on this catastrophic type of coverage while leaving uncovered such needs as routine medical checkups for older people and the provision of eyeglasses and hearing aids.

Mr. Chairman, last year when the administration offered an earlier version of the cost-sharing proposal, you and I and other Members of the Congress took vigorous exception. In addition you and I introduced a resolution calling upon the administration to submit legislative recommendations to improve Medicare coverage, rather than diminish it.

We also expressed opposition to the administration's proposals to increase out-of-pocket payments for the elderly and the disabled under Medicare.

It seems to me that the latest administration plan is subject to much the same objections—and perhaps to new objections—as was the case last year. I will, therefore, follow these proceedings closely, and work with you to assure that a national health insurance program—when it finally comes—results in better health care for the elderly, rather than in a setback for older Americans and all those who worked to enact Medicare 9 years ago.

Senator MUSKIE. Senator Harrison A. Williams, former chairman of this committee, has submitted a statement for the hearing record. Without objection, his statement will be inserted in the record.

PREPARED STATEMENT OF SENATOR HARRISON A. WILLIAMS

Mr. Chairman, your decision to devote 2 days of testimony to the potential effects of the President's proposed comprehensive health insurance program is very welcome.

As chairman of the Senate Committee on Labor and Public Welfare, I am very much concerned about the overall impact that CHIP would have upon health care for all persons in the United States. I am glad to see that it has several provisions which are distinct improvements over earlier administration approaches.

But, as a former chairman of the Senate Committee on Aging and now as its ranking member, I have a special concern about those provisions of CHIP which would change the way in which the Medicare program serves older Americans.

I am the first to admit that Medicare—as it now stands—is in need of improvement. The latest official estimates show that Medicare covers only a little more than 40 percent of medical bills of the elderly. Medicare does not cover such essentials as out-of-hospital prescription drugs, eye care and eyeglasses, and hearing aids—yet the costs to Medicare participants keep going up.

For all of its inadequacies, however, Medicare guarantees most older Americans payment of the bulk of average hospital bills and a large share of doctors' bills.

Obviously, Medicare needs improvement. The subcommittee, for example, has clearly made the case for improved home health care

benefits under Medicare and greater emphasis upon preventive health care services.

I'm all for making Medicare better than it now is, and it is with that viewpoint that I examine the proposed CHIP program.

CHIP—A Fullscale Retreat

After careful evaluation, however, I am forced to conclude that CHIP would be more than a step backward for Medicare; it would be a full-scale retreat.

The most obvious drawback of CHIP is that it would dramatically increase the cost of Medicare for most beneficiaries.

As things stand now, a Medicare patient pays the first $84 of a hospital bill and there are no coinsurance charges until the 60th day. Most hospital stays under Medicare, however, come nowhere near 60 days.

The administration would change this picture considerably. It would raise the $84 to $100, and then it would charge 20-percent coinsurance for every day spent in the hospital, beginning with the first day.

An average hospital stay for a person 65 years or older now stands at about 12 days, according to the American Hospital Association. Under present Medicare, the hospital charge would be $84. Under the administration plan, the average hospital bill could be almost four times that figure.

The fact that CHIP would provide unlimited coverage of hospital and medical charges in catastrophic illnesses after maximum patient charges of $750 is a point in its favor, but this improvement would help only a very small proportion of Medicare beneficiaries.

One part of the proposal which would affect a large proportion of the beneficiaries is the addition of income tests to determine how much of the increased charges aged persons in certain income groups must pay. This, I believe, is a proposal that is extremely ill advised.

One of the key principles of Medicare, as enacted almost 9 years ago, was that benefits should be a matter of right, paid for by payroll taxes during the work lifetime. This principle has worked well and should not be lightly tossed aside in favor of onerous income testing which will complicate and downgrade the Medicare program.

In addition, the Medicaid program which now assists the low-income aged would be gutted and left with only a residual long-term care program. This would reduce the health coverage available to the needy aged in many States.

And with regard to the coverage of out-of-hospital prescription drugs, the CHIP provision for Medicare coverage is welcome. But it requires a $50 per person deductible which still leaves uncovered a high proportion of drug costs for most Medicare beneficiaries.

All in all, the administration's proposal would provide only small additional coverage for a small proportion of beneficiaries. It fails to improve Medicare benefits substantially and increases rather than reduces charges.

Thank you, Mr. Chairman, for the opportunity to present this statement.

Senator MUSKIE. Before we turn to our first witness, Mr. Glasser, I would like to give an opportunity to other subcommittee members to comment on the opening of these hearings.

Senator Pete Domenici has submitted a statement he would like placed in the record. He planned to be here, but had to go instead to a hearing by the Subcommittee on Transportation.

So, without objection, his prepared statement will be included in the record at this point.

PREPARED STATEMENT OF SENATOR PETE V. DOMENICI

I am happy to participate in these hearings concerning the elderly and the administration's national health insurance proposal. Adequate protection against the economic as well as physical consequences of sickness is important to all Americans. For older Americans, though—whose health often fails at a time when purchasing power has also been substantially reduced—comprehensive health insurance is an issue of special import.

We are reminded fairly often of the economic plight of the elderly, but the situation bears repeating. In 1971, more than 50 percent of all older couples had incomes below $5,000 annually and over 20 percent of all older persons were living in poverty. The statistics on the health problems of the elderly are also impressive. For example, about 85 percent of older persons not in institutions have one or more chronic health conditions. Older persons have a one-in-four chance of being hospitalized during a year—this is twice as great as for persons under age 65. Once in a hospital, older persons on the average stay 17.5 days, again twice as long as for younger persons. Older persons are also twice as likely to wear glasses and 13 times as likely to use a hearing aid as younger persons.

Looking at the average older person's health and economic situation together, we see that maintaining one's health in retirement is going to cost more. Unfortunately, it also means that the elderly do not always get the health care they need because of the cost involved.

As if the economic and health problems facing older persons were not enough, in recent hearings before this committee we have heard emphasized other related concerns in the multiplicity of problems faced by older persons.

WEAKNESSES IN MEDICARE PROGRAM

Today we are specifically interested in health insurance proposals to better meet the needs of the elderly. Medicare was a major achievement. After 8 years, we are now, however, aware of some weaknesses in that program. For example, in spite of the statistics I mentioned on chronic illnesses among the aged, Medicare does not cover the cost of dental care, out-of-hospital drugs, eyeglasses, or hearing aids. Medicare contributes only a small amount toward home health care—currently less than 1 percent of all Medicare reimbursements. Medicare also provides inadequate coverage of catastrophic health care needs which causes great fear for many elderly. Neither does Medicare cover preventive health services.

Medicare costs, like other health costs, have been rising, and this is a concern to all of us. We, therefore, must investigate methods to encourage optimum utilization of health services—which is dependent to a great extent on the availability of sufficient and appropriate health service providers, including home-health services. We must also consider covering drugs prescribed by generic name only. As we have the responsibility for apportioning limited funds, we must make sure our programs are designed to achieve the best possible utilization of the Social Security tax dollars.

We also need to understand the economic burden of health care on the individual older person. Even with Medicare, private health care expenditures are still more for older persons than for others. The per-capita figures for fiscal year 1972 were $337 for persons aged 65 and over as compared to $265 for persons aged 19 to 64. In addition, the cost of medicare itself to an older person has risen sharply since its inception in 1966. The premium for part B, supplementary medical insurance, has risen from $36 to $75 annually while the hospital deductible has risen from $40 to $84—both represent over a 100 percent increase.

To help the elderly cope with these health and related financial problems, it is obvious that we need to look closely at the comprehensive health insurance proposals now before Congress, including the administration's national health insurance plan specifically being studied in these hearings.

The results of Congress' work on this issue will have a major impact on our older citizens. Our results must reflect our appreciation of the past and present contributions of today's senior citizens to this Nation, and our understanding of the special problems of this group.

Senator MUSKIE. Senator J. Glenn Beall, Jr., has also submitted a statement for the hearing record. Without objection, it will be inserted in the record at this point.

PREPARED STATEMENT OF SENATOR J. GLENN BEALL, JR.

Mr. Chairman, I sincerely regret that the necessity to be on the Senate floor will make it impossible for me to be present for today's hearings. These hearings are of vital importance because they address themselves to one of the most pressing problems confronting our Nation's senior citizens. Access to health care is of crucial importance to older Americans and this 2-day series of hearings is designed to shed light on the various legislative proposals pending before the Congress that are aimed at paying the bills for senior citizen health care.

The health care issue can and should be approached from two different directions simultaneously. One is obviously the problem of paying the health care bills. Second, and of equal importance in my mind, is the quality, efficiency and effectiveness of our health care delivery system. The hearings today and tomorrow are primarily designed to focus attention on the first aspect of this problem.

Mr. Chairman, I would like to take a minute to discuss a legislative proposal I have undertaken which is designed to grapple with the issue of how our health care services are delivered. On March 13, 1972, I introduced S. 3329, the predecessor of S. 723, and the first bill introduced in the Congress aimed at making research and development in

health care delivery as effective and important a science as biomedical research. S. 3329, which establishes a National Institute of Health Care Delivery, was added to the HMO legislation which passed the Senate in 1972, but final action was not taken on this legislation in the 92d Congress. I then reintroduced the proposal as S. 723, along with Senators Dominick, Hathaway, Hollings, Javits, Pastore, Stevens, and Young. The bill passed the Senate on May 15, 1973, as separate legislation.

"BURIED IN BUREAUCRACY"

When I introduced S. 723 in the Senate, I said the following with respect to the existing research and development effort in health care delivery:

> The Nation's effort in this area is at the National Center for Health Services Research and Development (now changed to the Bureau of Health Services Research). The Center is presently buried in the bureaucracy of HEW. In its present position, the Center lacks visibility and its clout is small. It lacks an effective organizational structure and the flexibility that characterizes many government research and development organizations. It is not funded adequately. Its research function has been shortchanged and over emphasized. It does not even have a legislative mandate. I doubt whether many in Congress other than those with a special interest in health or those who serve on the Health or Appropriations Committees, know the Center exists.

Of special interest to senior citizens, is that portion of the proposed Institute's mandate that would have it develop a policy "with respect to long-term care, particularly for mentally and physically handicapped individuals and senior citizens, with special emphasis on alternatives to institutionalization, including the use of home health aides." Many of the other functions of the Institute would also contribute directly to improving the quality of our health care delivery system and thus improve benefits to our Nation's senior citizens. Needless to say, I was especially pleased when the Senate, by a vote of 79 to 15, passed S. 723. Even though the Congress has not yet completed action on this legislation, I remain convinced that S. 723 best responds to existing deficiencies in our Government's efforts to improve the quality of health care delivery.

Mr. Chairman, I ask unanimous consent that the pertinent portions of Senate Report No. 93–131 be printed in the record of this hearing.

[See app. 1, p. 747, for material referred to above.]

Senator MUSKIE. We have, I think, an excellent list of witnesses this morning. And I am happy to begin with Melvin A. Glasser, director of the Social Security Department of the United Auto Workers.

Mr. Glasser, it is a pleasure to welcome you this morning, and we look forward to your testimony.

STATEMENT OF MELVIN A. GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UNITED AUTOMOBILE WORKERS OF AMERICA

Mr. GLASSER. Mr. Chairman, my name is Melvin A. Glasser and I am director of the Social Security Department of the United Automobile Workers of America.

I welcome this opportunity to testify before your committee on the potential impact on the aged of the administration's proposed comprehensive health insurance program. This is a matter of direct concern to our union. We have over 400,000 retirees and dependents who are covered by Medicare. Our active worker membership of over 1,400,000 also have a deep interest in the Medicare program. Their taxes are paying for Medicare; they have close identification with their fellowworkers no longer in the work force; most of them have parents and relatives covered by the program. Finally, they recognize that at some future date they too will be Medicare recipients.

Prior to the passage of Medicare the UAW was active in legislative efforts to translate the proposal into law. Since 1966, our union has studied the administration of Medicare, followed various proposals to strengthen and to weaken it and appeared before this committee and other committees of the Congress to share our experience and our views.

It was just a year ago that I had the privilege of appearing before this committee to protest an administration proposal to weaken Medicare through transferring insured costs to out-of-pocket payments by the elderly. Fortunately for our senior citizens, that proposal failed.

As I hope to delineate in this testimony, we have before us another administration proposal, in a different guise, and with the same objective. My comments are directed to S. 2970.

Improved Health Insurance Proposal

At the outset may I indicate that the Nixon administration's current proposals (identified with its acronym CHIP), represent an improvement over their national health insurance proposal of 2 years ago. More comprehensive benefits are stipulated. There are more mandatory coverage provisions and substantial improvement in benefit coverages. Unfortunately these improvements contain a good deal more form than substance as I hope to be able to illustrate this morning.

All of us interested in health care are nonetheless grateful to the administration for introducing its proposal. It brings back to first priority for consideration the need for the Congress to act expeditiously on what all parties, regardless of their points of view, have come to recognize as a constantly aggravating health care crisis in this country.

Mr. Chairman, your committee is, by definition, concerned primarily with those public and private health insurance arrangements which affect the health of persons age 65 and over. I have labeled this group the "elderly aged." I would like to suggest, however, that we need also to concern ourselves with an emerging group of persons whom I would define as the "early aged."

The early aged are under 65. Their number is rising. Voluntary early retirement programs, many pioneered by the UAW, are becoming industrywide phenomenons. Chronologically speaking, many of the early aged are in their fifty's. We know that many are in their early sixty's for the majority of those who now take old age retire-

ments under Social Security leave the work force before the age of 65 and are thus ineligible for Medicare for some years.

Another category of the early aged, increasing rapidly in recent weeks as a result of the energy crisis, consists of those who have been involuntarily retired. Last week the Detroit press reported that in the automobile industry, hundreds and perhaps thousands of high seniority nonunion salaried workers had been asked to retire early. These management requests carry a high degree of compulsion since these white collar workers lack the protection of a union contract.

But whether the retirements are voluntary or involuntary, the early aged are in many ways worse off than those who retire at 65 and are immediately eligible for Medicare. The early aged are prime candidates for America's greatest killers and cripplers. Cancer claims 34 percent of its victims among persons between the ages of 45 and 64; 21 percent of arteriosclerosis and hypertension deaths each year occur among persons in this age group.

It is well known that chronic illness and disability do not wait until age 65 to take their toll. For example, 20 percent of the population between the ages of 45 and 64 have some sort of limitation or are unable to carry out their normal activities due to chronic health conditions, compared to only 8 percent of persons between the ages of 17 and 44.

Effect on Early Aged

I suggest, therefore, that in addition to the impact of the Nixon administration proposals on Medicare recipients, this committee would wish to look carefully at the effect of the proposals on the early aged retired who, unless they are totally disabled, are not eligible for Medicare, do not usually have the continuation of their employer-paid insurance, are frequently labeled high medical risks which insurance company secret data banks label as inappropriate for continuing health insurance, and even when they are eligible are forced to pay premiums frequently beyond their financial means.

As for the elderly aged, the excellent work carried out on a continuing basis by this committee over the years has amply demonstrated that while the Medicare program has been of inestimable value to the elderly, its benefits have been slowly winnowed away so that costs have become more and coverages less. In fiscal 1972, the average person past 65 paid out of pocket $42 more for his medical care than in the year before Medicare began.

The cost to the Federal Government of Medicare in the first full year of operation was $4.7 billion. The administration's projected costs for the fiscal year 1975 are $13.4 billion.

Problems of access to physicians and other providers of health care, fragmentation of services, limited and often nonexistent quality controls, escalation of costs, disorganization of services, and the interrelatedness of these factors continue to plague the program and those it is designed to benefit.

The problems we face in Medicare today are well known to this committee. They are relevant to this morning's discussion because they are a reflection of the core causes of the health care crisis in this country. In Medicare, the problems are made more complex by in-

surance-industry-oriented statutory specifications which do not permit organizational change in health services and encourage extravagance and further distortions and fragmentation of medical care delivery. Further, the practices under this program have enlarged and intensified administrative, delivery, and cost problems not only for the elderly but throughout the entire private health sector.

About half of the elderly aged and an unknown though substantial portion of the early aged lack private health insurance protection. For the elderly aged, close to a majority do not have supplemental coverage to Medicare. A substantial portion do not have the income resources required to cover their share of the medical bills, let alone the expansion of those bills under the Nixon administration proposal. In 1972, 19 percent of all persons age 65 and over had incomes below the then established poverty line, and 37 percent of the aged persons living alone had incomes under the poverty level. These persons were at the mercy of State Medicaid programs. Their position will not be improved. Rather, it is likely to be worsened under the administration proposals.

Now, sir, I should like to talk about the CHIP proposal and the elderly aged.

The CHIP Proposal and the Elderly Aged

The administration proposes that Medicare be retained for the elderly aged with modification of benefits to conform with the CHIP programs for the employed and the needy. This basic proviso may for the first time create a situation in which Medicare benefits would be different in different States, for the new plan cannot be operative unless the States pass enabling legislation for the employee health insurance plan and for the assisted health insurance plan (which is designed to replace Medicaid) and for the new Medicare. Arizona today has no Medicaid program. It is therefore possible and likely that they would not pass an AHIP legislation or the enabling legislation for Medicare.

Several other States which have Medicaid programs have high Federal subsidies so that the State's share is quite low. Should they adopt the administration's AHIP plan, their share of the costs would substantially increase. The administration estimates that in the first year, the increased cost to States would be $1,100 million. These States, hard pressed as they are for adequate funds with which to support State programs, would have an incentive to continue Medicaid unchanged, and not pass S. 2970 enabling legislation. In such event, as I read the administration's proposal, Medicare could not become operative in these States. The elderly would simply keep their present Medicare program. This in many significant ways is different from the CHIP Medicare program which would be operative in the majority of the States.

The administration proposal anticipates this in that it provides for preservation of the present title XVIII trust fund to pay for Medicare benefits in States which have not implemented the new programs.

I believe this is a retrogressive step and is a part of one of the basic objections we have to CHIP; namely, that nowhere does the

legislation assure that access to decent health services is a right for all Americans. Rather, it continues to be a privilege for those who can meet the requirements of out-of-pocket funds, State legislation, and Federal strictures.

Disability beneficiaries who only recently have become eligible for Medicare coverage, would lose this eligibility and, under S. 2970 would presumably be eligible for AHIP. In those States which elect not to have AHIP, they would stay with Medicare. In those States which adopt AHIP, they would lose their entitlement as a right, and presumably be subject to the means test provisions of AHIP.

This, too, I believe is retrogressive.

Liberal Benefits Under Medicare?

The administration proposal provides what is claimed to be liberalized benefits under Medicare—and you refer to this, Mr. Chairman—which would conform with the other two CHIP programs. These are in four categories:

(1) Improved mental health benefits. There is some question as to whether the administration's proposed benefit of 30 days of full hospitalization and 60 days of partial hospitalization is better than the Medicare proviso of a lifetime limit of 190 days. In program design, I believe the CHIP benefit is a better one. For the elderly who experience substantially longer periods of hospitalization for mental illness than younger persons, the 30-day limit may in fact affect some of them adversely.

The provision for 15 covered visits for out-of-hospital mental health services from solo practitioners or 30 from organized mental health programs is a good one. It would be if the olderly used these benefits. The UAW has had even more liberal out-of-hospital mental health benefits for its retirees since 1966. This program provides no copayment by the beneficiary for the first five visits and lesser copayments than in the Nixon proposal. Based on careful study of the operation of the UAW program, we have found that for a number of reasons which there is not time to discuss this morning, retirees make exceedingly little use of this out-of-hospital mental health benefit. While the Nixon proposal for mental health benefits is an improvement, it is not likely to involve significant costs because utilization among the elderly can be expected to be exceedingly low.

(2) Prescription drugs. This is an urgently needed benefit which our union has been suggesting for several years and should be added to Medicare. We applaud its inclusion in the Nixon program but are constrained to point out that the requirement that the beneficiary pay the first $50 of such expenses each year makes of this considerably less than appears on the surface. In 1972 the elderly aged spent $90 per capita on drugs and drug sundries. In that year the CHIP benefit would have covered only 44 percent of the average beneficiary's drug expenses.

(3) S. 2970 provides no limit on hospital days, after the deductible and coinsurance sums are paid. Medicare provides for 90 days per year of coverage plus a one time additional 60 days. I shall deal with the cost effect of this new proposal a little later. You have already

referred to the fact that only about 1 percent of the elderly use the benefit for 60 days or more. So, in essence, 99 percent are being asked to pay more so that 1 percent might benefit.

(4) Catastrophic coverage. Beneficiaries would pay 20 percent coinsurance up to a maximum liability of $750 a year. This is designed to assure the elderly aged that they would not be bankrupt by excessive medical payments. However, it is estimated that in July of 1974 the average Social Security benefit will be $181 per month for a single person and $310 for a couple. If indeed an elderly person had to pay $62 a month from the meager income I have cited, his would be a catastrophic situation in the first month, not after he reaches the $750 maximum. In addition to this maximum, the beneficiary would have to pay the monthly Medicare part B premium, and he would also pay for other medical expenses for benefits not covered by the program.

"Cosmetic" Illness Protection

It would appear that this so-called catastrophic illness protection for the elderly aged is largely cosmetic.

Almost everyone concerned with the adequacy of health services recognizes the need to include preventive services. The CHIP plan recognizes this need and discriminates against the elderly in its benefiit structure. Eye examinations, developmental vision care, eyeglasses, ear examinations and hearing aids are covered for children up to age 13. But, as this committee well recognizes, the major problems in vision care and hearing and the major need for eyeglasses and hearing aids is not among children. It is among the elderly. They are not eligible for these benefits.

The elderly under the CHIP plan would be eligible for post hospital extended care of 100 days per year. They would be better off without CHIP. Under Medicare they are eligible for 100 days of post hospital extended care per benefit period. Since there is a 90-day corridor in Medicare, it is not infrequent that an elderly person would receive more than 100 days per calendar year under the present program. These "extra" days now possible under Medicare will be lost under the administration's program.

Mr. Chairman, you cited the figures of how much greater the charges would be for hospital care to the elderly under the President's proposal than under Medicare. I shall not repeat these figures. But the situation is even worse than it appears.

Under the CHIP program, physicians are required to accept reimbursement in accordance with State fee schedules as payment in full for all patients under Medicare, and under AHIP. Under the employee plan—that's for the workers—they would receive the same payments, but be permitted to bill additional sums to the patient. This would appear to be a seemingly invidious means of reimbursing providers. Older people already have great difficulty in finding physicians who are willing to provide care for them. Now the administration is proposing in essence to set up a two-class system: those who could pay the doctor more, and those for whom the doctor cannot charge more. We have had very considerable experience to demonstrate that this will

make it more difficult for elderly persons to find physicians willing to treat them. Furthermore, from our experience with some of the present organized medical programs we know, too, that once a physician is provided two levels of payment for the same service, the patient who pays the lesser sum inevitably receives less attention and poorer quality care.

The unfortunate way in which the elderly aged would be taken advantage of in this new proposal is further illustrated by the increase in premiums. As of July 1, 1974 the Medicare part B is slated to be $6.70. Under the CHIP program it would be $7.50 per month.

From a fiscal standpoint we see liberalized benefits, which in substantial measure are cosmetic, increased out-of-pocket payments by the beneficiaries, and a continuation of the present Medicare tax of 1.8 percent on income up to $13,200 on employees and employers. Spokesmen for the administration have claimed that their new proposal for the elderly is a more expensive package than the current program. We find the evidence does not appear to support this claim.

Voluntary Participation in AHIP

Those under 65 on voluntary or involuntary retirement who are on low or marginal incomes, which is the case in most instances, would presumably be covered by the AHIP. The States could contract with insurers for Federal-State subsidies for coverage for these persons, but participation in AHIP would be voluntary. Given the cost requirements of this plan, millions of poor people are likely to decline participation either because they would not have the funds to pay for participation or because they do not wish to subject themselves to demeaning means tests.

Most State Medicaid programs do not impose deductible and copay requirements on their enrollees. The early aged as well as all other eligible in AHIP would now have the privilege of paying these deductibles and coinsurance. Patient cost sharing features of AHIP are scaled to individual and family income. Two examples:

(*a*) Under the Nixon plan an early aged family with an annual income up to $2,499 would have to pay a direct coinsurance of 10 percent for all medical care and charges received up to a maximum of 6 percent of income. A family with $2,400 income would pay 10 percent coinsurance or $144 per year maximum.

(*b*) Under the Nixon plan a family with $3,000 income—family of four—would be obligated to make annual cash payments of up to $270 per year. Thus the poor and many of the early aged would be worse off under these proposals.

Furthermore, the CHIP plan does not take into account the fact that large numbers of these unemployed, marginally employed or early retired persons do not lead routinized or systematized lives. They simply do not have the personal life structure to participate in an insurance scheme requiring regular premium payments, deductibles and coinsurance. Many of these people will simply fall by the wayside, outside the system.

A major justification by administration spokesmen for the so-called cost sharing by the consumer is that it will prevent excessive demand and require the consumer to shop for the least expensive health care.

These claims ignore the basic fact that approximately 80 percent of all health care costs are controlled today by physicians, not consumers. They place people in hospitals and nursing homes and discharge them; they order prescription drugs and no one else can. Further, it is exceedingly naive to suggest that consumers have free choice to shop among physicians or hospitals to choose the best at the lowest price. Those who make such assertions have not tried to do so. And I suggest, Mr. Chairman, that perhaps when the administration comes here, you might ask them.

Despite long dicussions on the subject, and the number of studies, there is no definitive evidence to demonstrate that coinsurance and deductibles reduce the cost of health care, unless the coinsurance and deductibles are sufficiently high to deter needed preventive services, early diagnosis and treatment.

Administration Ignores Recommendations

The Medicare program under the Nixon plan would continue to be administered directly by the Social Security Administration through the present system of private insurance company fiscal intermediaries. The administration has chosen to ignore recommendations from its own Health Insurance Benefits Advisory Council beginning in 1968 which raised questions as to the appropriateness of using these fiscal agents.

These questions derive from concern as to the effectiveness of these fiscal agents in both cost and quality control. Subsequently, many more questions have been raised by reports of the Comptroller General of the administrative practices of these fiscal agents. The handling of Medicare funds by the private fiscal intermediaries—that means insurance companies—has been characterized by the Senate Finance Committee staff (in a 1970 committee report) as "erratic, inefficient, costly and inconsistent with congressional intent." But the administration is wedded to the private health insurance industry.

The total CHIP plan will double the annual income of the $26 billion insurance industry within a few years. Fully 15 percent of all the money collected will never reach the health care system. It will be retained by the insurers for overhead costs and profits. The 15 percent figure was given to the Congress by the administration. The insurers will keep more than $7½ billion and pass along the rest to the doctors and hospitals without any real controls over costs or quality of services. The incentives will be to inflate costs even further since the insurance retention—profits, et cetera—will increase accordingly.

The administration claims that the insurance commissions in the 50 States would control the charges and costs of insurance carriers for the EHIP and AHIP programs. In most States these controls are nominal to nonexistent and what controls there are vary among the States. Neither the record of the insurance industry to date—and I have substantial evidence on this, Mr. Chairman—nor the control mechanisms available to insurance commissioners indicates any evidence they have been able to have any meaningful influence on the skyrocketing costs of health care in the last decade or on the often questionable quality of that care. Yet the administration in its new proposal suggests we have more of the same.

S. 2970 would turn over many more billions of dollars to the insurance companies and through them to the providers of care, and the consumer is completely left out. He is given no direct voice at any point in the system, except the opportunity to foot the bill.

As one looks at the elderly's needs and their search for access to decent health care, certain characteristics merit attention:

The elderly believe that a lifetime of work and payment of taxes gives them the right to expect assured access to health services. S. 2970 does not assure that right, particularly for the early aged.

Basic Problems Unsolved

The elderly have trouble finding physicians who will care for them. The Nixon bill will worsen this situation.

The elderly are having increasing problems in meeting the out-of-pocket expenditures under Medicare. Their position would be even worse under CHIP.

The elderly want to feel they can readily seek out health services when they are worried about the many symptoms of ill health that are a part of the aging process. The Nixon plan sets up new barriers to early access to care.

The elderly are concerned about whether they are getting the right kinds of services, delivered in the right way. The administration is suggesting that untried physician controlled Professional Standards Review Organizations will deal with the quality problem. This concept opposed by many physicians and consumers alike does not appear to have a very good prognosis.

The elderly seek care centrally offered and easily available. The Nixon proposal does nothing about making these health services more readily available through system reorganization.

The elderly are deeply worried about problems of long-term custodial care. The Nixon plan does nothing about this and in fact reduces extended care benefits.

Because the Nixon program does little about the basic problems that are the causes of the present crisis in health care for the elderly and for all other Americans, it cannot be considered a meaningful approach to solution of these problems. The evidence, I believe, is substantial that it will exacerbate these problems through providing more limited benefits at higher costs to the elderly.

But there are constructive alternatives, Mr. Chairman. They lie in the adoption by the Congress of a comprehensive health security proposal which would provide universal access to health services for all Americans and which would make possible major changes in the delivery system and in cost and quality controls. Such a program is within the economic means of our country. In fact, immediately and over time, S. 2970 is likely to cost Americans more for fewer benefits than the health security program. It is possible to bring about comprehensive change which would help the elderly and all Americans within the parameters of what this country is now spending for health care. The program proposed in S. 3, the health security program now before the Congress is considered by our union to be a realistic and constructive approach to dealing with the basic causes of the problems with which we are grappling in these hearings. After re-

view of the CHIP proposal, we believe it becomes even more evident that health security is the far more realistic approach.

The elderly and this country need more than just a CHIP. We need a whole health program, Mr. Chairman. I hope these hearings will illuminate that need.

Senator MUSKIE. Thank you very much, Mr. Glasser for your excellent statement, which meets our high expectations for your testimony today.

Mr. GLASSER. Thank you.

Senator MUSKIE. You have anticipated many of my questions, but let me touch on a few points for emphasis, if I may.

You have given us your evaluation of the health insurance industry record on cost control by testifying that the industry gives no evidence of effective cost control.

NO ROLE FOR INSURANCE INDUSTRY?

Do you think it would be possible to integrate the resources of the health insurance industry and a national health insurance system without compromising cost control reforms?

Mr. GLASSER. My answer to you, sir, is no. I have studied this problem for some 12 years. Our committee for national health insurance has had a committee of technical experts studying the problem for some 5 years.

We are absolutely convinced by the very nature of the structure of the insurance business that it is not possible to turn over the administration of health care and insurance benefits to an industry which is primarily profit-oriented, which does not have the means for control, and expect control.

The evidence is a little startling, Mr. Chairman. The best segment in the sense of the industry is Blue Cross-Blue Shield, which is nonprofit. In the last 3½ years, for Chrysler workers in Michigan—that's our largest work group in the auto industry—for the same benefits the costs have gone up 92 percent. Premium costs have increased 92 percent in the last 3½ years. That far exceeds the curve on the national increases in health care.

The insurance industry is an industry that is devoted to the exchange of dollars. You give them so many dollars, they try to husband them and pay out so many dollars.

What we need is a health care administration system. The insurance industry has done nothing—zero—absolutely nothing about protecting the quality of health care. One of the simplest criteria of quality of care is accreditation of a hospital by the Joint Commission of Accreditation of Hospitals. At this point, after some 28 years in the business, between 1946 and 1973, no major insurance company requires accreditation of a hospital, so they pay on an equal basis to both a charnel house or a reasonably good hospital.

We have not in our experience been able to get any kind of quality control from the private health insurance industry. We have not been able to receive any kind of scripture on cost controls, and the record in our industry—and in the country in general—reveals that though they are interested, they do not have the capacity. And the notion that the administration would give to this industry twice as much money with

practically a guarantee of no risk loss—and then give them, in fact, this huge new profit administrative cost—is abominable.

Let me cite just one other figure and then I won't make any further speeches in response to a simple question.

Between 1970 and 1973, the administrative costs and the profits of the private insurers in this country, health insurers, grew 120 percent from $1.5 billion to $3.3 billion, this under cost control. It has been estimated that the CHIP proposal would double the $26 billion income of this industry in a few years.

Senator MUSKIE. Would, in your opinion, the administration's proposal change significantly the total amount of money from all sources that America now pays for health care?

SAME PREMIUM FOR ALL WORKERS

Mr. GLASSER. No, sir, I don't believe it would. The total amount of money that America pays for health care would continue. It would come different ways into the system. There would be further retrogression in the way in which the money is introduced in that the mandated premium would be the same for a worker who earns $7,500 a year as for a worker who earns $75,000 a year. There would be more out-of-pocket expenditures by the elderly. There would be more out-of-pocket expenditures by the poor, but the total would come to about the same.

Senator MUSKIE. Do you think it is possible to construct a national health care system which would increase the amount of health care Americans receive, and with a decrease in total cost?

Mr. GLASSER. No, I do not, sir. However, there has been a design developed for a national health insurance program which would provide substantially more benefits more effectively at approximately the same cost.

It is not our belief that we can get "economy" medical care. I do believe that through spending our money with better controls on cost and quality through the development of annual budgets that it is possible to take the dollars we are now spending and buy substantially more Medicare.

Senator MUSKIE. One problem that troubles the elderly is the fragmentation of the health care system, and their need to find services from a variety of uncoordinated institutions, and a variety of locations.

Do you think that the administration's plan contains proposals to correct fragmentation of health care?

Mr. GLASSER. No, sir, as a matter of fact, the administration's proposals go counter to integrating the health care structure. Please let me indicate to you, sir, that no week goes by that we do not have calls from those who are elderly and cannot find their way into the system. They can't get to doctors; or they can't get into a hospital; or, they have been referred to a specialist and they have no transportation. We are all too aware of the serious problems caused by fragmentation.

The President has signed into law the HMO legislation which passed both Houses of Congress. This bill provides also that employees, and others covered by the plan, may choose an HMO as an alternate means of care. But since the mandated benefits of the legislation now on the books are greater than those in this administration proposal, the ad-

ministration's proposal, if enacted, would submarine legislation now in the books given the lesser requirements. Furthermore, there is nothing in this legislation, aside from this HMO, that would do anything about bringing services together, making them more readily available in one place for the elderly, and increasing the availability of physicians and other health care providers whom the elderly simply cannot find.

Senator MUSKIE. Do you believe that the Medicare program coverage needs improvement rather than constriction? What is your view on that?

THREE MAJOR ALTERATIONS NEEDED

Mr. GLASSER. Our union, Mr. Chairman, feels very strongly that the Medicare program needs three major alterations. The first is a substantial improvement in benefits with the removal of economic deterrants to early diagnosis and treatment. The medical profession has told us that for 50 years, but somehow it hasn't reached their legislative agents in the Congress.

Second, the program needs to be integrated with the total program of health care for all Americans. At present, it is disfunctional and costly to provide medical care for the elderly as though they are the only ones in America that have problems.

Finally, it is our firm belief that if these programs were integrated with a comprehensive program containing a single uniform system of financing, the elderly would be infinitely better off.

Senator MUSKIE. The administration's proposal as described includes a prospective reimbursement system for hospitals.

In your view, is that a valuable device for increasing cost control?

Mr. GLASSER. Mr. Chairman, I have on many occasions testified in various places for a prospective reimbursement of hospitals. But I have also testified, and it has been our union's position, that it is not possible to control one piece of the system unless you look at the entire system as well.

Hospitals need to be on a budget. But so do extended care facilities and physicians. If one only controls a piece of the system, the costs in the remaining pieces are expanded. For example, if hospital costs are held down, nursing home costs escalate. This is not a theoretical discussion, Mr. Chairman; this has been our experience.

Last year, the Health Benefits Advisory Committee recommended to the Cost of Living Council, of which I am a member, that there be certain controls. The controls on physicians' charges were 2.5 percent. The controls on hospital charges were 6 percent last year. Everybody felt this was good fiscal policy as, in fact, both the hospitals and physicians stayed within their respective limits. Nevertheless, the total cost of health services went up 11.1. Well, it takes some strange kind of arithmetic to figure out how to average out 2.5 percent and 6 percent to come out with 11.1 percent.

What this illustrates at the national level is that any attempt to control a piece of what is in fact a total system simply means disproportionate increases elsewhere in the system. Consequently, I am for prospective budgeting of the total system. I think it is disfunctional to try to do it with one piece.

Reform of the Health Delivery System

Senator Muskie. That makes sense. Could I ask what provision should be included in the national health insurance plan to stimulate reform of the health delivery system?

Mr. Glasser. For those of us who have addressed the dilemma of health care delivery, it has become patently clear that such a system must provide access for not only the elderly but for all Americans.

It should have comprehensive benefits with no organizational or economic deterrants to early diagnosis, treatment and a full range of health care services. It should have controls on the cost for the budget for the whole system.

It should have effective controls on quality. Under the present delivery structure, the consumer is almost the last person to evaluate whether his services are any good. If he survives the medical care system, he obviously thinks he is in good shape. If he dies, he can't complain. The old marketplace caveat. "Let the buyer beware," has no place in health care. We need effective quality controls.

It should have financial and other incentives to restructure the system and thereby eliminate the fragmentation to which you refer.

It should have uniform and equitable financing, as well as multiple and diverse delivery patterns within a single financing system. We need centralized regional and local administration. We need mechanisms to assure that benefits which have been promised in the program will be delivered—which is not mentioned in the Nixon bill. And we need something else the Nixon bill neglects: effective consumer participation at each important level of policymaking. They are the people who pay for the program. They are the people who will receive the program. They ought to have their say on how it develops.

Senator Muskie. One final question. You say that the administration proposal does not assure access to decent health services as a right for all Americans. Rather, you say, it continues to be a privilege.

I would like to emphasize that and ask you to comment on the cost-sharing parts of the administration proposal in the light of the goal of making good health a right.

Mr. Glasser. This is one of the reasons, sir, that we have such strong reservations about the health insurance industry.

The insurance industry approach, in essence, equates insuring for access to good health with insuring one's home against fire or automobile against collision. They use the same principle for all situations.

Cost Sharing Deters Services

But we don't believe in the universality of this principle. We have been taught that early diagnosis and treatment are essential. Cost sharing—a key ingredient of the insurance principle—deters these services. If the cost sharing is minor, it doesn't deter it, but then there are no economic savings. So one increases the cost sharing which drives people from the system. We believe that access to health care has to be direct and quick, and we believe that the present system is not providing that access and that Mr. Nixon's plan will provide even less access.

We believe that the whole notion of cost sharing is some kind of an Alice in Wonderland thing that somebody has dreamed up. I would ask, Mr. Chairman, as I alluded to in my testimony, that we ask somebody in the administration to pick up the telephone, call seven doctors listed as surgeons in the Washington telephone book and say, "Dr. Surgeon, I need an appendectomy; my GP told me so. Because I am in a cost-sharing plan, I need to know how much you charge so I can compare your price to seven other fellows. The guy with the lowest price gets my business."

Finally, assuming he gets answers, he picks Dr. X. Now he must call seven or eight hospitals in Washington, D.C., to get their prices. This may seem ludicrous but this is an essential part of the Nixon plan. Our conscientious consumer calls these hospitals and says, "Hospitals, what do you charge for a semiprivate room, use of the surgery, X-rays, posthospital care, and any ancillary services?" and he lists all of them. Gentlemen, I've tried it and found that won't get the information you need.

But the problem doesn't end here. Our consumer must call the surgeon of his choice and say, "Dr. Surgeon, I picked you because you were the surgeon with the lowest price. I have picked hospital X because it has the lowest prices. I am ready to have my surgery." What does he then say when the surgeon says, "That's fine, but I'm not even on the staff of that hospital."

End of comment.

Senator MUSKIE. Thank you.

Senator Chiles.

Senator CHILES. I don't have any questions. I am delighted to read your statement. Thank you, sir.

Senator MUSKIE. Thank you very much, Mr. Glasser.

The next witness is an old friend who has appeared several times, Nelson Cruikshank, president, National Council of Senior Citizens.

Mr. Cruikshank, it is a pleasure to welcome you this morning to receive your testimony.

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

Mr. CRUIKSHANK. Thank you, Mr. Chairman, members of the subcommittee, it is always a pleasure to be before you, Mr. Chairman.

My name is Nelson H. Cruikshank. I am president of the National Council of Senior Citizens. Our national headquarters office is at 1511 K Street NW., Washington, D.C.

This is a nonprofit, nonpartisan organization of older people's clubs, with members in all States. The members of our more than 3,000 affiliated groups were in the forefront of the long campaign, alongside organized labor and other humanitarian groups, for the enactment of Medicare. In fact, the late President Lyndon Baines Johnson in a White House announcement on June 28, 1968, said: "Without the National Council of Senior Citizens, there would have been no Medicare."

You can understand therefore that we are particularly grateful for the opportunity to present the views of the national council with

respect to the administration's health insurance proposals particularly as they would affect the elderly and as they would cut back and weaken Medicare. The subcommittee is to be highly commended for its vigilance over the hard-won Medicare program and its perseverance in cutting through the formidable rhetoric to assess the claims of Medicare proposals.

The national council, having been born in the long legislative fight for Medicare, is greatly concerned with improving the Medicare program and safeguarding it from adverse proposals disguised as improvements.

CHIP—A Monstrosity of Multiple "Systems"

While I shall direct the major thrust of my testimony to the Medicare provisions of the President's proposal, I feel it essential first to assess the overall proposal labeled a Comprehensive Health Insurance Plan.

Why is it essential to look at the proposal as a whole? Because the goal of the National Council of Senior Citizens—and this was the goal enunciated by the 1971 White House Conference on Aging—is that health care for the aged be provided as an integral part of a coordinated system that provides comprehensive health services to the total population.

Under such a coordinated delivery system, everybody—rich and poor, old and young—would be assured of continuity of care for both short-term and long-term medical conditions. The system is concerned only with optimum care for the condition, not with the patient's age or finances.

And what does the President offer us instead? A monstrosity of multiple systems. "Systems," however, may be too kind a word since it implies organization. To administer the President's proposal would require a total of 154 systems in the continental United States alone.

Each of our 50 States and the District of Columbia would administer one bill-paying plan for the fully employed and another for those under 65 deemed to need assistance in paying their medical bills. These jurisdictions would still have to have a Medicaid program for certain benefits not otherwise covered, especially those essential to long-term care.

I am assuming in this count that all States would wish to cooperate in CHIP. But what if they didn't? Medicare would continue to be federally administered but the provisions relating to the low-income aged would, in effect, require that we then have two Medicare systems. And, of course, such a fragmented approach to the health needs of the Nation leaves outside the CHIP umbrella the separate health care systems of the Indian Health Service and the Veterans Administration.

Imagine the confusion as the individual goes from employed to unemployed status, moves up or down the income ladder, changes his State of residence, or celebrates his 65th birthday.

In short, the President has rejected the principal of a single universal system for all—old and young, rich and poor. Through an income test as well as the criterion of age, the White House proposes

various systems which would perpetuate invidious distinctions in health care and which, even in combination, would fall short of the goal of universal coverage.

CHIP Fails To Protect the Working Population

I have said that the National Council of Senior Citizens was born out of the fight for Medicare. I would stress that as an organization of older persons we would never have achieved Medicare were it not that the workers of America provided wholehearted support in the drive to push the program through the legislative process. Workers—younger and older alike—supported Medicare because they saw protection against medical costs in old age as an important right for their future retirement years as well as an immediate need for their aged parents.

Today, we of the National Council of Senior Citizens are equally concerned that the Nation embark on a national health insurance plan that will provide meaningful protection for workers and their families in their younger years as well as in their old age.

We find the President's proposal sadly lacking in this respect. This proposal does not protect against the medical costs that plague the average worker's family and too often serve as a barrier to timely care.

As an example, according to an analysis recently issued by the executive council of the AFL–CIO, a family of four with an annual income of $10,000 would spend the following for health care in a year under the Nixon plan before receiving any benefits:

Premiums (35 percent of average premium of $475 a year)	$166
Medicare tax (.9 percent of $10,000)	90
Medical deductible ($150 per person, maximum of $450 per family)	450
Drug deductible ($50 per person, maximum of $150 per family)	150
Total family expenses before receiving benefits under Nixon program	856
Plus Employer premium (65 percent of $475 a year)	309
Plus Employer share of Medicare tax (.9 percent of $10,000)	90
Total expenditures before eligibility for benefits under Nixon program	1,255

You will note then, total family expenditures of $856 plus employer premiums and employer's share of Medicare tax make a grand total of $1,255.

For the next $900 in medical expenses, the worker must pay $225. In other words, the Nixon plan would require an employee and employer to make a total expenditure for health—including premiums, taxes, deductibles and coinsurance, of $1,480 a year for $675 in benefits. Only after a family had spent $1,500 a year out of its own pocket for medical care—not including premiums or Medicare taxes—would 100 percent benefits be paid.

However, fewer than 2 percent of the people covered would have medical expenses in excess of $1,500 a year and, therefore, be eligible for full benefits. And the administration admits that 75 percent would not have medical expenses exceeding the deductibles and would not receive any benefits from the program in any given year.

Even at that, not everything is covered. Specifically, services not under the Nixon plan for employees are physicians' charges in excess of fee schedules, physical examinations for adults, dental, and eye care for persons over 13, and extended care over 100 days. These costs alone would strap the budgets of many families.

The administration recognizes that the time is ripe for national health insurance, but it would merely attempt to patch up the present "nonsystem" in a half-hearted way. Primary reliance would continue to be placed on the private health insurance industry—the shakiest pillar in the whole health structure—thus inviting rising fees and increasing the profit bonanza for the insurance industry.

Nowhere has the President or his spokesmen indicated that this program would assure access to decent health care as a matter of right for all Americans.

Medicare Undermined by CHIP

Of more immediate concern to millions of elderly people in the country whose interests are the interests of the National Council of Senior Citizens which I represent is the effort reflected in the President's proposal to alter profoundly the basic purposes and concepts of Medicare.

That there are weaknesses and shortcomings in the Medicare program I would be the last to deny. And your charts, Mr. Chairman, have documented and illustrated this in an admirable way. But the President's proposals attack these shortcomings by compounding them rather than getting at their root causes and seeking a cure.

For example, surely one of the major shortcomings of Medicare is the fact that it leaves—as your chart demonstrates—a significant part of the medical and hospital bill of the older patient to be paid out of his own income. The proportion of the total health care cost covered by the program has actually declined since its beginning due to increases in deductibles and coinsurance amounts, but more particularly as a smaller proportion of doctors have been willing to accept payment by the assignment method and have added more and more to their charges above the "reasonable charge" as determined by the law.

The Nixon proposal to meet this shortcoming is to add to the deductibles and coinsurance amounts resulting in even a smaller proportion of the total bill to be covered.

Again it is claimed the present program costs are excessive because hospital services are overutilized. The Nixon plan has a cure for that too: namely, to require the patient to pay 20 percent of each day's costs out of his own pocket above the $100 deductible subject only to the limitation on maximum liability. In short, make hospital care so costly to patients that they will plead with their doctors not to commit them to the hospital except in cases of urgent need. And when hospitalization is unavoidable patients would seek to be sent to the cheapest hospitals.

All this of course is further predicated on the notion that hospitalization is elective on the part of the patient. It undermines the concept that commitment to the hospital and the choice of the hospital should

be primarily a medical determination that can properly be made only by the doctor.

The accompanying three tables illustrate the impact of these so-called "cost sharing" and "utilization control" devices for that portion of the Medicare covered population not eligible for income-related reductions.

Rise in Out-of-Pocket Expenses

Table I shows the out-of-pocket costs under the existing Medicare program for covered medical and hospital services by size of medical service bills and number of days in hospital at $110 per day.

TABLE I

	Days in hospital—					
Medical services bill	0	5	10	20	40	80
0		$84	$84	$84	$84	$504
$50	$50	134	134	134	134	554
$100	68	152	152	152	152	572
$200	88	172	172	172	172	592
$400	128	212	212	212	212	632
$800	208	292	292	292	292	712
$1,600	368	452	452	452	452	872

Table II shows the out-of-pocket costs for the same services under the Nixon proposal.

TABLE II

	Days in hosptial—					
Medical services bill	0	5	10	20	40	80
0		$190	$300	$520	$750	$750
$50	$50	200	310	530	750	750
$100	100	210	320	540	750	750
$200	120	230	340	560	750	750
$400	160	270	380	600	750	750
$800	240	350	460	680	750	750
$1,600	400	510	620	750	750	750

Table III simply translates the data of tables I and II in terms of percentage increases (or decreases) in out-of-pocket payments under the Nixon Medicare proposal as compared to those under the present Medicare program.

TABLE III

[In percent]

	Days in hospital—					
Medical services bill	0	5	10	20	40	80
0		126.2	257.1	519.0	792.9	48.8
$50	0	49.3	131.3	295.5	459.7	35.4
$100	47.1	38.2	110.5	255.3	393.4	31.1
$200	36.4	33.7	97.7	225.6	336.0	26.7
$400	25.0	27.4	79.2	183.0	253.8	18.7
$800	15.4	19.9	57.5	132.9	156.8	5.3
$1,600	8.7	12.8	37.2	65.9	65.9	−14.0

Under table I, take a person with 10 days in the hospital with a $400 medical bill, he would today pay out-of-pocket $212 under the present program.

Follow those same axis in table II, the Nixon proposal of $400 medical bill and 10 days in the hospital, he would pay not $212 but $380.

And when translated into percentage that means it is a 79-percent increase in his out-of-pocket expenses.

A person with a 20-day hospital $200 medical bill would, under the present program, pays $172. Under the Nixon program, $560, or 225.6-percent increase in out-of-pocket expenses.

These tables make it clear that only those persons experiencing catastrophic health costs would be better off under the President's proposals. Such cases represent a very small proportion of the total number of persons covered under the program, as according to your charts, Mr. Chairman, about 1 percent.

Insurance, whether private insurance or social insurance, should be designed to protect the great majority of the covered population against the most common risk, rather than just the exceptional cases.

I remember, gentlemen, sometime ago seeing in the New Yorker magazine an excellent illustration of just what I am talking about.

It was a cartoon of a man reading over his medical insurance policy. He said to his wife, "Look, honey, we get $50,000 if we are run over by a heard of elephants on Fifth Avenue." [Laughter.]

That is just about what the Nixon proposal does. If something happens to you that happens to less than 1 percent of the people, you get a little better protection.

Senator MUSKIE. Mr. Cruikshank, wouldn't it be accurate to say that depending on what is the definition of catastrophic, not all of those who suffer catastrophic expenses are covered by the Nixon administration's proposals?

Mr. CRUIKSHANK. That is exactly right. Mr. Glasser pointed out very effectively, I thought, that for low-income people even these $300–400 costs can be catastrophic, and they would not be covered under the Nixon proposal.

You are quite right, sir.

The President has described his program as one which "improves" Medicare, but its guiding principle seems to be to take a lot from a great many in order to give a few people very little.

VIOLATION OF SOCIAL INSURANCE PRINCIPLES

It is obvious that many of the elderly presently under Medicare could not possibly pay the drastic increases in cost of care indicated in the accompanying tables. It was apparently obvious—even to the administration—that provision had to be made to help the low-income groups. This was done by making further changes in the program to provide sliding scale deductibles, coinsurance and premiums based on income.

The National Council of Senior Citizens has long led the fight for adequate protection against the medical costs that plague so many of our low-income elderly. But we want this protection through an expanded social insurance system that respects the dignity of the individual without subjecting him to an income test.

In contrast, the President's proposal undermines the basic purposes and principles of Medicare in three very significant ways.

First, the main reason for the enactment of Medicare was to give to the elderly, most of whom are retired, the same basic insurance protection against the costs of illness and the indignity of a means test that

was enjoyed by most people still in the working age group. The Nixon proposal flies in the face of this insurance concept and in its place offers certain protections the entitlement to which rests on proof of low income. Thus it would substitute the principles of welfare for the sound and proven principle of social insurance with entitlement as a right based on contributions made during the beneficiary's working years.

Second, the proposal in a real sense denies earned rights to any individual who, in his working years, has paid Social Security Medicare payroll taxes. And the higher his pay, the more likely he is to have income above the amount under which he would be eligible for the income-related reduction in payments. So the Nixon plan works out that the higher the contribution paid, the lower the benefits provided. If it should ever unhappily become the policy of this Government to provide medical care for the elderly primarily through a system of income-related welfare benefits, the program should at least be consistent and be financed as other welfare programs are; namely, out of general revenues rather than by a payroll tax.

Looking again, gentlemen, at this proposal, it brings to mind that there are two basic ways of attacking the problem. One is through welfare with its income test and its means test, and another is through the principle of social insurance. Both of them have some weaknesses and shortcomings. The Nixon proposal has the shortcomings of both systems.

Third, the Nixon proposal penalizes those individuals who by their own efforts individually or collectively have made supplementary provision for their security in old age. The basic Social Security program encourages individuals to add to their protections through such means as private savings, homeownership, and private pensions. The benefits under the Social Security program are not denied or reduced in the case of individuals who have made such provision. But this proposal would, in effect, say to the person who had, by means of acquiring a skill or by the provisions of a collective bargaining agreement, improved his wage or secured a private pension program, that he was ineligible for the basic protections of the system. This runs counter to the concept of our whole free enterprise system. Under that system, people are encouraged to improve their lot rather than being penalized for having done so.

Administration Proposal—A Step Backward

In fact, placed in the perspective of the historical development of our Nation's income maintenance programs, the administration proposal would mark the first step backward. In 1950, the Congress approached the problem of disability by authorizing grant-supported public assistance payments to the permanently and totally disabled. After 6 years of experience, the Congress moved forward and adopted payments to the disabled under the social insurance program.

In 1960, Congress attempted to meet the problem of medical care of the elderly by setting up a network of State-aided welfare payments for the so-called medically indigent. This it did through the Kerr-Mills Act. After 5 years, the inadequacies of this approach, together with public awareness of the indignities attached to a means test pro-

gram, prompted Congress to move forward from the concept of public welfare to the concept of social insurance. The result was the adoption by Congress of the Medicare Act in 1965.

While far from perfect in its operation, the Medicare program, in the nearly 8 years of its existence, has proven the wisdom of this forward movement. But now this administration would have us go backward. Back to the ideas that were abandoned in 1965. Back to the concept of public welfare as against social insurance.

I mentioned before that the President had described the changes proposed in the Medicare program as "improvements." As we examine some of them, they hardly seem to fall into this classification.

For example, among the proposed changes are cutbacks in the crucial home health services which have not been adequately utilized as an alternative to institutionalization. Home health services would be cut in half to 100 visits as opposed to the current provision of 100 under part A and 100 under part B.

Coverage for out-of-hospital prescription drugs has been a top priority goal for the National Council, but we have serious reservations about the provision in the administration bill because the all-important reimbursement format would be left to the discretion of the Secretary of HEW. Drug coverage would have a $50 annual deductible and 20 percent copayment for additional bills under the basic Medicare proposal. Moreover, when the Secretary appeared before the Health Subcommittee of the Senate Committee on Labor and Public Welfare last December and announced his plan to limit reimbursements for drugs to "the lowest cost at which the drug is generally available," he made it clear that it was his intention in all Government programs when the physician prescribed drugs at higher prices—or under trade names—the difference in cost would have to be borne by the patient. His proposal, therefore, when applied to Medicare might represent a saving to some taxpayers, or to the trust fund, but it would result in additional out-of-pocket expenses to the beneficiary.

Worst off under the administration proposal would be the disabled and persons with chronic kidney diseases who had Medicare coverage extended to them in July 1973. These people would completely lose Medicare benefits.

Any protection they might have would be dependent upon the State adopting an approved program.

Controls "Virtually Nonexistent"

President Nixon claims his program would control costs and quality of care. The fact is that cost and quality controls are virtually nonexistent. Completely ignored also is consumer participation.

It is largely self-defeating to pay out insurance money to health care providers without demanding quality and efficiency in return. After almost 8 years of experience with Medicare, Government officials should have learned that if you pour money into the health system without controls you can just get inflationary increases in charges and little or no organization improvement.

These are some of the major cutbacks in the present Medicare program that would result from the enactment of the President's so-called comprehensive health insurance plan. In the face of almost

universal recognition of the need for improving and strengthening the program he comes forward with proposals that would, for a very large proportion of the presently covered population, weaken and narrow it. These cutbacks are papered over with dubious piecemeal changes adding bits of protection for a tiny minority which are rhetorically referred to as "improvements."

At the outset of this statement I indicated that it was not possible to assess the provisions of the administration proposal as it affects the elderly without some examination of the plan as a whole. The basic philosophy and approach to health needs of the people naturally permeate the principles that control the approach to the health problems of the elderly.

According to the President's own descriptions of his plan, he relies on the commercial health insurance industry as one of the pillars of strength in an existing health care system. In our view, this bland assumption flies in the face of 65 years of experience, beginning with the adoption of the first of our health insurance programs; namely, the State workmen's compensation laws. The very terminology of the insurance industry which reports benefit payments as a "loss ratio" reveals there will always be a conflict between private profit and benefits whenever commercial concerns are in an underwriting role. To those of us who have tried for years to represent people's interest as against corporate interest, commercial insurance represents the weakest, not the strongest, element in our national health system.

The latest figures I have seen, incidentally, on the State workmen's compensation system shows that only about 64 cents out of the premium dollar goes to benefits. The rest goes to profits, to advertising, to lawyers' fees, to anything else except benefits to the injured workers.

CHIP Would Enlarge Private Insurance Role

But the administration plan is at least consistent with its philosophy in that it ascribes a vastly enlarged role to commercial insurance particularly in the EHIP and AHIP proposals. But this approach would certainly invite an enlarged role for commercial insurance in the revised Medicare program.

The role of the insurance industry in relation to Medicare would continue to be limited to that of fiscal intermediary. But would not the heavier deductibles and coinsurance increase the need for private supplementary health insurance—what is sometimes called "medigap coverage"—thus increasing the opportunity for private insurance to make additional profits at the expense of the elderly?

Perhaps I should interject here and comment that the National Council of Senior Citizens operates a health insurance program, but completely without any profits—directly or indirectly—to the National Council of Senior Citizens. We would be glad to dispense with our program any time there were a public program that would meet the needs of the elderly.

In fact, close examination of the administration proposal indicates that the biggest beneficiaries would not be the sick, but the health insurance industry.

According to recent estimates made by Business Week magazine, private insurers would find their cash flow more than double under

the Nixon plan. Secretary Weinberger admitted that the cost of administering the program would be at least 15 percent. This would indicate that profits and administrative expenses—which totaled a record high of $3.3 billion for this industry in 1973—would at least double under the Nixon plan.

But then this undue and wasteful reliance on private insurance is not really surprising since the President's major campaign contributor is insurance magnate, W. Clement Stone. Mr. Stone, chairman of Combined Insurance Companies of America, one of the most profitable insurance conglomerates in this Nation, contributed a mere $2 million to Mr. Nixon's "austere" 1972 campaign.

One of my newspaper friends remarked, "It was impossible to believe there was all this quid without some quo." [Laughter.]

Health insurance companies and organizations including Blue Cross and Blue Shield, have done little to bring about coordination of health services, improved quality, or greater efficiency. Instead, they have played a passive function, being middlemen (with a "cut off the top," of course) between patients and providers.

To control the utilization of services and therefore cost, the President relies largely on substantial cost sharing by the patient. However, it is usually the doctor and not the patient who decides what services are needed. To the extent that people are deterred from seeking preventive care or early treatment, cost sharing is counterproductive in controlling the cost of medical care.

The President is on weak ground when he turns to the as-yet-untested, physician-run Professional Services Review Organizations, the PSRO's, to reduce unnecessary utilization and cost. It is the proverbial situation of the fox set to guard the chicken coop.

The Nixon plan also looks to the State governments to regulate the private carriers and more importantly to negotiate with physicians a reimbursable fee schedule for Medicare services. Health providers would be forbidden to charge for services above the approved State fee schedule for the assisted plan and Medicare. And let me say here, again, that in my past years' experience when I had something to do with negotiated health bargaining plans, the conflict of interest emerges here because insurance companies would always present among their qualifications the fact of how well they got along with the doctors. And they report that they had no conflict with the doctors.

And one insurance plan would come in and say "Give your business with us because we get along fine with the doctors."

Built-in Conflict of Interest

And, of course they did as long as they never contested a doctor's fee, or hospital bill cost. So there is a built-in conflict of interest which the Nixon administration simply ignores as they expect the insurance industry—of all people—to negotiate these schedules that are supposed to protect the beneficiary.

The provision to which I have referred would eliminate the situation facing many Medicare recipients whose doctors refuse to accept Medicare reimbursement as payment in full, that is, the "assignment" method.

We have long advocated the concept of a fee schedule. However, since doctors are free to bill the employee health plan enrollees at rates considerably above the State fee schedules, many physicians might decline to treat assisted plan or Medicare patients.

This approach would inevitably establish a two-level system of medical care. A fee schedule is only equitable if it is negotiated in concert with consumers and if it is applied across the board—not just to the poor and the elderly.

In summary, CHIP is designed to enrich the profitmaking machinery of the private health insurance industry and to placate the American Medical Association, the American Hospital Association, and other health sector trade associations.

It does not attempt to create basic reforms or change the manner in which services are organized or delivered. Consumers are to be locked into a system in which their chief role is to pay the high costs.

At the end of last January the National Council of Senior Citizens' 65-member executive board met here in Washington. These board members represent elderly people from all across the United States.

They have intimate day-to-day experience with Medicare. They know the program's strengths and its weaknesses. They know what changes would weaken it further and they know how it can be improved.

The board had before it for consideration the proposals of the administration for comprehensive health insurance based on the Secretary's memorandum to Cabinet members and on the information that had been provided to me in one of the many briefings conducted by administration representatives. They had the advantage of the analysis of these proposals presented to them by a distinguished retired professional from the U.S. Public Health Service.

The executive board was quick to recognize that the President's proposal ignores the lessons gained in the 8 years of Medicare experience. We have learned, the board said, that the Federal Government has a responsibility that goes far beyond the mere provision of financing and bill-paying mechanisms. It has responsibility for improving the delivery of the health care system so that all people are assured of comprehensive coordinated care of high quality at the most economical cost.

Support for Kennedy-Griffiths Proposal

The executive board concluded their assessment by unanimously reaffirming the whole-hearted support of the National Council of Senior Citizens for the Kennedy-Griffiths proposal for national health security. We are committed to this approach, the board said, as the only effective means of building a health care system that assures all Americans equal access to comprehensive and continuous health services of high quality at economical costs. We are committed to the basic principles embodied in this legislation: no deductibles, copayments, or coinsurance; no billing of the patient; financing through payroll taxes and general revenue rather than through premiums taken out of retirement incomes.

Thank you for this opportunity to express our views.

Senator MUSKIE. Thank you very much, Mr. Cruikshank, for an excellent statement which supplements very well, I think, what has already been said this morning.

Some of my colleagues haven't had the opportunity to participate earlier this morning, so I will yield to them at this point.

Senator Hartke.

Senator HARTKE. Mr. Cruikshank, I am delighted to see you here. You have long been a champion of the elderly and we recognize that. Not only have you been a champion but an intelligent and courageous champion.

My 14-year-old daughter came home the other day and told me, "Dad, they told me in school that under the present circumstances for women that a girl the age of 14 would increase in longevity, and if we have the increase in medical science that we've had over the past few years, that she could expect to live to be 119 years old."

And she said, "Dad, I want to ask you two questions. One of them is: I'm supposed to work until I'm 65. Can I earn enough in 65 years to take care of me the next 64?"

She said, "Second, who is going to want a 119-year-old woman?" [Laughter.]

So I think this demonstrates that sometimes we think the young people don't think about the elderly, but they do.

In this measure, as you have indicated on the chart, 40 percent is paid by Medicare, and this is from the Social Security Administration, 40.3 percent.

Considering the fact that Medicare now only covers 40.3 percent of all health costs of the elderly, how would you assess the present program: As a success, as a failure, or I guess you could have some other terms, but characterize it as you please. How would you characterize it?

MEDICARE—A LIMITED SUCCESS

Mr. CRUIKSHANK. I think it has been a limited success, sir. Going back to the time when it was devised, and you had a prominent part as a member, also, of the Senate Finance Committee, in devising it, we were operating with public understanding that was of the level of 1965.

At that time, the Congress and public—both—Congress reflecting the view of the public, was saying, "Provide us with some means of paying the bills, but don't touch the system."

And we all responded to that—those who were supporting Medicare and those who supported it in the Congress.

So we left the system untouched. I think also that while it is true that only 40 percent now of the total cost of the elderly is covered by Medicare, there is some danger in relying too much on a general average. Those figures include all of those elderly who never meet the deductible amounts, for example. Therefore, they get no protection out of Medicare. This greatly reduces the figure in the resulting average. If you take people who have the average stay in the hospital of about 12 days, and a medical bill, and assume for the moment that their doctor accepts assignments, you will find that in the case of the

12-day hospitalization—and a $400–$500 medical bill—that about 75 percent of this total cost is covered, or even more.

So therefore, the people who have a serious hospital illness—Medicare does a better job. It doesn't do as good a job as it should. And if we would build on the experience of Medicare—8 years experience—we could greatly improve it. I would say again that it has been a limited success. It has not been a failure.

Mr. HARTKE. Let me ask you, Mr. Cruikshank, on the basis of your experience, are you opposed philosophically to any out-of-pocket charges for the elderly?

SOME INCONSISTENCIES DEMONSTRATED

Mr. CRUIKSHANK. Well, to say "any" I would answer that I am not opposed to small out-of-pocket expenditures. I think though that it has been demonstrated that there are some basic inconsistencies to out-of-pocket expenditures designed to control utilization.

First, to the extent that it does, it only applies to the poor. If you make a high out-of-pocket coinsurance or deductible, then you haven't done anything to cut overutilization on the part of the rich.

Second, various studies have supported the fact that if you make coinsurance and deductibles high enough to cut down utilization at all then you have prevented some proper utilization.

If you keep them low enough so that they don't prevent—don't serve as a barrier then they are so low they don't do anything on the utilization question.

Then there is a very basic inconsistency here on the part of the insurance industry. The insurance industry has historically said, "Now put in some deductibles and coinsurances and out-of-pocket expenditures here so that people won't overutilize the service."

And then they come in and say, "Now don't worry, this won't serve as a barrier to health services because we will provide a private insurance that will cover their out-of-pocket payments."

Now what is the insurance industry doing? Are they for deductibles and coinsurance to prevent overutilization or aren't they?

They really talk out of both sides of their mouth.

Senator HARTKE. Let me ask you, do you think that Medicare should be taken from the Social Security Administration and put into a new health agency, Department of HEW, as someone suggested?

Mr. CRUIKSHANK. No, sir, as long as there is primarily a basic income maintenance program, and as long as it is primarily on the insurance concept.

That is, a bill-paying mechanism—then it properly belongs in the Social Security Administration, I believe.

Senator HARTKE. You know, Mr. Cruikshank, I am not a sponsor of the bill you have endorsed.

The bill I am supporting is the Hartke-Hansen bill. We have more sponsors than any other measure in the Congress.

I might point out that my bill does not in any way interfere with the Medicare program as does the administration's proposal.

I would like to insert in the record a statement which we received from Andrew Biemiller, director, department of legislation, AFL–CIO as to what the administration does in regard to Medicare:

[The statement follows:]

MEDICARE

The Administration would modify Medicare to make its benefits conform with the mandated program; however, only those Medicare beneficiaries unlucky enough to have a very serious illness would receive improved benefits. Most Medicare beneficiaries would be worse off:

At the present time, a Medicare beneficiary hospitalized for 12 days pays $84 out of his own pocket; under the Nixon proposal he would pay $342.

For a 30-day hospital stay, a Medicare beneficiary now pays $84; under the Nixon plan he would pay $750.

A Medicare beneficiary who does not need hospitalization now pays an annual deductible for physician services of $60 a year; under the Nixon plan it would be $100 a year.

The present premium for Part B is $6.30 a month; under the Nixon plan it would go to $7.50 a month.

The present Medicare tax—1.8 percent of income up to $13,200 a year shared equally by employee and employer—would remain. The Medicare program would continue to be administered by private insurance companies.

Additionally, there is a complicated means test formula to determine eligibility of Medicare beneficiaries for reduced premiums and cost sharing. Thus, Medicare would be transformed from a dignified social insurance program to a demeaning government welfare program for many of the elderly. And because the disabled would no longer be covered under Medicare in the Nixon bill they would all be forced into a welfare program.

MINIMUM BENEFIT A NATIONAL DISGRACE

Senator HARTKE. But the Hartke-Hansen bill does not deal with that. Let me say, as far as the elderly are concerned, I think I am willing to stack my record against most anyone there.

I am for eliminating the earnings limitation at the present time. In addition, a minimum benefit of $81 a month is a national disgrace. Some widows don't even get $81 a month.

Failure to cover prescription drugs is also an atrocity which should be eliminated. We ought to have hearing aids, eyeglasses, and false teeth covered under Medicare.

We need additional outpatient treatment and something to be done in relation to this requirement that they have to go to the hospital first before they can go to a nursing home—some new utilization in these fields.

I think we need to have full coverage of psychologists' services. I think aggressive taxation is absolutely going to destroy the Social Security system among the younger people who are absolutely going to rebel if they have to continue to pay more in a lot of cases on Social Security tax than they do on Federal income tax.

Now, having said all of these things, let me also make a point that in the Kennedy bill, the Hartke-Hansen bill, the Ribicoff-Long bill, the administration bill, the McIntyre bill, and you name it, not a one of these bills, in any form, really directs itself toward the problem which is called for.

And that is an improvement of the health delivery service. And I say that anyone who tells you that it does is absolutely misleading the American people. That is not true.

All these bills do is: mechanisms of insurance to pay the bills. That's all they do.

I say that the Kennedy-Griffiths bill just skims $1 billion off the top for a program which is completely undefined. They say they are going to improve the health delivery service with $1 billion, and that is not a way to go.

You first ought to devise a program under the terms of your philosophy and then go ahead and pay the money. You shouldn't go the other way around. It should not be "Let's put the money in and hope to God that somebody comes up with a program"—that will get you into all kinds of trouble.

I am not unbendable as you all know, but I think those people who say the Kennedy-Griffiths bill improves the health delivery service absolutely are misleading the American people.

Now would you care to comment?

Mr. CRUIKSHANK. Well, sir, I would have to disagree with you in respect to the Kennedy-Griffiths bill. We have participated in very far-reaching studies on this. I don't suppose we could settle it here but I think there is a difference in kind in the Kennedy-Griffiths bill.

It is not an insurance bill. It is—in fact, the very name of it—a health security bill. It is not just a bill-paying mechanism. We are amenable——

Senator HARTKE. A regressive form of taxation?

Mr. CRUIKSHANK. In a very small way, only very minor, payroll taxes are involved and it would reduce the amount of the overall payroll tax.

THE CONTRIBUTION PRINCIPLE

And as far as that is concerned, I think that there is an important aspect to the contribution. We believe in support to the health system out of general revenues in a very substantial way. But we believe the beneficiary should also contribute to the system directly.

We would agree with you on reducing the payroll tax on the cash benefit side of Social Security by supplementing it out of general revenue.

But we would not wish to see general revenues take over the whole cost because I think a part of the whole concept and the acceptability of the program is that the entitlement to benefits is bottomed on the beneficiary participation in meeting the costs.

Senator HARTKE. Let me ask you a philosophical question.

Why is it fair to go ahead and pay for war machinery on a basis of a graduated income tax and not pay for the care for the elderly in the same way? Is the war machinery more important than the elderly?

Mr. CRUIKSHANK. No, sir, I don't think so at all. But there is, in our Social Security structure, there is—it's a social insurance program and people are insuring their income against the contingency of a loss due to retirement, disability, or death in the family of the breadwinner.

And the participation in that cost through the contributory system is the thing that saves it from the means test. I don't think Congress is yet prepared to give people an entitlement to liberal benefits as a

matter of right without proof of need when it is all met out of general revenue.

I think it should be a three-way participatory system: partly general revenues, and partly employer, and partly employee.

Senator HARTKE. Let me come back to the question I asked a moment ago. Could you really define in the bill, the Kennedy-Griffiths bill—I admit that the other bills—not admit, I contend that they do not change delivery system. I contend the Kennedy bill does not. Will you tell me how it does? How does it improve the health delivery system?

NEED FOR WELL-DEFINED PROGRAM

I think if you are going to spend a billion dollars, that is a thousand million dollars of the people's money, that you ought to have a well-defined program of how it is going to improve the health delivery service.

Mr. CRUIKSHANK. Well, sir, just as briefly as I can, it starts out with the establishment of a health program in service areas with the available funds to be made available to the providers of service on a budgeted basis, not just insuring the payment under the existing program, but it sets up a health delivery system and then provides a method for paying for it.

Senator HARTKE. Which is then going to be in direct conflict with the present system.

Mr. CRUIKSHANK. No, sir.

Senator HARTKE. To supplement it?

Mr. CRUIKSHANK. There might be some residual outside of the system remaining, but not a whole——

Senator HARTKE. Let me explain that to you. You mean you are going to have a system out here which is going to be paid for by the Government and it is not going to be in competition then with the other system?

Mr. CRUIKSHANK. It would be paid through a Government mechanism.

Senator HARTKE. The result is you have a direct conflict. And I will guarantee you that if you could get the same type medical treatment free that you would go and pay for then people are going to go where it is free. Why not take over the whole medical system?

Mr. CRUIKSHANK. I said it would take over a major part of it, but I think there might be some residual as there is in the British health service system. There are some people who still work outside.

Senator HARTKE. Let me say in closing that I admire you, Mr. Cruikshank, but I think that is a path in which you absolutely kill any chance of having any national health insurance—because what you are saying is: "I don't think the American people are prepared to have a duel system of medical delivery in this country."

Maybe you think they are, but I'm telling you I don't think they are ever going to buy that concept. And, in effect, if we pursue that policy, we will get nothing. I think it is high time that, as an industrialized Nation, we make that change.

Mr. CRUIKSHANK. Well, the last thing they want, sir, I agree—the last thing we want is a dual medical system.

Senator HARTKE. All right, thank you.

Senator MUSKIE. Senator Fong.

Senator FONG. Mr. Cruikshank, I am sorry I was not here to listen to you all the way through your statement to give me an idea of what you were thinking about.

ELIMINATION OF INSURANCE COMPANIES

May I ask: I have heard that you indicted the Nixon plan—saying that it was just helping the private insurance companies. Do I take it to mean that you want a national insurance health program without the insurance companies?

Mr. CRUIKSHANK. Yes, sir, I think that the participation of commercial insurance has, for more than 65 years, been a negative aspect of our whole health system.

Senator FONG. So you would eliminate the insurance companies entirely and set up a national insurance system?

Mr. CRUIKSHANK. Yes, sir, I would. I would set up a national health delivery system, not on the insurance basis. In a sense, sir, I would eliminate both private and public health insurance.

I don't think that insurance is the proper way to meet our health problems. Now I supported Medicare. That is an insurance system. But I believe that we have moved beyond that. I would like to see a system that analyzes the health needs of the people and then devises a program for meeting that health need rather than just a system which provides money to pay for the present sytsem.

Mr. FONG. I see. So you would have to set up what the services would be.

In your estimation, what should be the minimum service that should be given to the individual?

Mr. CRUIKSHANK. Well, I think you have to have a complete and comprehensive service, I think, starting with preventive care.

You have the models that are now existing in prepaid group practice plans, such as the Kaiser plan, such as Group Health Association.

I believe such operations could be done under the aegis of Government, but using the present privately owned and privately operated medical care services. We wouldn't have to take those over. We wouldn't have to have a Government system.

The Government program could use the existing health facilities and health personnel.

Senator FONG. In other words, you would just take money and pay over to the present deliverers of——

Mr. CRUIKSHANK. I would pay for services rather than reimbursing for the cost of services on an insurance system.

Senator FONG. You would fund this by a three-way funding, that is, by the employer, the employee, and the Government?

Mr. CRUIKSHANK. Yes, sir.

Senator FONG. Under those circumstances, how would you divide the cost?

TOKEN COST FOR EMPLOYEES

Mr. CRUIKSHANK. Well, I think there should be a lesser cost for the employee, more or less a token cost, a larger cost for the employer as he now pays under private plans that are negotiated—a larger share.

Most health plans that are now negotiated are what are called non-contributory with the employee paying nothing directly.

Now whether he pays indirectly or not—as this is a part of a total wage cost—is very difficult to decide. But he would pay a token part of a payroll cost, and the employer pay a larger percentage of payroll costs, and the Government pay a larger proportion—roughly, a third.

Senator FONG. A third each?

Mr. CRUIKSHANK. Yes, sir.

Senator FONG. Could you estimate the amount that would be paid by the Government?

Mr. CRUIKSHANK. In dollar amounts, I wouldn't be prepared to now. We have the figures and—but while we are dealing with these costs, sir, I would like to point out, if I may, that there is a fallacy that runs through many of these things.

The administration, for example, I think said that their plan would cost something like $6 to $7 billion a year, and they contrasted the Kennedy plan and said I think it would cost $70 billion a year.

Well, this is on the assumption that the only cost to the American public is what is paid through Government. It costs the American people for health services, whether they pay it in terms of contribution to a public system or they pay it out of pocket.

Both plans, I believe, would, in the initial years, cost roughly the same. I think, down through the years, a plan of health security such as the Kennedy plan would cost less because it would have an emphasis on preventive services and preventive care that the Nixon plan does not have.

It is very difficult to make those exact estimates but I want to emphasize very strongly the point which should be very obvious, I believe, that it cost the American people for medical service every cent they pay out to a private health insurance concern, or that they pay out of pocket to the nurse as they leave the doctor's office—or as they pay out a hospital bill—that is a cost to the American public, whether it goes through a Government channel, or whether it doesn't.

So when you compare the two programs and say one costs $6 billion and the other costs $70 billion, you are not making the same comparison at all, on the same basis.

Senator FONG. What you are saying then is that the total cost runs the same regardless of who pays it?

Mr. CRUIKSHANK. I think those estimates are roughly the same, yes, sir.

Senator FONG. But the administration proposal says that the Government should only pay $6 billion of it, and you have railed against that program as not sufficient—a $6-billion contribution by the Government to this program is really not sufficient?

Mr. CRUIKSHANK. Yes, because there is a lot of waste in it. A lot of those billions of dollars would go to insurance company profits, and go to the costs of advertising, competition, agents' fees, retentions, all of the other things that are packed into an insurance policy.

Senator FONG. Yes; now, if $6 billion is not sufficient to run the proposal presented by the President, and you say that that proposal would not deliver enough services, then how much more would you say that Government should contribute over the $6 billion to get a national health program going?

Mr. CRUIKSHANK. Well, you see, I don't support a health insurance program at all. I support a health security program, a program that plans for the health needs, and then plans to meet them.

And that would be very costly. It is costly now to the American people to pay their health bills, and I don't think it would be any more costly to provide a totally comprehensive complete health cost that is now being paid. In fact, somewhat less, and the total American health bill now is in the magnitude of $90 billion. I think we could do it for something less.

WHAT AMOUNT SHOULD GOVERNMENT PAY?

Senator FONG. The Government is not paying anything now for many, many of us as far as health insurance is concerned. We are paying it ourselves. Now, the Government is going to pick up a portion of this if it has this program. So, therefore, Government would have to get that money from somewhere. Government can only provide a certain amount, and this is what I am trying to get at: What amount should the Government pay for this program?

You know, we can write all kinds of insurance and we can provide all kinds of benefits depending on how much you are willing to pay.

Mr. CRUIKSHANK. Well, I think it's a little difficult to make this distinction, Senator, when you say Government should pay.

You see, Government would be in one sense, and one accounting method, be paying what flows from the employer and the employee tax.

If I understand your question properly, and please don't think I am trying to restate your question, it is: What proportion should come out of general revenues as opposed to what proportions should come out of a special marked tax?

Senator FONG. Yes; I'm trying to arrive at the amount of money. You stated that one-third of that should come out of general revenues. The $6 billion which is being proposed could take care of the needy, but is not sufficient for the kind of coverage that you want.

So on the kind of coverage that you are talking about, I was trying to see whether it projects into $12 billion or——

Mr. CRUIKSHANK. It would be more than that, sir.

Senator FONG. $20 billion?

Mr. CRUIKSHANK. It would be more than that.

I don't have estimates right before me. And if I might, could I supply those?

(See p. 722.)

Senator FONG. Yes.

Mr. CRUIKSHANK. I'd be happy to do it. I would be a little nervous about just picking out a figure right here, but I don't want to avoid your question. It is an important question. We all have to face up to it as part of the public policy which will have to be determined.

Senator FONG. Wouldn't it be better to start with something small and see where we go from there?

Mr. CRUIKSHANK. I think we did that 8 years ago with Medicare.

Senator FONG. Well, that was for the elderly, but now we are talking about the country as a whole.

Mr. CRUIKSHANK. Well, the Congress may decide to start with a part of the program, but we would hope they would start in the right

direction and not freeze us into something which would be very difficult to correct.

Senator FONG. You would eliminate insurance companies?

Mr. CRUIKSHANK. Yes, I think if you get frozen into that, you are in a bad way.

Senator FONG. Thank you.

Senator MUSKIE. Thank you very much, Mr. Cruikshank, for your excellent testimony.

Mr. CRUIKSHANK. Thank you, sir, and gentlemen.

(Subsequent to the hearing the following information was supplied:)

According to our projected revenue requirements of National Health Security, the program would cost $61.9 billion in calendar year 1975 and $65.6 billion in 1976.

Under National Health Security these funds would be derived from a one-half contribution from federal general revenues and one-half from a payroll tax on employees and employers.

As a result, the federal general revenues would be $31 billion in calendar year 1975 and $32.8 billion in 1976. However, it must be remembered that this figure does not represent net governmental outlays. The Federal, State and local governments are already paying billions of dollars for such programs as Medicare, Medicaid, Neighborhood Health Centers, and Comprehensive Health Planning, all of which would be very substantially reduced by our proposal.

Let me emphasize for the record a fact that I am sure is well known by the members of this Committee but has received practically no recognition in the public discussion of the various programs. That fact is that it is the American people who are going to pay out of their own pockets the costs of medical care and service which now run to about ten percent of our gross national product. To claim therefore, as the Administration claims, that the "cost" of their program is only in the neighborhood of nine or ten billion dollars and to contrast this figure with seventy or eighty billion dollars which, according to their estimates, would be the cost of Health Security, is utter nonsense. In the unhappy event that the Administration bill were ever to become law, who would pay the remaining ninety billion dollars of the health bill—who indeed but the American people?

The issue is not how many dollars are to be added to the consolidated budget by the inauguration of a comprehensive health program. The issue is how best to collect and channel the dollars necessary to provide a good health program. In fact it is not only conceivable but very likely that a seventy billion dollar Health Security program would actually cost the American people less than a ten billion dollar bargain basement program designed to pay only a fraction of the total of all the charges for health care leaving the balance to be paid by high deductibles and co-insurance carriers whose premiums would of course include the cost of advertising, sales commissions, profits, "retentions", and all the other gimmicks known to the insurance industry.

Senator MUSKIE. Our next witness of the morning is Cyril Brickfield, legislative counsel to the American Association of Retired Persons and National Retired Teachers' Association.

Mr. BRICKFIELD. Thank you, Senator Muskie. In order to save time, I have several documents that I would like to submit for the record. Rather than read them, I shall summarize them if that is agreeable.

Senator MUSKIE. That would be fine.

Mr. BRICKFIELD. The first thick document is our prepared statement. A lot of work has gone into its preparation, and we think it will be very helpful to the subcommittee.

Senator MUSKIE. We will include it in the record.[1]

[1] See appendix 4, p. 780.

Mr. BRICKFIELD. This second statement I was going to read, but if it is all right, I will summarize it.

Senator MUSKIE. All right.

Mr. BRICKFIELD. I will also ask my colleagues to address themselves to one or two important items we think the subcommittee should hear about.

Senator MUSKIE. Fine.

STATEMENT OF CYRIL F. BRICKFIELD, LEGISLATIVE COUNSEL, NATIONAL RETIRED TEACHERS ASSOCIATION-AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. BRICKFIELD. Mr. Chairman, I would like to introduce those who are with me at the witness table this morning.

On my left is Theodore Ellenbogen, who was, for many years, Assistant General Counsel for Legislation to the Department of Health, Education, and Welfare.

On my right is James Hacking, and on his right, Laurence Lane, both of whom are associates of mine.

Mr. Chairman, Senator Abraham Ribicoff [1] of Connecticut, today, is introducing a bill which our associations have spent 2 years preparing.

COMPREHENSIVE MEDICARE REFORM ACT

He is calling it the Comprehensive Medicare Reform Act of 1974. We undertook this matter, Senator, in order to carry out many of the health recommendations of the White House Conference on the Aged. The recommendations, among other things, called for immediate legislation looking toward comprehensive health care for the aged. Because of that, and other reasons, we have developed this bill that Senator Ribicoff has introduced this morning.

In my formal statement, I go over many of the statistics which you gentlemen have already heard. An important one is that Medicare is only covering 40 percent of the health care costs of the aged.

If you go back just 5 years, Senator, to 1969, it paid almost 46 percent. Its protection is decreasing. Each year it is covering less and less.

Something has to be done. Not only is Medicare paying for less of the costs of the elderly—but the elderly themselves have relatively less and less money. The average head of the family over 65 has less than half of the income of what the average family has today. So it cuts two ways, and both ways are cutting into them.

Out-of-pocket health care costs are rising and income—fixed retirement income—is less for the elderly than what the average family has.

Our bill does two things. It makes the benefits for the elderly more comprehensive. At the same time, it tries to bring in, in a very responsible way, cost restraints.

In the area of benefits, we would introduce intermediate nursing care which is not in Medicare today. We don't require prior hospitalization which Senator Hartke just referred to.

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[1] See statement, app. 2, p. 766.

We include dental care, eyeglasses, hearing aids, many of the things which the Senator from Indiana just mentioned.

We have in our bill expanded mental health care, neuropsychiatric care, whatever you want to call it. And we have in our bill catastrophic care.

CATASTROPHIC CARE

And as I believe Mr. Cruikshank and Senator Fong pointed out, catastrophic care can be a sometimes thing. One is covered by catastrophic care provided the services which one receives are covered in the law. For example, if intermediate nursing home care is not covered in the law—and the Nixon bill does not cover it—then catastrophic care does not come into play. You cannot incur $750 and continue to get intermediate nursing home care because it's not a covered service under the Nixon bill.

So catastrophic care is a great thing but one must be careful to make certain as to what, in fact, it covers in the way of benefits.

In the area of restraints, we provide in our bill—the Senator Ribicoff bill—for prior approval of hospital budgets, and also for negotiated fees for physicians. The thrust is to keep costs down.

As you brought out this morning, Senator, and Mr. Glasser, too, our prior approval of budget cuts across the entire medical delivery system and it includes the hospitals, the nursing homes, the HMO's, and other facilities.

Also, in the area of cost restraints, the Ribicoff bill provides for HMO's and seeks to emphasize preventive care, and out-of-hospital treatment.

It also provides—and I think this is most important—home health services.

If you would permit me to digress for a moment, I would like to describe the circumstances behind your organizations' 2-year effort in the development of our own health legislation. This bill, the Medicare Amendments of 1974, is scheduled to be introduced this morning by Senator Abraham Ribicoff of Connecticut.

With the prospect for enactment of national health insurance legislation in the immediate future in serious doubt because of fundamental disagreements over the comprehensiveness of benefits, the means of financing and delivering those benefits, the degree of Federal involvement, the nature and extent of cost sharing, and the nature of catastrophic protection, our organizations, acting on the recommendation of the 1971 White House Conference on Aging for immediate legislative action to provide comprehensive health care protection for the aged, developed the Medicare Amendments of 1974. This is our contribution toward the ultimate national goal for quality health care for all Americans.

Our bill is designed to reverse the present trend of declining Medicare protection and increasing out-of-pocket health care expenditures by reducing or eliminating the durational limitations on items and services already covered under present law, covering additionally needed items and services, and replacing existing cost-sharing devices with a single rational system of copayments subject to a catastrophic protection feature related to income.

While providing comprehensive health care protection for this Nation's aged and disabled, it would also confront directly the problem of escalating health care costs by completely reversing existing reimbursement procedures. Under our bill, Medicare charges by an institutional provider (such as hospitals, et cetera) would be approved for a year in advance on the basis of prospectively approved budgets and schedules of charges derived from those budgets. In the case of most noninstitutional providers (such as doctors and other licensed practitioners) reimbursement would be made on the basis of negotiated rates.

At this point, Mr. Chairman, I would like to bring to your attention the copy of our organizations' prepared statement. This document not only discusses our bill, but contains in parts 5 and 6 our analysis and criticisms of the Comprehensive Health Care Act from the point of view of the aged and disabled.

[See app. 4, p. 780, for prepared statement.]

In outlining what we have attempted to do in this prepared statement, I would ask you to turn to the table of contents. Part 2 of our statement is a statistical description of this Nation's health care needy—the aged and disabled. We have demonstrated statistically that, despite rising income from 1965 to date, a substantial percentage of the aged (18 percent or almost 4 million) remain below the poverty level and that the aged still have far less disposable income for the purchase of heath care protection than do the nonaged whose income rose more rapidly over the same period.[1] We also demonstrate that the aged, facing a higher incidence of illness and disability, are most in need of adequate health protection.[2]

Declining Health Care Protection

In part 3 of this statement, we have undertaken to demonstrate the declining health care protection being provided by the Medicare system in the face of rapidly escalating health care costs and to suggest that part of that escalation has been stimulated by the very nature of the Medicare system.[3] We have also undertaken to demonstrate the obvious consequence—substantial increases in out-of-pocket expenditures for health care on the part of the aged. Our conclusion is that health care legislation for this Nation's health care needy must, on the one hand, provide comprehensive health care protection, and on the other, deal directly with the problem of rising costs.

That the Medicare Amendments of 1974 carry out these objectives far more effectively than present law is the thrust of part 4.

In part 5, after presenting a description of the administration's Comprehensive Health Insurance Act of 1974, we demonstrate how this major legislation fails to meet the dimensions of the health care needs of the aged and disabled.

As this subcommittee is well aware, Medicare's health care protection over the years has fallen to the point where, in fiscal 1973, only

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[1] Prepared statement, pt. 2, p. 5. In 1972, households headed by an aged person had median income of only 42 percent of the national family level.

[2] On a percentage basis, the medical bill for an aged person in 1973 was $1,044; for the nonaged, $553.

[3] Prepared statement, pt. 3, subpart B, cost experience under Medicare from the point of view of the provider, p. 12.

40.6 percent of the health care expenses of the aged were covered by the system. As recently as 1969, the figure was 46 percent.[4]

While Medicare's protection has been declining on the one hand, health care costs, especially hospital costs, have been rising on the other.

With Medicare's reimbursement procedure under part A of Medicare structured so as to provide full cost recovery, hospital charges, in the absence of any incentive to restrain costs, are likely to be above the minimum level necessary to provide services. Hospitals are neither profit-maximizing nor competitive. There is little or nothing in the economic system that would tend to keep hospital costs to the minimum necessary to provide services of a given quality—except the inability of the patient to afford the price of services. To the extent that the Medicare system has removed this ultimate but crude restraint, it is logical that it has contributed to the increasing cost levels. Any system which reimburses all costs by a third party, whether it be the employee business expense account or hospital charges, must be closely monitored if costs are to be held to reasonable levels. The expansion of covered items and services under Medicare to provide the comprehensive health care protection needed by the aged and disabled must be coupled with the development of a system to monitor costs closely.

We believe, Mr. Chairman, that our bill, the Medicare Amendments of 1974, would accomplish both of these objectives; namely, comprehensive care and cost restraint.

Bill Adds Various Services

As to comprehensiveness, our bill, in addition to preserving present benefits, would add additionally needed ones. It would, for example, abolish prior hospital stay requirements and abolish other limitations. It would add intermediate care facility services. Psychiatric care benefits would be greatly expanded. Dental services and other professional and supporting services (for example, optometrists and podiatrists) would also be added. The bill would extend the coverage of drugs (including biologicals) so as to include outpatient drugs.[5]

Moreover, the present coverage for devices, appliances, and equipment would be expanded to all others (including eyeglasses and hearing aids) listed by the Secretary.

Present limitations on duration of inpatient hospital, skilled nursing, and home health care would be abolished.[6]

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[4] Over the same period, Medicare's share of doctor fees has declined from 61 percent to 55 percent. Refusing to accept an assignment and taking as full payment whatever Medicare deems reasonable, many physicians collect the amount of their fees (which in some cases may be whatever the traffic will bear) directly from the aged patient, leaving him, in turn, to collect Medicare's reasonable and sometimes inadequate payment. Finally, Medicare's coverage of hospital costs has fallen from 66 percent to 61 percent.

[5] However, during the first 5 years, drugs dispensed in pharmacies will be covered only if listed on a list of maintenance drugs established by the Secretary and, thereafter, if listed as appropriate on the Secretary's general list designed to provide practitioners with an armamentarium necessary and sufficient for rational drug therapy. Drugs dispensed in a physician's office would be covered if listed on the general list just mentioned.

[6] The durational limit applicable to benefits under our bill are a limit of 150 days of care in a benefit period for psychiatric inpatient care, a 160-day limit on psychiatric (mental health) services furnished to a patient of a mental health day care service affiliated with a hospital or approved by the Secretary, and a 20-consultation-a-year limit on psychiatric (mental health) services furnished in a psychiatrist's office.

Premiums, deductibles, and coinsurance under present law would be eliminated. Instead, the bill would substitute a system of minimum copayments with respect to the more expensive items of health care.[7] However, these copayments and remaining limitations on benefits would be subject to a catastrophic protection feature. Low-income persons would pay nothing, and others would pay out-of-pocket amounts related to their income but in no case more than $750 per family per year.

As to cost restraint under the bill, participating institutional providers (hospitals and so forth) would be required to submit annually a budget and schedule of proposed rates and charges, based on the cost of efficient delivery of services, for approval. Reimbursement would be based on predetermined, approved rates, thereby providing incentives for efficiency and economy.[8]

With respect to noninstitutional services of licensed professional practitioners (physicians and so forth), payment would be provided in accordance with annually predetermined fee schedules for local areas. Finally, a provider would be required to accept the Medicare payment (plus any copayment) as full charge for the service.

Evaluation of Administration Bill

Using our organizations' health bill as the standard, we shall now address ourselves to an evaluation of the administration's Comprehensive Health Insurance Act from the point of view of the aged.

The administration's bill (pt. C of title I) would replace Medicare in certified States, but not in others, with a Federal health care benefits program (FHIP).

Eligibility, under FHIP, would be limited to an aged individual who wishes to participate and who is entitled to the Social Security section 202 benefits or is a qualified railroad retirement beneficiary.[9]

In comparing FHIP with present Medicare, we wish to point out that there is no provision for voluntary enrollment in the absence of Social Security section 202 entitlement or qualified railroad retirement entitlement (except for transitional entitlement). The disabled are not covered at all. This latter group would have to be covered under the State-administered assisted health insurance program (AHIP), if resident in a certified State. While it may be argued that the FHIP program should not be evaluated out of context of the AHIP plans available in a certified State, we wish to point out that certification for FHIP is not contingent upon the availability of AHIP plans. In

[7] Inpatient hospital services, skilled nursing services, home health services, physician and dentist services, mental health day care, diagnostic outpatient services, and independent laboratory or independent radiology services, devices, appliances, and equipment, certain drugs, and ambulance services. (See prepared statement, pt. 4, subpt. B, sec. 4, "Cost sharing," p. 39.)

[8] Physician and other services generally available to institution patients, whether performed by employed staff or by arrangements made by the institution, would be treated as institutional services except for services by physicians, dentists, or podiatrists with respect to their private patients.

[9] Under the Comprehensive Health Insurance Act, employment with the Federal, State, or local governments in certified States would be covered employment for purposes of the health insurance taxes. A Government employee could be deemed entitled to Social Security section 202 benefits, on the basis of such services but solely for the purpose of entitlement to FHIP. Such employment is not covered directly under present law. This new provision may be subject to challenge by the States.

other words, if a certified State is not induced by the Federal grant to establish an AHIP program, those who are disabled and covered for Medicare purposes, would be without adequate health care protection. With an added cost of $1 billion projected for the States under the Comprehensive Health Insurance Act, and faced with diminishing resources, we cannot be certain what the States will do.

In comparison, our organizations' health bill would cover all the aged, and continue to cover the disabled.

With respect to the services which would be covered under an FHIP plan, skilled nursing care would be limited to posthospital, and would be subject to a 100-day limit per year. Home health services would be limited to 100 visits per year. Inpatient hospital services for mental illness would be limited to 30 days per year. Such things as eyeglasses and hearing aids and dental care would not be available to aged persons. While coverage of outpatient drugs would be an improvement over current law, the entire FHIP benefit package when considered in the context of durational limitations, represents little if any expansion of benefits in comparison with those available under Medicare.[10] We would hasten to add, that in the case of many persons presently entitled to Medicare, the benefit package available under FHIP would constitute a significant curtailment of services.[11]

Needless to say, in comparison with our organizations' bill, the benefit package of the FHIP plan is not comprehensive.

An FHIP plan would require the payment of premiums,[12] deductibles, and coinsurance, with the amount of the deductibles and coinsurance related to income. However, it would also provide a catastrophic protection feature that is income related and subject to a $750 annual maximum per person.[13]

Present Law Lacks Catastrophic Protection

In comparison with present Medicare, FHIP is a commendable improvement—simply because present law lacks a catastrophic protection provision. However, for comparison purposes, since the cost-sharing amounts under our organization's bill are minimal, and since its income classes are more liberal, the aged and disabled would be afforded greater protection against out-of-pocket health care costs than under the FHIP program.

With respect to payment procedures, FHIP plans would establish a charge account against which would be charged the cost of covered services without regard to deductibles and coinsurance. In general, payment for covered services would be made at the applicable reimbursement rates. Full and associate participating providers would receive payment without reduction on account of deductibles and coinsurance (unless the account is in default), and the individual would be billed by the carrier for portion chargeable to him.

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[10] It is difficult to compare the benefit packages of present law and FHIP because of the presence of the "spell of illness" limitation and other complex lifetime durational limitations of present law.

[11] Prepared statement, pt. 5, subpart B, sec. 3, p. 85.

[12] Except that, no premiums would be required for persons in income classes I and II.

[13] See prepared statement, pt. 4, subpart B, sec. 8, p. 61, not 145.

Full and associate participating providers would have to accept this payment as payment in full, except that this rule would not apply to associate participating providers in the case of outpatient drugs and biologicals.

This exception troubles us. HEW has announced that Medicare will soon pay for covered drugs only at the lowest rate at which such drugs are available under generic names in the locality. This exception to the full payment rule for outpatient drugs and biologicals is designed to permit the pharmacy which furnishes a brand-name prescription drug to recover cost in excess of the generic drug cost.

With respect to payment procedures, each certified State would have to prescribe reimbursement rates and standards applicable to payments by FHIP plans in accordance with criteria established by the Secretary of HEW. However, no specific standards are set forth in the bill. The matter is left wholly to the discretion of the Secretary and the individual certified States. While there are provisions in the bill with respect to PSRO's, institutional planning, and utilization review, these provisions are not likely to be effective in restraining health care costs.

On the other hand, under present law, the statutes provide specific standards for the purpose of determining reasonable cost or reasonable charges. The lack of standards for the promulgation of regulations by the Secretary under the administration's bill seems to be an unwise abdication of accountability. Simply delegating the matter to the States is not the "cure-all" for rising costs. Moreover, since the FHIP program and the relevant provisions of the Comprehensive Health Insurance Act would be in effect only in States which are certified, an administrative problem of monumental dimensions could result, since we assume that present standards for Medicare would govern in noncertified States.

Restraining Rising Health Care Costs

It may be that the Comprehensive Health Care Insurance Act (CHIP) contemplates the establishment by certified States of prospective budget review procedures for institutional providers and negotiated rates for noninstitutional providers on the basis of which payments would be made. Our organization's bill, however, specifically so provides and in substantial detail. We believe that such procedures will result in a more rational and efficient utilization of health care resources and aid substantially in restraining rising health care costs.

In conclusion, Mr. Chairman, our organizations consider the Comprehensive Health Insurance Act of 1974 to be inadequate in its protection for the health care of the aged and disabled. It does, however, have some good features. The concept of catastrophic benefits is commendable. We think the charge account payment procedure has merit and we like the general revenue financing principle. But we are particularly concerned that there can be no FHIP program unless the State is certified. We are also concerned that the disabled will not be covered. The inadequate coverage of long-term care because of the 100-day and posthospital limitations on skilled nursing services and

the absence of coverage of intermediate care services is unacceptable. Also the 100-visit limitation on home health visits dissatisfies us.

Our organization's bill and CHIP address themselves to the same elements (except with respect to payment procedures). We ask serious consideration of our provisions as a substitute for FHIP. Such a revised provision could be easily incorporated into whichever total national health care plan is ultimately adopted by Congress. These are some of the items that are in our bill.

Senator Muskie, Senator Fong—three of my associates would like to address themselves to specific issues.

I would ask Mr. Hacking to address the committee on hospital charges under the Ribicoff bill and also what happens if the States fail to cooperate, or to participate in the programs under the administration's bill.

Second, my colleague, Mr. Ellenbogen, has raised what we think are serious Constitutional questions in connection with the Nixon administration bill.

Finally, my other colleague, Mr. Lane, will speak on the deletion of the disclosure of ownership provisions in the nursing home care part of the bill.

With that introduction I would ask Mr. Hacking to address the committee.

STATEMENT OF JAMES HACKING, NATIONAL RETIRED TEACHERS ASSOCIATION-AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. HACKING. Sir, as Mr. Brickfield has indicated, our organizations are concerned primarily with two things: providing the elderly with comprehensive health care protection and doing something about restraining increasing health care costs. These are the goals of our bill.

We have evaluated the administration's bill in terms of these same goals. As far as we are concerned——

Senator FONG. You are putting more emphasis on the elderly?

Mr. BRICKFIELD. Yes; we are here on the elderly.

Mr. HACKING. As far as we are concerned the statistics do not support the overworked contention that rising health care costs are due to overutilization. Because of its contention that rising health care costs are the result of overutilization, the administration's remedy is to introduce substantial cost-sharing requirements with respect to short-term health care.

As a matter of fact, I think that this subcommittee has assisted in exposing the overutilization myth. The problem is not on the demand side of the economic coin but rather on the supply side. We therefore think that the administration's entire approach to the rising health care cost problem is wrong.

Specifically, the problem is the cost of supplying health services, but not all health services, rather primarily the cost of supplying hospital services.

Trend Toward Higher Hospital Costs

As was noted here today, hospital care constitutes 38 percent of the Nation's health bill. Hospital costs have continued to rise and we think this trend to higher hospital costs is largely a result of financing by the Government programs and by private insurance on a cost-reimbursement basis.

Part A of Medicare all along has provided relatively full cost reimbursement. Because this is the case, the level of hospital costs have been above the minimum level necessary to provide hospital services of a given quality.

Throughout the Medicare period, hospitals have been expanding their staffs and investing extensively in plant and equipment, in the complete absence of cost restraints.

Two questions therefore arise as far as we're concerned. To what extent does Medicare finance these outlays and to what extent have they been cost effective?

It is clear to us that hospitals are neither competitive nor profit-maximizing. Hence, there is nothing in the economic system that would tend to automatically keep cost down, with one exception.

That exception is the inability on the part of the patient to pay for the services. To the extent that Medicare has removed this rather crude constraint, it is logical that Medicare has contributed to rising hospital costs.

The Social Security Amendments of 1972 seem to have recognized this by introducing such things as the requirement that there be excluded from "reasonable cost"—costs found unnecessary in the efficient delivery of health care services, the requirement that institutional providers establish operating capital budgets, and the requirements for institutional planning.

We think this isn't enough. It's a good start, but it isn't enough. We think that methods must be found to analyze hospital spending plans to assure that proposed outlays are going to be cost effective.

Any system which tends to reimburse all costs by a third party—and I don't care whether we are talking about the employee business expense account, or whether we are talking about hospital charges—is going to have to be closely monitored if costs are going to be held to reasonable levels.

As far as I can see, the administration's bill does nothing in this respect. It would pour a lot of money into the health care system, but it would simply leave the reimbursements procedures and standards to the uncontrolled discretion of the Secretary and the States almost as if dropping the problem of rising costs in the lap of the States is a cure-all for it.

While it has been said that the administration's bill contemplates a prospective reimbursement procedure—even negotiated fees—we don't see it in the bill. The procedures and standards are not there.

As long as those procedures and standards are not there they may never be.

Overall the administration's bill will probably exacerbate the problem of rising costs. That is a problem we tried to deal with in our own bill—and in very great detail.

Thank you.

Mr. BRICKFIELD. If there are no questions of Mr. Hacking——

Senator MUSKIE. I wonder if he would give us briefly the approach in your bill to control of rising costs.

Mr. HACKING. Since our bill would provide coverage only for the aged and the disabled, we didn't feel that we could try to restrain rising costs by reorganizing the delivery of service mechanisms by mandating the use of HMO's such as would be done by H.R. 1, and the Kennedy-Griffiths bill.

PERSPECTIVE REIMBURSEMENT PROCEDURES

Instead we had to turn to perspective reimbursement procedures for institutional providers. Basically, institutional providers would be required to submit annually a budget for the year and a schedule of charges derived from this budget.

All of these would have to be approved either by the Secretary of HEW or the State rate review agency, if one exists.

On this basis, payments would be made during the course of the year subject to a year-end adjustment if, in limited cases, costs exceeded what was planned for during the year. We really tried to limit the exceptions to the general rule of nonreadjustment at the end of the year.

We want to see institutional providers plan how much they are going to spend, and for what, during the course of the year. There has to be some planning.

They can't simply be allowed to spend freely and invest wherever and for whatever they want.

And with respect to noninstitutional providers—and here we are talking primarily about physicians, optometrists, dentists, and other licensed professional practitioners—the country would be divided up into regions.

Within each region, or within parts of a region, the Secretary would attempt to establish a negotiated schedule of fees for services.

However, in the absence of successful negotiations, the Secretary would have residual authority to prescribe the fee schedules.

The rates that are contemplated here are rates that would provide fair and equitable compensation but in no event more than what would be provided under the "reasonable charges" standard of present law.

We are not trying to prevent providers from getting back a fair return. We are simply trying to keep down costs.

Mr. BRICKFIELD. Standards would have to be put in the administration's bill by the Congress; they are not there now, Senator. They would be left to the discretion of the Secretary and the States.

And, you know, we're worried—we'd rather see them put in the bill—not the regulations themselves but the standards that would set the guidelines.

Senator MUSKIE. Does your bill contain such standards?

Mr. HACKING. Yes. As I just indicated with respect to noninstitutional providers, for example, the standard is fair and equitable compensation but not to exceed the "reasonable charges" standard of present law.

Mr. BRICKFIELD. This is Theodore Ellenbogen, Senator. He, for many years, was the Assistant General Counsel to the Department of Health, Education, and Welfare in connection with legislation.

STATEMENT OF THEODORE ELLENBOGEN, NATIONAL RETIRED TEACHERS ASSOCIATION-AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. ELLENBOGEN. I hadn't prepared anything for this. I was just called on. If I may, I may not confine myself entirely to the constitutional aspects. I think these aspects are tied in with philosophical aspects also in this administration proposal.

I might say, though, that obviously a tremendous amount of work has gone into the development of the administration's proposal. I'm not trying to—in raising certain questions—I'm not trying to belittle that effort.

The thing that concerns me in the context of what Mr. Brickfield was saying about the questions I have raised is something that permeates the entire bill, all three parts of the program, and that is that these programs would be inoperative in States that are not certified by the Secretary of HEW under the proposed section 1861 of the Social Security Act. This holds true not only for the assisted health insurance program, which would be a federally aided State program, but also for the new Medicare program, which would be a straight Federal benefit program, and for the employee health insurance program, which is a Federal regulatory program based on the commerce clause.

In the case of the employee health insurance program, the employee is protected only if employed in a State that is certified under section 1861.

In the case of the assisted health insurance program a State plan qualifies only if the State is certified under that section and the individual must be a resident of such a State, or, if brought in by his employer, must be employed in the State. And in the case of the new Medicare program, the individual would have to be a resident of such a certified State. If he is not, the old Medicare program would apply to him.

TWO SO-CALLED MEDICARE PROGRAMS

The result of that—focusing now on the special interest of your committee in relation to the aged—is that the bill envisions the possibility—and the administration hopes otherwise, I'm sure—that there may be two so-called Medicare programs operating side by side—one for the aged in States that are certified under section 1861, and one for the aged and disabled in States that are not certified.

And also, as has been mentioned this morning, I believe, the disabled would not be eligible under the new Medicare program. They could qualify under the old Medicare program if resident in a non-

certified State or under the assisted health insurance program if resident in a certified State.

Even the truncated Medicare program, as proposed by the bill, would be available only in States certified under section 1861.

Section 1861 is a section which looks to the States for regulation of insurance carriers, including keeping their rates within reasonable limits for the employee insurance program.

It looks to the States for regulation of the charges or rates of institutional and other health care providers, and it looks to the States for the certification of participating providers, both institutional and noninstitutional.

I think the whole trouble of the administration's bill in this respect springs from the fact that it looks to the States for this and has no substitute in the event that a State either chooses not to participate in this regulatory program, or does not meet the Federal requirements.

To me, it is unthinkable that a straight Federal program would be created—there are two such programs here, the new Medicare program and the Employee Health Insurance Program—which relies entirely on the cooperation of the States.

It may be entirely appropriate for the States to be invited to discharge these functions even in those two programs, but if a State chooses not to, that should not result in penalizing individuals that live in such a State.

So I think it would have been essential for the bill to provide that if a State does not undertake these functions, or, having done so, does not carry them out, the Federal Government would do so. The bill not only fails to provide for this but does not even provide for decertification of a certified State that so changes its law as to be no longer certifiable, or that fails to carry out its law.

It seems to me that when a straight Federal health insurance benefit program denies to an individual participation and eligibility unless he resides or is employed in a certified State, it thereby discriminates against individuals residing in another State in such a manner as to raise a serious question of constitutionality under the Fifth Amendment, which in recent times has been interpreted by the Supreme Court to embody in effect an equal protection clause.

Apparently, the administration just shrank from the idea of having a so-called march-in provision in the bill which would operate in the event the State does not participate, even though such a provision had been included in amendments submitted by Secretary Richardson to the administration's health insurance proposal in the 92d Congress.

Bill Amends IRS Code

Again, on the last page of the bill—and this is all connected with this pervasive problem—the bill amends the Internal Revenue Code so as to make subject to Federal employer and employee hospital insurance taxes the States of the Union and municipalities and employees thereof that are now exempted from these Federal taxes, but this is effective only with respect to wages in States certified under section 1861. In

other words, States would be taxable as employers if they are States certified under section 1861. So would municipalities in such a State.

And they would not be so taxable if the State is not certified under that section. Here again, I think a serious constitutional question is presented, and this wholly apart from the unsettled and sensitive question whether States may be federally taxed on the privilege of employment. The tax on employers is an excise tax. The Constitution of the United States, if I remember my constitutional law, requires that Federal excise taxes shall be uniform throughout the United States. With respect to the tax on wages of employees of States and municipalities, which is an income tax, the fact that the tax would be laid only on employees in States certified under section 1861 raises a question under the due process clause of the Fifth Amendment, which has in recent years been held to embody the concept of "equal protection."

So this, I think, raises serious questions.

For noncertified States, what the administration bill would do is amend section 218 of the Social Security Act, which now provides for Federal-State agreements for coverage of State and local government employees under title II of the Social Security Act (including Medicare), in return for the State's undertaking to pay amounts equal to payroll and wage taxes. Under the amendments, States that have such agreements would have to pay the equivalent of the Federal hospital insurance taxes, only if the State is not a State certified under section 1861.

The mobility of our population also poses a problem as between the so-called "old Medicare" ssytem, which would be continued for persons who reside in States that are not certified, and the new system which would be available only to residents of certified States.

Problems in Moving From State to State

Thus, as a person changed his residence from one State to another, he could move from the old Medicare system to the new one and vice versa, regardless of the State in which his qualifying wages were earned, yet wages and self-employment income earned in a certified State would go into the new trust fund and those hereafter earned in a noncertified State would go into the old hospital insurance fund. This could create quite a problem especially for an aged person who wishes to move from a certified State in which he has earned his wages to a noncertified State.

It also might have a chilling effect on the freedom to travel from State to State—to which the Supreme Court has paid much attention in recent years. I am not prepared to say that that aspect would necessarily be unconstitutional, but it raises a real doubt on that score, too, and would seem to put a heavy burden on the Government to sustain the approach of the bill against attack on that ground.

On philosophical grounds, as I indicated at first, all of these matters are also very, very questionable in my view.

Mr. Brickfield. Finally, Mr. Larry Lane on the disclosure provisions on the ownership of nursing homes.

STATEMENT OF LAURENCE LANE, NATIONAL RETIRED TEACHERS ASSOCIATION-AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. LANE. Yes, sir; I would just make several comments briefly.

Probably one of its greatest areas of success of the Senate Special Committee on Aging has been in the area of extended care. And, in particular, one of the major accomplishments which this subcommittee cooperating with the subcommittee on Long-Term Care was able to get through the 92d Congress in the passage of Public Law 92–603 was to get some meat into the definitions within section 1861 of the present law.

One of the areas where we did get some substance was to require disclosure of ownership, and I must say that it is a very minor point when you look at this bill. However, when you come on third in a list of witnesses, you are looking for some new things to say.

One of the things that really bothered us, and I think it bothers others in this room—Val Halamandaris, I know, feels this way—is in the list of definitions on skilled nursing facilities they deleted the requirement that was imposed by Public Law 92–603 on disclosure of ownership.

In response to our question on home health care services, we received the answer from the Department of Health, Education, and Welfare—"Oh, the fact that we dropped 100 days of home health care were just an oversight."

Senator, we can't believe that they dropped the disclosure requirement on skilled nursing care as an oversight because all they needed to do was to photostat that page of the statute, and it would have read in sequence.

HOME HEALTH SERVICES

You don't go from No. 9 to No. 11. As it relates to home health services, if I may just add another comment, we feel that the administration's bill falls way short. Our associations are very pleased with the leading effort that you have been giving in the area of home health care to improve services, to expand services, and to make that section of the Social Security law of the Medicare section have substance. I might add that in the piece of legislation which we have drafted, which Senator Ribicoff is introducing, we provided for unlimited home health services—in many ways copying what your committee has suggested was needed.

One other deletion in the administration's bill is in the definition of physician's services, the administration's bill drops even the limited provision for chiropractic service that was put in for us by Public Law 92–603.

I would suggest that the members of this committee might wish to very carefully review those definitions when you make your recommendations to the Senate Finance Committee.

Somehow in those definitions some of the things that have been done already seem to have disappeared.

We can't believe that all of them were by oversight.

Senator MUSKIE. Thank you very much. You have given us a great deal to digest, and I am sure it will all be very helpful.

May I say that on the question of finding something new to say, that repetition in this field is often as useful as something new, so we ought not be overly concerned. But I understand what you are saying.

I have just three or four questions that might be helpful for you to respond to.

Lack of Standards

On page 94 of your detailed statement, you mention a criticism of CHIP: The lack of standards for the promulgation of regulations by the Secretary regarding State reimbursement standards which, in your words, "seems to be an unwise abdication of responsibility."

Could you enlarge upon the possible consequences of this?

Mr. Hacking. Yes, Senator, as I said earlier, without describing in the bill procedure for reimbursement and the standards to be used, there is nothing there on which to base reimbursement. I think the end result is going to be an exacerbation of the problem we've been having throughout the Medicare period with rising costs—especially, rising hospital costs.

The administration's bill would apparently wipe away all the standards that are presently in the Medicare law.

The "reasonable costs"—the "reasonable charges"—standards and all that goes with it—it's just wiped away in the case of the Federal health care insurance programs in certified States.

In noncertified States, I would assume that the existing standards would continue to apply. They are going to have tremendous administrative problems where you may have different reimbursement procedures for different States—and, indeed, different reimbursement procedures functioning in the same State. The whole thing just couldn't possibly work without uniformity across the entire country.

I think that the administration has not considered this matter as well as it should. I certainly hope the Congress would before this particular bill begins to move along.

There are other problems that will arise because of this lack of uniformity. The fate of the disabled is a great concern of ours, and we make several points about it in our prepared statement.

We thought we were making some progress by extending Medicare coverage to some of the disabled. We also hoped that when some statistics were available as to what the cost of covering the disabled would be, we would be able to expand and extend that coverage.

But this particular bill would leave them under the assisted health care insurance programs in certified States provided that those certified States decided to establish such a program.

But there is nothing in that bill that requires as a condition for certification that a State establish such a program.

Since the disabled are not covered under the Federal Health Care Insurance program which would apply in certified States, but a certified State decides not to establish an assisted health care program because it doesn't think the Federal grant is adequate, then the disabled are without protection—even those disabled who are presently covered with Medicare.

Mr. Lane. Senator, I would add that I believe we have learned from Medicaid that sometimes this did not work, leaving it to the States.

The requirements written into the original Medicaid law have since been deleted—the requirements of keeping care up, requirements of having a program in full.

Those requirements when it gets down to the cost analysis at one point or another get amended so they no longer have any merit. This has happened with Public Law 92–603.

Fragmentation of Program

Senator Muskie. You seem to have the same evaluation that Mr. Cruikshank has. What this does is create more than 50 systems that would probably insure inadequate protection and fragmentation of the program.

Mr. Ellenbogen, I just want to emphasize a point you raised. If a person pays payroll tax in the State of Michigan, then moved to a noncertified State, would he be entitled to nothing?

Mr. Ellenbogen. Under the new Medicare? That's exactly right, so long as he remains in that noncertified State, but he would be entitled to benefits under the old Medicare system that the bill would continue in such States. But the Hospital Insurance Trust Fund under the old program would not be replenished from earnings in Michigan if that's assumed to be a certified State.

First of all, the new section 1831 says: "The Secretary shall establish a Federal health care benefits program"—that's on page 27 of the bill—under which an individual residing in a State certified by the Secretary under section 1861 would enjoy entitlement to the new program.

Then the effective date provision, on page 104, says in effect:

> Notwithstanding the general effective date provision, the provisions of title XVIII of the Social Security Act as in effect prior to the enactment of this act shall remain in effect on and after January 1, 1976 with respect to individuals entitled to hospital insurance benefits under section 226 of the Social Security Act as amended by this act.

Note that this bill amends section 226 so as to limit entitlement to the old Medicare, which is based on section 226, to individuals residing in a noncertified State.

So, going on here: shall remain in effect on and after January 1, 1976 with respect to individuals entitled to hospital insurance benefits under section 226 of the Social Security Act as amended by this act, "and wages and self-employment income earned in States not certified by the Secretary under section 1861 of the Social Security Act, as amended by this act." The phrase I have quoted with respect to earnings in noncertified States would have the effect of continuing to earmark the taxes on those earnings for the present Hospital Insurance Fund, from which part A of the present Medicare program would continue to be financed. Whether such financing would then be adequate is, of course, speculative.

But individuals while residing in States other than those certified, could come in only under the preexisting Medicare program, no matter in which State the qualifying wages were earned.

So if they have moved from State to State, some States certified, some not, this might seriously adversely affect their rights.

It would create a rather confusing situation in addition to the inequities that would arise, and may raise constitutional questions.

Senator MUSKIE. You certainly would need a lawyer. [Laughter.]

Could I ask some questions about your plan? What role would insurance companies and fiscal intermediaries have in your plan?

Mr. BRICKFIELD. Do you mean the Senator Ribicoff bill?

Senator MUSKIE. Yes.

Mr. BRICKFIELD. There will always be need, we feel, for supplemental insurance coverage. While our bill goes a long way, even under it there will be need for supplemental insurance coverage because of its copayment features.

Of course, as you know, when Social Security was enacted in 1935 many thought that we wouldn't need pension systems. Well, we need more pension systems than ever.

When Medicare was enacted in 1965, they thought that this would do away with supplemental insurance provided by the insurance industry. It hasn't done that, Senator.

What it has done is bring about an awareness on the part of people for better and more medical care.

As long as that concept exists, we feel that there will be a need for supplemental insurance. And I will tell you that our associations would hope to provide, or make available, or recommend, high-quality supplemental insurance in the health care field.

Mr. HACKING. Senator, could I supplement Mr. Brickfield's answer?

Senator MUSKIE. Yes.

Mr. HACKING. Besides the risk-bearing function of private insurers to which Mr. Brickfield was addressing himself, our bill would in administering coverage and so forth, also use private insurers as fiscal intermediaries in much the same way as they are presently used for Medicare in the administration of the Medicare program.

MEANS TEST

Senator MUSKIE. With respect to your program again, I understand that you also impose a means test. Do you feel that your members would not oppose such a test?

Mr. BRICKFIELD. I will let Mr. Hacking answer that, Senator. We don't think it is semantics; we think it's an income test rather than a means test. But I would defer to Mr. Hacking.

Mr. HACKING. Senator, the bill that was introduced today is really the second version of our bill. In 1972, we had a health care bill that provided benefits very similar to those in our bill today; benefits constituting comprehensive protection for the elderly.

At that time, of course, the disabled were not covered under Medicare. So our bill was directed at older persons age 62 and over.

That bill was S. 4101. It was introduced by Senator Pell and did not contain any cost-sharing features. We felt that every older person should have a right to comprehensive health care without this combination of deductibles, coinsurance, and premiums that is presently in our Medicare law.

We found however, that as a political and legislative reality, we could not, without great difficulty, get anyone to sponsor that bill.

Many Senators and Congressmen we approached felt that, in return for comprehensive protection, the aged should pay something.

For others, the cost was simply too high. The added cost to the Federal Government under that first bill would have been something in the neighborhood of $19 billion.

The individuals that we approached, seeking sponsors, simply thought the cost was too much or thought that the cost should be shared.

We decided we would work on a second bill. We wanted to do that because we felt that in all the discussion about national health insurance legislation, the aged were being overlooked.

People were saying, "Well, they've got Medicare."

We felt a strong need to focus some attention on the aged and disabled. So we worked out a second bill.

We wanted to have it receive legislative consideration. We wanted it to be something that would generate some discussion of the health care needs of the aged by the committees of Congress with jurisdiction over that kind of legislation.

We felt it necessary therefore to introduce some sort of cost-sharing features. We looked at what others have done. We looked at H.R. 1, and we looked at the Kennedy bill, and we looked at some of the other bills that have come along like the Long-Ribicoff bill.

These bills contain catastrophic protection benefits. Most often, catastrophic benefits are defined in terms of income. In most of those bills a catastrophe is viewed as a relative thing and defined in terms of income.

So we put in a test for purposes of the catastrophic feature—you may want to call it a means test, if you like—I prefer to call it an income test, and I prefer to call it that because it defines what a catastrophe is with respect to different categories. The "test" is used only for the purpose of the catastrophic feature. Our "test" has nothing to do with eligibility for coverage as is normally the case with a means test.

I would also add this: our bill in its financing would use a number of different methods. It would use some payroll tax contributions, but it would also use a substantial amount of general revenues. We think this is the way we should be going.

And we think that to the extent you get away from the payroll tax manner of financing, and get away from insured status under Social Security for covered services, you can also get away from this rigid adherence to this principle that there should be no means test in a social insurance program. If our bill is social insurance, it is social insurance in a very diluted form.

We are going to use general revenue contributions to a substantial extent. We don't think it is too much to ask that the elderly and the disabled should be somewhat responsible for part of the cost by contributing something for the comprehensive care they receive.

Low-Income Persons Exempt

We do, however, think that a low-income person should not have to pay anything. Consequently, our catastrophic protection benefit

provision would exempt all low-income persons as they are defined in dollar terms from any cost sharing under our bill.

And our bill simply has one cost-sharing system; it's simply copayments. There is no combination of deductibles, premiums, coinsurance and so forth.

The low-income are exempted completely from cost sharing. Not only that, they are also exempt from any out-of-pocket expenditures for health care services that are covered under our bill, but are durationally limited.

The individuals who are in categories or classes above the lowest class would be required to pay something related to their income, but certainly no more than $750 a year for a family. We think the cost sharing is very minimal and we think that to seize upon this test as a means test is a little bit unfair.

I think it is unwise at this point. If we come down to a choice, Senator, between getting comprehensive health care protection for the elderly while all these questions with respect to national health insurance, like delivery, and the extent of the benefit package, and so forth, are being resolved, or adhering to the principle that there should not be a means test in any social insurance program, we'd opt right now for comprehensive health care protection.

Senator MUSKIE. My only purpose in raising the issue is to get an explanation. You said that the cost of your original bill would have been $19 billion. What is the cost of this one?

Mr. BRICKFIELD. $17 billion.

Mr. LANE. I would add, Senator, on that $17 billion, I do have marked up here—we're speaking approximately of an induced cost with $2.5 billion, transferred from the private sector of approximately $11.5 billion, transfer between States and local government—current Medicaid costs transferred back to the Federal Government—approximately $3.1 billion.

So the total additional cost that we are speaking of, which would be your induced cost, and you transfer from the private sector, would come to approximately about $14 billion. That is in addition to current Medicare expenditures.

Senator MUSKIE. Which figure would you use to compare with your original $19 billion?

Mr. HACKING. Senator, I would like to point out that our original bill would have only covered the aged. There was no coverage there for the disabled because they weren't covered under Medicare at the time.

That $19 billion figure would have been substantially higher if our original bill had also covered the disabled. We would probably be talking about $22 billion, or more.

You have got to understand in comparing the costs of our two bills that the persons who would be covered under our bill now are two groups: the aged and the disabled, whereas, under the prior bill, there was just the aged.

Mr. BRICKFIELD. I would like to make this chart a part of the record, if I may, Senator.

Senator MUSKIE. Of course.

TABLE 1.—*Estimate of added cost to Federal taxpayers of proposed national health bill dated February 25, 1974*

	Millions
Transferred from private sector	$11,514
Transferred from State and local governments	3,116
Induced cost to Federal Government	2,485
Total	17,115

TABLE 2.—NATIONAL HEALTH EXPENDITURES AFTER TAX ADJUSTMENT BY PROPOSAL FISCAL YEAR 1974

[In billions of dollars]

Proposal	Total	Private sector				Governmental sector		
		Total	Individual direct payments	Health insurance	Other	Total	State and local	Federal
1. None	105.4	62.3	32.0	26.4	3.9	43.1	11.1	32.0
2. AARP (March 1974 estimated)	107.9	50.8	22.5	24.4	3.9	57.1	8.0	49.1
3. Ullman	112.3	55.7	22.1	30.3	3.3	56.6	6.5	50.1
4. Griffiths-Corman	113.8	15.9	11.2	1.9	2.8	97.9	6.5	91.4

Senator MUSKIE. It seems to be the same price tag.

Mr. HACKING. But we expanded the coverage.

Senator MUSKIE. I understand. I am just trying to measure the shock effect that persuaded you to move to the income test.

Mr. LANE. Senator, on working on this, we did our best to try to get the cost—to be as cost conscious as possible.

But, again, we do stick to this feeling that health should be a right and cost should not be a deterrent. Therefore, that's what we ended up with.

Senator MUSKIE. I understand the problem. I was just trying to get a definition of the basic thrust of your bill.

You do have some small copayments. Would you comment on whether they would be such as to have a real impact on utilization?

COPAYMENTS IMPACT ON UTILIZATION

Mr. HACKING. No, Senator, it is very unlikely that they are going to have an impact on utilization. As a matter of fact, as far as we're concerned, we don't think that the deductibles and coinsurance of the present law, really have an effect on utilization of services.

They may have an effect on utilization with respect to some of the less costly items like physician services, services of optometrists, and so forth, but when you are talking about hospitalization, we just don't think that deductible coinsurance, copayments, or anything like that, are really going to hold down utilization unless the cost sharing is so high as to preclude its serious consideration by the Congress.

If you charged enough by way of copayments, coinsurance, deductibles, or whatever, certainly you would have an effect on utilization. But you would have to charge substantial amounts.

Senator MUSKIE. How would you apply that principle to the administration's proposal for cost sharing?

Mr. HACKING. Well, the cost-sharing provisions under each of those basic programs under the employee health care insurance, assisted health care insurances, and so forth, all differ.

Certainly the cost sharing is more substantial under the employee health care insurance plans. We don't think that the cost-sharing features under the Federal health care insurance program would be completely able to restrain utilization, but it would affect short-term health care services.

We didn't consider the employee health insurance plan and the assisted health care insurance program in as much detail as we considered the Federal health care insurance program.

Senator MUSKIE. If you recall Mr. Cruikshank's testimony, the increased costs for short-term care for the elderly, from the President's proposal, was rather substantial—as much as 200 to 400 percent.

You don't regard that as inhibiting utilization?

Mr. HACKING. Well, the higher the cost sharing, the more likely the restraint on utilization.

But it's really hard to say. If a doctor says you need hospitalization, for example, and it's either that or die, how many people sit down and figure out what it's going to cost?

Senator MUSKIE. Under that analysis, there is no inhibition at any level.

Mr. HACKING. I don't know what the level is, Senator, I'm just speculating.

Mr. LANE. You might add, Senator, the deterrent cost of the initial cost, if there is any administration bill, is quite substantial and it may be a deterrent to the individual to seek medical care, to seek hospital care.

But a decision to put an individual into the hospital is not the consumer's decision. It is the physician's. Therefore, when Jim was speaking of the effect on utilization, he was speaking in terms of cost-consciousness. One of the arguments that the administration has used is that the impact would be to lower utilization into lower costs.

OUT-OF-POCKET COST

In looking at it from the consumer's standpoint there definitely would be a great out-of-pocket cost, and there may be an effect—which this committee explored last year—that an individual would deter seeking medical care on preventive, or just on a regular basis, and instead would hold off until his situation was so acute that he would require a higher level of care.

Therefore, not only would the cost to him be greater but the cost to the providers, or Medicare, would be greater—because he would need acute care at a greater degree.

But we really don't have the statistics to fully comment on where this level of marginal deterrents might be.

Senator MUSKIE. Well, in my statement I used an illustration, which you may recall: a 12-day stay would cost $344 under the President's proposal as opposed to the present charge of $84.

Is that kind of escalation likely to have an impact on utilization, in your judgment?

Mr. LANE. The statistics that were drawn up on the SMI program of Social Security would give you an indication that as it relates to current utilization, the cost level of seeking care would have been income related.

The impact has been that for those who are in the low-income class and had Medicaid, there has not been that great a difference in utilization.

For those with higher incomes there seems to be a higher use of utilization.

Those in the intermediate range—those just over the level of Medicaid into a moderate income level have appeared not to use the SMI supplemental medical insurance benefit.

So, obviously, there is some statistical information available to indicate that the deductible, or threshold cost such as imposed in the Nixon bill, would in fact have a deterrent effect.

But the analyses which we presented here last year before your committee also pointed out that when you were talking of hospital care, you are talking about a description of utilization that is not in the consumer's hand.

And this is where the figures on the out-of-pocket cost of $375, or so, might be a deterrent because the individual may not be able to afford to seek treatment.

Bill May Put Elderly in Worse Shape

Now we would agree that this is an extremely high level out-of-pocket payment and the fact that the administration's bill emphasizes short-term out-of-pocket costs to the individual, that we are in fact in a position here where this bill may put most elderly in a worse shape than they are now.

Senator Ribicoff has done work and has figured out that $1.2 billion in out-of-pocket costs to the elderly if you use the statistics that are available for utilization rates in the number of hospital stays.

Senator Muskie. You still seem to minimize the impact on utilization of increases in cost sharing.

Let me put the question this way: Are you saying that if we had no Medicare program that all the people who have been benefited by, and who have health care under the program, would have had it anyway?

I mean, that they would have made the decision to go to hospitals, or doctors, even without Medicare?

Mr. Hacking. Absolutely not, Senator, a person who can't pay for hospital services, probably would not receive those services.

If he can't pay for it then he can't obtain the service, even if it is recommended by a doctor. You are asking——

Senator Muskie. So it is true that it does decrease utilization?

Mr. Hacking. At some point, that's true. We think that the administration's cost sharing is substantial. It is more than the aged would have to pay under the present law. We think that is a step backward—and a major step backward.

We are interested in going the other way. We are interested in providing comprehensive protection and reducing out-of-pocket costs.

The administration is really going backward here. It is quite obvious we don't support the cost-sharing features of the administration's bill. We think the principle of catastrophic protection is a good one but that doesn't mean we are also supporting the cost-sharing features that were introduced in the administration's bill in order to determine when catastrophic protection takes hold.

Senator MUSKIE. I just wanted to make sure that the record was clear as to what your position was.

I appreciate your testimony and I appreciate your unveiling your plan before this subcommittee. I look forward to studying it with interest.

Thank you very much.

[Whereupon, the hearing was recessed at 1:10 p.m.]

APPENDIXES

Appendix 1

SENATE REPORT NO. 93-131, SUBMITTED BY SENATOR J. GLENN BEALL, JR.

NATIONAL INSTITUTE OF HEALTH CARE DELIVERY ACT OF 1973

APRIL 27, 1973.—Ordered to be printed

Filed under authority of the order of the Senate of April 18, 1973

Mr. KENNEDY, from the Committee on Labor and Public Welfare, submitted the following

REPORT

[To accompany S. 723]

The Committee on Labor and Public Welfare, to which was referred the bill (S. 723) to establish a National Institute of Health Care Delivery, and for other purposes having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

SUMMARY

S. 723 amends the Public Health Service Act to establish a National Institute of Health Care Delivery as a separate agency within the the Department of Health, Education, and Welfare.

The Institute's mission will be to carry out an accelerated multidisciplinary research and development effort to improve the organization and delivery of health care in the nation.

The bill also authorizes up to eight regional centers and two National Special Emphasis Centers, a Health Care Technology Center, and a Health Care Management Center.

The total authorized funding level for both the Institute and the Centers will be $100 million for the initial year, $150 million for the second year, and $180 million for the third year, for a total authorization over the three year period of $430 million.

A twenty-one member National Advisory Council on Health Care Delivery will advise the Institute on the development, priorities, and execution of its program.

Background and Need

S. 723 was introduced on February 1, 1973 by Senator J. Glenn Beall, Jr., and was cosponsored by Senators Peter Dominick, William Hathaway, Ernest Hollings, Jacob Javits, John Pastore, Ted Stevens and Milton Young.

The proposal was initially introduced as S. 3329 in the 92nd Congress and was considered by the Labor and Public Welfare Committee in connection with the Health Maintenance Organization and Development Act of 1972, S. 3327. The Committee incorporated the Institute as Title V of S. 3327, which was subsequently considered and passed by the Senate on September 20, 1972, by a vote of 60–14. No opposition was voiced during Senate consideration of the HMO legislation to the Institute though the Committee made a number of modifications to the bill as introduced in order to conform it to other related provisions of S. 3327, particlarly with respect to the Commission on Quality Health Care Assurance as authorized by S. 3327.

Senator Kennedy reintroduced the HMO legislation, S. 14, in this Congress in the identical form, including the National Institute of Health Care Delivery, as passed by the Senate last year. The Committee, in order to give this proposal the visibility and national attention it deserves and merits, decided to report this measure as separate legislation. The Committee was unanimous in recommending favorable action by the Senate on S. 723 but the version reported by the Committee does not contain the conforming amendments to the HMO bill referred to above, since the Committee decided to report it as a separate bill.

Since World War II, the United States has invested approximately $20 billion in biomedical research. This investment has produced many dividends in terms of major medical breakthroughs and has made the nation preeminent in the world in medical research.

On the other hand, comparatively small investments have been made in research and developments to improve the organization and delivery of health care. Appropriations for fiscal year 1973 contrast our investment in medical research as compared to health care delivery research. The total outlays for fiscal 1973 for the National Institutes of Health, the Federal Government's chief biomedical research organization, is estimated to be $2.009 billion, while the estimated budget for the National Center for Health Services Research and Development for the same year is $64.4 million. By citing this contrast, the Committee is not suggesting or implying that spending on medical research is out of line. To the contrary, the Committee and the Congress have supported an acceleration of the nation's research effort. The Committee does suggest that this disparity in spending between biomedical research and health care delivery research may help account for the nation's preeminence in biomedical research, the deficiencies in our present delivery system, and the growing gap between what medical science knows and what is delivered to our citizens.

The American people are aware of and grateful for the achievements of medical science, but they are also aware of this "gap" which is a source of public dissatisfaction. Our citizens marvel at the miracle-like heart transplants that are taking place, but their plea to the health care community is to make available, accessible, and affordable

the achievements, methods, and procedures developed by medical science over the last quarter to one-half century.

To develop the means and methods to deliver the results of medical research and know-how to our citizens, wherever they live and at a price they can afford, is the principal task facing our nation and the health community. This is the challenge that will be the work of the National Institute of Health Care Delivery.

Committee Concerns

The Committee wishes to emphasize in very strong terms that the mandate given to the National Institute of Health Care Delivery will be very difficult to carry out and that it is, therefore, essential that the activities of the Institute be undertaken in a prudent and orderly manner. The dual goals of the Institute are to enhance the breadth and effectiveness of health services research and development in the nation through an expansion of available funds and through the transfer of the National Center for Health Services Research and Development to the Institute and to create a capability to carry out health policy research, development, and training through the staff of the Institute, and the Regional and Special Emphasis Centers.

While this innovative approach to policy research and formulation is, in the Committee's view, urgently needed and deserving of support, there are serious constraints which will plague this effort. These constraints are: (1) there is in the nation essentially no tradition of health policy research and development and no suitable models on which to base the establishment of a complex, large, and multi-faceted R&D effort. (2) there is in the nation essentially no body of experienced managers to initially head up an effort of the magnitude the Committee's bill ultimately envisions. (3) there is in the nation a critical shortage of qualified professional personnel in respect to the broad-based function of the Institute and, therefore, the recruitment of adequate numbers of such persons will be arduous.

Given these formidable constraints, it is clear that it is not possible to draw a complete analogy between this proposed Institute and the ongoing National Institutes of Health. When the NIH was established (in 1937), there was a large pool of well-trained biomedical researchers who were then constrained principally by the lack of money and resources with which to carry out high-level biomedical research. At that time, there was also a large body of potential investigators eager for training if resources could be made available. Such is not the case in health policy research today, in which there is only a small body of practitioners from economics, law, medicine, social sciences, etc., which has specialized in the conduct of the kinds of efforts which are intended to be carried out by the Institute.

The Committee, therefore, believes that, if the efforts of the National Institute of Health Care Delivery are to be successful, priorities must be set which will take cognizance of these constraints. For example, the small number of qualified policy analysts leads the Committee to the conclusion that only a few centers of excellence are possible at the outset of the Institute's activities. The Committee also urges that the Institute devote a major share of its effort to the creation of a major intramural health care research effort analagous to the clinical center of the NIH. The Committee also urges the estab-

lishment within the Institute of a specific unit charged with supporting and developing training programs and training centers for health policy and health care research workers. The expansion of trained manpower in this area is absolutely essential to the viability of the Institute's long-term program. The Committee further urges that the Institute and the Department of HEW give serious thought to the relationships between the Institute's program and the Lister Hill Center for Biomedical Communications which is located in the Department at the National Library of Medicine.

In summary the Committee wishes to stress that the initial years of operation of the Institute will be critical in respect to the long-term success or failure of the Institute, and that the decisions that are taken in respect to the initial year's activities should be made with the greatest possible care, commonsense, and vision.

Finally, the Committee believes it is essential that the legislation establishing the Institute be compatible with those provisions of the HMO legislation, S. 14, particularly the proposed Commission on Quality Health Care Assurance.

Present Efforts Inadequate

The present effort in this respect is largely the responsibilty of the National Center for Health Services Research and Development. This Center presently is buried in the Department of Health, Education, and Welfare, being one of many units of the Health Services and Mental Health Administration.

The Committee's bill proposes to transfer and upgrade the National Center by transferring it to the new Institute. At its present layer in the Department, the Center lacks visibility and its clout is small. It lacks an effective organizational structure and the flexibility that characterizes many government research and development organizations. It is not funded adequately. It does not even have a real legislative mandate as it operates only under general research authority.

Although some interesting efforts have been undertaken at the Center and elsewhere, efforts to date for the most part have contributed disappointingly little either to a solution of the problems of the present delivery system or to the creation of alternative systems. Important questions raised about health care delivery ten years ago are still being asked today.

The Committee is of the opinion that we cannot wait another decade for these answers, not only because of the urgency of these problems, but also because decisions with respect to the directions of health care delivery must be made.

To help find the answers to the many health care delivery questions, the Committee believes that research into health care delivery must be made as important as medical research. A new National Institute of Health Care Delivery, with a clear legislative mandate, top management, the necessary organizational structure and administrative provisions, and adequate resources, is needed, in the judgment of the Committee, to achieve this objective.

Location and Approach

The National Institute of Health Care Delivery will be a separate agency within the Department of Health, Education, and Welfare

comparable in organizational structure to the National Institutes of Health. This organizational position is needed in view of the urgency of the health care delivery problems. This elevated structure will give health care delivery research and development the necessary visibility and raise its stature among the public, the health community, and within the government; will permit the new Institute to attract the necessary top management and the talented men and women; and provide the needed strong voice for an increased investment and interest in research and development in health care delivery.

The Institute, in carrying out its research and development efforts, will utilize the multidisciplinary approach. Teams from such academic disciplines as health, medicine, economics engineering, science, accounting, statistics, social sciences, architecture, law, education, and the management sciences, will interact and devote their energies and their attention to an objective inquiry in the public interest and generate action and problem oriented research on the critical and complex problems of health care delivery.

In research and development, one frequently hears the concept "critical mass", a term borrowed from nuclear physics. In research and development this term is used to indicate the minimum size and composition needed to achieve a self-sustaining, creative atmosphere for the undertaking.

The number necessary for this "critical mass" varies with the undertaking. In theoretical basic research, one or two researchers may be adequate. On the other hand, in complex and large research efforts, the "critical mass" may require many more individuals from many disciplines. In these larger and more complex undertakings when the "critical mass" is not achieved, researchers tend to pursue smaller tasks, individually. The Committee believes that the "critical mass" concept is an important one and that the synergism that can occur when a "critical mass" of problem solvers from many academic disciplines interact has not been adequately developed.

Professor William B. Schwartz of the Tufts University School of Medicine last year emphasized the importance of the multidisciplinary approach when he said:

> There is a clear implication that the problems will require a multidisciplinary approach—we are not simply dealing with economic problems to be formulated and analyzed by economists or manpower problems to be dealt with by physicians. The problem of delivery or primary medical care, for example, obviously has an enormous number of facets. It involves not simply a question of more and larger medical schools training more physicians but a range of issues including the maldistribution of physicians, inducements to rural and ghetto practice, restriction of physician entry into specialties that are overpopulated, the use of allied medical personnel to replace physicians in the delivery of primary care, the introduction of computer-aided diagnosis and management as a means of upgrading the non-physician's performance and increasing his range of responsibilities, the use of television as a link between doctors and patients, and the introduction of new transportation strategies as a means of making high quality care available to areas of low population density.

> In weighing these approaches, consideration must also be given to patient acceptance of new personnel and new technology, to the reliability of computer-aided diagnosis and managment, to the response of the physician to incursions of new health personnel and new technology into his domain, to legal problems related to licensure and malpractice, to the time lags involved in the introduction of new strategy, and to the trade-off between quality and quantity that is implicit in changing the traditional patterns of health care. Only in this way can we allocate resources appropriately and can a desirable mix of manpower and technology be brought to bear.

The need for improved policy analysis in the nation is critical. Even the Department of Health, Education, and Welfare with its enormous responsibilities has only a small number of individuals at the secretariat level dealing with these matters and their time and attention are too often devoted to "fire fighting" or responding to daily crises. As a result, little if any time remains for exploring long-term issues, no matter how important. The situation in the Congress is similar with the pressures of everyday work and legislation preventing only negligible attention to policy analysis.

Yet, the resolutions of major policy issues will fundamentally shape the future of health care in the United States. Thus there is an urgent need for the development of important analytical capabilities to cope with the larger, more complex, and in the long run, the more important health issues.

Policy analysis will be an important part of the work of the Institute. The Committee intends that there be established within the Institute a Health Policy Analysis division to enable groups of professionals to concentrate on long-term policies in the health field.

The Institute will be headed by a Director, appointed by the President with the advice and consent of the Senate. The Director's salary will be at Executive Level Four, which is similar to and competitive with other Federal Research and Development agencies. The Director is authorized to appoint a Deputy Director and up to four Assistant Directors.

Mandate

The National Institute is provided with a board legislative mandate to examine all aspects of the health care system and the ways and means to improve that system, as well as the devising and testing of alternative systems. Its functions will be carried out through both an intramural capability and through an extramural effort at the Regional Health Care Centers and two National Special Emphasis Centers, the Health Care Technology Center and the Health Care Management Center, and through broad authority to: (1) make grants to states, political subdivisions, universities, hospitals, and other public or nonprofit agencies, institutions, or organizations and (2) contract with public or private agencies, institutions, or organizations for the conduct of research and development, experiments, studies, demonstrations, and the training of individuals to plan and conduct such efforts.

Specifically, the Institute is directed to "pursue methods and opportunities to improve and advance the effectiveness, efficiency,

and quality of health care delivery in the states, regions, and communities of the United States, through initiation and support of studies, research, experimentation, development, demonstration of, but not limited to, the following:

(1) The existing health care system, emphasizing means and methods to improve such system and the devising and testing of alternative delivery systems;

(2) Health care systems and subsystems in states, regions, and communities which give special attention to the effective combination and coordination of public and private methods or systems for health care delivery;

(3) Preventive medicine and the techniques and technology, including multiphasic screening and testing, to improve the early diagnosis and treatment of diseases, particularly for preschool children;

(4) Systems and technical components of emergency health care and services (including at least one experimental statewide helicopter transportation emergency care system), which utilize, where possible, the skills of returning military corpsmen;

(5) Systems and components of rural health services;

(6) The development of policy with respect to long-term care, particularly for mentally and physical handicapped individuals and senior citizens, with special emphasis on alternatives to institutionalization, including the use of home health aides;

(7) Methods to meet the Nation's medical manpower requirements, including new types of manpower and their utilization and the extent to which tasks performed by physicians and other health professionals may be safely delegated to other appropriately trained individuals in both new and existent health occupations;

(8) Continuing education and the exploration of programs and methods to help health professionals to stay abreast of current developments and to maintain professional excellence;

(9) Health manpower credentialing, licensing, and certification;

(10) The medical malpractice problem, particularly as it relates to quality care, the practice of 'defensive medicine' and added costs to the public;

(11) Programs for educating health manpower and the accreditation of such education programs;

(12) Application of all forms of technology, including computers and other electronic devices, in health care delivery;

(13) The efficiency, management, and utilization of new and existing health care facilities including studies of admission practices and examination of cost-finding techniques;

(14) The development of tools and methods to improve planning, management, and decisionmaking in the health care system;

(15) The development of information by which quality, efficiency, and the cost of health care may be measured;

(16) The development of uniform accounting practices, financial reporting, and uniform health records;

(17) The development and testing of incentive payment mechanisms that reward efficiency in health care delivery without compromising the quality of care;

(18) The needs of individuals, families, and groups for health care and related services, emphasizing the various life styles, including environmental, recreational, and nutritional factors that bear on an individual's health; identification of those factors affecting acceptance and utilization of health care and related services; and the development of educational materials and methods communicating to the public the importance of personal decisions and actions on health;

(19) The economics of health care and related services, and the impact of the total system of health care delivery and related services upon the standards of living and the general stability of the national economy;

(20) Proposals for the financing of health care, including the potential cost and benefits, and their impact on the health care system;

(21) Concepts and data essential to formation of a factual basis for national health policies; and

(22) The effects on health care delivery of the organization, functions, and interrelationships of Federal, State, and local governmental agencies and programs concerned with planning, organization, and financing of health care delivery.

Training and Technical Assistance

The Committee is aware that our ability to expand research and development in the health field will require additional skilled, and talented personnel. The Committee is further aware that the number of economists, health professionals, engineers, lawyers, and other experts, qualified by training and experience to work in the health policy field is limited. The Committee believes, however, that the flexibility granted to the Institute and its Centers will assist it to recruit qualified individuals.

Similarly, the training authority of the Institute and Centers is also broad and will help to create the additional manpower needed. They are directed to develop methods and support for the training of individuals to plan and conduct research, development, demonstration and evaluation of health care delivery.

The Committee believes that the recruitment and training of top caliber personnel must be an important priority of the Institute, for the ultimate success of the enterprise will depend on the men and women who direct and work in the Institute and the Centers.

The Institute is also directed to provide technical assistance and to develop methods for the transfer of new knowledge, components and assistance to the health community and to collaborate and exchange information with other countries for the advancement of health care in the United States and cooperating nations.

Evaluation Role

The Committee envisions a major evaluation role for the Institute and the Committee's bill specifically directs the Institute to evaluate the quality, the effectiveness, and the efficiency of all Federal health programs.

The Committee believes that Federal health programs have not been adequately evaluated in the past and that the Institute will materially

enhance the Federal Government's evaluation capacity in the health field.

For such evaluation, the Secretary of Health, Education, and Welfare is authorized to transfer evaluation funds appropriated pursuant to Section 513 of the Public Health Service Act as he deems necessary.

Supplemental Incentive Grants to Encourage Experimentation

Sec. 1214 authorizes the Director of the Institute to make supplemental incentive grants to individuals, institutions, and health facilities to encourage experimentation. Under this authority, the Director may supplement regular Federal health grant-in-aid programs in order to encourage experimental projects which would not otherwise be undertaken without such assistance and which have been designated as "essential" by the National Advisory Council. There are two limitations on this authority. First, the Federal portion of the funding of the project may not exceed 80 percent and, secondly, not more than 10 percent of the funds appropriated to the Institute may be used for such grants.

Active Advisory Council

The Institute will have a twenty-one member National Advisory Council on Health Care Delivery. Fifteen of the members will be selected by the President from: (1) persons who are leaders in the field of medical science, or in the organization, delivery, or financing of health care; (2) leaders in the management sciences; and (3) representatives of the consumers of health care. The Committee believes that at least one member of the Council should be a practicing physician. At least seven of the appointed members must be representatives of consumers.

The Secretary of Health, Education, and Welfare, the Chief Medical Officer of the Veterans Administration, a medical officer designated by the Secretary of Defense, the Director of the National Institutes of Health, the Administrator of the Health Services and Mental Health Administration, and the Director of the National Institute of Health Care Delivery will serve as ex officio members of the Board. The Committee intends, however, that all members of the Council participate fully in the Council activities—discussions, voting, etc.—and that there will be no distinction made in such activities between appointed and other members.

The President will designate the Chairman of the Council. The Council will meet at the call of the Chairman, but not less than four times yearly. The Committee intends that the Council should be an active one and specific responsibilities are outlined in the legislation. The Council will be responsible for: (1) reviewing the programs, policies, and priorities of the Institute and Centers; (2) examining and coordinating health care delivery efforts within the Department of Health, Education, and Welfare and other federal agencies so as to avoid duplication; (3) assuring that significant research and development findings are communicated within the research community and to the public; and (4) evaluating the impact that the Institute's research and development efforts are having on the health care system.

As further indication of the Committee's views regarding the Coun-

cil's active role and its importance, the Council is provided with its own executive director, accountable only to the Council.

This will help to assure that the Council will be able to meet its responsibilities and maintain the independence envisioned by this legislation.

Administrative Provisions

There are some common characteristics of federal research and development agencies, such as the National Science Foundation, the National Institutes of Health, the National Aeronautics and Space Administration and the new National Institute of Education.

Because adequate administrative provisions are important to the functioning of an effective research and development health organization, the Committee has provided the Institute with the needed and necessary administrative provisions. These include the authority for a flexible personnel system; the authority to carry over unexpended funds from one year to the next; the authority for multigrant projects; and a specific direction to provide for the coordination of research and development activities in this field.

The Committee is particularly concerned with the problems of duplication and lack of coordination in the health field. The health efforts of the Federal Government are scattered over a dozen departments and agencies. Each has an interest in health services and to some extent contributes to the federal research and development effort in health. There is little coordination of these efforts and the lack of common statistics preclude even elementary comparisons of efforts and results. A number of provisions are aimed at this problem. First, the Institute is directed to establish offices and procedures to coordinate its research and development activities with those conducted by other federal agencies and public and private agencies.

Secondly, the National Advisory Council is granted the specific assignment of examining and coordinating health care delivery efforts of the Department of Health, Education, and Welfare, and other federal agencies so as to avoid duplication. Thirdly, the President is granted for a two year period the authority to transfer to the Institute any programs or personnel of the Department of Health, Education, and Welfare when he feels such action is desirable.

With the many priorities in the health and other domestic areas, the failure to coordinate and share the results of research and development between federal departments and agencies represents a serious loss. The Committee believes that these provisions will help to maximize resources and eliminate needless duplication.

Disseminating Results

It is not enough merely to produce significant results in health care delivery research and development. Such findings must not be allowed to remain on some shelf or in some federal storage room. They must, in order to be useful, be disseminated in a timely manner to the health care system and federal agencies responsible for health services. Health is a field in which change may occur rapidly and it is important that researchers and administrators be kept abreast of the current status of developments and not have to rely on information which may be a number of years old.

Accordingly, the legislation creates within the Institute, an Office of Health Care Delivery Information Services to facilitate the communication of the research results. This Office would provide, or arrange for, the provisions of indexing, abstracting, translating, or other services leading to a more effective dissemination of health care delivery information and undertake programs to develop new or improved methods for making such information available.

A variety of media could be used by the Health Care Information Services, including a computerized storage and retrieval system, microfiches and suitable periodicals or other publications. The Office might also publish or support a monthly Journal which would abstract both national and international literature bearing on health services. In addition, it would be useful for the Office to establish or to encourage the establishment of a high quality, timely publication service for research reports, monographs, state of the art papers, and other information in the field.

The Committee views the functions of this Office necessary not only to assure that promising improvements in the delivery of health care reach the proper individuals in a timely manner, but also to prevent needless duplication of research efforts and the waste of scarce resources.

Regional and Special Emphasis Centers

The Committee's bill also authorizes up to eight Regional Centers and two Special Emphasis Centers, the Health Care Technology Center and the Health Care Management Center. The Regional Centers are designed to: (1) enable the study of the different health care delivery problems peculiar to the various regions of the country; (2) broaden and strengthen the nation's research and development base in health care delivery; and (3) link better research and development activities and actual practice.

The Regional Centers' locations will be determined by the National Advisory Council. In selecting these locations, the Committee expects the National Advisory Council, to the extent feasible, to bring about the broadest possible geographical distribution of such Centers. The Centers will be funded by the Federal government for an initial period of three years.

The Committee wishes to emphasize that the legislation authorizes "not to exceed eight regional centers". This number would result in a Center for the various regions of the nation. While this number may be ultimately desirable, the Committee is aware of the possible manpower constraints that exist and indeed, has directed the Institute to give the manpower problem a top priority. It is not the intent of the Committee that all eight centers be created initially. For example, two may be the maximum number of centers that could be started at the outset. The actual number to be established initially, and subsequently will be determined by the Director and the Advisory Council, giving due considerations to the manpower and other constraints. Clearly, these programs should be begun in an orderly and prudent manner, consistent with the effective use of the Nation's resources in this respect.

Health Care Technology Center

Two Special Emphasis Centers, a Health Care Technology Center and a Health Care Management Center are also authorized.

The Health Care Technology Center will focus on all forms of technology and its application in health care delivery. The achievements of this nation in technology, such as in space, electronics, communications, and data processing, have been truly amazing. Yet, much of the health care system continues to employ outdated manual procedures.

President Nixon, last year, both in his State of the Union Address and his Health Message to the Congress, emphasized the need to stimulate the application of science and technology to the solution of domestic problems. The President's 1972 Health Message specifically identified health as a "vital" area for exploiting technology.

The Health Care Technology Center will be expected to exercise leadership in mobilizing the involvement and investment of private industry for the successful development of such technology will depend on our ability to motivate the involvement of industry.

The Committee wishes to emphasize that the Center's purpose is to encourage the development of technology to solve the health problems of our citizens and our health institutions and not as a place to find markets for available technology.

Presently, there are only a small number of individuals concerned with such problems. The Health Care Technology Center is designed to remedy this situation and serve as a focal point for an accelerated research and development effort on both program and hardware development. This Center will also provide us with an opportunity to utilize the talents of some of the unemployed engineers and scientists.

The Committee believes there is great potential for the use of technology in the health delivery area and that such utilization would result in enormous benefits to the public and the patient.

Health Care Management Center

The second Special Emphasis Center is the Health Care Management Center. This Center will focus on the improvement of management and organization in the health field, the training and retraining of health administrators and the development of leaders, planners, and policy analysts in the health field.

The job of Administrators and Managers in the health field is exceedingly complex. To carry out these responsibilities with maximum effectiveness health managers need a basic understanding of a wide variety of management skills. Some background in such areas as health, economics, computer technology, statistics and the management sciences are just samples of areas in which health managers should be familiar.

In practice, however, medical administrators are often elevated to positions without adequate preparation for their new responsibilities. Certainly American industry would ascertain that its top executives are adequately trained and the health system must do no less. The following comments from a letter of a health administrator illustrates the need for a Health Care Management Center:

"Practitioners of health care administration, among whom I am one, have been flying by the seat of their pants for too long. The nation

deserves better. There is currently no systematic effort I know of to reach decision makers in the health care field with the results of innovative research and to stimulate a research orientation to many of the problems we all face in the financing, organization, and delivery of services. There is moreover, an almost total neglect of more formal continuing education opportunities for health care administrators . . . After ten years or more in the field, many of us are in positions of responsibility and strong in experience but weak in understanding of fundamental advances in health care systems, e.g. the problem-oriented medical record, how to organize a prepaid group practice, the use of television in medical diagnosis and treatment, computer applications to health systems problems, etc."

Dr. Kerr White of Johns Hopkins University at the Second Sun Valley Forum on National Health last summer similarly emphasized the importance of improved management in the health field when he stated: "Vastly improved managerial expertise is a prerequisite for any meaningful improvement in our health care system at the operating and geographical levels."

The Regional and Special Emphasis Centers have a separate authorization of $20 million for the initial year and a total of $75 million for a three year period. Support for a Center, other than support for construction, shall not exceed $2 million per year per center, except for the Health Care Technology Center. Federal assistance to such Centers may be used for research and development, staffing and other basic operating costs, training, demonstration purposes, and construction where the National Advisory Council deems such is necessary.

Conclusion

The health care enterprise is the Nation's second largest industry. In the fiscal year 1972, health spending totaled $83.4 billion, or 7.6 percent of our Gross National Product. By 1974 health expenditures will exceed $100 billion and probably make health the largest single segment of our society. By 1980, it is possible that one out of every ten dollars spent in the Nation will go for health care.

The magnitude of health care expenditures alone argues for a strengthened research and development component in the health area. There is considerable public frustration and dissatisfaction with aspects of health care. The public is alarmed over rising costs, is concerned over the manpower and facility shortages as well as their maldistribution, and is distressed that the benefits of medical science are not reaching them. Change is already occurring in the health field. The pace of such reform is likely to accelerate in the years ahead.

The Committee believes that it is imperative that we strengthen our research and development capabilities in the health area so that we may make more intelligent choices and foster constructive changes. We desperately need to have advance warnings of approaching "crisis"; we badly need more information upon which to base decisions and make comparisons in the health area; we need to sharpen our capabilities to illuminate issues and to identify possible options and their implications; and we need better evaluation and monitoring of both experimental efforts and ongoing programs. In short, we need a framework for evolving health care policies for the long haul as we continue to deal with the short-term policies. The National Institute of Health Care Delivery will provide that framework.

The respected "Science" Journal in commenting favorably on the proposal to establish a National Institute of Health Care Delivery said: "A major tour de force is needed now—an administrative mandate backed by appropriate funding—to dramatize the importance of rational organization and planning services . . . if the magnificent benefits of American medical research are meant for all of our people then an effective science of health care delivery is as important as the medical research itself".

The Committee believes that the Institute and its Centers will provide this "major tour de force" to make health care delivery as important as medical research, and to help speed the benefits of medical science and the scientific discovery system to the people of the United States.

Section-by-Section Analysis

(Section) The short title of this Act is the "National Institute of Health Care Delivery Act of 1973".

(Section 2) States the findings of the Congress that:

1. the United States faces a crisis in health care;
2. health care costs have increased in the last five years twice as fast as the general cost of living;
3. there exists an acute shortage and maldistribution of physician and other medical manpower in inner city and rural areas;
4. millions of Americans do not have access to quality health care;
5. since World War II the United States has invested approximately $20,000,000,000 in biomedical research, and that this investment has resulted not only in wide recognition of the preeminence of biomedical research in the United States, but also produced many, often spectacular, advances in medical sciences;
6. during the same period comparatively few resources were invested to deliver the discoveries of medical research and technology to our citizens;
7. the American public is concerned with the gap between the knowledge and capabilities of medical science and what is delivered to the patient, and that this is a source of public discontentment and dissatisfaction;
8. significant changes regarding the health care system have been proposed and may be implemented in the near future;
9. the potential costs and benefits associated with the various proposals are largely unknown; and
10. inadequate attention, emphasis, and resources have been devoted to health policy analysis and health care delivery.

The Section also indicates that the purpose of this Act is to establish a National Institute of Health Care Delivery and regional and special emphasis centers to improve health care delivery and to help speed the delivery of the benefits of medical science and the scientific discovery system to the people of the United States.

(Section 3) Amends the Public Health Service Act by adding a new Title XII entitled, "Title XII—National Institute of Health Care Delivery".

(Section 3—New Section 1201) Defines health care delivery for purposes of this Act.

Establishment of Institute

(New Section 1202) Establishes in the Department of Health, Education, and Welfare a separate National Institute of Health Care Delivery. The Institute will carry out a multidisciplinary research and development program to improve health care delivery and shall be the principle government agency for improvement of health care in the United States.

Functions of the Institute

(New Section 1203) Provides that the function of the Institute is to improve the effectiveness, efficiency and quality of health care in the United States through initiation and support of studies, research, experimentation, development, demonstration, and evaluation of (but not limited to) the following:

1. the existing health care system, emphasizing means and methods to improve the system and the devising and testing of alternative delivery systems;
2. health care systems and subsystems in states, regions, and communities which would give special attention to the effective combination and coordination of public and private methods or systems for health care delivery;
3. preventive medicine and the techniques and technology, including multiphasic screening and testing, to improve the early diagnosis and treatment of diseases, particularly for preschool children;
4. systems and technical components of emergency health care and services, including at least one experimental statewide helicopter transportation emergency care system, which would utilize, where possible, the skills of returning military corpsmen;
5. systems and components of rural health services;
6. the development of policy with respect to long-term care, particularly for mentally and physically handicapped individuals and senior citizens, with special emphasis on alternatives to institutionalization, including the use of home health aides;
7. methods to meet the nation's medical manpower requirements, including new types of manpower and their utilization and the extent to which tasks performed by physicians and other health professionals could be safely delegated to other appropriately trained individuals in both new and existent health occupations;
8. continuing education and the exploration of programs and methods to help health professionals to stay abreast of current developments and to maintain professional excellence;
9. health manpower credentialing, licensing and certification;
10. the medical malpractice problem, particularly as it relates to quality care, the practice of "defensive medicine" and added costs to the public;
11. programs for educating health manpower and the accreditation of these education programs;
12. application of all forms of technology, including computers and other electronic devices, in health care delivery;
13. the efficiency, management, and utilization of new and existing health care facilities including studies of admission practices and examination of cost-finding techniques;

14. the development of tools and methods to improve planning, management, and decisionmaking in the health care system;

15. the development of information by which quality, efficiency, and cost of health care could be measured;

16. the development of uniform accounting practices, financial reporting, and uniform health records;

17. the development and testing of incentive payment mechanisms that would reward efficiency in health care delivery without compromising the quality of care;

18. the needs of individuals, families, and groups for health care and related services, emphasizing the various life styles, including environmental, recreational, and nutritional factors that would bear on an individual's health; identification of those factors affecting acceptance and utilization of health care and related services; and the development of educational materials and methods communicating to the public the importance of personal decisions and actions on health;

19. the economies of health care and related services, and the impact of the total system of health care delivery and related services upon the standards of living and the general stability of the national economy;

20. proposals for the financing of health care, including the potential cost and benefits, and their impact on the health care system;

21. concepts and data essential to formation of a factual basis for national health policies; and

22. the effects of health care delivery of the organization, functions, and interrelationships of federal, state and local governmental agencies and programs concerned with planning, organization, and financing of health care delivery.

Also requires the Institute to:

1. develop methods and ways to support the training of those individuals who will research, develop, demonstrate, and evaluate the delivery of health care (and its related services);

2. provide technical assistance and develop methods to transfer new information obtained to those public and private entities that are involved in improving the health care delivery system; and

3. collaborate with foreign health care systems in order to promote the advancement of health care delivery in the United States and in cooperating nations.

Requires the Institute to evaluate Federal health programs and their role in improving health care delivery in the United States.

Administrative Provisions

(New Section 1204) Authorizes the administrative power that enable the Institute to carry out the provisions of title XII. Such powers include: making grants to public or nonprofit private entities to conduct projects in connection with this title and to train individuals to conduct such projects; making contracts with public or private entities to conduct such projects; appointing and compensating personnel; promulgating rules and regulations; acquiring or constructing facilities, equipment, and real property; leasing buildings; employing experts; appointing advisory committees; utilizing other public agencies; accepting voluntary services; accepting unconditional gifts; transferring available funds; establishing procedures to provide

for coordination of activities carried on under title XII with related research and development activities being carried on by other public and private agencies and organizations; and taking such other actions necessary to accomplish the provisions of title XII.

Compensation

(New Section 1205) Provides for compensation of the Director and Deputy Director of the Institute.

Joint Waiver Funding Authority

(New Section 1206) Provides the Director, where funds are advanced for a single project by more than one federal agency, may act for all such agencies in administering such funds and permits a single non-federal share requirement to be established according to the portion of the funds advanced by each federal agency. Also authorizes the Director to waive technical grant or contract requirements which are inconsistent with similar requirements of the Institute.

Transfer of Research Funds

(New Section 1207) Permits the transfer of research funds of other government agencies to the Institute if such agency approves such transfer. Requires that such transfers can be made only if the Institute will use such funds for the purpose for which the transfer was made.

Transfer of National Center for Health Services Research and Development

(New Section 1208) Transfers the National Center for Health Services Research and Development to the Institute. Authorizes the President to transfer to the Institute those additional functions of the Department of Health, Education, and Welfare that relate to the functions of the Director of the Institute. Such additional transfers must be made within two years after the enactment of this title.

National Advisory Council

(New Section 1209) Establishes a National Advisory Council on Health Care Delivery. Council shall consist of twenty-one members including the Secretary of Health, Education, and Welfare, the Chief Medical Officer of the Veterans' Administration, a Department of Defense Medical Officer, the Administrator of the Health Services and Mental Health Administration, the Director of the National Institutes of Health, the Director of the National Institute of Health Care Delivery, and fifteen additional members who are not fulltime employees of the United States. Such additional members are to be appointed by the President and shall be individuals who are recognized as leaders in the medical sciences or in the organization, delivery, and financing of health care, leaders in the management sciences, or representatives of consumers. Of the fifteen, at least seven shall be representatives of consumers who are not related to the delivery of health care.

Appointed members shall serve a four year term. Such members cannot serve more than two consecutive terms.

The Council is directed to:

1. review programs, policies, and priorities of the Institute and centers established under section 1213;
2. examine and coordinate health care delivery efforts in federal agencies to avoid duplication of efforts; and
3. assure that the findings of the Institute are being disseminated and evaluate the impact of such findings.

Directs the Council to submit a progress report on the Institute and its centers (as an appendix to the report required under section 1210).

Annual Report

(New Section 1210) Requires the Director of the Institute to submit an annual report to the Secretary of Health, Education, and Welfare to be transmitted to the President and the Congress. Such report must include:

1. an appraisal of the Institute's activities;
2. annotated bibliographies and summaries of research projects performed or supported by the Institute; and
3. recommendations concerning factors that inhibit the implementation of the Institute's findings or factors which inhibit innovation in health care.

Health Care Delivery Information Services

(New Section 1211) Creates within the National Institute of Health Care Delivery an Office of Health Care Delivery Information Services. The office would provide:

1. for the provision of indexing, abstracting, translating, and other services leading to a more effective dissemination of information on research and development in health care delivery, to public and private agencies, institutions, and individuals engaged in the improvement of health care delivery and the general public; and
2. for the undertaking of programs to develop new or improved methods for making this information available.

Authorization

(New Section 1212) There are authorized to be appropriated to carry out the provisions of new title XII (excluding new section 1213):

$80 million for fiscal year 1974;
$125 million for fiscal year 1975; and
$150 million for fiscal year 1976.

Regional and Special Emphasis Centers

(New Section 1213) Authorizes the Director of the Institute to enter into cooperative arrangements with public or nonprofit private agencies or institutions to pay all or part of the costs to plan, establish, and provide basic support for:

1. a maximum of eight regional centers specifically designed to carry out multidisciplinary research and development in health care delivery; and
2. two national special emphasis centers (one to be designated as the Health Care Technology Center and the other to be designated as the Health Care Management Center).

Authorizes Federal payments (under this section) to be used for:

1. construction (as deemed necessary by the National Advisory Council on Health Care Delivery);
2. staffing and basic operating costs;
3. research and development;
4. training; and
5. demonstration purposes.

Excluding construction, support under this section must not exceed $2 million per year per center (excluding the Health Care Technology Center). Such support may be funded for a maximum of three years. However, upon additional recommendations of the Council, the Director may extend a center's support for an additional three years.

Requires the Commission to determine the location of regional centers (with a view towards the broad geographical distribution of such centers). Requires the Administrative Officer of each regional and national center to submit an annual report.

There are authorized to be appropriated to carry out the provisions of this section:

$20 million for fiscal year 1974;
$25 million for fiscal year 1975; and
$30 million for fiscal year 1976.

Supplemental Incentive Grants

(New Section 1214) Authorizes the Director to provide funds to be used to supplement the Federal contribution to research and development projects (under Federal grant-in-aid programs) over and above the originally authorized Federal contribution. Such funds are to provide the incentive assistance to encourage individuals, institutions, and health facilities to participate in research and development projects that might not otherwise be carried out.

Provides that the Federal contribution (as supplemented under this section) cannot exceed 80 percent of the costs. Defines the term "Federal grant-in-aid programs." Provides that not to exceed 10 percent of the funds authorized by title XII shall be available to carry out this section.

Appendix 2

STATEMENT BY SENATOR ABRAHAM RIBICOFF, MARCH 12, 1974

COMPREHENSIVE MEDICARE REFORM ACT OF 1974

Today I am introducing the Comprehensive Medicare Reform Act of 1974. This legislation is the culmination of two decades of efforts to provide full health insurance protection for older Americans.

In 1961, following a decade of debate on health insurance for the aged, the new Kennedy Administration took an active leadership role in bringing the Medicare debate to legislative reality. As Secretary of Health, Education and Welfare, I headed a task force to draft a Medicare bill. While Congress rejected it in the early 1960s, Medicare became law in 1965. As a Senator and a member of the Senate Finance Committee which shapes such legislation I was proud to play a role in developing and supporting Medicare.

Medicare was a major breakthrough in assuring a measure of health protection for one segment of the population. Because it was a new concept, however, Congress limited its coverage. It was, in fact, a financial program to help meet some of the costs of short-term and acute medical care.

Since its enactment in 1965 we have found that the program should be improved and expanded. I have suggested expanding its coverage in a number of ways. Since 1965 we have expanded Medicare to cover all disabled persons, those who have chronic kidney conditions and many more. Its services have likewise been expanded to cover a wider range of non-hospital items.

At the same time we have found a need to curb costs and abuses under Medicare. Major oversight hearings which we held in 1969 led to improvements in the administration and cost control mechanisms of Medicare.

Since Medicare's inception in 1965, I have watched its progress and participated in its development at every step of the way.

It is time to change the Medicare from a limited financial program to the program which we originally envisioned--comprehensive national health insurance for all older Americans.

The Medicare program I envision is one which provides a range of care from preventative and diagnostic physician's services to the most acute hospital care. Nursing home, home health care, dental care, eye care, hearing care, prescription drug coverage are just a few of the areas which should be covered. In short, Medicare should be a balanced program which encourages the best kind of care with the greatest possible freedom of choice for the patient. And it should be a program that provides reasonably for all the providers in the system--hospitals, doctors and others and at the same time is efficiently administered at the smallest possible cost to the government.

The American Association of Retired Persons/National Retired Teachers Association has played a leading role in the development of this legislation. The legislation, which has been developed over the past two years, reflects their tireless efforts. The proposal also reflects the recommendations of the 1971 White House Conference on Aging and recommendations made in recent years by one of America's leaders on issues affecting older Americans, Nelson Cruikshank.

PRIORITY ON HEALTH CARE PROTECTION FOR AGED

In dealing with programs to provide comprehensive health coverage for all Americans at a cost which the taxpayers can afford, priorities must be established as to who should be covered.

The population over 65 is in most need of protection. For the most part their income is limited and the costs of illness for them is higher than for the population as a whole.

At the turn of the century there were only three million older persons, every 25th American. Since that time, the older population has grown faster than the rest of the population. Today there are over 20 million senior citizens--every 10th American. By the year 2000, every ninth American will be over the age 65. It is not a static population. Every day, 4,000 Americans reach age 65.

Unfortunately, however, the median income of older families and individuals is less than half that of their younger counterparts. While the Social Security benefit increases of recent years have had a dramatic impact in reducing poverty for older Americans, over 2 million older Americans were living below the poverty threshhold in 1973.

Most older Americans depend on Social Security. But Social Securit benefit increases are too often negated by the tide of inflation. Thus, while the Department of Labor estimates that a minimum low budget for a retired couple is $3,442 a year, social security benefits are $110 a year under that bare bones minimum budget.

There are also an estimated additional 2 million aged persons who, while not classified as poor because they live in families with incomes above the poverty line, are in fact poor. In sum, while the aged make up 10% of the population, they make up 20% of the poor. If you are old, you are twice as likely to be poor.

As might be expected, older people, because they have half as much income as younger people, are forced to spend half as much. They must stretch their food, clothing, rent and medical dollars much farther than the non-poor. Proportionately, older consumers spend more of thei income on these items than do those under 65.

The problems of income are complicated by problems of health. Older Americans have less money but more health problems. Eighty-five percent of those who are over 65 and have at least one chronic conditior Eighty percent have some degree of arthritis. Dental problems, hearing and eye problems and the need for prescription drugs all increase with old age. Drug costs for older Americans, for example, run three times higher than for the younger population. Charges for prescriptions range up to 67¢ higher per prescription for older people, mainly because they often need expensive maintenance drugs.

The major chronic diseases among older persons-heart disease, cance strokes, arthritis, diabetes - are costly to older Americans not only in terms of invalidism and pain but also in financial terms.

At the same time that older Americans need more health care, real growth in health care utilization for the elderly has not kept pace with other age groups in recent years. The elderly in America are not utilizing the full range of health services they need because they can't afford to. They are economically forced to wait until they need acute inpatient hospital care. The economically disadvantaged aged population is further discouraged from obtaining health care because they are concentrated in urban centers and rural areas - often geographically distant from health service areas.

MEDICARE PERFORMANCE

Until 1965 older Americans had to depend almost exclusively on thei own resources for health care. Since the enactment of Medicare, the federal government has assumed a portion of the medical costs of older Americans.

During fiscal year 1973, the Nation spent $94.1 billion for personal health care. Persons aged 65 and over accounted for 28% of this cost, although they make up only 10% of the population.

The average personal health care outlay for the total population was $441.00 in fiscal 1973. For the senior citizen it was $1,000.00.

Despite increases in government and other third party sources such as Medicare, average out of pocket payment by aged persons was $276 in fiscal 1972, three times the amount paid out of pocket by non-senior citizens. This $276 out of pocket cost is higher than the amount paid for health care by older Americans at the start of 1966 ($234) before Medicare was enacted. As costs have risen then, Medicare is picking up an ever smaller amount of the older Americans' health costs. In 1969, Medicare paid 46% of their health bill. Today it pays 42%.

The decline in Medicare's share of the health bill of the aging is related not only to inflationary factors but to basic problems in the Medicare structure.

The time has come to re-shape the Medicare program - building on its strengths and eliminating its weaknesses.

THE COMPREHENSIVE MEDICARE REFORM ACT OF 1974

PURPOSE

The legislation I am proposing today would re-structure the Medicare program to provide health care benefits to all older Americans as a matter of entitlement. The bill would broaden the Medicare benefit package to meet the full range of medical services needed by older Americans and extend the duration of those benefits which are limited under the present program. It would reduce the out of pocket personal health care expenditures of those eligible for Medicare coverage, establish a program of income-related catastrophic health insurance protection for senior citizens. And it would improve the administration of Medicare while it attempts to control increases in health care costs

STRUCTURE

The bill establishes a single integrated program of comprehensive health insurance forthe aged and disabled financed out of general revenues. Parts A and B of the Medicare program are combined into a single, expanded benefit structure with a single trust fund.

Requirements for premium payments and deductibled are eliminated. Minimal co-insurance provisions are designed so that while persons who can afford to pay will do so up to a predetermined maximum level, cost will not be a deterrent to quality health care.

The Act also provides coverage for all care and services for the aged presently covered by the Medicaid program.

ENTITLEMENT

The new Medicare program is expanded to all persons 65 years of age or older regardless of insured status under the Social Security or Railroad Retirement cash benefit program. The only requirement is that the individual be a citizen or national of the United States or a legal resident alien. This means that for the first time all public employees, including teachers, policemen and firemen will be automatically eligible for Medicare.

The Medicare program also provides eligibility to all those who are now eligible for Medicare because of special circumstances such as disability.

REIMBURSEABLE SERVICES

The Medicare Reform Act provides a comprehensive range of benefits:

- Unlimited inpatient hospital coverage:
  -- includes pathology and radiology services;
  -- includes 150 days of care during a benefit period for a psychiatric inpatient undergoing active diagnosis or treatment of an emotional or mental disorder.

- Unlimited outpatient hospital coverage.
- Unlimited skilled nursing facility services with no requirement for prior hospitalization.
- Unlimited intermediate care facility services, effective July 1, 1978.
- Unlimited home health services with no requirements for prior hospitalization.
- Certain services offered by public or non-profit private rehabilitation agencies or centers and public or non-profit private health agencies.
- Unlimited physicians' services, including major surgery by a qualified specialist and certain psychiatric services.
- Unlimited dental services.
- Outpatient prescription drugs -- including biologicals such as blood, immunizing agents, etc. -- subject to certain limitations to insure quality control.

- Medically necessary devices, appliances, equipment and supplies, such as: eyeglasses, hearing aids, prosthetic devices, walking aids. Also included are any items covered under present law.
- Services of optometrists, podiatrists and chiropractors.
- Diagnostic services of independent pathology laboratories and diagnostic and therapeutic radiology by independent radiology services.
- Certain mental health day care services.
- Ambulances and other emergency transportation services as well as non-emergency transportation services where essential because of difficulty of access.
- Psychological services; physical, occupational or speech therapy; nutrition, health education and social services; and other supportive services.

COST SHARING

Under this proposal there are no periodic premium payments or deductibles.

There are, however, minimum initial co-insurance payments (based on the type of service) as follows:

Initial co-insurance payments (based upon type of service) are as follows:

Type of Service	Co-insurance Payments
1. inpatient hospital services	1. $5.00 per day
2. skilled nursing facility	2. $2.50 per day
3. home health services	3. $2.00 per visit
4. physicians' services	4. $2.00 per visit
5. dentist services	5. 20% of approved charges
6. mental health day care	6. $2.00 per day
7. diagnostic out-patient services of independent laboratory or of independent radiology services	7. 20% of approved charges
8. devices, appliances, equipment and supplies	8. 20% of approved charges
9. drugs	9. $1.00 per each filling or refilling
10. ambulance services	10. 20% approved charges

CATASTROPHIC HEALTH INSURANCE

While the features of the bill already outlined are designed to deal with the basic health costs, older Americans are more likely than any other segment of the population to incur extraordinarily large costs. Therefore, this legislation also includes a catastrophic health insurance section for older Americans.

Senator Russell Long and I have already introduced legislation which establishes a catastrophic health insurance program for the non-aged. This provision is complementary in a sense to that proposal. At the same time it contains a novel feature which, while equitable, should be tried out on a smaller scale before being implemented on a full national health insurance program.

I refer to an income-related catastrophic ceiling. Essentially, health costs which are catastrophic to one family may not be as burdensome to a more affluent family. For that reason, families should be able to bear differing burdens of cost for health care depending on their income. This income-related feature will present an administration challenge and should be tested.

REIMBURSEMENT AND COST CONTAINMENT POLICIES

While Medicare reimbursement is continuing to grow, some of the new cost containment features in Medicare are holding down increased costs. My legislation incorporates all present Medicare cost control and utilization review provisions.

Payments will be made only to a "participating provider" (one who has filed a participation agreement with the Secretary of HEW) except for emergency services. Providers will include not only institutions but independent practitioners and suppliers of drugs and medical appliances.

Reimbursement will be made to a participating institutional provider based upon a predetermined schedule of patient care charges. The schedule must be based on a system of accounting and cost analysis in conformity with prescribed standards. Periodic interim payments will be made to institutions during the accounting year on the basis of cost projections, with final adjustments based on the approved schedule of charges.

Reimbursement for services of physicians, dentists, optometrists, podiatrists, chiropractors and other non-institutional services of licensed professional practitioners will be made in accordance with annually predetermined fee schedules for their local areas. These schedules will be worked out in negotiation with the providers and it is intended that the fees will be reasonable and equitable for provider and patient alike.

One of the problems in the present Medicare program is that physicians are increasingly refusing to accept Medicare assignment because Medicare does not provide adequate compensation to them. In fiscal year 1969, the net assignment rate was only 61%. In 1972, it declined so that only 56.4% of the claims were direct payments to doctors on an assignment basis. Doctors increasingly preferred to bill the patient and have Medicare bill the patient directly. In this way, the doctors could collect more from the patient above the Medicare payment.

While the payment mechanism in this bill requires participating doctors to accept assignment or not participate at all, it also establishes a fair way to set fees.

Fee schedules will be established through negotiation among representatives of government, providers and consumers. Final fee schedules will be established only after public hearing. And the Secretary of HEW is required to make public for each local area the established fee schedules and the names, professional fields, and business addresses of participating practitioners.

To make Medicare a full success it must not only provide adequate benefits to beneficiaries but it must adequately compensate those who provide the services under that program. I am hopeful that this legislation will make adequate provisions for all providers.

SUMMARY

The proposal I am making today must be considered together with other Congressional initiatives in the field of national health insurance. Senator Kennedy, a leader in the health field has proposed legislation which would cost some $80 billion. The President's package would cost $40 billion.

The American taxpayers cannot afford to pay these additional costs. Social Security taxes are already as high as they should go. I and Senator Long, joined by 23 other Senators of both parties have introduced health insurance legislation which recognizes both that certain priority health needs must be met--but at a cost which the taxpayer can afford. The Long-Ribicoff bill's cost is less than that of any other health insurance proposal. In part this is because our legislation builds on the existing Medicare program and would not create a new government bureaucracy. It is also less costly because it recognizes that there are certain health care needs which are of a priority nature and it provides coverage for those areas--catastrophic costs, for example, which can financially destroy the average family.

This legislation I am introducing today is likewise designed to meet priority needs of the elderly at the lowest possible cost. It too builds upon the expertise, experience and mechanisms of the Medicare program. And it provides an important and meaningful role for providers of health care--the doctors, hospitals and insurers.

Passage of this legislation will reduce the cost of national health insurance legislation by billions of dollars. Costs under the Long-Ribicoff bill would be reduced by as much as $4 billion if this legislation is enacted.

The Medicare program in 1973 paid out $9.5 billion. The additional costs of this program will be approximately $3 billion in induced federal costs.

These extra costs should be met by general revenues. In his health message to Congress, the President indicated that the $6 billion federal cost of the federal part of his program could be financed out of general revenues with no additional taxes. New induced federal costs of this proposal can likewise be met by general revenues.

As congressional debate on national health insurance progresses, I hope the concepts embodied in this Comprehensive Medicare Reform Act of 1974 will be considered.

By lowering the price-tag for initial health care, older persons will be encouraged to seek the basic medical check-ups needed to diagnose and stop an illness before it becomes critical.

Older Americans who have worked their entire lives deserve a measure of security. This legislation will provide them with the assurance that their health needs will be provided for.

Appendix 3

STATEMENT SUBMITTED BY THE AMERICAN SPEECH AND HEARING ASSOCIATION

At the outset, the American Speech and Hearing Association (ASHA) wants to express, on behalf of its close to 18,000 members and the many thousands of communicatively handicapped Americans they serve, its appreciation to the Committee for providing this platform, so that organizations and individuals concerned about the health and welfare of America's elderly can attempt to focus national attention on the special needs of this very special population. Our intention in this statement is to comment on but one of the many needs of the communicatively handicapped elderly which have been overlooked in past health-care plans, and continue to be overlooked in S. 2970 and other current proposals for national health-insurance legislation.

This Committee has previously heard delineated the issues which still contribute to our inability to assure reasonably priced quality rehabilitation services to the elderly hearing-impaired[1/] -- issues which have concerned the Congress for at least a decade.[2/] But never before have these issues been so thoroughly and tirelessly researched, so well documented, so clearly drawn. And never before has the voice of the hearing-handicapped elderly consumer been heard quite so strongly as it is being heard now through the agency of such consumer-interest spokesmen as Ralph Nader's Retired Professional Action Group,[3/] the Minnesota Public Interest Research Group,[4/] the Public Interest Group in Michigan,[5/] and public-interest journalists in such large metro-

1/ "Hearing Loss, Hearing Aids, and the Elderly," Hearings before the Subcommittee on Consumer Interests of the Elderly of the Special Committee on Aging, U.S. Senate, 90th Cong., 2nd Sess., July 18 and 19, 1968.

2/ "Prices of Hearing Aids," Senate Report No. 2216, 87th Cong., 2nd Sess., October 1, 1962.

3/ Public Citizen's Retired Professional Action Group, Paying Through the Ear, Public Citizen, Inc., Washington, D. C. (1973).

4/ "MPIRG Report," Hearing Aids and the Hearing Aid Industry in Minnesota, November 13, 1972.

5/ "A PIRGIM Report," You Know I Can't Hear You When the Cash Register's Running: The Hearing Aid Industry in Michigan, Public Interest Research Group in Michigan, Lansing, Michigan, December, 1973.

politan areas as Minneapolis-St. Paul, Detroit, and Baltimore.6/

Had consumer influence been brought to bear earlier on the problems discussed here today, perhaps legislative committees of the Congress would have been moved to follow up with meaningful legislative proposals the impressive initiative this special congressional panel took in July of 1968; perhaps, too, the pro-consumer recommendations of the 1962 Kefauver Subcommittee (on Antitrust and Monopoly, Senate Judiciary Committee) would not have been transformed from what then seemed a consumers' shield into a sword wielded against America's hard-of-hearing public.7/

The critical central issue of these and the earlier congressional hearings has not changed. It is our fervent hope, however, that congressional regard for that central issue will change in the direction of meaningful, creative legislation, as a consequence of the new ingredient of consumer outrage at the marketplace treatment of hearing-impaired older Americans.

The critical issue which obviously pervades these hearings and the reports of those conducted in 1968 and 1962 is that the hearing-aid delivery system in the United States represents and fosters a clear and continuing conflict of hearing-aid-industry interest of significant proportions.

6/ See, e.g., Minneapolis Star, November 13, 14, 1972; Minneapolis Tribune, November 14, 1972; Detroit Free Press, February 25, 26, 1973; Baltimore Sun, May 13, 1973

7/ A major Kefauver panel recommendation was for establishment of hearing-aid dealer licensing requirements by states as a means of controlling untoward dealer sales practices. According to a recent issue of the Hearing Aid Journal, the industry's monthly news magazine, "a veritable avalanche of opposition" to the concept came from industry members. In the meantime, however, the primary focus of state dealer-licensure legislation has changed from consumer protection to industry protection. "Most of the dealers operating in the 14 unlicensed states are now clamoring for the passage of a good protective licensing act." (Milton Bolstein, "Licensing...And How It Has Changed," Hearing Aid Journal, July 1973, p. 3.) One industry spokesman goes so far as to label licensing for hearing-aid dealers as "the key to... survival." (W. Hugh Conaughty, "The Licensing Effort Never Ends," ibid., p. 5.)

The economies of the industry and its retail practitioners depend exclusively on sales volume -- the more sales made, the more fiscally successful the retailer, the greater the industry's profits. ASHA is assuredly not opposed to profit or to the full and fair operation of the free enterprise system. But it does have profound reservations about any system which pits the financial interest of a seller against the health and economic interests of a buyer and then permits the seller the choice of alternatives. Our reservations in this regard are heightened by the fact that unless hearing-aid dealers qualify as audiologists or physicians specializing in diseases of the ear, they are simply unable to satisfactorily evaluate the integrity of the auditory (hearing) system, to locate the anatomical location of an auditory problem, or to assume responsibility for the rehabilitation of the hearing impaired. The percentage of dealers so qualified is so infinitesimal as to defy calculation.

The solution to this conflict-of-interest situation is as obvious today as it was when last this Committee held hearings on hearing aids and the elderly, or when the Kefauver Subcommittee earlier undertook its inquiry into the pricing practices of the hearing-aid industry. If this and earlier congressional efforts as well as recent consumer-group initiatives are to mean more to the elderly hearing-impaired than ineffectual gestures, however well-intended, hearing-aid salesmen must be precluded by law and appropriate administrative regulations from selling a hearing aid without first obtaining an order, written by a physician specializing in diseases of the ear or by an audiologist, to provide a specific aid to a specific customer whose hearing has been evaluated by the prescribing professional. Unless such regulation at national and state levels occurs, we shall continue to have a situation in which untrained non-professional personnel diagnose complex health problems, prescribe

prosthetic devices, and accept payment for providing a device which the seller cannot assure is appropriate to the buyer's health need or needed at all. Unless the Committee calls for such regulation in its final report on these hearings, we believe it will have failed to meet effectively the objective it set for itself more than five years ago: i.e., "...to help older Americans -- those most vulnerable to deafness and near-deafness -- to save themselves from the isolation, demoralization, and hazards that occur when hearing deterioration becomes severe."8/

For decades, the sale of eyeglasses to the visually handicapped has been possible, under law, only after prior examination and prescription by a physician specializing in diseases of the eye or an optometrist. ASHA believes that the hearing-handicapped people of this country should be accorded equal protection of law; that they, too, should be assured the expert advice of an appropriately qualified health professional prior to their purchase of a health appliance. In the instance of the hearing handicapped, the appropriately qualified health professional is an audiologist or a physician specializing in diseases of the ear.

ASHA is a national scientific and professional society of speech pathology and audiology practitioners, 2103 of whom, as of the start of fiscal 1974, have been certified as clinically competent in the area of audiology.9/ Five hundred and fifty-four (554) additional individuals were on the continuum of professional preparation, having fulfilled their master's degree requirement

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8/ Hearings before the Subcommittee on Consumer Interests of the Elderly, op. cit., p. 1.

9/ Edward Bruder, "Official ASHA Counts: July 1, 1973" (unpublished report), August 13, 1973, p. 7.

and in the process of accumulating the supervised clinical work experience required for certification.[10/]

The ASHA Certificate of Clinical Competence in Audiology represents that its holder has earned a master's degree in audiology from a graduate training program which meets course-content and supervised clinical-work criteria established by ASHA; completed the equivalent of nine months of full-time, supervised experience in the practice of audiology; and passed the National Examination in Audiology, which is administered by the Educational Testing Service, Princeton, New Jersey.[11/] Government health and education programs universally define "audiologist" as the possessor of the ASHA Certificate of Clinical Competence in Audiology (or its equivalent, in terms of appropriate education and experience).[12/] Audiologists regarded by the U.S. Social Security Commission as "qualified" to render audiology services to federal health-program beneficiaries include both those fully certified (i.e., the 2103 figure, supra.) and those who have met the education requirement for ASHA certification and are in the process of fulfilling the supervised clinical experience requirement (i.e., the 554 figure, supra.).[13/] The total number of audiologists qualified to render Medicare-covered diagnostic

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10/ Ibid.

11/ A full delineation of the requirements for the Certificate of Clinical Competence in Audiology appears as addendum I, infra.

12/ See, e.g., 38 F.R. 18978 (July 16, 1973, effective July 13, 1973); Occupational Outlook Handbook in Brief, U.S. Department of Labor, Bureau of Labor Statistics (Spring 1972), p. 6; Announcement WA-7-27: Professional Careers in Audiology and Speech Pathology, Interagency Board of U.S. Civil Service Examiners (August 22, 1967); Dictionary of Occupational Titles (Vol. I), U.S. Department of Labor, Bureau of Employment Security (1965), p. 30; and see 38 F.R. 18623 (July 12, 1973).

13/ See, e.g., 38 F.R. 18623, 18978, ibid.

audiological services to hearing-impaired Americans age 65 and older, then, as of July 1, 1974, is 2657.

We offer these figures in an effort to point up as graphically as possible the fallacy which attaches to the premise proffered in some quarters that there are insufficient numbers of audiologists in the country to adequately meet the rehabilitation needs of America's elderly hearing-impaired. Based on that premise are assertions that a written audiologist's prescription should not be made a prerequisite for the purchase of a hearing aid -- even in the event that the Medicare system begins to assume hearing-aid costs now being paid by hearing-handicapped older Americans.

A calculation involving the number of Americans 65 years of age and older (20.8 million)[14/] and the prevalence of significant hearing impairments in that group (29 of every 100),[15/] indicates that about 3000 full-time equivalent audiologists are needed to provide appropriate hearing-aid-related services to every elderly American with a bilateral hearing loss significant enough to affect his ability to hear and understand speech.[16/] To add to this calculation the facts that there are 5500 to 6000 physicians in this country who specialize in diseases of the ear,[17/] that the current number of ASHA-

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14/ Source: United States Bureau of the Census: 1972.

15/ Source: National Center for Health Statistics: Vital and Health Statistics, Series 10, No. 79.

16/ "Determination of Manpower Needs in Speech Pathology-Audiology" (unpublished report), American Speech and Hearing Association (July 26, 1973), p. 4. In addition to several realistic, even conservative assumptions related to such of its elements as the number per-client hours involved in meeting primary hearing-habilitation needs, the calculation assumes that the audiologists involved devote their total professional effort to meeting the hearing-habilitation needs of persons 65 and older.

17/ Source: Unpublished data based on 1973 survey of members of the American Council on Otolaryngology.

certified audiologists is expected to more than double in five years,[18] and that clinical programs offering qualified audiology services are widely available throughout the country[19] . . . to add these elements to our calculation is to knock into a cocked hat any and all assertions that there are too few genuinely qualified professionals in the hearing-health field to permit the introduction of a legal prescription requirement into the existing hearing-aid delivery system.

The audiologists' preparation to select and prescribe appropriate amplification, and provide other rehabilitative services is recognized by federal and state agencies and acknowledged in existing statutes. Hearing aids are both selected and dispensed by audiologists in the Veterans Administration and Armed Services. Most, if not all, State Crippled Children's Services require a prescription by an audiologist for a hearing aid prior to authorizing purchase of a hearing aid for a child. The Social and Rehabilitative Services (HEW) reports that approximately 50% of hearing aids purchased by state vocational rehabilitation programs are upon recommendation by audiologists. Some state statutes relating to the sale of hearing aids include an age restriction clause which prohibits dealers from selling aids to children without a prior prescription from an audiologist and medical clearance by an otolaryngologist. Other states require only a prescription by an audiologist or otolaryngologist. Minnesota recently promulgated a registration act which requires that hearing aid dealers obtain a prescription from an audiologist or a physician before they sell a hearing aid to an elderly person or to a

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18/ Source: Unpublished data based on 1973 survey of members of the American Speech and Hearing Association.

19/ See A Guide to Clinical Service Programs in Speech Pathology and Audiology 1973 (Washington, D. C.: American Speech and Hearing Association), 1973, which appears as addendum II, infra.

child. Certainly there is ample precedence for an audiological prescription prior to authorizing the purchase of a hearing aid for a person with hearing impairment.

It is ASHA's major recommendation to this Committee that your report on these hearings call for such a prescription requirement. It is our further hope that the Senate Finance and House Ways and Means Committee will be encouraged to include in any national health-insurance legislation a provision for Medicare-reimbursement to hearing-impaired elderly Americans who purchase hearing aids on the written order of an audiologist or a physician specializing in diseases of the ear. ASHA has previously outlined its belief that an economically manageable, as well as humanitarian, Medicare hearing-aid program could be established by reducing the cost of aids through the development of a national hearing-aid-purchasing program, and by carefully determining the hearing-loss level at which eligibility for an aid would attach.[20/] At the very least, hearing-aid-related services performed by the audiologist or physician should be considered Medicare-reimbursable under any national health-insurance program.

20/ Hearings before the Subcommittee on Consumer Interests of the Elderly, op. cit., p. 148.

APPENDIX 4

PREPARED STATEMENT

of the

NATIONAL RETIRED TEACHERS ASSOCIATION

and the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

THE COMPREHENSIVE HEALTH INSURANCE ACT OF 1974

before

THE SUBCOMMITTEE ON HEALTH OF THE ELDERLY

of the

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

March 12, 1974

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PART ONE

INTRODUCTION

With the prospect for enactment of national health insurance legislation in the immediate future obscured by fundamental disagreements over the extent of covered items and services, the means of financing and delivering those items and services while assuring quality control, the degree of federal involvement, the nature and extent of cost-sharing, and the nature of catastrophic protection, the National Retired Teachers Association and the American Association of Retired Persons, as their contribution toward the ultimate national goal of quality health care for all Americans, undertook a two-year effort to develop legislation responsive to the immediate health care needs of those groups for whom the need is greatest -- the aged and the disabled. This legislation is designed to reverse the present trend of declining Medicare protection and increasing out-of-pocket health care expenditures by reducing or eliminating the durational limitations on items and services already covered under present law, covering additionally-needed items and services, and replacing existing cost-sharing devices with a single rational system of copayments subject to a catastrophic protection feature related to income. While providing comprehensive health care protection for the needy, it would also confront directly the problem of escalating health care cost by completely reversing existing reimbursement procedures. This legislation would establish procedures

for prospective reimbursement to institutional providers on the basis of prospectively approved budgets and schedules of charges derived from those budgets. In the case of non-institutional providers, reimbursement would be made on the basis of negotiated rates. It is this legislation, the Medicare Amendments of 1974, which is the primary subject of this statement.

While recognizing the increase in the income level of the aged over the Medicare period of 1965 to 1972, PART TWO of this statement will demonstrate statistically that a substantial percentage of the aged remain at or below the poverty level and that the aged still have far less disposable income for the purchase of health care protection than do the non-aged whose income level over the Medicare period has increased far more rapidly. That the aged, as a class, face the highest incidence of illness and disability and are therefore, most in need of adequate health care protection, will also be demonstrated. In effect, PART TWO describes statistically this nation's health care needy, who cannot afford to wait for adequate protection.

PART THREE of this statement demonstrates the declining health care protection being provided by the Medicare system in the face of rapidly escalating health care costs and suggests that part of that escalation has been stimulated by the very nature of the Medicare system. It also demonstrates the obvious consequence -- substantial increases in out-of-pocket expenditures for health care on the part of the aged. PART THREE's conclusion is that health care legislation for this nation's health care needy must,

on the one hand, provide comprehensive health care protection and on the other, deal directly with the problem of rising health care costs.

That the Medicare Amendments of 1974 carry out these objectives far more effectively than the present law, is the subject of PART FOUR. This PART contains, following a description of those Amendments, a detailed comparison between the provisions of current law and the provisions of the Amendments, with respect to entitlement and duration of entitlement, covered items and services and their durational limitations, cost-sharing, the conditions of and limitations on payments for services, and the financing of health care benefits.

PART FIVE, after presenting a detailed description of the principal provisions and features of the Comprehensive Health Insurance Act of 1974, demonstrates how this major legislation would respond to the dimensions of the health care needs of the aged and disabled by measuring the degree of comprehensiveness of the health care protection it would provide to those groups and by evaluating its efforts with respect to health care cost restraint. The standards used in analyzing the Comprehensive Health Insurance Act of 1974 are present law and the Medicare Amendments of 1974.

PART TWO

THE INCOME SITUATION AND
HEALTH CARE EXPENDITURES OF THE AGED

Over the period 1965 to 1972, the Medicare period, family median income in the United States increased by 60 per cent. In terms of the aged, however, this overall figure is misleading. In the case of an aged male, median income increased over this same period by only 45 per cent -- from $2,052 in 1965 to $3,046 in 1972. In the case of an aged female, however, median income increased 93.7 per cent -- from $980 in 1965 to $1,899 in 1972. While the income of the aged has therefore been rising, this is only one dimension of their present income situation.

The most recent figures given by the Bureau of Census add another dimension -- 3,738,000 aged persons currently have incomes below the poverty level. This translates into 18.6 per cent of the total aged population and contrasts strongly with the incidence of poverty for the non-aged (approximately 11.4 per cent).

In 1970, the median annual rates of social security recipients were as follows:

Married Men, age 65	5,780
Married Men, age 62	5,140
Married Women, age 65	6,000
Married Women, age 62	5,330
Non-Married Men, age 65	2,850
Non-Married Men; age 62	2,120
Non-Married Women, age 65	2,380
Non-Married Women, age 62	1,910

In 1970, poverty thresholds were defined to be $2,350 for married persons, $1,180 for non-married men and $1,860 for non-married women. If these figures are converted into the percentage of recipients whose total income leaves them below the poverty level, the following then obtains:

Married Men, age 65	8%
Married Men, age 62	16%
Married Women, age 65	13%
Married Women, age 62	9%
Non-Married Men, age 65	27%
Non-Married Men, age 62	44%
Non-Married Women, age 65	35%
Non-Married Women, age 62	49%

Since social security benefits have increased by 50 per cent since the date of this study, the incidence of poverty is certainly not as high today as these figures indicate. The fact remains, however, that 18 per cent of the elderly population have incomes below the poverty level and this is so despite rising income levels.

The description of the income situation of the aged acquires a third dimension when the increase in their median income over the period 1965 to 1972 is compared with that of the non-aged. In 1965, families headed by an aged person had median income equal to 54 per cent of the national family level. By 1972, however, households headed by an aged person had median income of only 42 per cent of the national family level. As should be evident from the foregoing, despite the increase in the income of the elderly over the period 1965 to 1972, a substantial percentage of the aged

population remains at or below the poverty level and the aged, as a group, have less disposable income for the purchase of health care than do the non-aged whose incomes rose more rapidly over the same period.

With an income situation less favorable than the non-aged, the aged require far more health care. In 1972, the aggregate expenditures for health care of the aged were only $20.1 billion, for the non-aged, $52.7 billion. On a per capita basis, however, the medical bill for an aged person was $960; for a non-aged person, only $509. In 1973, aggregate expenditures for the health care of the aged were $22.3 billion; for the non-aged,$57.2 billion. On a per capita basis, the medical bill for an aged person was $1,044, for a non-aged person, $553.

These income and health care expenditure statistics should be adequate to indicate the need for health insurance protection in the case of the aged. With the enactment of Medicare in 1965, a response to that need was forthcoming. However, as will be demonstrated in PART THREE, the health care protection provided by the Medicare system has been declining in the face of the rapid escalation in health care cost during the Medicare period -- a part of which escalation has been stimulated by the very nature of the Medicare system.

PART THREE

THE IMPACT OF MEDICARE

A. COST EXPERIENCE UNDER MEDICARE FROM THE POINT OF VIEW OF THE AGED BENEFICIARY

During fiscal 1973, the average medical bill of a person age 65 or older was $1,044.[1] This compares with $384 for persons age 19 to 64 and $169 for the young.[2] In the absence of Medicare, the average medical bill of an aged person would have absorbed 25 per cent of their income level. The average hospital bill for an aged person was ten times that for youth and nearly triple that for persons in intermediate age groups. With respect to physician's services, the aged person's health bill was double and triple that for the intermediate group and youth, respectively. Even with Medicare, the average out-of-pocket expenditures for an aged individual was $303 in fiscal 1973, as compared with $276 in fiscal 1972.[3] These out-of-pocket expenditures in fiscal 1973 are nearly three times the average out-of-pocket expenditures for the non-aged. In 1971, prescription drug expenses by Supplementary Medical Insurance enrollees averaged $74.00[4] -- an amount greater than the annual premium paid by enrollees for all Supplementary Medical Insurance covered services. (In fiscal 1973, per capita expenditures by the aged for drugs amounted to $97.20.[5]) Over the years,

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[1] B. Cooper, P. Piro, "Age Differences in Medical Spending" - Fiscal Year 1973, Social Security Administration (Office of Research and Statistics), Dept. of HEW, Pub. No. (SSA) 74-11701 March 27, 1974).

[2] Id.

[3] Id. (Table 1).

[4] Martin Ruther, Robert K. Mitchel, and Dennis Hefner, Prescription Drugs 1967-1971, Office of Research and Statistics, 1973.

Medicare's share relative to expenses has fallen to the point where in 1973, only 40.6 of those expenses were paid by the system. In 1969, this figure was 46 per cent. Medicare's share of doctor fees has declined from 61 per cent in 1969 to 55 per cent in 1973. Refusing to accept an assignment -- whatever Medicare deems "reasonable" -- the physician collects the amount of his fee (the amount of which, in some case, may be "whatever the traffic will bear") directly from the patient, leaving the patient to collect Medicare's "reasonable" and sometimes inadequate payment. Medicare's share of hospital costs over the 1969 through 1973 period changed from 66 per cent to 61 per cent. In view of rising health care costs and declining Medicare protection, it is not at all surprising that the aged individual's out-of-pocket annual expenditures for health care is increasing.

The following table should help to indicate why this trend has occurred. Over a period when the average social security cash benefit was increasing by 96 per cent, premiums, deductibles, hospital and extended coinsurance rates were increasing by approximately 110 per cent.

It is likely that this upward trend of out-of-pocket expenses will continue unless durational limitations on items and services already covered under Medicare are reduced or eliminated, new items and services are covered, and the cost-sharing mechanism is altered and made subject to a catastrophic protection feature.

TABLE 1

Year	Inpatient Hospital Deductible	Inpatient Hospital Coinsurance 61-90	91-150	Extended Care Coinsurance	SMI Premiums
1968	$40	10	20	5.00	3.00
1969	44	11	22	5.50	4.00
1970	52	13	26	6.50	5.30
1971	60	15	30	7.50	5.60
1972	68	17	34	8.50	5.80
1973	72	18	36	9.00	6.10
1974	84	21	42	10.50	6.30

Source: 1974 Social Security and Medicare Explained, Commerce Clearing House, pp 610, 635.

B. COST EXPERIENCE UNDER MEDICARE FROM THE POINT OF VIEW OF THE PROVIDER

In fiscal year 1973, total national health care expenditures increased from $84.7 billion in fiscal year 1972 to $94.1 billion -- an increase of $9.3 billion.[5] Although the 11 per cent increase in health care cost during fiscal 1973 was relatively restrained in comparison with the rate of increase in prior years, the commensurate increase in the gross national product over the same period (10.9 per cent) left health care expenditures at approximately the same proportion of GNP as in fiscal 1972 -- 7.7 per cent.[6]

[5]B. Cooper, N. Worthington, P. Piro,"National Health Care Expenditures, 1929-73", Social Security Bulletin 7 (March 1974).
[6]Id. 3.

Although there has been a great deal of talk about "overutilization" of medical care resources, especially in the Medicare period, as the cause of rapid medical care price increases, there is very little evidence to support this contention. Table 2 should confirm the fact that demand changes have been quite moderate throughout the period.

TABLE 2

Fiscal Year	Admissions (in thousands)	Patient Days (in thousands)	Ave. Length of Stay (days)	Occupancy Rates (days)
1965	26,557	202,098	7.6	77.1
1966	26,831	203,647	7.6	76.4
1967	27,048	214,454	7.9	78.0
1968	27,465	221,891	8.1	78.2
1969	28,027	227,633	8.1	78.5
1970	29,247	231,643	7.9	77.4
1971	30,312	234,441	7.7	77.1
1972	30,706	232,892	7.6	75.1

Source: "Hospital Indicators," Hospitals, midmonth issue.

From 1965 to 1972, admissions increased by 15 per cent, patient days by 15 per cent, average length of stay exhibited no change at all and occupancy rates actually fell. If occupancy rates are considered as a rough measure of capacity utilization, it is clear that the problem of increasing cost is not of a "demand pull" nature.

The $9.3 billion health care cost increase for fiscal 1973 is far less a function of the use of services, and more a function of the supply of facilities and personnel available for health care delivery and, more precisely, of the cost of health care services. The percentage increases and various prices set forth below should be considered in the light of the fact that over period 1967 to 1974, consumer prices increased by 32.8 per cent and consumer services by 39.1 per cent.

TABLE 3

Percent Increase in Prices 1967-1974

Doctors' Fees	38.2%
Drugs and Prescriptions	5.9%
X-Rays	31.8%
Operating Room Charges	79.1%
Daily Service Charges	74.7%
Semi-Private Room Charges	83.1%

Source: Bureau of Labor Statistics 1974

The problem then, is apparently neither drugs and prescriptions nor doctor fees -- all of which increased by slightly less than services in general. (Outlays for physician services increased 8.5 per cent in fiscal 1973 to $18 billion.) The problem is hospital charges and it is here where the Medicare system has undoubtedly contributed to medical care inflation.

Hospital care constituted 38 per cent of the nation's total health bill ($36.2 billion) in fiscal 1973.[7] Costing more than $100 per patient per day in community hospitals, it is also the most expensive item.

While hospital charges may have been somewhat restrained during fiscal 1973 as a result of the economic stabilization policies, hospital expenses per adjusted patient day (as reported by the American Hospital Association) continued at a high rate of increase, largely because most financing is on a cost reimbursement basis under government programs or private insurance.[8] The expenses per adjusted patient day in community hospitals increased 9.3 per cent in fiscal 1973, almost twice the Consumer Price Index figure for semi-private accommodation charges.[9] With a 9.3 per cent increase in community hospital cost, it is therefore not surprising that total health care expenditure increased by 11 per cent.

The nature of the Medicare system's contribution to the rate of increase in hospital costs over the period 1967 to 1974 must be very closely specified. The reimbursement mechanism under the Hospital Insurance program is structured so as to provide full cost recovery. Because this is the case, the level of these costs is likely to be above the minimum level necessary to provide

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[7] Id. 3.
[8] Id. 7-8.
[9] The hospital component of the CPI does not adequately reflect cost. In addition, the weight assigned to the hospital component is too small. Hospital care outlays represent 45 per cent of personal health care expenditures. Yet the weight in the medical care index is only 27 per cent. (B. Cooper, N. Worthington, P. Piro, "National Health Expenditures 1929-73", Social Security Bulletin 12 (March, 1974).

services -- simply because hospitals lack any incentive to restrain these costs.

Throughout the Medicare period, the operating costs of hospitals have been rising rapidly. These costs are essentially a function of the overall inflation rate. Wages too, have been influenced by the inflation rate. Further, this same period has been marked by increases in the real wages of hospital employees who for years have been underpaid. It would appear, therefore, that control of hospital costs depends significantly on what the federal government does with respect to inflation.

In addition to these considerations, it is also necessary to consider the significant increases in hospital staffing levels as well as the substantial expenditures for sophisticated plant and equipment. The question then is to what extent has Medicare financed these investments and other outlays, and further, to what extent were these outlays cost-effective. Certainly hospitals in general are not considered profit-maximizing entities. Neither are they competitive. Hence, there is little or nothing within the system that would tend to keep hospital costs to the minimum necessary to provide services of a given quality -- except perhaps the inability of the patient to afford services after charges reach a particular level. To the extent that Medicare has removed this constraint, it is logical that it contributed to the increasing cost levels observed over the last few years. Indeed, in recognition of this, the Social Security Amendments of 1972 introduced important limitations. For example, in determining "reasonable

cost", any cost in excess of that actually incurred and incurred costs found to be unnecessary in the efficient delivery of health care services will be excluded. Also, provisions to promote planning activities for health care and services and to avoid the use of federal funds to support unjustified capital expenditures were added. A third provision requires hospitals and other institutional providers to maintain an annual operating budget and a three-year capital expenditure plan. These provisions, however, are not likely to be enough. Methods must be found to analyze hospital spending plans and insure that proposed outlays will be cost effective. Any system which reimburses all costs by a third party, whether it be the employee business expense account or hospital charges, must be closely monitored if costs are to be held to reasonable levels.

Indeed, this need for an effective monitoring system becomes all the more critical when considered in the light of the substantial growth of third party payments over the last 20 years. While inflation and other factors have tripled per capita expenditures from 1950 to 1973, the proportion of total health care bills paid directly by patients has been reduced by approximately 50 per cent.[10] In 1973, third party payments were covering an estimated 75 per cent of the individual's health care bill (38 per cent being paid by the government and 26 per cent being paid by private health insurance).[11]

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[10] Id. at 13.
[11] Id.

Not only has the impact of third party payments been substantial when considered overall, but when considered in relation to hospital care, the need for an effective monitoring system comes sharply into focus. From 1950 through 1973, the proportion of hospital bills being paid directly by patients has been reduced from one-third to one-tenth.[12] With respect to physician services, third party payments have increased from 15 per cent of the physician's bill in 1950 to 50 per cent by 1970.[13] For other types of care, however, (including dentist, dental care and other professional services, drugs, eyeglasses and appliances), third party payments have increased from only 11 per cent in 1950 to 34 per cent at the present time.[14] Obviously, then, the expansion of covered items and services under Medicare and other public and private health insurance, will necessitate even more the development of a system to monitor closely the cost of health care if such cost is to be held to a reasonable level.

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[12] Id. at 13-14.
[13] Id. at 14.
[14] Id.

PART FOUR

DESCRIPTION OF THE MEDICARE AMENDMENTS OF 1974

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DETAILED COMPARISON OF THOSE AMENDMENTS WITH CURRENT LAW

A. DESCRIPTION OF THE MEDICARE AMENDMENTS OF 1974

Medicare, known officially as Health Insurance for the Aged and Disabled,[15] has major deficiencies. It is divided into two distinct programs -- Hospital Insurance Benefits for the Aged and Disabled[16] and Supplementary Medical Insurance Benefits for the Aged and Disabled.[17] The basis for this division is historical rather than rational; the result is an uneven distribution among the intended beneficiaries of the intended degree of health care protection.

Eligibility for benefits under the Hospital Insurance program is based on insured status under the social security and railroad retirement cash benefit programs, while eligibility under the voluntary Supplemental Medical Insurance program is based on residence or, alternatively, entitlement to Hospital Insurance. The deductibles (inpatient hospital deductible per spell of illness, the annual deductible, and the blood deductibles), coinsurance (with respect to inpatient hospital care and skilled nursing care under Hospital Insurance, and 20% coinsurance under Supplementary Medical Insurance), and premiums (for voluntary enrollees under both programs) reflect rising health care costs and now constitute

[15] Soc. Sec. Act §§1801-1879.
[16] Soc. Sec. Act §§1811-1818.
[17] Soc. Sec. Act §§1831-1844.

a substantial burden on low and relatively fixed income aged and disabled persons. The limitations on inpatient hospital and skilled nursing facility care, on home health services, and on the amounts of inpatient and outpatient psychiatric care, and the limitation of skilled nursing facility care and home health services to post-hospital care under the Hospital Insurance program severely restrict the degree of health care protection. Moreover, the exclusion of intermediate facility care, the exclusion of dental care and dentures, of eyeglasses and examinations for prescribing them, of hearing aids and examinations therefore, and certain other professional services, and of orthopedic shoes and certain other walking aids, and outpatient drugs (except injectibles when administered to an outpatient in a physician's office or hospital) further limit the protection available under the programs.

Certainly Medicaid, known officially as Grants to States for Medical Assistance Programs,[18] is not a suitable means of compensating for the indefinite future for the deficiencies of the Medicare programs. First, Medicaid imposes, as a condition for eligibility, a means test which should not be imposed for health care of the aged. Also, being a federally-aided rather than a federal program, it is not in effect in every state. Furthermore, many states have not extended the Medicare program to those whose income is above the cash public assistance level but who are medically indigent. Many states, even among those that do not cover the medically indigent, have had great difficulty in meeting their share of costs

[18] Soc. Sec. Act §§1901-1910.

and have cut back on eligibility and services. Finally, Medicaid varies widely among the states in its benefit coverage and in its eligibility requirements, thus aggravating inequitable distribution of national health care resources among those in need of its benefits.

The Medicare Amendments of 1974 would revise and expand the Medicare program and would build upon the Medicare cost experience by, among other things, integrating the Hospital and Supplementary Medical Insurance programs into a single benefit structure, with a single trust fund. The program would be financed in full through health insurance taxes on wages and payroll, self-employment income, and unearned income, through government contributions from general revenues, and through earnings from investment of proceeds of these taxes and government contributions.

With respect to eligibility and coverage, these Amendments would extend the benefits of the program to all aged United States citizens, and to most aged non-citizens living in the United States, without requiring that they be entitled to social security cash benefits and would keep under the program the disabled persons under age 65 added by the 1972 Social Security Amendments[19] but with the benefit of all the new and enlarged services added by these amendments to the same extent as in the case of the aged.

With respect to benefits, these amendments would preserve the types of benefits presently available under Medicare but would abolish the requirement of prior hospital stay with respect to skilled nursing care and home health services. These amendments

[19] Soc. Sec. Amendments of 1972, Pub. L. 92-603.

would also provide coverage of intermediate care facility services under the program beginning July 1, 1978, greatly expanded psychiatric care benefits including inpatient, day care patient, and outpatient, dental services on an unlimited basis including preventive, diagnostic, therapeutic, and restorative services and other professional and supportive services such as professional services of optometrists and podiatrists, diagnostic services of independent pathology laboratories and diagnostic and therapeutic radiology furnished by independent radiology services, mental health day care services provided by an HMO, a hospital, or community mental health center, or, to the extent of not more than 160 full days during or following a benefit period, when provided by a service affiliated with a hospital or when provided by a day care service approved by the Secretary of HEW for this purpose, professional services of chiropractors and ambulance and other emergency transportation services.

The Medicare Amendments of 1974 would expand the coverage of drugs (including biologicals) so as to include, in addition to those furnished to hospital and skilled nursing facility inpatients or in a physician's or dentist's office, drugs furnished to enrollees of a participating HMO and prescribed drugs dispensed by pharmacies, except that during the first five years, only if listed on a list of maintenance drugs established by the Secretary and thereafter only if listed as appropriate in a list, established by the Secretary, designed to provide practitioners with an armamentarium

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necessary and sufficient for rational drug therapy incident to comprehensive care. Moreover, the present coverage under Medicare of prosthetic and other devices, appliances, and equipment would be extended by these amendments to all others (including eye glasses and hearing aids) listed by the Secretary as important for the maintenance or restoration of health or employability or self-management of individuals.

Medicare Amendments of 1974 would confront directly the problem of benefit durational limitations under existing law. Present limitations on duration of general inpatient hospital care, skilled nursing facility care, and home health services would be abolished.

The Medicare Amendments of 1974 would eliminate all requirements for premium payments, and so-called deductibles and coinsurance. Instead, a system of copayments with respect to inpatient hospital services, skilled nursing services, home health services, physician's and dentist's services, mental health day care, diagnostic outpatient services and independent laboratory or independent radiology services, devices, appliances and equipment, certain drugs, and ambulance services would be established. However, these copayments and any remaining limitations on benefits would be subject to a catastrophic protection feature pursuant to which such copayments or limitations would be eliminated in the case of low-income persons and in the case of other persons, would be eliminated after such persons have incurred out-of-pocket expenses in a maximum amount related to their income.

All providers of services, not merely institutional providers as under present law, would be required to qualify as participating providers (except in emergencies and certain cross-the-United States-border hospital services). The term "provider" would be defined to include independent practitioners with respect to their private patients and suppliers who furnish items (e.g. drugs, or prostheses or appliances) to an individual in their own right and not in behalf of another.

Pursuant to these Amendments, participating hospitals and other institutional providers would be required to submit annually a budget and schedule of proposed rates and charges, based on the cost of efficient delivery of services, for approval to the Secretary of HEW or to the state rate review agency in any state that has an equivalent institutional rate review and approval law; reimbursement for services to such providers would be based on the predetermined approved rates, thus providing incentives for efficiency and economy for such providers. Moreover, physician and other services generally available to institution patients, whether performed by employed staff or under arrangements made by the institution, would be treated as institutional services, except for services by physicians, dentists, or podiatrists with respect to their private patients.

With respect to non-institutional services of independently practicing physicians, dentists, podiatrists, or other licensed professional practitioners, payment would be provided in accordance with annually predetermined fee schedules for local areas. These

schedules would be established, to the extent feasible and subject to public hearing, through negotiations of representatives of appropriate professional societies and representatives of associations of retired persons (or associations otherwise representative of Medicare beneficiaries) and based on a forecast of fair and equitable compensation (not exceeding "reasonable charges") in the area in the applicable fiscal year.

Finally, with respect to reimbursement procedures, a provider would be required, as a condition precedent to participation, to agree to accept the Medicare payment (plus any copayment) as the full charge for the services.

Under the Medicare Amendments of 1974 beneficiaries would have the option of having all covered care provided (or, in the case of emergencies or urgent out-of-area services paid for) by an HMO, including within the definition thereof a medical foundation, with which the Secretary would contract and which, as under present law, would be reimbursed either on a risk-sharing or cost reimbursement basis, with interim per capita payments during the contract year.

These Amendments would also amend the present Medicaid program to make it, in the case of those entitled to health care benefits under these Amendments, supplementary to Medicare on a transitional basis, primarily for long-term care, until all durational limitations in Medicare have expired or been repealed.

Finally, under Title III of these Amendments, studies and reports to Congress would be required with respect to a comprehensive plan or plans for making long-term health and health-related

institutional care readily and appropriately available to all who need such care. Studies would also be required with respect to the need for, and the most equitable means of meeting the cost of, additional facilities of various kinds for the long-term institutional care of persons who, because of age or disability or other cause, are unable to live at home without assistance as well as with respect to the need for additional services to enable such persons (if possible) to live in their own homes and the best way to provide and finance such services.

B. DETAILED COMPARISON OF THE MEDICARE AMENDMENTS OF 1974 WITH CURRENT LAW

1. In General

a. Present Law

Title XVIII of the Social Security Act,[20] known officially as Health Insurance for the Aged and Disabled, contains two programs of medical care -- Hospital Insurance Benefits for the Aged and Disabled[21] and Supplementary Medical Insurance Benefits for the Aged and Disabled.[22] Each of these programs has its own eligibility requirements, benefit package, limitation and cost-sharing features, reimbursement procedures, financing mechanism, and trust fund.

b. The Medicare Amendments of 1974

The Medicare Amendments of 1974 would repeal Parts A and B of Title XVIII, except Section 1817 (provisions

[20] 42 U.S.C. §§1395b-1 to 1395pp (1970).
[21] Soc. Sec. Act §§1811-1818.
[22] Soc. Sec. Act §§1831-1844.

governing the Federal Hospital Insurance Trust Fund) and replace the two Medicare programs with a single, comprehensive health insurance program for the aged and for those persons who are disabled and presently covered for purposes of Medicare.

2. Entitlement and Duration of Entitlement

a. Present Law

Under Section 226 of the Social Security Act, Hospital Insurance benefits are provided for an individual who is age 65 or over and who is entitled to monthly Old Age or Survivors Insurance benefits under Section 202[23] of Title II of the Social Security Act or who is a "qualified railroad retirement beneficiary."[24] Entitlement to Hospital Insurance benefits begins with the first day of the month in which he reaches age 65 and ends with the month he ceases to be entitled to social security section 202 benefits or ceases to be a qualified railroad retirement beneficiary.[25] In the case of an individual who is not or ceases to be entitled to social security 202 cash benefits and is not or ceases to be a qualified railroad retirement beneficiary, entitlement to Hospital Insurance benefits will depend upon his meeting the requirements

[23]Not included are transitionally insured or uninsured persons age 72 and over who are entitled to special monthly cash benefits under Soc. Sec. Act §§227, 228.

[24]Soc. Sec. Act §§226(a)(1).

[25]But see, Soc. Sec. Act §§226(c)(2) under which an individual will be deemed entitled to social security 202 benefits or qualified railroad retirement beneficiary status for purposes of Hospital Insurance entitlement for the month in which he died if he would have otherwise been so entitled.

for "transitional entitlement"[26] or, failing that, the requirements for voluntary enrollment.[27]

An uninsured individual will be deemed entitled to social security 202 benefits for purposes of entitlement to Hospital Insurance benefits (transitional entitlement) provided he attained the age of 65 before 1968 or attained the age of 65 after 1967 and has not less than three social security or railroad retirement quarters of coverage for each year elapsing after 1966 and before the year in which he reached age 65. Hospital insurance protection begins with the month in which the requirements are met and ends with the month before the first month in which the individual is entitled to social security 202 benefits, or becomes certifiable as a qualified railroad retirement beneficiary, or with the month of his death.

Hospital insurance is available to an individual under the age of 65 who has been entitled for not less than 24 consecutive months to social security or railroad retirement benefits on the basis of a disability.[28] In this case, Hospital Insurance protection would begin with the 25th consecutive month of entitlement to social security or railroad retirement disability benefits or July, 1973 whichever is later. Entitlement continues until the end of the month following the month in which notice of

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[26]See Soc. Sec. Amendments of 1965, §§103, Pub. L. 89-97.
[27]Soc. Sec. Act §§1818.
[28]Soc. Sec. Act §§226(b).

termination of disability status is mailed or, with the end of the month before the month of attainment of age 65, whichever is earlier.[29]

Hospital Insurance benefits are also available to an individual under age 65 and medically determined to have chronic renal disease and to require hemodialysis or renal transplantation, who is either fully or currently insured for social security benefits or entitled to monthly social security benefits or is the spouse or dependent child of an individual who is so insured or so entitled.[30] Eligibility begins with the third month after the month in which a course of renal dialysis is initiated and ends with the twelfth month after the month in which the individual has a renal transplant or the course of dialysis is terminated.[31]

Finally, Hospital Insurance protection is available on a voluntary basis to an individual who is 65 or over, and not otherwise entitled under the regular or transitional provisions of the law.[32] However, he must be a resident of the United States, a citizen of the United States or an alien lawfully admitted for permanent residence who has continuously resided here for not less

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[29] See Soc. Sec. Act §§226(b) under which the individual will be deemed entitled to social security or railroad retirement disability benefits for purposes of Hospital Insurance entitlement for the month in which he died if he would have otherwise been so entitled.

[30] Soc. Sec. Act §§226(e).

[31] Soc. Sec. Act §§226(f) [Pub. L. 92-603, section 299I, redesignated subsection (e) as subsection (f) and added new subsections (e), (f) and (g) resulting in more than one subsection (f)].

[32] Soc. Sec. Act §§1818.

than five years immediately preceeding the month of application. In addition, he must also be enrolled under the Supplementary Medical Insurance program. In general, the provisions governing enrollment and coverage under the Supplementary Medical Insurance program are also applicable to enrollment in the Hospital Insurance program.[33]

An individual eligible to enroll in the Supplementary Medical Insurance program or deemed to have automatically enrolled is limited to an individual entitled to Hospital Insurance benefits or to one age 65 or over who is a resident of the United States and a citizen of the United States or an alien lawfully admitted for permanent residence or a resident for a five year period immediately preceeding the month of application.[34]

Except in the case of enrollment under a federal-state agreement, an individual may enroll in the Supplementary Medical Insurance program, only during an enrollment period. In the case of an individual meeting the enrollment requirements before March 1, 1966, the "initial general enrollment period" began on September 1,

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[33]However, the "initial general enrollment period "for an individual meeting the eligibility requirements before June 1, 1973 began on December 1, 1972 and ended August 31, 1973. The coverage period for an individual enrolling for Hospital Insurance benefits during this period began with the month following the month of enrollment, July, 1973, or the month in which the eligibility requirements were met.

[34]While no one could become entitled to Supplementary Medical Insurance benefits before July, 1973 without enrolling in the program, as of July, 1973, an individual entitled to Hospital Insurance benefits would be automatically enrolled and covered for Supplementary Medical Insurance benefits, unless he indicated that he did not wish to be enrolled for such coverage.

1965 and ended May 31, 1966. Otherwise, the "initial enrollment period" for an individual begins with the third month before the month in which the eligibility requirements are met and ends seven months later. In the case of an individual who failed to enroll in the "initial general enrollment period" or in his "initial enrollment period" or in the case of an individual who wants to re-enroll,[35] there was a general enrollment period" from October 1, 1967, to March 31, 1968, and beginning with 1969 there was and will be a general enrollment period from July 1 to March 31 of each year.

In the case of an individual who voluntarily enrolls, or is automatically enrolled in the Supplemental Medical Insurance program, coverage begins in accordance with the provisions of Section 1837 of the Social Security Act, but in no event before July 1, 1966 (or July 1, 1973 in the case of a disabled individual).

Entitlement to benefits under the Supplementary Medical Insurance program continues until the individual's enrollment is terminated. Such termination will be effected by the death of the individual, the filing of a termination notice, or as a result of non-payment of premiums, whichever first occurs. The termination of coverage by notice will take effect at the close of the

[35]Under Soc. Sec. Act §§1837(b) no individual may enroll more than twice.

calendar quarter following the calendar quarter in which such notice is filed. Termination for non-payment of premiums will take effect with the end of the"grace period"[36] during which overdue premiums may be paid and coverage continued.

In the case of an individual entitled to Hospital Insurance benefits and consequently Supplementary Medical Insurance benefits, on the basis of disability, coverage ends with the close of the last month for which he is entitled to Hospital Insurance benefits.[37]

b. The Medicare Amendments of 1974

The Medicare Amendments of 1974 would greatly simplify the confusing network of eligibility and coverage requirements of present law. Under these Amendments, every individual who, at the time any service covered under Title XVIII is furnished to him, has attained the age of 65 and is a citizen or national of the United States, or is an alien lawfully admitted for permanent residence and is living in the United States, or is an alien and has been on a continuing basis, for a period of not less than 30 days immediately proceeding the furnishing of that service, lawfully present in the United States, or is an alien entitled to social security section 202 benefits or qualified as a railroad retirement beneficiary would

[36]Soc. Sec. Act §§1838(b)(2).
[37]Soc. Sec. Act §§1838(c).

be entitled to Health Insurance benefits with respect to that service.[38] The provisions of current law with respect to entitlement and duration of coverage of disabled individuals are retained.[39]

With respect to an individual who is under age 65 and who is medically determined to have chronic renal disease requiring renal dialysis or kidney transplantation, such an individual would be entitled to Health Insurance benefits provided that he is entitled to monthly cash benefits under Title II of the Social Security Act or to an annuity under the Railroad Retirement Act of 1937 or is a fully or currently insured individual or is the spouse or dependent child of such a person. Coverage would begin with the third month after the month in which eligibility requirements are met and a course of renal dialysis is initiated and would end with the twelfth month after the month in which the individual receives a kidney transplant or in which the course of renal dialysis terminated.

3. Health Care Benefits and Durational Limitations

a. Present Law

The benefits provided to an individual by the Hospital Insurance program of present law consist of entitlement to have payment made on his behalf for inpatient hospital

[38]Medicare Amendments of 1974 §§111(b)(amending Title II of the Social Security Act).

[39]Also retained, but in modified form, is the provision pursuant to which an individual is deemed entitled to social security 202 or 223 (disability) benefits or is deemed a qualified railroad retirement beneficiary for the month in which he dies, if he would have otherwise been so entitled.

services (including psychiatric and tuberculosis hospitals), post-hospital extended care services provided by a skilled nursing facility and post-hospital home health services.[40] These services are limited in duration, however, in accordance with the beginning or ending of a "spell of illness."[41]

Inpatient hospital services[42] are covered for up to 90 days[43] per spell of illness.[44] In addition, each beneficiary has a lifetime reserve of 60 days of additional coverage after exhaustion of the 90-day period. Post hospital extended care services[45] furnished by a skilled nursing facility are covered for only 100 days during a spell of illness. Post hospital health services[46] are covered for up to 100 visits provided during a one-year period beginning after the commencement of a spell of illness and ending before the commencement of the next spell. Finally, services provided by a qualified Christian

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[40] Soc. Sec. Act §§1812(a).

[41] Under Soc. Sec. Act §§1861(a), a "spell of illness" is a period of consecutive days that begins with the first day (not included in a previous spell of illness) on which an entitled patient is furnished inpatient hospital or extended care services by a qualified provider. (Admission to a qualified skilled nursing facility will begin a spell of illness even though payment for the services cannot be made because the prior hospitalization or transfer requirement has not been met.) The "spell of illness" ends with the close of a period of 60 consecutive days in which the patient is neither an inpatient of a hospital or skilled nursing facility regardless of whether such a hospital or facility is a qualified provider.

[42] Defined in Soc. Sec. Act §§1861(b).

[43] Soc. Sec. Act §§1812(a).

[44] Under Soc. Sec. Act §§1812(b)(3) and (c), there are further limitations with respect to inpatient hospital services of a psychiatric hospital including a lifetime limit of 190 days for such services.

[45] Defined in Soc. Sec. Act §§1861(h), (i).

[46] Defined in Soc. Sec. Act §§1861(m), (n).

Science Sanitorium are covered for up to 180 days in the same spell of illness -- up to 150 days of hospital services, and up to 30 days of extended care services.

Supplementary Medical Insurance, as a separate program, has its own package of covered services which builds upon, reinforces, and to some extent, duplicates Hospital Insurance benefits. The benefits provided to an enrolled individual consist of entitlement to have payment made to him or on his behalf for "medical and other health services"[47] (including physician's services) and entitlement to have payment made on his behalf for home health services for up to 100 visits per year (no prior hospital stay requirement), "medical and other health services" furnished by a provider of services (hospital, skilled nursing facility or home health agency), excluding, however, most physician's services and outpatient physical therapy services.[48]

b. The Medicare Amendments of 1974

Health care protection would be far more comprehensive under the Medicare Amendments of 1974. New services would be covered and limitations on services already covered would be reduced or eliminated.

Under the Medicare amendments of 1974, entitlement of an individual to benefits would consist of the right to

[47]Defined in Soc. Sec. Act §§1861(s).
[48]Soc. Sec. Act §§1832(a).

have payment made on his behalf or to him when so specified, for covered institutional services[49] including inpatient and outpatient hospital services and including such services in a psychiatric or tuberculosis hospital or other specialized hospital, skilled nursing facility services, intermediate care facility services (furnished after June 30, 1978), home health services, health and health-related services and items for the rehabilitation of handicapped individuals, inpatient services of a Christian Science sanitorium, and health, health-related services and items that are furnished to an individual by an institution that is a public health agency or nonprofit private health agency or furnished by others under arrangements.[50]

Covered non-institutional services for purposes of the Medicare Amendments of 1974 include the following: professional services of a physician[51] (when not covered as institutional services), services, materials, and supplies (including drugs), furnished as an incident to a physician's professional services and commonly

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[49] Under Medicare Amendments of 1974, §§111(a)("1813(b)"), the term "institutional services," includes all services that are furnished or held out as available generally to patients or classes of patients of the institution involved and are furnished by the institution or by others under arrangements made by the institution, including pathology and radiology services, and all other professional and non-professional services so furnished or held out as available, except that the term does not include medical, surgical, or dental services by an independent physician or dentist, or podiatry services by an independent podiatrist furnished to an individual as the practitioner's private patient.

[50] Medicare Amendments of 1974, §§111(a)("1813").

[51] Medicare Amendments of 1974, §§111(a)("1814").

furnished in the physician's office with or without separate charge, psychiatric (mental health) services to patients other than inpatients, but only if furnished by an approved HMO, a hospital, or a mental health center or (up to 60 days) by a mental health day care service affiliated with a hospital or approved by the Secretary, or (up to 20 consultations a year) by a psychiatrist in his office, dental services[52] (when not covered in institutional services) including preventive, diagnostic, therapeutic, and restorative services, professional services[53] of an optometrist and podiatrist, diagnostic services of independent pathology laboratories and diagnostic and therapeutic radiology furnished by independent radiology services, chiropractor services, ambulance and other emergency transportation services, and non-emergency transportation services found essential by the Secretary to overcome special difficulty of access to covered services, and supporting services[54] not otherwise covered (such as inpatient and outpatient psychological, physical, occupational, or speech therapy services, and nutrition, social work, and health education services).

Drugs are covered under the Medicare Amendments of 1974[55] as an institutional or non-institutional service as the case may be when furnished, in the manner

[52]Medicare Amendments of 1974, §§111(a)("1815").
[53]Medicare Amendments of 1974, §§111(a)("1816(a)").
[54]Medicare Amendments of 1974, §§111(a)("1816(b)").
[55]Medicare Amendments of 1974, §§111(a)("1817").

hereinafter set forth, by or on prescription of a physician or dentist participating as a provider or acting on behalf of a participating provider. However, the drug must be furnished to an enrollee of an HMO or administered by a hospital's inpatient or outpatient department or administered to an inpatient of a skilled nursing facility or to a patient in a rehabilitation agency or center. A drug may also be furnished in a physician's or dentist's office as an incident to his professional service (with or without separate charge) but only if the drug is on a general list, established by the Secretary, designed to provide practitioners with an armamentarium sufficient for rational drug therapy, or if furnished (on prescription) but only if included in a special list established by the Secretary and then only if prescribed for a disease or condition for the treatment of which the drug is specified on that list, except that a drug furnished after June 30, 1981 (beginning with the sixth fiscal year of outpatient coverage under the law) would be covered (without regard to the condition for which it is prescribed) if listed on the Secretary's general list of drugs.

Devices, appliances, equipment and supplies, not otherwise covered, would be covered under these Amendments[56] if prescribed or certified as medically necessary by a

[56]Medicare Amendments of 1974, §§111(a)("1818").

professional practitioner participating as a provider or acting on behalf of a participating provider and if included on a list established by the Secretary. This list must include, among other items, eyeglasses, hearing aids, prosthetic devices, walking aids, and durable medical equipment.

The only durational limits applicable to benefits under the Medicare Amendments of 1974 are a limit of 150 days of care in a benefit period for psychiatric inpatient care, a 160-day limit on psychiatric (mental health) services furnished to a patient of mental health day care service affiliated with the hospital or approved by the Secretary, and a 20 consultation a year limit on psychiatric (mental health) services furnished in a psychiatrist's office.

The services which are excluded under current law[57] and which would continue to be excluded under the Medicare Amendments of 1974[58] include services furnished outside the United States (with certain across-the-border exceptions for hospital services and for professional services incident to the hospital services), services not medically necessary, reasonable or appropriate, personal comfort items, custodial care, cosmetic surgery, services furnished or paid for under workmen's compensation laws, services for which the individual has no

[57]Soc. Sec. Act §§1862.
[58]Medicare Amendments of 1974, §§111(a)("1819").

legal obligation to pay, and most services furnished by a federal provider.

4. Cost Sharing

a. Present Law

Under the Hospital Insurance program, inpatient hospital services are subject to an inpatient hospital deductible[59] for each spell of illness. The amount of the deductible (presently $84) is determined by the year in which the spell of illness begins.

Inpatient hospital services after the 60th day and before the 91st day during a spell of illness, are subject to daily coinsurance[60] equal to one-fourth of the inpatient hospital deductible. Inpatient hospital service after the 90th day and through the 150th day during a spell of illness are subject to daily coinsurance[61] equal to one-half of the inpatient hospital deductible.

Whole blood or packed red blood cells received by a beneficiary as part of the services furnished to him under the Hospital Insurance program during any spell of illness are subject to a deductible[62] equal to the cost of the first three pints. However, the patient may not be charged for these first three pints if he arranges for their replacement on a pint-for-pint basis.

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[59]Soc. Sec. Act §§1813(a)(1).
[60]Soc. Sec. Act §§1813(a)(1)(A).
[61]Soc. Sec. Act §§1813(a)(1)(B).
[62]Soc. Sec. Act §§1813(a)(2).

Post-hospital extended care services after the 20th day during a spell of illness are under the Hospital Insurance program subject to daily coinsurance[63] equal to one-eighth of the inpatient hospital deductible.[64]

Persons who voluntarily enroll in the Hospital Insurance program must pay monthly premiums.[65] The premium is set at $33.00 a month for each month before July 1974 subject however, to subsequent adjustment.[66] The amount of this premium will be increased for delinquent enrollment in the same manner and to the same extent as it is for premiums under the Supplementary Medical Insurance program (see below).

Coverage under Supplementary Medical Insurance program is contingent upon the payment of a monthly premium (presently $6.30).[67] In the case of an individual whose Supplementary Insurance coverage period begins pursuant to enrollment after his "initial enrollment period" or who reenrolls after a termination of coverage, the monthly premium amount otherwise applicable will be increased by ten percent for each full twelve months in which he could have been, but was not enrolled.[68]

Under the Supplementary Medical Insurance program, there is also an annual deductible of $60.00[69] and a

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[63]Post hospital services furnished by a Christian Science sanitorium during any spell of illness will be subject to coinsurance in the same amount. However, this coinsurance amount will be charged for each day of these services during a spell of illness.
[64]Soc. Sec. Act §§1813(a)(3).
[65]Soc. Sec. Act §§1818.
[66]Soc. Sec. Act §§1818(d)(1)(2).
[67]Soc. Sec. Act §§1839.
[68]Soc. Sec. Act §§1839(d).
[69]Soc. Sec. Act §§1833(b).

20 per cent coinsurance feature[70] that requires a sharing of expenses above the deductible amount.[71] This annual deductible and coinsurance amounts are not, however, applicable to cover expenses incurred each year for radiology or pathological services furnished to a hospital inpatient by a physician.[72] After October 30, 1972 they are not applicable with respect to diagnostic tests performed in a laboratory for which payment is made to the laboratory at a negotiated rate.[73] Finally, there is no 20 per cent coinsurance amount imposed in respect to home health benefits, effective with respect to services furnished in accounting periods beginning after 1972.[74]

Like the Hospital Insurance program, the Supplementary Medical Insurance program imposes a deductible equal to the expenses incurred for the first three pints of whole blood or packed red blood cells.[75]

b. The Medicare Amendments of 1974

The Medicare Amendment of 1974 would eliminate completely premium payments and all deductibles. However, these Amendments would establish a system of copayments[76] with respect to inpatient hospital services ($5.00 per

[70] Soc. Sec. Act §§1833(a).
[71] After application of the annual deductible, payments from the trust fund will cover 80 per cent of the remaining "reasonable charges" or "reasonable cost" as the case may be of expenses
[72] covered by the program.
[73] Soc. Sec. Act §§1833(a)(1)(B).
[74] Soc. Sec. Act §§1833(a)(1)(D).
[75] Soc. Sec. Act §§1833(a)(2).
[76] Soc. Sec. Act §§1833(b)
Medicare Amendments of 1974, §§111(a)("1821(a)").

day), skilled nursing facility services ($5.00 per day), home health services ($2.00 per visit), physician's services ($2.00 per visit), dentist's services (20% of approved charges except no copayment for certain services), mental health day care ($2.00 per day), diagnostic outpatient services of independent laboratories or independent radiology services not otherwise covered as institutional services (20% of approved charges except when a negotiated rate agreement precludes copayment), devices, appliances, equipment and supplies (20% of approved charges except no copayment for examination for glasses or when copayment is waived), drugs,[77] ($1.00 per filling or refilling of a prescription), and ambulance services (20% of approved charges).[78]

The incurring of copayments by an individual entitled to health insurance protection under the Medicare Amendments of 1974 would be subject to a catastrophic protection feature related to income.[79] These Amendments would establish five income classes, with income class I including all low income individuals and families. The income ranges for the different income classes would be subject to automatic annual revision in accordance

[77] No copayments for drugs furnished to an HMO enrollee or administered within a hospital to an inpatient or outpatient or administered to an inpatient of a participating skilled nursing facility or for drugs furnished to an individual by a physician, a dentist as an incident to his professional services.

[78] Medicare Amendments of 1974, §§111(a)("1821(b)").

[79] Medicare Amendments of 1974, §§111(a)("1822(a)").

with the consumer price index, but initially the income ranges would be set as follows:[80]

TABLE OF INCOME CLASSES

Family Size and Income Ranges

Income Class	Single Individual	Family of 2	Family of 3	Family of 4 or more
1	$0 -$2,110	$0 -$2,730	$0 -$3,340	$0 -$4,280
2	$2,111-$3,160	$2,731-$4,090	$3,351-$4,460	$4,281-$5,340
3	$3,161-$4,740	$4,091-$5,450	$4,461-$5,570	$5,341-$6,410
4	$4,741-$6,330	$5,451-$6,810	$5,571-$6,980	$6,411-$7,480
5	Above $6,330	Above $6,810	Above $6,980	Above $7,480

Persons in income class 1 would never be subject to copayments (or be subject to coverage limits, to the extent there are any, on services).[81] Persons in income class 2, 3, 4 and 5 would initially be subject to the copayments described above. However, copayments would cease when, in a given year and the preceeding calendar quarter, a specified out-of-pocket expenditure limit is reached. For income classes 2, 3 and 4, that limit would initially be set at $125, $250 and $375 respectively (but subject to annual revision in accordance with the CPI).[82] In the case of income class 5, the out-of-pocket expenditure limit would be 6 per cent of annual income or, if lower,

[80] Medicare Amendments of 1974, §§111(a)("1823(b)(1)").
[81] Medicare Amendments of 1974, §§111(a)("1822(b)(1)").
[82] Medicare Amendments of 1974, §§111(a)("1822(b)(2)").

$750 (subject to annual revision of dollar limit in accordance with the CPI).[83] Credit towards the out-of-pocket limits would be made for expenditures incurred for copayments, and any expenditures incurred for services furnished in excess of the coverage limits (in case of certain psychiatric services). Moreover, when the out-of-pocket expenditure limit has been reached, these coverage limits would cease to apply for the rest of the year.[84]

5. Conditions of and Limitations on Payment for Services

a. Present Law

Under the Hospital Insurance program, payments for services furnished an individual may be made only to providers of services[85] and only if a written request for payment has been made by the individual (or in certain cases, by someone acting on such individual's behalf), a physician certifies (recertifies where such services are furnished over a period of time) the necessity for certain services covered under the program, and, in the case of inpatient hospital services and post

[83] Medicare Amendments of 1974, §§111(a)("1822(b)(3)").
[84] Medicare Amendments of 1974, §§111(a)("1822(b)(4)").
[85] See, Soc. Sec. Act §§1814(c)-(i) for provisions precluding, allowing, limiting or otherwise regulating payment to federal providers of service, payment for emergency hospital services, for inpatient hospital services prior to notification of non-eligibility, for certain inpatient hospital services furnished outside the United States, for services of a physician rendered in a teaching hospital, for post hospital extended care services, and for post hospital home health services.

hospital extended care services, such services are not found to be medically unnecessary under the system of utilization review.[86]

The amount paid to any provider with respect to services for which payment may be made under the program is the lesser of the "reasonable cost"[87] of such services, the customary charges with respect to such services, or (if such services are furnished by a public provider of services free of charge or at nominal charge to the public), fair compensation.[88]

Existing law provides, in general, that the reasonable cost of any service is the cost actually incurred and is to be determined under regulations establishing the method or methods to be used and the items to be included in determining such cost for various types and classes of institutions, agencies and services.[89] These regulations must take into account the principles developed and generally applied by national organizations or established prepayment organizations in computing the amount of payment to be made by third parties to providers of service. These regulations must also take into account direct and indirect cost to providers in order that costs incurred with respect to individuals covered by the Hospital Insurance and Supplementary Medical Insurance

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[86] Soc. Sec. Act §§1814(a); also see, Soc. Sec. Act §§1151-1170.
[87] Soc. Sec. Act §§1861(v).
[88] Soc. Sec. Act §§1814(b).
[89] Soc. Sec. Act §§1861(v)(1)(A).

programs will not be borne by individuals not so covered, and the costs incurred with respect to individuals not covered will not be borne by the Insurance programs. Also, the regulations must provide for making retroactive corrective adjustments where reimbursement during a fiscal period proves to be less than or more than reasonable cost.[90]

The Social Security Amendments of 1972 introduced important limitations[91] in determining reasonable cost. These limitations require the exclusion from the recognition of "reasonable cost", any cost in excess of that actually incurred and incurred cost "found to be unnecessary in the efficient delivery of health care services."

Important provisions designed to avoid the use of federal funds to support unjustified capital expenditures and to encourage planning activities for health facilities and services in the various states were also added.[92] Under these provisions, the Secretary of HEW is authorized to withhold or reduce amounts otherwise reimbursable to providers of services and HMO's under Health Insurance for depreciation, interest and, in the case of proprietary providers, the return on equity capital when certain capital expenditures are determined to be inconsistent with state or local health facility plans.

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[90]See Soc. Sec. Act §§1861(v)(1)(B)-(E) for other factors to be taken into account in determining "reasonable costs".
[91]Pub. L. 92-603,§§223.
[92]Soc. Sec. Act §§1122.

These Amendments also added provisions for demonstration projects to determine the feasibility of prospective reimbursement under Health Insurance.[93] These projects are to develop methods and techniques to provide positive financial incentives for providers to use their facilities and personnel more efficiently, thereby reducing their own as well as Health Insurance costs while maintaining or improving the quality of the health care. Both capital planning and the demonstration projects should be facilitated by additional requirements which are also added to the law. After March 1973, a hospital and other participating providers of services must have, as a condition of participation of the Hospital Insurance program, a written overall plan and budget reflecting an annual operating budget and capital expenditures plan.[94]

As a general rule, the Hospital Insurance program will pay only for semi-private accommodations in connection with inpatient hospital or skilled nursing care.[95] Payment will be made for more expensive accommodations only when medically necessary.[96] Finally, effective for periods beginning after final regulations are adopted, present law[97] contains special provisions concerning

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[93] Pub. L. 92-603, §§222.
[94] Soc. Sec. Act §§1861(e)(8), (j)(10), (o)(5), (z).
[95] Soc. Sec. Act §§1861(v)(2)(A).
[96] Soc. Sec. Act §§1861(v)(2)(A); see Soc. Sec. Act §§1861(v)(3) for provisions governing payment where accommodations less expensive than semi-private are furnished, neither at the request of the patient nor for reasons consistent with the purposes of the Hospital Insurance program.
[97] Soc. Sec. Act §§1861(v)(5).

the amount a provider may be paid as reasonable cost with respect to the services of a physical, occupational, or speech therapist or the services of another health specialist. Under these provisions, payment for the reasonable cost of these services, furnished under arrangements with the provider, may not exceed an amount equal to the salary and other cost that would reasonably have been payable if the services had been performed in an employment relationship plus the cost of such other incidental expenses.

As a general rule, reimbursement under the Supplementary Medical Insurance program is on the basis of "reasonable charges".[98] Payment will generally be made to the extent of 80 per cent of the reasonable charges amount[99] and will be made on the basis of an itemized list to the individual or on the basis of an assignment to the one who furnished the services. In the case of expenses incurred in any calendar year for physician's services and items and supplies in connection with the treatment of mental, psychoneurotic , and personality disorders of an individual who is not an inpatient at the time the expenses are incurred, payment under the program will take

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[98] Soc. Sec. Act §§1833(a)(1); but see, Soc. Sec. Act §§1833(a)(1)(A), under which an organization providing "medical or other health services" on a prepayment basis may elect to be paid on the basis of "reasonable cost" for such services instead of on the basis of "reasonable charges".

[99] But see, Soc. Sec. Act §§1833(a)(1)(B), (D), (G), for 100 per cent reimbursement for reasonable charges with respect to expenses incurred for radiology or pathology services, and for 100 per cent of negotiated rates with respect to diagnostic tests performed in a laboratory.

into account only the lesser of $312.50 or 62-1/2 per cent of such expenses.[100]

With respect to services for which an enrolled individual is entitled to have payment made on his behalf (home health services, medical and other health services furnished by a provider of services or by others under arrangement (except most physician services and outpatient physical therapy services)), payment will be in amounts equal to, in the case of home health services, 100 per cent, and with respect to other services, 80 per cent of the lesser of the reasonable cost of such services, the customary charges with respect to such services, or (in a case where the services are provided by a public provider of services free of charge or a nominal charge to the public) fair compensation.[101]

Certain limitations also apply with respect to payments under the program. No payment will be made with respect to any service furnished individuals to the extent that such individuals are entitled to have payment made with respect to such services under the Hospital Insurance program.[102] No payment will be made where information and records necessary to determine the amount of payment has not been provided.[103] In the case of the purchase or rental of durable medical equipment, special provisions

[100]Soc. Sec. Act §§1833(c).
[101]Soc. Sec. Act §§1833(a)(2).
[102]Soc. Sec. Act §§1833(d).
[103]Soc. Sec. Act §§1833(e).

and procedures apply for purposes of payment.[104] In the case of covered outpatient physical therapy services furnished by a physical therapist in his office or in the individual enrollee's home, no more than $100 per year will be considered incurred expenses for purposes of determining payment under the program.[105]

Under the Supplementary Medical Insurance program, payment will be made to providers (hospital, skilled nursing facility, and certain clinics, rehabilitation agencies, and public health agencies) for services provided to enrolled individuals pursuant to written request and physician's certification procedures similar to those applicable under the Hospital Insurance program.[106]

The law governing the determination of "reasonable charges" for purposes of the Supplementary Medical Insurance program, requires that a carrier administrating the program take necessary action to assure that, where payment is to be made for services on a cost basis, cost is reasonable cost and where payment is to be made on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier.[107] In determining the

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[104] Soc. Sec. Act §§1833(f).
[105] Soc. Sec. Act §§1833(g).
[106] See, Soc. Sec. Act §§1835(b)(1)(2) for payments to non-participating hospitals for emergency services or in the alternative to the enrolled individual on the basis of an itemized bill; see also, Soc. Sec. Act §§1835(d)(e) for provisions governing payment in special cases.
[107] Soc. Sec. Act §§1842(b)(3).

reasonable charges for services, the "customary charges" for similar services as well as the "prevailing charges" in locality "for similar services" must be taken into account. The 1972 Social Security Amendments expanded these requirements so that no charge may be determined to be reasonable after December 31, 1970 if it exceeds the higher of the prevailing charge recognized by the carrier for similar services in the same locality in administrating the program on December 31, 1970 or the prevailing charge level that would cover 75 per cent of the customary charges made for similar services in the same locality during the calendar year preceeding the start of the fiscal year in which the bill is submitted or request for payment is made.[108] The prevailing charge levels determined for this latter purpose for fiscal years beginning after June 1973 may not exceed in the aggregate the levels for fiscal year 1973 except to the extent justified by economic changes reflected in the appropriate economic index data (only in the case of physician's services).[109]

The 1972 Social Security Amendments also added a provision under which, in the case of medical services, supplies, and equipment that do not generally vary significantly in

[108] Soc. Sec. Act §§1842(b)(3)(E).

[109] In the case of a charge that exceeds either the customary charge or the prevailing charge in the locality, or both, may be found to be reasonable only where there were unusual circumstances or medical complications requiring additional time, effort, or expense to support the additional charge, and only if it is acceptable medical practice in the locality to make an extra charge in such cases. The mere fact that the physician's customary charge is higher, the prevailing charge does not justify the determination of reasonable charge higher than the limit established on the basis of prevailing charges.

quality from one supplier to another, the charges incurred after 1972 and determined to be reasonable may not exceed the lowest charge level at which these services, supplies, and equipment are widely and consistently available in a locality except under the circumstances specified by the Secretary.

b. The Medicare Amendments of 1974

The Medicare Amendments of 1974, in order to better restrain health care costs, would build upon the conditions and limitations on payment for services under current law. While existing features such as utilization review, professional standards review organizations, and institutional planning would be retained, there would be superimposed on this existing structure a prospective reimbursement procedure to a participating institutional provider (with reimbursement based on a prospectively approved budget and derived schedule of charges) and to a participating non-institutional provider (with reimbursement based on negotiated rates). Such positive stimulation should lead to more rational and efficient utilization of health care facilities and personnel.

Under these Amendments, payment is to be made only to "a participating provider"[110] (when it has filed and has in effect, a participation agreement with the Secretary).[111]

[110] Medicare Amendments of 1974, §§111(a)("1861(u)(4)").

[111] See Medicare Amendments of 1974, §§111(a)("1833"), for exceptions in cases of emergency and covered across-the-United-States-border hospital and related services.

The term "provider" includes not only institutions but also independent practitioners with respect to their private patients, suppliers who furnish items (drugs or prosthetics), to individuals in their own right and not on behalf of another. Inasmuch as the legislation requires that payment for services in the United States be made only to a participating provider (except in emergency cases) and not to the individual, a participating practitioner must agree to accept the Medicare payment (plus any copayment) as the full charge for the service, such that the practitioner could no longer, by refusing to accept an assignment, bill the patient directly and thus require the patient to pay fees in excess of the Medicare reimbursement (plus copayment).[112] A patient of a non-participating practitioner in the United States except in the case of emergency services, could no longer be able to obtain any reimbursement from Medicare (even such a practitioner, if he accepts an assignment from an individual for emergency services, would be paid on the "reasonable charge" basis and would be precluded from collecting additional amounts from the patient except the copayment if one applies).

An institutional provider is to be treated as a provider of services to his patients with respect to all institutional services regardless of the legal or

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[112]Medicare Amendments of 1974, §§124(a)("1866(a)(1)(B)").

financial arrangements between the institution and the person furnishing the services.

The amount of reimbursement to a participating institutional provider for institutional services is to be made on the basis of a predetermined schedule of patient care charges approved[113] for an accounting year of the institution by the Secretary (or a review mechanism under which the fiscal intermediary for the institution generally makes the initial determination)[114] or, in a state that has a state review and approval agency operating under equivalent standards, approved by that state agency.[115] (Capitation charges if submitted by a provider and if meeting standards, may also be approved.)[116] The schedule of charges must be based upon a system of accounting and cost finding in conformity with standards[117] prescribed or approved by the Secretary, and on the institution's operating and capital budget in the accounting year involved,[118] which budget must also be approved by the Secretary or the state[119] rate review and approval agency, as the case may be. A schedule of charges may be approved only if it did not exceed the estimated reasonable cost for the efficient delivery of services as determined under the definition of "reasonable cost" and implementing regulations.[120]

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[113] Medicare Amendments of 1974, §§111(a)("1832(b)").
[114] Medicare Amendments of 1974, §§111(a)("1832(d)(2)(A)").
[115] Medicare Amendments of 1974, §§111(a)("1832(e)").
[116] Medicare Amendments of 1974, §§111(a)("1832(b)(1)").
[117] Medicare Amendments of 1974, §§111(a)("1832(c)").
[118] Medicare Amendments of 1974, §§111(a)("1832(d)(1)(B)").
[119] Medicare Amendments of 1974, §§111(a)("1832(d)(2)(B)").
[120] Medicare Amendments of 1974, §§111(a)("1832(d)(1)(B)").

A revision of the approved schedule of charges during an accounting year would be permitted only under exceptional circumstances.[121] Periodic interim payments would be made to the institution during the institution's accounting year on the basis of projections, with final adjustments (after the close of the accounting year) based on the approved schedule of charges.[122]

A hospital that is not a participating institutional provider, if eligible for reimbursement, would be paid on a reasonable cost basis or, if less, in the case of a private hospital, its customary charges.[123] In the case of a non-participating hospital that elects not to claim payment under the program but to collect from the individual, payment would be made to the individual at the reasonable charge rate (less copayment).[124]

With respect to non-institutional services of a physician, dentist, optometrist, podiatrist and chiropractor and such other non-institutional services of a licensed professional practitioner as may be specified in regulations, the Medicare Amendments of 1974 provide for payment in accordance with annually predetermined fee schedules for the local areas[125] and provide for establishing these schedules, to the extent feasible, on the basis of negotiations with representatives of the professional societies

[121]Medicare Amendments of 1974, §§111(a)("1832(d)(1)(C)").
[122]Medicare Amendments of 1974, §§111(a)("1835(a)").
[123]Medicare Amendments of 1974, §§111(a)("1833(b)(1)").
[124]Medicare Amendments of 1974, §§111(a)("1833(b)(2)").
[125]Medicare Amendments of 1974, §§111(a)("1836(b)(d)").

and representatives of associations of retired persons or associations otherwise representative of Medicare beneficiaries.[126] The final schedule could, however, be established only after public hearing.[127] This system would apply only to services in the United States and not to exceptional cases of across-the-border services.[128] These schedules are to be based on a forecast of what would be fair and equitable compensation not exceeding "reasonable charges" in the area in the applicable fiscal year.[129]

The Secretary of HEW would be required to make public for each local area the established fee schedule for the area, and the names, professional fields and professional addresses of the participating practitioners in the area.[130]

In other cases, a participating non-institutional provider (pharmacy, etc.) is to be paid on a "reasonable charge" basis,[131] except that a non-profit organization that runs on a prepayment basis may on its request be reimbursed under the provisions for payments to institutional providers.[132] In emergencies, if the service in the United States is furnished by a non-participating provider, (one that has not filed a participation

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[126]Medicare Amendments of 1974, §§111(a)("1836(d)(2)(C)").
[127]Medicare Amendments of 1974, §§111(a)("1836(d)(2)(C)").
[128]Medicare Amendments of 1974, §§111(a)("1836(b)(1)(B)").
[129]Medicare Amendments of 1974, §§111(a)("1836(d)(2)(E)").
[130]Medicare Amendments of 1974, §§111(a)("1836(d)(2)(F)").
[131]Medicare Amendments of 1974, §§111(a)("1836(b)(1)(B)").
[132]Medicare Amendments of 1974, §§111(a)("1836(b)(2)(B)").

agreement with the Secretary), payment of the "reasonable charge" may be made either to the patient on the basis of an itemized bill, or to the provider on assignment from the patient if the provider agrees that the reasonable charge is his full charge.[133]

The Medicare Amendments of 1974 merged the present Hospital Insurance provisions for use of fiscal intermediaries and the Supplementary Medical Insurance provisions for the use of carriers into a single section providing for use of carriers (including the type of organization which under the present system is a fiscal intermediary under Hospital Insurance in the administration of the program), but adding the above-noted new functions relating to budgets and predetermined, approved rates for institutional providers and the negotiation and establishment of fee schedules for non-institutional services.[134] The Secretary must give priority to the fiscal intermediary types of organizations in selecting "carriers" to act for him with respect to covered services provided by institutional providers for which payment is to be made on an approved charge basis.[135]

6. Payments to Health Maintenance Organizations

a. Present Law

Under present law, as amended by the Social Security Amendments of 1972, the reimbursement to health maintenance

[133]Medicare Amendments of 1974, §§111(a)("1836(a)(2)").
[134]Medicare Amendments of 1974, §§111(a)("1837").
[135]Medicare Amendments of 1974, §§111(a)("1837(f)(2)").

organizations is made either on a risk-sharing or cost reimbursement basis, with interim per capita payments during the contract year.[136]

b. The Medicare Amendments of 1974

Under the Medicare Amendments of 1974, the provisions of present law are retained. However, in addition to technical corrections, these Amendments make a number of clarifying changes,[137] including amendments to make clear that a medical foundation may qualify as an HMO[138] and provisions somewhat amplifying and clarifying the provisions relating to an HMO that arranges with a group or groups of professional practitioners for services to enrollees.[139]

7. Other Changes to Coordinate the Availability and Delivery of Health Care Protection to the Aged and Disabled (Federal Employee Health Benefit Plans)

a. Present Law

With the enactment of the Health Insurance for the Aged and Disabled in 1965, it was intended that the Hospital Insurance and Supplementary Medical Insurance programs would provide basic health protection for the

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[136] Soc. Sec. Act §§1876.

[137] Under the Medicare Amendments of 1974, §§132("1880"), if the Secretary of HEW finds that an organization proposing and eligible to qualify as a participating HMO cannot be incorporated or otherwise do business in a state in which it proposes to provide covered services because of state laws which the Secretary finds restrictive or otherwise incompatible with the Health Insurance program, he may issue a certificate of incorporation to the organization and the restrictive state laws will not apply.

[138] Medicare Amendments of 1974, §§111(d)(6)("1838(b)(3)(C)").

[139] Medicare Amendments of 1974, §§111(d)(6)("1838(b)(3)(B)").

aged and that it would pay its beneficiaries, or on their behalf without regard to any other benefits that might be payable under an employee health benefits plan. Such plans were expected to adjust their benefit policies to supplement and compliment the protection provided under Medicare, rather than duplicate benefits.

Under present law, federal employees and annuitants who enroll for federal employee health benefits may also be covered under the Health Insurance for the Aged and Disabled programs.

The Federal Government has not adjusted the health insurance protection it makes available to its employees and annuitants to make such protection supplementary to Hospital and Supplementary Medical Insurance. The FEHB plans consequently duplicate many benefits. In cases where health care expenses are covered under Hospital and/or Supplementary Medical Insurance and an FEHB plan, the Hospital and/or Supplementary Medical Insurance benefits are paid first and the FEHB plan then pays in an amount which, when added to the benefit amounts already payable, may not exceed 100 per cent of the expenses allowable under the FEHB plan.

The law was amended, effective after 1974, to assure that no payment will be made under Hospital Insurance or Supplementary Medical Insurance, for any item or service

that is also covered and furnished under an FEHB program.[140] This provision will not apply if, prior to date, an item or service is furnished, the Secretary of HEW determines and certifies that the FEHB program has been modified to assure that there is available to federal employees or annuitants one or more FEHB plans that supplement the combined protection of both the Hospital and Supplementary Medical Insurance programs, the Hospital Insurance program alone, and the Supplementary Medical Insurance program alone. Moreover, the FEHB program must be found to be making a contribution towards the health insurance of each federal employee or annuitant that equals its contribution for high option coverage under the government-wide FEHB plans. The contribution, whether by the federal government or by the individual plan, may be in the form of a contribution towards the supplementary FEHB program or a payment to or on behalf of the individual employee or annuitant to offset the cost of his purchase of Medicare protection, or a combination of the two.

The Medicare Amendments of 1974 would replace the 1972 provisions to take into account the structural changes in the law and the elimination of premiums under the Health Insurance program and clarify the intent of the 1972 Amendments. Specifically, each FEHB plan would be required to offer to eligible enrollees, under a distinct

[140]Soc. Sec. Act §§1862(c).

part of the carrier's overall plan, the option of benefits supplementary to Health Insurance at a subscription rate actuarially commensurate with that option, and to deal with situations where a federal employee or annuitant is enrolled under the FEHB program for himself and family but only some members of the family unit (and possibly excluding the enrollee himself) are entitled to Health Insurance benefits and others should be covered under the carrier's overall plan.[141]

8. The Financing of Health Care Benefits

a. Present Law

Under the Hospital Insurance program, Hospital Insurance benefits available to individuals who are entitled to monthly social security benefits or who are qualified railroad retirement beneficiaries, are financed from taxes imposed under Internal Revenue Code §§3101(b), 3111(b) and 4101(b). In the case of uninsured individuals who are transitionally entitled to Hospital Insurance protection, benefits are financed out of appropriations from the Federal Government. In the case of voluntary enrollees under the Hospital Insurance program, benefits are financed from the payment of premiums.

Under the Supplementary Medical Insurance program, benefits to voluntary enrollees are financed from premium payments by the enrollees, together with contributions from funds appropriated by the Federal Government.

[141] See, Medicare Amendments of 1974, §§141.

b. The Medicare Amendments of 1974

Under the Medicare Amendments of 1974, health care benefits would be continued to be financed by taxes imposed by Internal Revenue Code §§3101(b), 3111(b) and 4101(b), except that the taxes would be called health insurance taxes and in the case of the taxes imposed under Internal Revenue §§3101(b), such taxes would be imposed on the amount of the social security tax base for that particular year plus 25 per cent[142] and except that the payroll taxes imposed on the employer under Internal Revenue Code §§3111(b) would be imposed on a tax base of total payroll.[143] If the present social security taxable wage base of $13,200 were to remain in effect, the health insurance taxes imposed under Internal Revenue Code §§3101(b) under the Medicare Amendments of 1974 would be imposed upon an initial tax base of $16,500. However, should the social security taxable wage base be increased under the enacted escalator provisions, the tax base may rise further beginning in 1975.

In addition to these modifications of existing tax systems, the Medicare Amendments of 1974 would impose a new tax on unearned income (designated as a tax on "health insurance unearned income") of every individual not entitled to benefits under Title XVIII of the Social Security Act.[144] The tax imposed would be a stated

[142] Medicare Amendments of 1974, §§201(c)("I.R.C.§§3121(u)").
[143] Medicare Amendments of 1974, §§201(c)("I.R.C.§§3121(s)(2)").
[144] Medicare Amendments of 1974, §§212("I.R.C.§§1403(a)").

percentage (similar to the rate of tax imposed under social security payroll and self-employment taxes) of "health insurance unearned income."[145]

To supplement the revenue which would be generated through this combination of taxes, the Medicare Amendments of 1974 would provide for a Federal Government contribution to the Medicare Trust Fund out of general revenues.[146]

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[145]Under Medicare Amendments of 1974, §§212("I.R.C.§§1403(b)"), the term "health insurance unearned income" would be defined as an amount determined by deducting from the adjusted gross income of an individual any part of that income in excess of the health insurance contribution base (the taxable wage base for purposes of the employee portion of the social security payroll taxes) and deducting from the remainder any part of the adjusted gross income that consists of wages subject to tax under I.R.C. §§3101(b)(the payroll tax), self-employment income taxable under I.R.C. §§4101(b)(the tax on self-employment income), amounts excluded from wages (otherwise taxable under I.R.C. §§3101(b)) by reason of I.R.C. §§3121, and renumeration for services performed for another in an employment capacity but excluded from the definition of "employment" under I.R.C. §§3121(t) and from the definition of "trade or business" under I.R.C. §§1402(c).

[146]Medicare Amendments of 1974, §§112(a)("1839(c)(1)").

PART FIVE

DESCRIPTION OF THE COMPREHENSIVE HEALTH INSURANCE ACT

and a

COMPARISON OF THAT ACT WITH CURRENT LAW
AND THE MEDICARE AMENDMENTS OF 1974

A. DESCRIPTION OF THE COMPREHENSIVE HEALTH INSURANCE ACT OF 1974

The Comprehensive Health Insurance Act of 1974 would replace the present Title XVIII of the Social Security Act and would substitute therefore an entirely new Title XVIII.[147]

1. Entitlement

Each employer would be required to provide each of his non-aged, "full time" employees with the opportunity to obtain coverage for himself and the non-aged members of his family under an "employee health care insurance plan", an assisted health care insurance plan, or a prepaid health care plan.[148] The employer may use a carrier or may self-insure. The required coverage may also be provided under a "special employee health care program."[149] Any carrier in a certified state[150] that provides an employee health care insurance plan to a

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[147]But only with respect to "certified" states; See Comprehensive Health Insurance Act of 1974, §§102(b).

[148]Comprehensive Health Insurance Act of 1974, §§101("1801(a)").

[149]Comprehensive Health Insurance Act of 1974, §§101("1844"), setting forth the requirements for approval of a "special employee health care benefit program" contemplates allowing a more liberal program than the minimum required for employee health care insurance plans; however, by allowing such programs to have "lower (durational) limitations" than those required with respect to covered services under Employee Health Care Insurance Plan, the matter is in doubt.

[150]States must be certified by the Secretary of HEW, Comprehensive Health Insurance Act, §§101("1861").

small employer would be required to offer the same plan to all employers in the same state.[151]

Through federal grants, each state would be encouraged to offer, through carriers, an "assisted health care insurance plan (AHIP)" to state residents who are not entitled to benefits under the "federal health care benefits program (FHIP)" and are not covered under a plan provided directly by the employer (EHIP etc.) and who have aggregate incomes of less than specified amounts and to state residents who are not entitled to benefits under an FHIP and are not eligible for coverage under an employer-provided health care plan.[152] An AHIP must also allow an employer, required to provide EHIP or comparable protection to his employees, to obtain health care benefits under an AHIP for his employees who are state residents.[153] All persons eligible, either directly or through an employer, under the state AHIP program would have the option of obtaining coverage either under an AHIP or prepaid health care plan.

An aged resident in a certified state who is entitled to social security section 202 benefits[154] or is a qualified railroad retirement beneficiary would be entitled to federal health care benefits under the FHIP or entitled to have the Secretary

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[151] Comprehensive Health Insurance Act, §§101("1861(a)(5)").
[152] Comprehensive Health Insurance Act, §§101("1822(a)").
[153] Comprehensive Health Insurance Act, §§101("1822(a)(2)").
[154] Or would be so entitled if employment with the federal, state or local governments or agencies or instrumentalities thereof were covered employment for purposes of social security cash benefits.

of HEW make reasonable payments for comparable coverage under an approved prepaid health care plan.[155]

A resident of a certified state who attained the age of 65 before January 1, 1976[156] or has not less than three quarters of coverage for each year elapsing after 1975 and before the year in which he attained age 65, is not otherwise entitled to FHIP protection, is a resident of the United States, is a citizen or alien lawfully admitted for permanent residence and has filed proper application, will be deemed entitled to social security 202 benefits for purposes of FHIP entitlement (transitional entitlement).[157]

2. Health Care Benefits and Durational Limitations

All of the health care insurance plan programs and prepaid health care plans described in the Comprehensive Health Insurance Act of 1974 would, as a minimum, provide payment for items and services including inpatient hospital services, physician services, medical and other health care services (physician services, services and supplies, including drugs and biologicals which cannot be self-administered and which are furnished as an incident to physician services in his office, hospital services incident to physician services rendered to outpatients, diagnostic services furnished to hospital outpatients, outpatient physical therapy services, physician extender services (services performed under the

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[155]Comprehensive Health Insurance Act, §§101("1831(b)(2)").
[156]But see, Comprehensive Health Insurance Act, §§105, 102.
[157]Comprehensive Health Insurance Act, §§105.

supervision and control of a physician by a physician's assistant, nurse practitioner, or other trained individual), diagnostic X-ray tests, X-ray therapy, durable medical equipment, necessary ambulance services, prosthetic devices (other than dental)), home health services, post-hospital extended care services, outpatient drugs and biologicals, routine dental services for children, vision care services for children, and hearing aids and examinations therefore for children.[158] However, payment will not be made for covered items and services which are not "reasonable and necessary"[159] nor for eyeglasses or hearing aids or examinations therefore.[160] Payment will not be made for items or services for which the individual has no legal obligation to pay, or are not provided within the United States (except for emergency inpatient hospital and physician services).[161] Personal comfort items, orthopedic shoes, custodial care, cosmetic surgery, routine foot care, kidney dialysis or transplantation unless provided by a kidney dialysis or transplantation center or facility which meets requirements of the Secretary and items and services prescribed and covered under workmen's compensation laws are also excluded from coverage.

Post-hospital extended care services are limited to a maximum of 100 days per calendar year; home health services are limited to 100 visits per calendar year.[162] Inpatient

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158 Comprehensive Health Insurance Act, §§101("1841(a)").
159 Comprehensive Health Insurance Act, §§101("1841(a)(2)(A)").
160 Except in the case of children under age 13, Comprehensive Health Insurance Act, §§101("1841(a)(2)(B)").
161 Comprehensive Health Insurance Act, §§101("1841(a)(2)(C)(D)").
162 Comprehensive Health Insurance Act, §§101("1841(h)(1),(2)").

hospital services for the treatment of mental illness must be limited to 30 days per calendar year.[163] Outpatient services for the treatment of mental illness are also limited.[164]

3. Cost-Sharing

a. Employee Health Care Insurance Plan

With respect to EHIP's premiums for employer groups of 51 or more employees[165] and other groups offered EHIP, protection would be negotiated between the employer and other groups and the insurance carrier. Expenses for an insured individual which exceed $10,000 in a calendar year cannot, however, be attributed to the experience rating of the employee group through which the individual has obtained coverage.[166] The rates applicable to coverage under the plan must be the same for all employees of any employer to whom the plan is provided.[167]

An EHIP would be required to impose, with respect to all items and services other than outpatient drugs and biologicals, and blood and blood products, an annual

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[163] Comprehensive Health Insurance Act, §§101("1841(b)(3)").

[164] Comprehensive Health Insurance Act, §§101("1841(b)(4)"), Limited in accordance with the estimated cost of 30 outpatient visits to a private practitioner for treatment of mental illness (and payment for such services other than services provided on an outpatient basis in a comprehensive community care center must be limited to one-half of that amount).

[165] Comprehensive Health Insurance Act, §§101("1861(a)(5)"): carriers in certified states that provide EHIP to an employer with less than 50 employees would be required to offer the plan to all employers in the state with less than 50 employees and would be required to offer such EHIP under the same rating structure and at the same rates.

[166] Comprehensive Health Insurance Act, §§101("1841(g)(6)").

[167] Comprehensive Health Insurance Act, §§101("1841(q)(7)"); except that, the rate for coverage of employees without any family members under the age of 65 will be 40 per cent of the rate for coverage of employees with one or more family members under the age of 65.

deductible per individual in an amount of $150,[168] (subject to adjustment after 1977). An annual drug deductible of $50 per person would also be imposed. Finally, a blood deductible must also be imposed (to be prescribed by the Secretary by regulation).

With respect to expenses in excess of the applicable deductibles, the EHIP must impose a coinsurance amount of 25 per cent.[169] (Note: approved "special employee health care programs" may set lower limits with respect to deductible and coinsurance requirements than these.)

b. Assisted Health Care Insurance Plan

With respect to AHIP premiums, an annual deductible per individual with respect to items and services other than outpatient drugs and biologicals and other blood and blood products, an annual drug deductible, a blood deductible (to be prescribed by the Secretary by regulation) and coinsurance would be imposed. The amounts of the premiums, deductibles and coinsurance would be related to income. The following tables should serve to illustrate these cost-sharing features with respect to AHIP:

(See following page for tables)

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168 Comprehensive Health Insurance Act, §§101("1841(c)(1)"); except that no further deductible would be imposed in any calendar year after three members of a covered family satisfied the deductible.

169 Comprehensive Health Insurance Act, §§101("1841(c)(2)").

SINGLE					
	Annual Income	Contribution*	Per Person Deductible Drugs	Other	Coinsurance
I	$ 0-1,749	$ 0	$ 0	$ 0	10%
II	1,750-3,499	0	25	50	15
III	3,500-5,249	120	50	100	20
IV	5,250-6,999	240	50	150	25
V	7,000 +	360	50	150	25

*Based on 50 per cent of average group single rate in Group III, 100 per cent in Group IV, and 150 per cent in Group V. Expected average group single premium rate equals $240.

FAMILY					
	Annual Income	Contribution**	Per Person Deductible Drugs	Other	Coinsurance
I	$ 0-2,499	$ 0	$ 0	$ 0	10%
II	2,500-4,999	0	25	50	15
III	5,000-7,499	300	50	100	20
IV	7,500-9,999	600	50	150	25
V	10,000 +	900	50	150	25

**Contributions based on 50 per cent of average group family premium rate in the State for Group III, 100 per cent for Group IV, and 150 per cent for Group V. Expected average group family premium rate equals $600.

c. Federal Health Care Insurance Plan

An annual premium in an amount equal to 15 per cent of the amount which the Secretary determines is the "estimated average cost of coverage for that year under the plan of an individual in income class IV" would be imposed.[170] (About $90 per person annually.) With respect to all items and services other than outpatient drugs and biologicals and other than blood and blood products, an annual deductible per individual would be imposed.[171] An annual drug deductible per individual and a blood deductible (as prescribed by the Secretary) would also be imposed.[172] Finally, coinsurance would be added.[173] All these premium, deductible and coinsurance requirements would be related to income.

4. Catastrophic Protection

a. Employee Health Care Insurance Plan

An EHIP must provide for catastrophic protection after the total of deductibles and coinsurance in any calendar year equals 10.5 per cent (in the case of employees without family members) or 15 per cent (in the case of employees with one or more non-aged family members) of the income class base which is set at $10,000 initially.[174] Any deductible or coinsurance amount

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[170]Comprehensive Health Insurance Act, §§101("1832(b)(1)").
[171]Comprehensive Health Insurance Act, §§101("1832(b)(2)(A)").
[172]Comprehensive Health Insurance Act, §§101("1832(b)(2)(B),(C)").
[173]Comprehensive Health Insurance Act, §§101("1832(b)(2)").
[174]Comprehensive Health Insurance Act, ss101("1841(c)(3),'1825(b)(5)(D)").

charged against a covered individual under any other approved health care insurance plan must be taken into account in determining when the deductible and coinsurance requirements are satisfied.

b. Assisted Health Care Insurance Plan

Under AHIP, no premium will be charged in the case of family groups (other than family groups for whom protection is obtained by the employer) in income classes I and II. The annual and drug deductibles will not be imposed with respect to these family groups in income class I.

In addition, no further deductible or coinsurance will be imposed in any calendar year after the total amounts equal specified percentages of the annual income of covered individuals in the various income classes and any deductible or coinsurance amount charged against a covered individual under any other approved health care insurance plan must be taken into account. In the case of an individual in income class V and employees of employers who provide mandated health insurance protection under an AHIP, the applicable deductible coinsurance limit will equal 10.5 per cent (in the case of one-member family groups and employees without any family members under the age of 65) or 15 per cent (in the case of more than one-member family groups and employees with one or more family members under the age of 65) of the

income class base for the calendar year ($1,050 in 1976 and 1977) subject, however, to adjustment in later years. The following table should serve to illustrate:

Maximum Liability
6% of income
9% of income
12% of income
15% of income
$1,050

c. Federal Health Care Insurance Plan

Under FHIP, no premiums would be imposed on individuals in income classes I and II. Neither the annual deductible nor the drug deductible would be imposed in the case of an individual in income class I. In addition, no further deductible or coinsurance requirement would be imposed during any calendar year after the total deductible and coinsurance amount equalled specified percentages of annual income of individuals in income classes I, II and III. In the case of individuals in income classes IV and V, no further deductible or coinsurance requirement would be imposed during any calendar year after the total deductible and coinsurance amount equalled 7.5 per cent ($7.50 for 1976-1977) of the income class base for the particular calendar year. As with EHIP and

AHIP, any deductible or coinsurance amount charged against a covered individual under any other approved health care insurance plan would be taken into account in determining if the deductible and coinsurance requirements have been met.

5. Conditions of and Limitations on Payment

All persons covered under an approved health care insurance plan, including an FHIP, would be furnished with an identification card which would be evidence of financial protection for all covered items and services.[175] Specifically, an account would be established against which a covered individual may charge the cost of obtaining items and services covered under the approved health care insurance plan. Payment will be made only on the basis of charges against the account and then only at the applicable reimbursement rates. Unless the account is in default, payment will be made to "full and associate participating providers" without reduction on account of deductibles and coinsurance. The covered individual will be billed for that portion of any payment chargeable to him on account of the deductibles and coinsurance plus interest. An account will not be considered in default unless amounts are 90 days in arrears. Finally, the general rule that payments for items and services will be made only on the basis of charges against that account is subject to an exception in the case of emergency services.

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[175] Comprehensive Health Insurance Act, §§101("1825(d), 1832 (c), 1841(f)").

Again with the exception of emergency services, payment will be made only to participating providers certified by the state, and then, only in accordance with the applicable reimbursement rates and standards established by the certified state in conformity with regulations of the Secretary of HEW.[176] The provisions of present law with respect to institutional planning and professional standard review organizations would also be applicable in governing the making of payments.

In order to be certified as a "full participating provider," an individual or entity must agree to accept as payment in full, the payments made by approved health care insurance plans and approved special health care programs on the basis of charges against the established account, except in the case where the particular account is in default.[177]

In order to be certified as an "associate participating provider," an individual or entity, other than a hospital, skilled nursing facility or home health agency, must agree to accept reimbursement on a basis of charges against the account as payment in full for all items and services furnished to an individual covered under an AHIP or under a FHIP (except with respect to outpatient drugs and biologicals) and must agree to accept reimbursement as payment of the insured amount paid by an EHIP. In this latter case, an associate participating provider could collect the remainder of his fee from the patient by billing him directly.[178]

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[176] Comprehensive Health Insurance Act, §§101("1841(g)(1), (2)").
[177] Comprehensive Health Insurance Act, §§101("1845(a)(2)").
[178] Comprehensive Health Insurance Act, §§101("1845(b)(1)(B)").

Under the Comprehensive Health Insurance Act, states must be certified.[179] This status is contingent upon the state's providing, by statute or regulation, for the establishment of reimbursement rates and standards applicable to payments by health care insurance plans and special health care programs or pursuant to AHIP or FHIP for items and services provided within the state. Such rates and standards must be in accordance with such procedures and criteria as the Secretary of HEW may, by regulation, prescribe. The state must also disseminate the rates and standards for purposes of reimbursement to carriers, self-insured employers, employers providing special health care programs, certified providers, and covered individuals in accordance with procedures prescribed by the Secretary.

A state must also, by statute or regulation, meet certain additional requirements. First, the state would have to require that the carriers and self-insured employers providing the basic plan, file their plans with the state and keep the state advised of the employers and employees to whom the plan is provided. Second, the state would be required to provide for prompt review of the plan and prompt determination as to whether the plan conforms with the requirements of the law. Third, a state must also require that premium rates and rating structures be reviewed for reasonableness for all private

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[179] In the case of a non-certified state, old Title XVIII of the Social Security Act would remain in effect on and after January 1, 1976 with respect to individuals entitled to Hospital Insurance and Supplementary Medical Insurance.

health insurance. Fourth, enrollees would have to be guaranteed against non-coverage and non-payment of claims related to the basic health care insurance plan resulting from the insolvency of the carrier, self-insured employer, or carrier of prepaid health care plans. Fifth, an annual audit must be required for all insurance carriers offering coverage under a health care plan and carriers would have to be required to disclose information with regard to items and services covered, rates, and the relation between premiums and benefits paid. Sixth, the state would also have to have in effect an agreement with the Secretary pursuant to section 1122 of the Social Security Act. All capital investment of over $100,000 for health care would have to be approved by a state designated planning agency in order for the provider to receive reimbursement under the health care insurance plan. Finally, providers would be required to make available to patients, information regarding charges for services, hours of operation and other matters affecting access to service.

6. Financing

With respect to an EHIP, costs would be financed jointly by employers and employees.[180] However, the federal government would subsidize the employer whose payroll costs increased by more than 3 per cent as a result of the health insurance

[180] Under Comprehensive Health Insurance Act, §§101("1806"), state governments and political subdivisions thereof would be considered employers and therefore required to provide their employees with the option of obtaining coverage under an EHIP. (Under section 1806, only the United States Government and the government of the District of Columbia, a foreign government or an international organization or agency or instrumentality of such a government or organization is excluded from the term "employer".)

plan.[181] The excess cost over 3 per cent would be subsidized to the extent of 75 per cent during the first year and reduced 15 percentage points each year thereafter.

Cost of an AHIP above the income derived from enrollees would be shared by the state and federal governments. Federal funds would be appropriated and paid to the states which have approved plans for the provision of health care benefits. The state's share of the cost of the AHIP plans would be related to factors such as current levels of state expenditures, ability to pay, and anticipated future expenditures under the assisted health insurance plan.[182]

Costs under the FHIP program would be financed from premiums by covered individuals, (plus deductibles and coinsurance) and by payments from the Federal Health Care Benefits Trust Fund. Amounts generated through the hospital insurance portion of the payroll taxes and the taxes on self-employment income would be transferred to the Trust Fund and, with respect to these taxes, federal, state and local governments and their agencies and instrumentalities would be required to pay the employer portion of the payroll tax with respect to their employees.[183] Additional funds would be appropriated to the Trust Fund for specified purposes.[184]

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[181] Comprehensive Health Insurance Act, §§103.

[182] Under Comprehensive Health Insurance Act, §§101("1823(a)"), it would appear that the amount of the federal contribution will be affected by the amount it pays out in health care benefit costs on behalf of the elderly state residents who are in income classes I, II and III for purposes of FEHP's which expenditures would not have been made had such state elderly residents been in income class IV.

[183] Comprehensive Health Insurance Act, §§306.

[184] Comprehensive Health Insurance Act, §§101("1836").

B. COMPARISON OF THE COMPREHENSIVE HEALTH INSURANCE ACT OF 1974 WITH PRESENT LAW AND WITH THE MEDICARE AMENDMENTS OF 1974 FROM THE PERSPECTIVE OF THE AGED

1. In General

The Comprehensive Health Insurance Act of 1974 would replace the existing two Health Insurance for the Aged and Disabled programs of Hospital Insurance and Supplementary Medical Insurance and establish in their place for the aged, a Federal Health Care Benefits Program.[185] A residual Medicaid program for long-term care services would continue with the current federal-state Medicaid matching formula.

The benefits of the Federal Health Care Benefits Program, would consist of the opportunity, at the option of the individual, to obtain coverage under a "federal health care insurance plan", or to have the Federal Government pay, at reasonable rates, to any approved prepaid health care plan, for coverage comparable to that under a federal health care insurance plan.[186]

2. Entitlement and Duration of Entitlement

a. The Comprehensive Health Insurance Act of 1974

Any person residing in a certified state who has attained the age of 65 and is entitled to social security section 202 benefits, is a "qualified railroad retirement beneficiary", or would be entitled to social security section 202 benefits if his employment with federal, state, or local governments, their agencies and

[185] But see, Comprehensive Health Insurance Act, §§102(b).
[186] Comprehensive Health Insurance Act, §§101("1831(b)(2)").

instrumentalities (described in I.R.C. §§3121(b)(5),(6)(A), (B),(C), and (7)), were covered employment for purposes of determining entitlement to those benefits, will be entitled to federal health care benefits under the Federal Health Care Benefits Program. Entitlement would begin with the first day of the month in which the individual reaches age 65 and would end with the month in which he ceases to be entitled to social security section 202 benefits or ceases to be a qualified railroad retirement beneficiary (however, an individual will be deemed entitled to social security section 202 benefits or be deemed to be a qualified railroad retirement beneficiary for the month in which he died if he would have otherwise been so entitled).[187]

An uninsured individual will be deemed entitled to social security section 202 benefits (transitional entitlement) provided he attains the age of 65 before the effective date of the program (January 1, 1976, subject to postponement), or attains such age after the effective date but has not less than 3 quarters of social security or railroad retirement coverage for each calendar year lapsing after 1966 (assuming 1967 is the effective date of the program), and before the year in which he attains such age.[188] Furthermore, such an individual must be a resident of the United States and either a citizen of the

[187]Comprehensive Health Insurance Act, §§101("1831(a)(2)").
[188]Comprehensive Health Insurance Act, §§105(a).

United States or an alien lawfully admitted for permanent residence in the United States and must have filed an application. Entitlement would begin with the first month in which these requirements are met and would end with the month of death or, if earlier, the month before the month in which the individual becomes entitled to federal health care benefits under the regular rules.

b. Present Law

While existing law with respect to entitlement is similar to the entitlement provisions under the federal health care benefits program, its chief similarity is with respect to eligibility for the Hospital Insurance program and then only with respect to entitlement under that program based upon entitlement to social security section 202 benefits and qualified railroad retirement status.[189] While there is transitional entitlement to Hospital Insurance benefits, the applicable dates vary.[190] While the availability of federal health care benefits is optional with the individual and contingent upon the payment of premiums as is the case with voluntary enrollment in the Hospital and Supplementary Medical Insurance programs, unlike voluntary enrollment in those programs, the option is not available if the individual is not otherwise entitled on the basis of social security section 202 benefit status or qualified railroad retirement beneficiary status.

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[189]See Soc. Sec. Act §§226.

[190]See Soc. Sec. Amendments of 1965, §§103, P.L. 89-97.

One important aspect, in which entitlement under the Federal Health Care Benefits program, insofar as it differs from entitlement under the Hospital Insurance program, deserves comment. Under the Comprehensive Health Insurance Act of 1974, employment with the federal, state or local governments, their agencies or instrumentalities, will be covered employment for purposes of the health insurance taxes imposed under I.R.C. section 3101(b) and section 3111(b). Thus, a government employee will be deemed entitled to social security section 202 benefits, but solely for the purpose of entitlement to federal health care benefits. Since, under present law, this employment is not covered,[191] entitlement to social security cash benefits and Hospital Insurance benefits may depend (if the government employee were otherwise uninsured for social security purposes) upon the existance of a federal-state agreement under Social Security Act section 218 pursuant to which the state pays, although indirectly, the equivalent of the OASDI and HI taxes.[192]

In some respects, the entitlement provisions under the Federal Health Benefits Program represent a contraction of eligibility in comparison with existing law. First, there is no provision for voluntary enrollment in the absence of social security section 202 status (or deemed

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[191] See I.R.C. §§3121(b)(5), (6)(A),(B),(C),(7).

[192] This new provision may be subject to Constitutional challenge if the Comprehensive Health Insurance Act of 1974 is enacted.

social security section 202 status[193] or qualified railroad retirement beneficiary status (except for transitional entitlement) as there is under both Hospital and Supplementary Medical Insurance programs. Secondly, the disabled are not covered under the Federal Health Care Benefits Program as they are under existing law; rather, this group would have to be covered under Assisted Health Care Insurance plans.[194] While it may be argued that the FHIP program should not be evaluated in terms of entitlement out of context of the AHIP plans available in a certified state pursuant to the Comprehensive Health Insurance Act, certification is not contingent upon the availability of AHIP plans. If the grants to a certified state to induce it to establish an AHIP program, coupled with federal participation cutbacks in its Title XIX program, should not constitute sufficient incentive, those who are disabled and deemed disabled and covered for existing Title XVIII purposes now would be without adequate health care protection. With an added cost of $1 billion projected for the states under the Comprehensive Health Insurance Act (primarily for AHIP) and with diminishing resources, the inducement may be totally inadequate (see S. Rep. 1230, 92d Cong. 2d Sess. 201 (1972) - where state costs were

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[193] Comprehensive Health Insurance Act, §§101("1831(a)(1)(B)").

[194] A determination of whether persons who are disabled or deemed disabled and covered for purposes of Hospital and Supplementary Medical Insurance purposes would be better protected under an AHIP plan is open to conjecture.

given as the primary reason for the removal of the requirement that states move toward comprehensive Medicaid programs under Pub. L. 92-603, §§230). Finally, persons medically determined to have chronic renal disease requiring hemodialysis or renal transplantation who are covered for Hospital Insurance and Supplementary Medical Insurance purposes, would not be covered under the Federal Health Care Benefits Program; rather, these persons, like the disabled, would be eligible for AHIP protection, provided that a certified state offers such a program.

c. The Medicare Amendments of 1974

In comparison with the entitlement provisions of the Medicare Amendments of 1974, the provisions with respect to entitlement to federal health care benefits are narrow. The Medicare Amendments with respect to eligibility, would extend the benefits of the program to all those who are most in need of health care protection -- aged U.S. citizens and most aged non-citizens living in the U.S. without regard to social security cash benefit or railroad retirement status and would retain for benefits under the program . . . those disabled or deemed disabled and covered for purposes of Hospital and Supplementary Medical Insurance benefits. All of these would benefit from the new and expanded services added by these amendments. While the impact of the FHIP plans and the AHIP is obscure with respect to both the low-income aged and those who are

disabled and deemed disabled and covered under present law, there can be no doubt that these most health-care-needy groups would benefit under the Medicare Amendments of 1974. Not only is the group, including the aged, which are entitled to benefits under the Federal Health Care Benefits Program, constricted in comparison with the group entitled to benefits under the Medicare Amendments of 1974, but the duration of entitlement to benefits under the Comprehensive Health Care Benefits program would appear to be more tenuous because it is conditioned upon social security insurance status and railroad retirement status.

3. Health Care Benefits and Durational Limitations

a. Comprehensive Health Insurance Act of 1974

A FHIP would provide for payment for items and services including inpatient hospital services, physician services, medical and other health services, (e.g. physician's services, services and supplies furnished as an incident to a physician's professional service, either without charge or included in the physician's bill, hospital services rendered to outpatients, diagnostic services, outpatient physical therapy services, physician extender services, diagnostic X-ray tests, and X-ray therapy), post-hospital extended care services, home health services and outpatient drugs and biologicals.[195] However,

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[195]Comprehensive Health Insurance Act, §§101("1841(a)(1)").

post-hospital extended care services would be limited to 100 days per calendar year. Home health services would be limited to 100 visits per calendar year. Inpatient hospital services for the treatment of mental illness would be limited to 30 days per calendar year. Services provided on an outpatient basis for the treatment of mental illness would be limited according to the estimated cost of 30 outpatient visits to a private practitioner for the treatment of mental illness.[196]

The following items, among others, are specifically excluded from coverage: items and services not reasonable and necessary for the diagnosis or treatment of congenital defects, illnesses, or injuries or to improve body functioning, eyeglasses, hearing aids, and examinations therefore;[197] services for which the individual has no legal obligation to pay for, services not provided within the U.S. (except for emergency inpatient hospital and physician services), services constituting personal comfort items, orthopedic shoes and other supporting devices, custodial care, cosmetic surgery, services provided by an immediate relative or member of his household, the treatment of flat foot conditions and routine foot care, kidney dialysis or transplantation except where provided by a kidney dialysis or transplantation center or facility

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[196] Under Comprehensive Health Insurance Act, §§101("1841(b)"), payment for such services other than services provided on an outpatient basis in a comprehensive community care center, would be limited to one-half of the cost of such services.

[197] These services would be available to children under age 13 under EHIP and AHIP plans.

which meets such requirements as the Secretary may by regulation provide, and services covered under workmen's compensation.

b. Present Law

While coverage of outpatient drugs under federal health care insurance plans is an improvement over those benefits available under current law, the entire benefit package available when considered in the context of its durational limitations, represents at best, a slight expansion of benefits in comparison with those available under the Hospital and Supplementary Medical Insurance Programs when viewed in the context of their durational limitations.

Under Hospital Insurance, inpatient hospital services, post-hospital extended care services, and post-hospital home health services are limited in accordance with the beginning or ending of a "spell of illness" (see PART FOUR). The Supplementary Medical Insurance program has its own separate benefit package which builds upon, and to some extent, duplicates Hospital Insurance benefits. For example, an individual entitled to benefits under both programs may receive post-hospital home health services for up to 100 visits during a one-year period (again, limited by the spell of illness context) under the Hospital Insurance program and still be entitled to

100 visits per year for home health services under the Supplementary Medical Insurance program.

While it is difficult to compare the benefit packages available under present law with the benefit package which would be available under FHIP plans because of the presence of the "spell of illness" limitation and other complex lifetime durational limitations of current law, it seems certain that in the case of many persons presently entitled to Hospital and Supplementary Medical Insurance who would also be entitled to FHIP protection, the benefit package available under the latter program will constitute a significant curtailment of services.

c. Medicare Amendments of 1974

In comparison with the benefit package which would be available under the Medicare Amendments of 1974, the benefit package of the FHIP plan is seriously deficient. The Medicare Amendments of 1974, in order to provide comprehensive protection and to promote proper utilization of services, would cover institutional services including inpatient and outpatient hospital services, silled nursing facility services, intermediate care facility services (furnished after June 30, 1978), home health services, and many health and health-related services without durational limitation.[198] Covered non-institutional services include professional services of a physician (when not

[198]Medicare Amendments of 1974, §§111(a)("1813").

covered as an institutional service), services, materials, and supplies (including drugs), outpatient mental health services, dental services, and devices, appliances, equipment and supplies including eyeglasses, hearing aids, prosthetic devices, walking aids and durable medical equipment.[199] The only durational limit applicable to these benefits are a limit of 150 days of care in a benefit period (similar to "spell of illness") for psychiatric inpatient care, a 160-day limit on psychiatric (mental health) services furnished to a patient of a mental health day care service, and a 20-consultation-a-year limit on mental health services furnished in a psychiatrist's office. Obviously, the benefit package available under the Medicare Amendments of 1974 is far more comprehensive than that which would be available under the FHIP plans.

4. Cost-Sharing and Catastrophic Protection

a. The Comprehensive Health Insurance Act of 1974

A FHIP plan would require the payment of premiums, deductibles, and coinsurance. The premiums for each calendar year would be an amount equal to 15 per cent of the amount which the Secretary determines is the "estimated average cost of coverage for that year under the plan" of an individual in income class IV. (See below for income class structure.) An annual deductible would be charged with respect to covered items and services

[199]Medicare Amendments of 1974, §§111(a)("1815").

other than outpatient drugs and biologicals and other than blood and blood products. The amount of the deductible would initially be $50 in the case of an individual in income class II and $100 in the case of an individual in income classes III, IV and V (all covered individuals would be divided among five income classes on the basis of income level,[200] subject to adjustment in years after 1977).[201] FHIP would also impose an annual drug deductible per individual of $25 in the case of an individual in income class II and $50 in the case of an individual in income classes III, IV and V, subject to later adjustment after 1977.[202] A blood deductible, determined and prescribed by the Secretary, may also be imposed.[203]

There will also be imposed a FHIP plan with respect to expenses in excess of any applicable deductible, coinsurance of 10 per cent in the case of individuals in income class I, 15 per cent in the case of individuals in income class II, and 25 per cent in the case of an individual in income classes III, IV and V.

These cost sharing requirements under a FHIP plan, would be subject to a catastrophic protection feature. First, no premium would be charged in the case of individuals in income classes I and II. Second, neither the annual deductible nor the drug deductible would be

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200 Comprehensive Health Insurance Act, §§101("1825(b)(5)").
201 Comprehensive Health Insurance Act, §§101("1825(b)(2)(E)").
202 Comprehensive Health Insurance Act, §§101("1832(b)(2)(B)").
203 Comprehensive Health Insurance Act, §§101("1832(b)(2)(C)").

imposed with respect to an individual in income class I. Third, no further deductible or coinsurance requirement would be imposed in any calendar year after the total of deductible and coinsurance amounts imposed under the plan equals 6 per cent of annual income in the case of an individual in income class I, 9 per cent of annual income in the case of an individual in income class II, 12 per cent of income in the case of an individual in income class III, and in the case of an individual in income classes IV or V, no further deductible or coinsurance amounts would be imposed in any calendar year in excess of 7.5 per cent of the income class base (presently 7.5 x $10,000 = $750).[204]

b. Present Law

Under the Hospital Insurance program, there are a variety of cost-sharing features including the inpatient hospital deductible (presently $84) per spell of illness, daily coinsurance (1/4 of the inpatient hospital deductible for inpatient hospital services after the 60th day and before the 91st day during a spell; 1/2 of the inpatient hospital deductible for inpatient hospital services after the 90th day and through the 150th day during a spell), a blood deductible equal to the cost of the first

204 Under Comprehensive Health Insurance Act, §§101("1832(b)(5)"), any deductible or coinsurance amount charged against the covered individual under any other approved health care insurance plan would be taken into account in determining if the deductible and coinsurance requirements have been met.

three pints of blood (subject to reduction if the blood is replaced on a pint-for-pint basis), daily coinsurance with respect to post-hospital extended care services after the 20th day during a spell of illness (equal to 1/8th the inpatient hospital deductible), and monthly premiums in the case of individuals who voluntarily enroll in the program. Under the Supplementary Medical Insurance program, cost-sharing takes the form of a monthly premium (presently $6.30), an annual deductible of $60 and a 20 per cent coinsurance feature.

Present law has no catastrophic protection feature. The absence of such a feature from the law has resulted in a substantial increase in out-of-pocket health expenditures by the aged in the last few years.

c. The Medicare Amendments of 1974

Under these amendments, all premium, deductible and coinsurance requirements would be eliminated. Instead, a system of copayments with respect to inpatient hospital services, skilled nursing services, home health services, physician and dentist services, mental health day care, diagnostic outpatient services and independent laboratory and independent radiology services, devices, appliances and equipment, certain drugs, and ambulance services, would be established. The amounts to be charged would be minimal and would be subject to a catastrophic protection feature

pursuant to which copayments and durational limitations on benefits (to the extent there are any) would be eliminated in the case of entitled low-income persons and, in the case of other entitled persons, would be eliminated after these persons had incurred out-of-pocket expenses in a maximum amount related to their income.

A single system of copayment geared to the more expensive cost items of health care, would appear more rational and more administerable than the combination of cost sharing features proposed under the Comprehensive Health Insurance Act of 1974. Moreover, since the cost sharing amount under the Medicare Amendments of 1974 are minimal, and since the income classes under these amendments are more liberal than those under the FHIP program, covered individuals would be afforded greater protection against out-of-pocket health care costs under the Medicare Amendments of 1974.

5. Conditions of and Limitations on Payment for Services

a. The Comprehensive Health Insurance Act of 1974

FHIP plans would provide[205] for the establishment of an account against which a covered individual may charge the cost of obtaining covered items and services without regard to deductible and coinsurance requirements. Except with respect to emergency services, payments for items

[205]Comprehensive Health Insurance Act, §§101("1832(c)").

and services covered under the plan would be made only on the basis of charges against this account, and only at the applicable reimbursement rates.[206] "Full" and "associate participating providers" would receive payment for all items and services without reduction on account of deductibles and coinsurance, unless the account is in default and the covered individual would be billed for any portion of a payment properly chargeable to him on account of these limitations.[207] Interest would accrue on amounts owed, but an account will not be regarded as in default unless amounts owed are 90 days in arrears.[208]

To be certified as a "full participating provider", an individual or entity must agree to accept the payment made by the FHIP on the basis of charges against the account as the sole means of obtaining payment for so much of the charges for the provision of items and services as is payable under the plan. Moreover, a full participating provider must agree to accept reimbursement through this procedure as payment in full (without regard to deductibles and coinsurance except where an account is in default) for covered services. An "associate participating provider", in order to be certified, must also agree to accept the payment made by the FHIP plan on the basis of charges against accounts as full payment for

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[206]Comprehensive Health Insurance Act, §§101("1832(c)(2)").
[207]Comprehensive Health Insurance Act, §§101("1832(c)(3)").
[208]Comprehensive Health Insurance Act, §§101("1832(c)(4)").

the provision of items and services (except outpatient drugs and biologicals).[209]

Each state, which is certified pursuant to section 1861, must provide, by statute or regulation, for the establishment or reimbursement rates and standards applicable to payments by FHIP plans for services provided within the state in accordance with such procedures and criteria as the Secretary of HEW may by regulation provide. In addition, these rates and standards must be disseminated to affected carriers, certified providers, self-insured employers, employers providing special health care programs, and covered individuals in accordance with procedures prescribed by the Secretary.[210] No specific standards or regulations are set forth in the statute. The matter is left to the discretion of the Secretary and the individual certified state.[211]

Other provisions affecting the payment for items and services provided pursuant to a FHIP plan, include the requirement that the certified state have in effect an agreement with the Secretary for purposes of institutional planning, and provide for utilization review with respect to inpatient hospital and skilled nursing facility services.

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[209]Under Comprehensive Health Insurance Act, §§101("1845(b)(2)"), a hospital, skilled nursing facility, or home health agency may not be certified as an associate participating provider.

[210]Comprehensive Health Insurance Act, §§101("1861(a)(2)").

[211]Apparently, reimbursement to physicians and perhaps other licensed professional practitioners would be based on negotiated rates. Some form of prospective reimbursement system for hospitals and other provider entities is also contemplated.

b. Present Law

The conditions and limitations on payment for services under the Hospital and Supplementary Medical Insurance programs, have been described in detail in PART THREE. It should be noted, however, that existing law prescribes specific standards for the purpose of determining "reasonable cost" or "reasonable charges" as the case may be. While the absence of certain standards under the Comprehensive Health Insurance Act of 1974 may allow certified states to take into account local or regional peculiarities when prescribing the reimbursement standards, the lack of standards for the promulgation of regulation by the Secretary, pursuant to which certified state reimbursement standards would be set, seems to be an unwise abdication of responsibility. Moreover, since FHIP and the relevant provisions of the Comprehensive Health Insurance Act of 1974 would be in effect in only states which are certified, to the extent that states are not certified, and the present programs of Hospital and Supplementary Medical Insurance would remain in effect, with their specific standards for reimbursement and their variety of exceptions from the general reimbursement standards, an administrative problem of monumental dimensions could result.

The certification procedures with respect to full and associate providers of services that would be established

under the Comprehensive Health Insurance Act of 1974 would appear to be a substantial improvement over the situation under present law. By requiring certified providers, in general, to accept the payment made pursuant to the FHIP plan as full payment for services rendered and without any reduction for deductibles or coinsurance, the situation, especially under the Supplementary Medical Insurance program, where physicians are refusing to take assignment of payments (payments are therefore being made to the covered individual on the basis of an itemized list) and are charging the covered individual substantial amounts above "reasonable charges" for services would be corrected. Moreover, much of the administrative burden on providers of services under present law, would be eliminated since they would not have to seek payment for amounts which are not reimbursable under Hospital or Supplementary Medical Insurance programs.

c. The Medicare Amendments of 1974

It may be that the Comprehensive Health Care Insurance Act of 1974 contemplates the establishment by certified states of prospective budget review procedures for institutional providers and negotiated rates for non-institutional providers on the basis of which payments would be made pursuant to the FHIP plans.[212] The Medicare Amendments of 1974, however, specifically so provide and in

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[212]Comprehensive Health Insurance Act, §§101("1861(a)(2)").

substantial detail. Such reimbursement procedures should result in a more rational and efficient utilization of health care facilities and personnel and aid substantially in restraining rising health care costs resulting from existing lack of planning (the 1972 Social Security Amendments began to contend with this problem).

Like the Comprehensive Health Insurance Act of 1974, payment under the Medicare Amendments of 1974 would be made only to "participating providers" (except in the case of emergency services) who would be required to agree to accept the payment as the full charge for the services provided. Hereafter, a professional practitioner would no longer, by refusing to accept an assignment, and by billing the patient directly, require the covered patient to pay fees in access of the reimbursable amount.

The Medicare Amendments of 1974 do not provide for the establishment of accounts on behalf of covered individuals to which all covered items and services would be charged and would not provide for paying providers for their services in full without reduction for copayment amounts. Moreover, they would not bill the covered individual for the amount of any such copayment.

In this one respect, but only in this respect, the Comprehensive Health Insurance Act of 1974 appears superior in its payment procedures.

6. The Financing of Health Care Benefits

a. The Comprehensive Health Insurance Act of 1974

The payment for items and services covered under FHIP plans would be financed by the payroll and self-employment taxes imposed by I.R.C. §§3101(b), 3111(b), and 4101(b). It should be noted that covered employment for purposes of these acts would be expanded to embrace employees of federal, state and local governments, their agencies and instrumentalities.[213] In addition, there would be appropriated to the Federal Health Care Benefits Trust Fund sums deemed necessary for payments with respect to covered services rendered to low-income individuals (although it appears that the federal contribution to AHIP plans would be lower as a result of payments made under FHIP plans to low-income aged persons in the particular state)[214] and to take account of administrative expenses and any lost interest to the Trust Fund resulting from such payments. In addition, premiums are required except in the cases of individuals in income classes I and II (as indicated above).

b. Present Law

Benefits under the Hospital Insurance program are, as described in the preceding part, financed by the payroll and self-employment Health Insurance taxes imposed

213 Comprehensive Health Insurance Act, §§101("1861(a)(2)").
214 Comprehensive Health Insurance Act, §§101("1823(a)").

under I.R.C. §§3101(b), 3111(b), and 4101(b) and by premium payments from voluntary enrollees. The Supplementary Medical Insurance benefits are financed by premiums paid by enrollees and contributions from the Federal Government. As noted hereinabove, state and local governments, their agencies and instrumentalities, are not taxed directly for health insurance benefits available to their employees. However, states which have agreements with the Secretary of HEW pursuant to Social Security Act §§218 pay an amount equivalent to what would be paid if taxes were imposed directly.

c. The Medicare Amendments of 1974

The Medicare Amendments of 1974 would finance health care benefits through a variety of taxes. Like the Comprehensive Health Insurance Act of 1974, the existing payroll and self-employment taxes imposed pursuant to I.R.C. §§3101(b), 3111(b) and 4101(b), would be retained except that in the case of the taxes imposed under I.R.C. §§3101(b), such taxes would be imposed on 125 per cent of the social security tax base for that particular year and except that the payroll taxes imposed on the employer under the I.R.C. §§3111(b) would be imposed on a tax base of total payroll. Since the payroll and self-employment taxes are, by their vary nature, and even when viewed in terms of benefits to be derived, regressive (the incidence

of the employer portion of the payroll tax - I.R.C. §§ 3111 - substantially devolves upon the employee) the taxable wage base revisions of the Medicare Amendments of 1974 would lessen, to some extent, the regressive impact of these taxes.

In addition, the Medicare Amendments of 1974 would impose a new tax on unearned income which is neither imposed under current law nor would would be imposed under the Comprehensive Health Insurance Act of 1974. Finally, the Medicare Amendments of 1974 would provide for a Federal Government contribution to the Medicare Trust Fund out of general revenues as would the Comprehensive Health Insurance Act of 1974. However, the amount of the contribution from general revenues under the Medicare Amendments is likely to be far more substantial than the contribution under Comprehensive Health Insurance, since, in the latter case, the amount appropriated is strictly limited in accordance with specified purposes.

PART SIX

CONCLUSION

Using as a standard the Medicare Amendments of 1974, which were designed specifically to accommodate the health care needs of the aged and the disabled by providing comprehensive protection on the one hand while simultaneously confronting the problem of rising health care costs on the other, the National Health Insurance Act of 1974 is less than adequate. It fails to address itself to the nation's health care needy by providing the proper degree of protection. Moreover, it fails to come to grips with the problems of rising health care costs.

In some respects, the entitlement provisions under the FHIP plans represent a contraction of eligibility in comparison with existing law. Moreover, the status of those who are disabled or deemed disabled and covered now for purposes of Medicare is obscure. Their health care protection might be jeopardized. In comparison, the eligibility provisions of the Medicare Amendments of 1974 are very liberal.

With respect to health care benefits, the coverage of outpatient drugs under FHIP plans is an improvement over the benefits available under current law. However, the entire benefit package when considered in the context of durational limitations, represents at best, a slight expansion of protection. It falls far short of the comprehensive protection of the Medicare Amendments of 1974, the benefits of which would add, among other things,

coverage of intermediate care facilities, greatly expanded psychiatric care including (day care and outpatient), dental services, services of optometrists and podiatrists, and outpatient drugs to services already available -- and with few durational limitations.

While the FHIP plans would provide catastrophic protection, the protection would be less than that available under the Medicare Amendments of 1974 because the maximum ceiling is lower and the income classes limits higher under the latter bill. Moreover, the complex system of premiums, deductibles, and coinsurance under the FHIP plans would constitute a cost burden on those administrating the plans and on those subject to the cost-sharing features. The single system of minimum copayments geared to the more expensive items of health care under the Medicare Amendments of 1974 makes better sense.

With respect to the procedure for the payment for covered services, the FHIP plan idea for the establishment of an account against which a covered individual may charge the cost of obtaining items and services without regard to deductible and coinsurance requirements is commendable. Requiring a full "participating provider" (but not the "associate provider" in some cases) to accept the payment as full payment is another provision that is desirable and needed. While the Medicare Amendments of 1974 would not provide for the establishment of accounts such as is contemplated under the FHIP plans, payment under the Medicare Amendments would also have to be accepted by participating providers as full payment (without exception).

The complete absence of standards for the promulgation of regulations by the Secretary of HEW pursuant to which certified state reimbursement standards would be set, seems to be an unwise abdication of responsibility and likely to promote rather than restrain the rate of increase in hospital and health care costs. While the Comprehensive Health Insurance Act may with respect to FHIP plans contemplate the establishment by "certified" states of prospective budget review procedures for institutional providers and negotiated rates for non-institutional providers for payment purposes under FHIP plans, the Medicare Amendments of 1974 specifically so provide. Such reimbursement procedures should tend to promote rational and cost efficient utilization of health care facilities and personnel and thereby restrain rising health care costs.

While inadequate in its protection for the health care needy -- the aged and disabled -- the FHIP plans have some good features. Since the Medicare Amendments of 1974 and the Comprehensive Health Insurance Act of 1974 have common elements (except with respect to payment procedures where CHIA has nothing more than unqualified discretion in the Secretary of HEW to prescribe regulations), it may be possible to combine them to provide comprehensive health care protection for the aged and disabled and basic protection for the non-aged and disabled through the EHIP, AHIP and prepaid health plans. If the Comprehensive Health Insurance Act is to be given services consideration, such a fusion should be seriously considered.