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

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Barriers to Health Care for Older Americans:
Part 1. Washington, D.C., March 5, 1973.
Part 2. Washington, D.C., March 6, 1973.
Part 3. Livermore Falls, Maine, April 23, 1973.
Part 4. Springfield, Ill., May 16, 1973.
Part 5. Washington, D.C., July 11, 1973.
Part 6. Washington, D.C., July 12, 1973.
Part 7. Coeur d'Alene, Idaho, August 4, 1973.
Part 8. Washington, D.C., March 12, 1974.
Part 9. Washington, D.C., March 13, 1974.
Part 10. Price, Utah, April 20, 1974.
Part 11. Albuquerque, N. Mex., May 25, 1974.
Part 12. Santa Fe, N. Mex., May 25, 1974.
Part 13. Washington, D.C., June 25, 1974.
Part 14. Washington, D.C., June 26, 1974.
Part 15. Washington, D.C., July 9, 1974.
Part 16. Washington, D.C., July 17, 1974.

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

CONTENTS

BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

WEDNESDAY, MARCH 13, 1974

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

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

Present: Senators Muskie, Stafford, Mondale, and Percy.

Also present: William E. Oriol, staff director; Elizabeth Heidbreder, professional staff member; Reid Feldman, legislative assistant to Senator Muskie; John Guy Miller, minority staff director; Margaret Fayé, minority professional staff member; Patricia Oriol, chief clerk; Gerald Strickler, printing assistant; Yvonne McCoy, assistant chief clerk; and Dorothy McCamman and Herman Brotman, consultants.

OPENING STATEMENT BY SENATOR EDMUND S. MUSKIE, CHAIRMAN

Senator MUSKIE. The committee will be in order. I have a brief opening statement, designed to summarize somewhat, yesterday's hearing as a prelude to today's hearing.

Yesterday, this subcommittee began 2 days of hearings specifically to examine the effect that the administration's proposed new comprehensive health insurance plan would have upon health care for older Americans. To fashion the comprehensive health insurance plan most Americans now agree is needed will require a process of careful scrutiny and cooperation by all parties. I believe that the administration's proposal is a step forward in this cooperative process.

The testimony in yesterday's hearings, however, raised serious questions about the adequacy of the administration's proposal in meeting the health needs of the elderly.

The administration plan does offer some improvements over earlier proposals. But the evidence we have heard so far indicates that it would create an unwieldy and perhaps unworkable apparatus which would impose increased health care costs on most elderly Americans while failing to guarantee needed improvements in kinds of health care they can receive.

This subcommittee's hearings, of course, are not focusing on all the provisions of the administration's plan—other congressional units will take on that task in the months ahead.

To the Committee on Aging, however, the administration's plan—CHIP—is of immediate concern because it would considerably alter the Medicare system, and—in the opinion of the witnesses yesterday—it would alter Medicare for the worse.

They were concerned, as am I, about the "cost-sharing" provisions in CHIP. They testified that the administration proposal could add hundreds of dollars to an average hospital bill, and significantly more to a doctor's bill.

Later on, in questioning, I'll give examples showing that the CHIP bill would clearly result in much higher out-of-pocket expenses for older patients.

"COST-SHARING"—"OVERUTILIZATION"

For now I will say only that Secretary Weinberger and I had a conversation in hearings before this subcommittee about 1 year ago about the pros and cons of "cost-sharing." He maintained that higher costs to the Medicare enrollees would prevent what he called "over-utilization" of medical facilities. But the evidence we heard showed that "cost-sharing" would not change utilization patterns except when it put needed care beyond the patient's financial reach. I invite whatever new evidence he may have on this crucial issue.

The Secretary may also argue, as he did last year, that the elderly patient with a long-term hospital stay will benefit from the administration plan. Most Medicare patients, however, come nowhere near the length of stay required to receive such advantages.

The Secretary should also know that yesterday's hearing produced other testimony questioning the usefulness of CHIP to the elderly:

Nelson Cruikshank said that CHIP seems to "take a lot from a great many in order to give a few people very little." He pointed out that it violates the social insurance principles on which Medicare is based, and that "the biggest beneficiaries would not be the sick, but the health insurance industry."

Melvin Glasser said that CHIP nowhere assures that access to decent health services is a right for all Americans. "Rather," he said, "it continues to be a privilege for those who can meet the requirements of out-of-pocket payments, State legislation, and Federal strictures."

One point emphatically made by two witnesses is that Medicare benefits under CHIP could vary widely from State to State—a concept resisted by Medicare supporters and the Congress in the early 1960's. Surely there is no good rationale for retrogression now.

The American Association of Retired Persons also questioned the usefulness of the "cost-sharing" provisions for controlling health costs. They questioned whether the States could be expected to take upon themselves the responsibilities which the overall CHIP plan would require. And they said that if benefits were to vary sharply among the States, CHIP could even be challenged on constitutional grounds.

Such questions, to my mind, warrant careful consideration by the administration, just as the CHIP proposal warrants careful attention by the Congress.

Mr. Secretary, it is a pleasure to welcome you here this morning. I know that your schedule is busy and yet I suspect it may be useful to you, as it is to us, to unveil this portion of the administration's proposal before this subcommittee and we welcome that.

STATEMENT OF HON. CASPAR W. WEINBERGER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY JAMES B. CARDWELL, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; ARTHUR S. FLEMMING, COMMISSIONER, ADMINISTRATION ON AGING; STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION; WILLIAM A. MORRILL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION; HOWARD N. NEWMAN, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION; HENRY E. SIMMONS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH

Secretary WEINBERGER. Thank you very much, Mr. Chairman. I am delighted to be here, and, as you say, it will be an unveiling of only a portion of what is a national plan for everyone in the country, regardless of age, but I am delighted to have the chance to discuss the portions you are particularly interested in.

I am accompanied by my colleagues: James B. Cardwell, Commissioner, Social Security Administration, DHEW; Arthur S. Flemming, Commissioner, Administration on Aging, DHEW; Stephen Kurzman, Assistant Secretary for Legislation, DHEW; William A. Morrill, Assistant Secretary for Planning and Evaluation, DHEW; Howard N. Newman, Commissioner, Medical Services Administration, DHEW; Henry E. Simmons, M.D., Deputy Assistant Secretary for Health, DHEW.

Between all of us, maybe one of us can answer some of your questions.

Mr. Chairman and members of the committee. I am pleased to be here in response to your request to testify before this committee today regarding the modifications which would occur in the Medicare and Medicaid programs under this administration's proposed Comprehensive Health Insurance Act, S. 2970.

This subject is of crucial significance for the 23 million Medicare and 4.5 million aged Medicaid beneficiaries as well as for all of us who are involved in planning, legislating, and administering health financing programs for this population. It was the undisputed health needs of the elderly which prompted Congress to enact Medicare in 1965—the Nation's first major health financing program which was not an income-related program.

We find ourselves now at a similar historic junction. However, the issue extends beyond the question of the health care of every American, regardless of age, health status, employment status, marital status, or income. And it is significant that in this debate we can benefit from the experience of administering Medicare and Medicaid, particularly with respect to the need for cost controls. In the nearly 8 years of these programs' operations, we have gained a wealth of experience in the many areas which bear on health care financing—provider participation, utilization and medical review, cost-sharing,

use of intermediaries and carriers in administration of the programs, the economic effects of health care financing, cost-control measures, regulation of insurors and providers, standard-setting, and so forth.

Most of the national health insurance proposals currently pending before Congress, including the administration's proposal, seek to establish health care financing or care for all Americans. The Medicare and Medicaid programs as they exist today will under many of these proposals be altered to conform to the larger health care or health financing systems established by these proposals. This is true of the administration's proposal.

The proposed modifications in Medicare and Medicaid which would occur under the administration's proposal have already received extensive press coverage. Unfortunately, much of this coverage has given the impression that the Medicaid and Medicare programs will be cut back and that current beneficiaries will be worse off than they are now. I hope that our discussions today will make clear that, contrary to such reports and even to your opening statement yesterday, Mr. Chairman, health insurance coverage for the aged under our proposal will be far superior to that which is presently available under Medicare and Medicaid because it expands benefits and provides improved protection. We will be spending $1.8 billion more under CHIP for the aged than we are currently spending under Medicare.

Before turning to a discussion of the specific changes which our proposal will make in the Medicare and Medicaid programs. I would like briefly to discuss with you the broad outlines of the administration's comprehensive health insurance proposal to provide the overall picture in which any changes for present Medicare and Medicaid beneficiaries must be viewed.

Overview of CHIP

Under our proposal for comprehensive health insurance, every U.S. citizen could be covered under one of three programs: The Employee Health Insurance Plan [EHIP], the Assisted Health Insurance Plan [AHIP], or Medicare.

Medicare will cover virtually all persons 65 and over, EHIP will cover most full-time workers and their families under 65, and AHIP will cover all those of any age who are either ineligible for Medicare or who find it economically advantageous to enroll in AHIP. Persons with low incomes, early retirees, high-risk persons and some self-employed are among the groups which could be covered under AHIP.

All three programs will cover the same services, including: unlimited inpatient hospital care, unlimited physicians' services, unlimited outpatient prescription drugs, mental health services, special and preventive services for children and mothers, home health services, posthospital extended care services in skilled nursing facilities, blood and blood products, and other medical services currently covered under Medicare, including prosthetic devices, dialysis equipment and supplies, X-rays, laboratory tests, and ambulance services.

In designing this comprehensive benefit package we made a conscious decision to cover basically the same broad range of services under all three programs. This decision was based on the conviction

that one of the principal goals of an insurance program should be protection against major medical expenses. The services that would not be covered largely represent the more routine medical services which can be budgeted for—or left to State and local general assistance—and should not be covered under a health insurance program which primarily seeks to provide financial protection.

The cost-sharing schedules established for CHIP vary according to plan, but are based on ability to pay, so that the full-time employee group pays more than the low-income group or the aged. We recognize that some may disagree with the actual cost-sharing rates in our proposal; however, we believe the concept of cost-sharing is an important and essential feature of any national health insurance program. Through cost-sharing we are able to reduce total premium costs, expand the beneficiary group and relate an individual's contributions to his or her utilization of health services. Cost-sharing also instills cost-consciousness on the part of the enrollee and thus reduces unnecessary or inappropriate utilization of health services. This is essential to prevent the health system from being overwhelmed by persons who do not need services while persons who do need services are unable to obtain them.

In terms of total benefits, the vast majority of aged persons are going to be better off under CHIP than they are under the current Medicare program. Under CHIP the value of the benefit package for the aged will rise from $565 to $620—or put another way, the Federal Government will be spending $55 more for every aged person under CHIP than is now being spent under Medicare. The total increase in Federal spending for the aged will be approximately $1.8 billion.

All enrollees under the three programs will be able to charge the cost of covered medical care on a healthcard account. They may then pay the charges not covered by insurance on an installment basis if need be. The deferred payment approach will enable all enrollees to obtain needed medical care even if they do not have the cash on hand currently to pay for their deductible and cost-sharing charges. Maximum limits will be established on interest charges for unpaid balances on healthcard accounts.

Requirements for professional review of medical care will be provided under CHIP to assure that care provided is of high quality and medically necessary. There will also be provisions for strong regulation by the States of insurance carriers participating under the plan.

Medicare Under CHIP

A major objective of Medicare has been to remove those financial barriers that prevent the elderly from obtaining necessary medical services of high quality. This it has done to a considerable degree. Our proposed changes in the Medicare program will build on the existing program to make it more responsive to the health needs of the aged. Our proposed changes are in four basic areas: Eligibility, benefits, cost-sharing and physician reimbursement.

(A) *Eligibility.* Although Medicare currently covers most of the elderly population, it does not cover all persons 65 and over. Those who are ineligible for part A benefits are largely Federal, State, and

local employees and others without the necessary periods of employment covered under Social Security. Ninety-eight percent of the 21.5 million aged persons in this country have part A coverage, while 96 percent have part B coverage. Since eligibility for part B is not related to insured status under Social Security, persons ineligible for part A may nevertheless elect to enroll in part B. Under a special provision most of these individuals may also purchase part A at cost, currently $33 a month. This will rise to meet rising costs in the future.

Under CHIP, Medicare coverage will generally be available to persons 65 years of age and older. Conversely, no person under 65 will be eligible for Medicare. Dependents of Medicare beneficiaries below age 65 would be eligible to enroll in AHIP or EHIP.

Federal, State, and local government employers and employees will participate in the Medicare system and be subject to the Medicare payroll tax. We believe that the same responsibilities and benefits conferred on private employers and their employees should apply to Government employers and employees as well.

Like the current Medicare, the new program would cover persons who are insured under the Social Security program. Under temporary transitional provisions, which are similar to those established when the original Medicare law was enacted, every citizen—or permanent alien resident—who has reached age 65 in the first year of the program would automatically be covered under the plan. In following years, eligibility would be extended to additional persons who have specified credits under Social Security, but not enough to meet regular Medicare requirements. These temporary transitional provisions would "wash out" when the requirements for Social Security credits became the same as the regular requirements for insured status under Social Security.

Medicare beneficiaries 65 and older who are low-income will not have to pay the same premium and cost-sharing charges as other beneficiaries. The income testing and income definitions for this group would be tied to those used in the Supplemental Security Income program administered by the Social Security Administration, which will also continue to administer Medicare.

Disabled persons under 65 and persons under 65 needing dialysis or kidney transplantation because of chronic renal disease who are currently eligible for Medicare would ordinarily be eligible for AHIP—or EHIP if a family member is employed—instead of Medicare. These two groups were included in Medicare only very recently, at a time when there was no national health insurance program to meet their special need for protection against unusually high health care costs. Now that a truly comprehensive national health insurance program is being planned, there is no longer any need to keep these younger people under the Medicare program. Also, as a group, they receive better benefits because most of them are low-income.

(B) *Benefits.* The lack of catastrophic coverage for inpatient services under the present Medicare program means that a beneficiary who experiences catastrophic illness or disability is unprotected against further health care costs after his or her Medicare benefits are exhausted. In effect, current beneficiaries lose benefits when they are most needed. In this sense, the high cost-sharing for lengthy hospital-

ization under the current Medicare program is just the opposite of desirable protection. When these benefits are exhausted, the only alternatives, if the individual is without private supplementary insurance, are (1) to pay for needed care out of savings, or (2) if no other financial resources are available, the beneficiary may receive care under Medicaid if his or her income and financial resources are diminished to a point low enough for Medicaid eligibility.

Medicare Benefit Package

The Medicare benefit package under our proposed Comprehensive Health Insurance Act has been expanded to provide unlimited coverage for hospital and outpatient care. Drug benefits would also be broadened to include outpatient prescription drugs, which is one of the major gaps in the present Medicare program. In addition, a wide range of mental health services would be covered. We believe that the CHIP benefit package is one which is clearly superior to the present Medicare benefit package. It covers virtually all the services currently covered under Medicare and extends the present coverage which Medicare provides.

(C) *Cost-sharing.* In developing the cost-sharing schedules for CHIP, we sought to eliminate two major problems which characterize most insurance policies, including Medicare: The financial incentives to use hospitalization rather than outpatient care and the open-ended liability for all costs above the limits of coverage. Under the present program for inpatient hospital care for the first 60 days of a benefit period, all covered services are paid for after an $84 deductible has been met. For the next 30 days of the benefit period there is a $21 per day copayment charge, and for each of the 60 lifetime reserve days there is a $42 per day copayment charge. Of course, after the 150 day of inpatient hospital care the beneficiary must pay 100 percent of charges, unless he or she has supplementary private insurance or is eligible for assistance under Medicaid or another public program. Similarly, for posthospital skilled nursing facility care there is no deductible for the first 20 days and a $10.50 per day copayment charge for the 21–100 days.

Under part B, there is, in addition to the premium, a deductible of $60 per year on covered medical expenses and a 20 percent coinsurance charge without any upper limit.

The amount of cost-sharing paid by long-term care patients is inordinately high. For example, the patient pays 50 percent of the first day's deductible amount for each day of hospitalization during the 60-day lifetime reserve period. This amounts to around two-thirds of actual hospital charges and in many cases exceeds the actual bill.

Under CHIP, Medicare beneficiaries would continue to pay premiums, which will be similar in amount to what they are currently paying under part B. Medicare beneficiaries would have an annual per-person deductible of $100 on all covered services except for outpatient drugs for which there would be a separate $50 per-person deductible. Beneficiaries would pay 20 percent coinsurance on expenses above the deductible. However, unlike the current program, a beneficiary would have to face a maximum annual cost-sharing liability of only $750 per person and most would spend considerably less

since $750 in cost sharing would occur only after $3,350 in covered medical expenses. In addition, under CHIP the uniform cost-sharing charges will not bias an individual's decision to use inpatient or outpatient services and the coinsurance schedule will tie the Medicare beneficiary's cost sharing to actual services rendered and their actual price, unlike the present system.

Reduced Cost-Sharing Charges

As I indicated earlier, Medicare beneficiaries who are low income would be eligible for reduced cost-sharing charges. For example, aged persons with incomes below $1,750 would pay no premium or deductible charges, and would pay only a 10 percent coinsurance rate up to a maximum annual liability of 6 percent of income, or $105. Similarly, persons with incomes between $1,750 and $3,500 would pay no premium charges, and would pay reduced deductibles of $25 and $50 for drugs and other services, respectively, with a 15 percent coinsurance rate, up to a maximum liability of $315 per year.

We believe the concept of true catastrophic coverage and the maximum annual liability feature of our proposal, which provides protection against lengthy illness and a guarantee against catastrophic medical care costs, are not only a significant improvement over the present Medicare program's benefit package but a feature which has become an absolute necessity in any comprehensive health care financing system. We believe it will be a feature on which the elderly in particular will place a high value.

It is true that at a given time some Medicare beneficiaries under our proposed Medicare program could be faced with higher cost-sharing charges than they currently pay. This is due to the 20 percent coinsurance on all covered services under the revised Medicare program and is more than offset by broader benefit coverage and the maximum annual liability feature. Whereas the present Medicare inpatient coverage tends toward first-dollar coverage with limited benefits and open-ended cost sharing, the proposed Medicare program emphasizes uniform cost sharing on all types of benefits until a maximum annual liability is reached beyond which the beneficiary pays nothing more for covered services. The Federal cost of this increase in benefits for the aged will be $1.8 billion.

Catastrophic Protection Tradeoff

Thus, our proposed program provides somewhat smaller payments at the beginning of an illness, when expenses are budgetable, in exchange for expanded benefits and catastrophic protection when it is most needed. We consider this tradeoff to be not only desirable but essential for the guarantee of true protection against catastrophic illness.

I have several examples which will illustrate how the CHIP cost-sharing schedule would work. These examples do not take into account the out-of-pocket expenses elderly persons would experience if their physicians do not accept assignment of Medicare claims and are thus free to charge fees higher than those allowed by the carrier.

I should note that currently more than 50 percent of the Medicare beneficiaries are subject to these higher charges; moreover, the number of elderly persons in this situation is increasing. In addition, these examples also do not indicate eligibility for or assistance from Medicaid, which would absorb most—or all—of the cost for aged persons in income class I.

Now, these examples of various different kinds of cases.

The first one is where a patient would be hospitalized for 100 days, he would have $1,500 physician's expenses. His total bill would be $12,800. Under current Medicare cost, the out-of-pocket expense would be at least $1,782—would probably be more than that—because many providers do not accept assignment.

Under our program, if he is in low income, instead of $1,782 under the current system, he would have to pay $90. If he were in the second category, he would pay $270. If he were with an income of $5,000, he would pay $600—all compared with $1,782 for that kind of catastrophic illness he would have to pay.

Under a chronic condition, requiring drugs and physician's visits, which is our second example, an elderly person with a chronic condition requiring drugs, for a total bill of $700. Under the current Medicare, he would pay $604, at least, and more if his physician or providers charged him more, as more than half of them are doing now.

For short-term hospitalization, an elderly person hospitalized for 10 days for $120 a day, a total bill of $1,650, he would pay $222 under current Medicare, at the minimum, assuming his providers charged him no more than assignment and more than half of them do charge more than that.

If he were very low, under our plan, he would pay $90. If he were with an income of $3,000, he would pay $270 and if his income was $5,000, he would pay $410.

This is one of the examples in which cost sharing under our plan would bring him out to more than the minimum cost sharing of Medicare, but that is a minimum that we know can be exceeded. My fourth example is a situation in which an elderly person might have an illness which requires three physician visits, at $15 a visit, a short-term kind of thing. He would have to pay $45 under current Medicare. If he were in a low-income category under our program, he would pay only $4.50, and if his income goes up, he would have to pay $45. That $45 under Medicare might well be more because the providers could charge more than that.

[The material follows:]

EXAMPLES OF ELDERLY PERSONS UNDER FEDERAL HEALTH CARE INSURANCE AND MEDICARE[1]

1. CATASTROPHIC EXPENSE EXAMPLE

An elderly person who is hospitalized at $110 per day for 100 days, with $1,500 in physician expenses and $300 in outpatient drugs, and a total bill of $12,800, would have the following expenses under the present and proposed Medicare programs in fiscal year 1975:

[1] These examples do not indicate eligibility for or assistance available from Medicaid, which would absorb most (or all) of the cost for aged persons in income class I.

	Current Medicare	CHIP income class I[2]	II[3]	III[4]
Total expenses	$12,800	$12,800	$12,800	$12,800
Paid by insurance	11,018	12,710	12,530	12,200
Out-of-pocket[1]	1,782	90	270	600

[1] This may not be total out-of-pocket expenses because most providers participating in Medicare do not accept assignment.
[2] Income of $1,500.
[3] Income of $3,000.
[4] Income of $5,000.

2. CHRONIC CONDITION REQUIRING DRUGS AND PHYSICIAN VISIT EXAMPLE

An elderly person with a chronic condition requiring $10 of drugs per week ($520 per year) and a monthly physician visit at $15 per visit ($180 per year) with a total bill of $700 would pay the following amounts under CHIP and Medicare.

	Current Medicare	CHIP Income class I[2]	II[3]	III
Total expenses	$700	$700	$700	$700
Paid by insurance	96	630	531	440
Out-of-pocket[1]	604	70	169	260

[1] This may not be total out-of-pocket expenses because most providers participating in Medicare do not accept assignment.
[2] Income of $1,500.
[3] Income of $3,000.
[4] Income of $5,000.

3. SHORT-TERM HOSPITALIZATION EXAMPLE

An elderly person who is hospitalized for 10 days for a hernia repair at $120 per day with a physician bill of $450 and a total bill of $1,650 would pay in fiscal year 1975:

	Current Medicare	CHIP income class I[2]	II[3]	III[4]
Total expenses	$1,650	$1,650	$1,650	$1,650
Paid by insurance	1,428	1,560	1,380	1,240
Out-of-pocket[1]	222	90	270	410

[1] This may not be total out-of-pocket expenses because most providers participating in Medicare do not accept assignment.
[2] Income of $1,500.
[3] Income of $3,000.
[4] Income of $5,000.

4. NOT EXCEEDING DEDUCTIBLE EXAMPLE

An elderly person with three physician visits at $15 per visit, and total bill of $45 would pay in fiscal year 1975:

	Current Medicare	CHIP income class I[2]	II[3]	III[4]
Total expenses	$45	$45.00	$45	$45
Paid by insurance	0	40.50	0	0
Out-of-pocket[1]	45	4.50	45	45

[1] This may not be total out-of-pocket expenses because most providers participating in Medicare do not accept assignment.
[2] Income of $1,500.
[3] Income of $3,000.
[4] Income of $5,000.

(D) *Physician reimbursement.* Another aspect of the present Medicare program which is related to cost sharing is that of reimbursement to physicians. Under the present program a physician who does not accept an assignment of Medicare benefits is not required to accept the reasonable charge determination of reimbursement from the carriers as full reimbursement for services provided. The physician may bill the Medicare beneficiary an additional charge. This practice has resulted in Medicare beneficiaries paying higher out-of-pocket costs than they would have had to pay if the physician had accepted assignment. Medicare beneficiaries are, on the average, currently paying 15 percent more out-of-pocket for medical care when the physician refused to accept assignment. The percentage of physicians who will accept assignment now averages below 50 percent and is even below 30 percent in some States.

Our proposed Medicare program would remedy this situation by requiring all physicians who participate in the Medicare program to accept as full reimbursement for services provided to Medicare beneficiaries the amounts determined by each State as reasonable for the service rendered. The rates established by the States will be the basis for reimbursing providers; these rates would be based on amounts determined after consultation with providers and other interested parties. They will be based on reasonable cost and thus will not deter providers from participating in the program.

Second, an innovation of our proposal which we expect to be favorably received by both beneficiary and provider is the healthcard. Beneficiaries will use the healthcard to charge service, including deductible and coinsurance charges which they may repay to the carrier on an installment basis. Providers will be reimbursed directly by the carriers and all other bookkeeping will be handled through the carrier. This will sharply reduce billing and bad debt costs to providers and create an incentive for their participation as full participating providers.

Impact of CHIP on Medicare

I would now like to turn to a discussion of how our comprehensive health insurance proposal will impact on Medicaid.

In spite of its achievements in providing health care financing to over 4.5 million aged, we are all familiar with the shortcomings of the current Medicaid program.

One of the problems with the current Medicaid program is that it is available only to certain categories of persons and it can cover such persons even when they have reasonably high incomes; Medicaid is not available to persons with greater needs who are not in these arbitrary categories. A second problem is that eligibility and benefits vary greatly between States. This, too, is unfair and inequitable.

In designing CHIP we have looked at the totality of the low-income population's need for health care financing. We have attempted to get away from these concepts of categorical eligibility in our new program to achieve universality in coverage of the low income.

We believe that the loss of some benefits by some current Medicaid eligibles is inevitable in the process of removing the inequities and establishing uniform national entitlement and benefits. If we insisted on adopting a plan which assured that no current recipient was worse off under CHIP, we would build greater inequities, severe notches and other deficiencies into the new plan, and make it expensive beyond reason or need.

I would now like to discuss the impact of CHIP on Medicaid in more detail.

(A) *Eligibility.* The Medicaid program's primary weakness is that it simply does not provide medical assistance to all those who need it. Because Medicaid eligibility standards are, within statutory limits, determined by each State, Medicaid eligibility varies considerably from State to State. We are all familiar with the wide variations in income levels which States establish as eligibility factors. An aged person with only $2,000 in income would be eligible for Medicaid in some States but not in others. Although 33 States have spend-down provisions under their Medicaid program which enables any aged person to become Medicaid eligible only after his or her medical care expenses have brought his or her income and resources down to the level established by the State for Medicaid eligibility, in the other States, an aged person with income only slightly above the Medicaid eligibility level is ineligible for Medicaid no matter how great were his or her medical expenses; this phenomenon is one we are all familiar with as "the Medicaid notch." Most State plans also include asset tests which can force aged persons to sell most of their possessions in order to qualify for Medicaid.

Under CHIP, Medicaid as a health financing program for all but the long-term care needs of the poor will be terminated. Medicaid beneficiaries over 65 will generally receive basic coverage under the new Medicaid program as will most other elderly citizens. Most important, there will be uniform nationwide income standards which will provide equitable treatment of low-income aged persons. Thus, aged persons with similar incomes will receive identical benefits regardless of State of residence.

(B) *Benefits.* In addition to the wide variations in eligibility, and the fact that many of the elderly poor in all States remain ineligible, substantial inequities result from the differences among States in the types and scope of services covered. Seven broad areas of coverage are required by law to be provided: Inpatient hospital, outpatient hospital, other lab and X-ray, skilled nursing home, home health, and physician services—in addition to screening services for children and family planning services which do not affect the aged. However, States may exercise broad discretion in establishing the limits of coverage. Federal regulation requires that covered services "must be sufficient in amount, duration, and scope" to achieve the purpose of the program. Consequently, some States cover all necessary hospitalization while others severely limit coverage. For example, a State may have a limit of 10 days of hospital coverage per admission and as few as 12 physician visits per year.

UNLIMITED HOSPITAL CARE AND PHYSICIAN'S SERVICES

CHIP is designed to provide to all enrollees the same benefits. For current Medicaid beneficiaries this will result in gains of benefits in some areas and losses in others. Services which will be gained will include primarily the unlimited hospital care and physician's services.

(C) *Cost-sharing.* While the current Medicaid program has little formal cost sharing, significant real cost sharing can exist for many Medicaid eligibles because they in effect pay 100 percent coinsurance for medical care which is not covered by the State's Medicaid program. Under CHIP, Medicaid eligibles will be required to pay cost sharing; however, they will generally be eligible for the reduced cost sharing which is available to all low-income persons. We consider the cost-sharing schedules to be reasonable and not beyond the ability of low-income persons to pay. After all, when we refer to the cost-sharing charges for aged persons in the $1,750 income bracket we are talking about a 10 percent coinsurance share. If the charge for a physician's visit is $15, then we are in effect placing a $1.50 charge on the patient. We believe this is a reasonable and not excessive charge. In addition, we believe that the payment of cost-sharing charges as part of a reimbursement system based on reasonable cost will broaden access to health services by the poor.

Second, the purpose of the cost-sharing provisions is to remove first-dollar coverage and thereby create cost-consciousness on the part of the patient. Without the disincentives which cost sharing provides for utilization of medical care, a person may tend to overutilize health care services. If cost sharing is limited to outpatient services the provider may tend to institutionalize the patient.

I would also like to stress at this point that the use of the health-card will permit all persons to obtain needed medical care even if they are short of cash-on-hand at the time the service is needed.

Another point I would stress at this time is that the maximum annual liability limits established under our proposal will benefit the Medicaid population no less than the Medicare population. No longer will a person have to spend virtually all of his income and resources on medical care to become eligible for Medicaid. Under our proposal the maximum amount an aged person will have to spend on covered services in any 1 year is $750. This amount is much less if a person has a low income—$105 or less if income is below $1,750. This provision will provide much needed relief to the poor who are now in many States paying much more than this amount for needed medical care. In addition, the maximum liability feature will eliminate the Medicaid notch effect whereby in many States a person with $10 too much in income is ineligible for Medicaid no matter how much he has spent on medical care.

(D) *Provider reimbursement.* Another area in which the CHIP proposal is better than Medicaid is in assuring access to needed medical care. Medicaid programs frequently set low physician reimbursement schedules, thereby denying Medicaid eligibles financial

access to needed medical care on the same basis as middle income persons. In addition, States impose administrative barriers which can severely limit physician participation in the program. These include poor administrative practices which result in late payment of bills, and in requirements for preauthorization for specified services. These reimbursement schedules and administrative barriers result in a situation where in many areas too few doctors accept Medicaid patients and others keep the Medicaid portion of their practice within strict limits. This often results in Medicaid eligibles having noncoverage or second-class medical care.

Under CHIP, the problem of depressed fee schedules will no longer exist inasmuch as the State reimbursement rates established for Medicare, AHIP, and EHIP will be identical. These rates will be based on a reasonable level of reimbursement, so that the current situation where a State can pay as little as 50 percent—or less—of the usual and customary charges under its Medicaid program will cease. We expect in this manner to broaden access to services through an increase in the number of providers who participate in the program. Thus, more "real" services would be available under CHIP to persons who were Medicaid eligibles than are available under the current program.

Long-Term Care—Impact on Income

Because of the nature of long-term care and its impact on and close relation to a person's income, we are studying this need in relation to our efforts in welfare reform. We do not believe that a national health insurance program is the appropriate vehicle to finance long-term institutional care. As we all know, long-term institutional care necessarily includes a high proportion of social services and income support. Loading this type of care onto any national health insurance program would greatly increase the costs of that program. In addition, determining the appropriate utilization of long-term services is more difficult than for other services. For these reasons and because our comprehensive health insurance program is intended to provide active treatment in addition to protection against acute and catastrophic health expenses, we have not included more than the 100 days of skilled nursing facility care currently available under Medicare in our CHIP benefit package.

Pending resolution of this problem long-term care will be provided by a residual Medicaid program. This will operate under the same statutory provisions as govern the current Medicaid program. States would have the prerogative of determining eligibility standards, amount of benefits provided, and reimbursement to providers. The residual Medicaid program would provide the following services: (1) Services in a skilled nursing facility; (2) care in mental institutions for persons under age 21 and over age 65; (3) services in an intermediate care facility; and (4) home health services. All of these services would continue to be eligible for Federal matching funds at the current rate.

We realize that a continuation of the present Medicaid program on even a limited, residual basis is not an ideal solution to the needs of the aged for long-term institutional care. Nor do we see it as a

permanent solution. We have initiated a thorough analysis of alternative approaches to assisting low-income persons requiring long-term institutional care. Following the completion of this analysis and discussion we intend to develop any desirable legislative proposals on this subject to submit to Congress.

Mr. Chairman, the statement is lengthy because the subject is a comprehensive one and I wanted to speak to the charge that the benefits under our Medicare version of the Comprehensive Health Insurance Plan would not be less than at the present time. We believe they will be more and a measure of this increase is the fact we will be spending an additional $1.8 billion for the aged under CHIP.

I appreciate very much this opportunity to present this statement and my colleagues and I will be glad to answer your questions.

Senator MUSKIE. Thank you very much, Mr. Secretary. It is a very useful statement and I appreciate its comprehensive nature. You have given us a great deal of information to help us understand the thrust of your program and that is what we want to do.

I am reminded of the days that I used to do business as a young father with a number of life insurance agents trying to decide what company's policy to buy. Each salesman tried to persuade me that his policy was best. I learned what I had to try to do for myself was to understand the tradeoffs involved in each policy. When we understand what the tradeoffs are in national health insurance, we can judge better the nature of the choices, and judge which choices we think would be best.

So I am going to try to direct some questions at the outset to get an understanding of the tradeoffs.

UNLIMITED BENEFITS?

In your statement, I was a little troubled by your description of the three programs in the administration's proposal as providing unlimited inpatient hospital care, unlimited physicians' services, unlimited outpatient prescriptions.

Now, it is clear from your statement that there are limits so I wonder what you meant by the use of the adjective "unlimited"?

Secretary WEINBERGER. No, they are unlimited. There are costing and deductibles, but the benefits are unlimited. There is no number of days after which the benefits terminate and the physicians' services are unlimited.

This is not a program of "free health care" for everybody. It is a program that has cost sharing but many of the services that are covered are not limited.

Senator MUSKIE. That is the point that I wanted to illuminate in my question.

What you are saying is that the only limits to the financial assistance provided patients are imposed by cost-sharing devices of one kind or another?

Secretary WEINBERGER. And those are not even imposed after the catastrophic point is reached. Once that point is reached, all of the covered services are delivered without charge to the individual beneficiary.

Senator MUSKIE. For example, and I do not really want to get involved in just a play on words, but you emphasized throughout your presentation the value of maximum annual liability.

Now, that maximum annual liability is limited to the extent to which the patient's costs are reimbursed?

Secretary WEINBERGER. No, sir; that is the limit on the patient's requirement to pay coinsurance and deductibles. When that limit is reached, $750 for persons age 65 and over who are in the middle-income category, there is nothing further to pay. If his income is very low——

Senator MUSKIE. But he does pay that $750?

Secretary WEINBERGER. Yes. If he is in the middle-income category.

Senator MUSKIE. So his reimbursement is not unlimited; the assumption of the cost of his care by the program is not unlimited?

Secretary WEINBERGER. Well, the program, as we have said many times, is not a program in which the services are purported to be provided free, but paid for by huge taxation increases.

This is a program under which the individual will have to pay some of the costs. There will be some cost sharing, there would have to be some payment of premiums.

After the maximum specified in the program—which varies with age and with income—is reached, all of the covered services are then furnished completely without further payment by the enrollee as part of the insurance coverage. There is no limit on the number of days of hospitalization services; there is no limit on the number of medical services or visits; there is no limit on the prescription drugs that are furnished.

There are payments required for these. There are maximum points at which the payments are cut off and that is what we call the maximum annual liability or the catastrophic feature.

Senator MUSKIE. I understand; but if there are limits on his ability to assume the cost-sharing obligations, then, to that extent, there are limits on his ability to take advantage of the services.

Secretary WEINBERGER. There are limits on various people's ability to pay for various things in the total economy.

Senator MUSKIE. I am talking about this program.

CUTOFF POINTS FOR THE VERY LOW INCOME

Secretary WEINBERGER. But this program has two or three features in it which can insure that there will be, I think, an ability to pay, even for the lowest income, because we are talking about very low payments required for the very low-income categories, and we are talking about the cutoff points for the very low income—for example, of $105—when everything else would be covered. We are also talking about a big system under which each of those payments can be spread over a large number of months, so that, if the ability to pay, even those low amounts, is limited by various factors, there would be a pickup in it, in the ability over a length of time.

We have to recognize the deficiencies of the current system. Under the current system, there are no benefits at all available after a

certain time for many people and there are requirements that people exhaust all of the excess income and assets before they get any benefits. Neither of those undesirable features is part of our program.

Senator MUSKIE. You do not recognize, then, that there may be limits upon the ability of patients to assume the cost-sharing obligation?

Secretary WEINBERGER. I recognize that there may be limits but we believe we have recognized those limits and made provisions for them and scaled them down to the point where they are within the ability of the various incomes—starting at the lowest income groups—to handle. If there is difficulty even with that, the payments can be spread over a number of months or a number of years, if the patient wishes to do so.

Senator MUSKIE. The second point that you seem to emphasize in your perception of the value of the program is that you traded off something in the way of assumption of a short-term cost for an assumption of catastrophic cost of illness.

Secretary WEINBERGER. There is a somewhat higher cost sharing on short-term cost under our program than is the theoretical case under the present Medicare program. I say theoretical because the present Medicare program costs cannot be accurately estimated when over half of the providers have the opportunity to charge more than the assignment schedule and do. You cannot really get a completely fair comparison, but I think it is proper to say that in short-term hospitalization cases, there may be a somewhat higher cost sharing required under our program.

In return for that, there are a great many other benefits, including much more extensive coverage of such benefits as drugs and mental illness and a number of other benefits, including the catastrophic feature and the ability to charge and defer payments.

Senator MUSKIE. It is understandable, Mr. Secretary, that you have described a positive aspect of your program. I would like to throw a little light on the other side of that tradeoff, if I could.

Secretary WEINBERGER. It is fair to say to you, Mr. Chairman, I am prejudiced in favor of this program. We have spent a lot of time developing it and we do believe it is the most comprehensive and the most beneficial for people of all ages in the country, of any that has been developed, so if I sound like a partisan in favor of it, that is because I am.

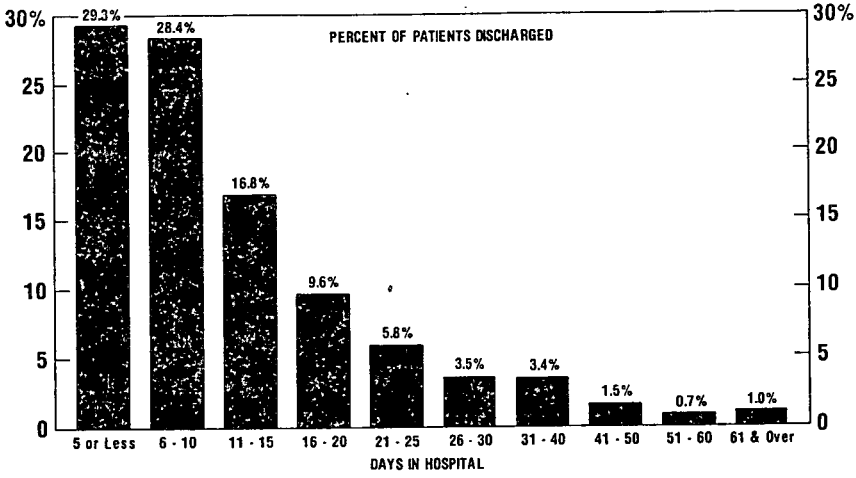
Senator MUSKIE. I do not criticize you for that. You are up here to sell the program, and I expect you to do so, but I would like you to throw a little illumination on some of the other aspects of it.

I have on the stand here several charts prepared by the staff of the subcommittee, and I think the staff has distributed copies to you.

I would like you to look at chart 5, if you would. This chart is based on data from the Social Security Administration. It undertakes to analyze the length of stay of Medicare hospital patients, as revealed by the 1971 statistics. I assume those data are the latest ones available to the Social Security Administration because we asked for the latest ones.

CHART 5.

LENGTH OF STAY OF MEDICARE HOSPITAL PATIENTS, 1971



Source: Social Security Administration

Now, this chart shows that 99 percent of the hospital days accumulated by Medicare hospital patients were for less than 60 days; that only 1 percent were for stays longer than 60 days. Do the Social Security people question this chart at all or its relevance?

Secretary WEINBERGER. No, I think they prepared it.

Senator MUSKIE. I think that was my impression but I can never be sure and I'd like to nail it down.

As I understand, you use the average hospital stay for Medicare patients, which is about 12 days. Is that an accurate conclusion?

Secretary WEINBERGER. Yes, that is accurate. We might make a stipulation about the source of the data. The Social Security Administration complied and published the data about hospitalization, medical care, and medical costs, and we have looked at these particular copies that you gave us this morning and they clearly are derived from those sources.

Senator MUSKIE. Then, I wonder if you would look at chart 4. Now, this is based upon the theoretical $110 hospital charge per day. I guess that is not just theoretical; that is about what the average hospital charge per day is.

Secretary WEINBERGER. That is getting to be a bargain, Mr. Chairman.

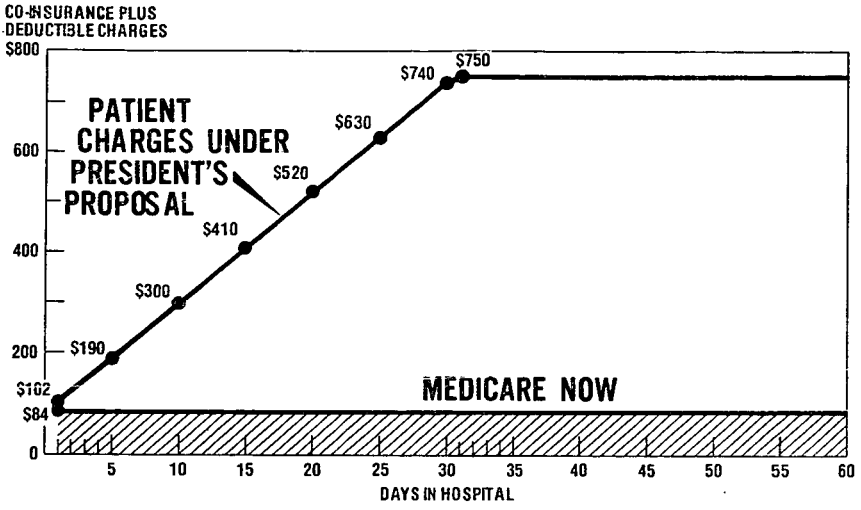
Senator MUSKIE. Let us use that figure for the purpose of comparison. In my testimony yesterday, I posed a hypothetical situation and I would like to have you tell me whether or not that is a realistic picture of some of the consequences of your proposal.

Looking at chart 4, Medicare now poses a deductible $84 but no insurance charges until after 60 days of hospitalization. Now, this is shown by the straight line of $84 at the bottom of the chart.

CHART 4.

PRESIDENT'S PROPOSAL INCREASES HOSPITAL COSTS FOR MEDICARE PATIENTS

BASED ON $110 HOSPITAL CHARGES PER DAY



Secretary WEINBERGER. Mr. Chairman, you appreciate the fact that Medicare patients do pay a premium? They have to pay something to get Medicare.

Senator MUSKIE. Yes; under the President's proposal, there would be a $100 deductible and 20 percent insurance charge after the deductible is satisfied, beginning on the very first day. Thus, in our illustration, there would be a charge of $102 for the first day, $22 for each succeeding day, until the maximum charge of $750 is reached and that maximum would be reached on the 31st day—which is beyond the 12-day average of most Medicare patients.

Secretary WEINBERGER. It is also quite an untypical case, Mr. Chairman, because it assumes there are no physician charges; it assumes there are no drug charges; it assumes there is nothing else in there but just plain hospitalization and I have never seen a case like that.

Senator MUSKIE. Let me proceed.

Secretary WEINBERGER. Yes, sir.

Senator MUSKIE. For the 12 days we are talking about an average, it would cost $344 under the President's proposal, compared to the present charge of $84. Is not that so?

Secretary WEINBERGER. You have got to have an idea of the income of the person who is involved because our program has income related cost sharing and if in the sample we cited in our statement——

Senator MUSKIE. This illustration is on the $5,000 income?

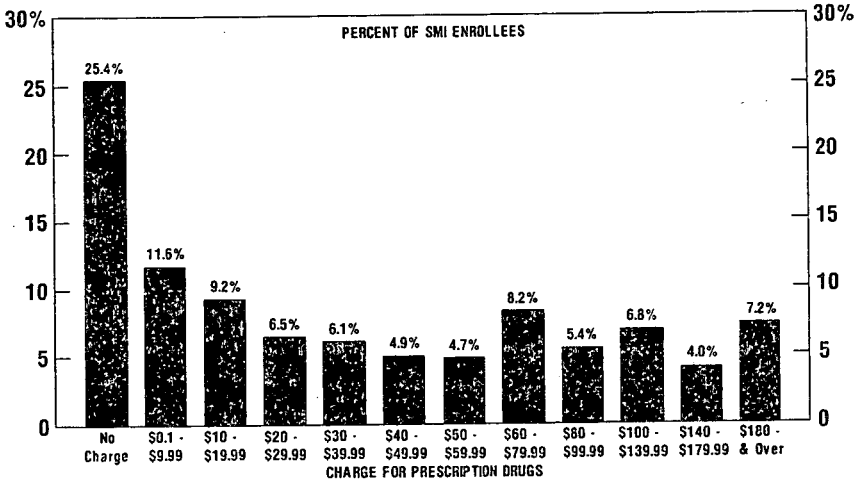
Secretary WEINBERGER. Under the illustration cited in our statement, where an elderly person is hospitalized for 10 days, he has a

total bill of $1,650, of which the physician's bill is $450. Under current Medicare, he would have to pay $222 and under our program, if he is in the lowest levels of income, he would pay only $90.

If he was in an income category of about $3,000, he would pay $270 and he would pay $410 if he had an income of $5,000. On the other hand, the $222 out-of-pocket cost for Medicare is something less than realistic, because over half the doctors treating Medicare patients are free to charge more than that and might very well do so, and so you can have a comparison based on the highly odd case of a person who only goes to the hospital and has no other charges or you can have a comparison based on a normal situation in which there are drug bills and physician bills and then you have to know his income to get a proper comparison under our program.

CHART 6.

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



*Supplementary Medical Insurance — Part B Medicare

Source: Social Security Administration

Senator MUSKIE. Now, I would like you to look at chart 6. I would like to ask whether or not this chart is an accurate description; I assume it is because, there again, it is based on data from the Social Security Administration.

Secretary WEINBERGER. Mr. Chairman, again, we tried to establish some understanding of what is meant by "annual average charge," and I assume this means all drug charges and not just drugs for chronic care.

Senator MUSKIE. I understand so. What I was told this chart represents is this: About 25 percent had no charges for prescription drugs, while a total of almost 40 percent had drug costs—that is prescription drug costs—of less than $50. And another 18.3 percent

had charges of between $50 and $100, so less than half of their drug costs would be covered. I simply want to know whether that is an accurate description of the distribution of drug costs and the impact of the administration's $50 deductible approach.

Secretary WEINBERGER. To me, the chart displays experience in drug charges for Medicare patients, up until this time. It does not provide, in its raw form, any effective information about how the administration's drug coverage would be applied except that you have established that there is a cutoff point at which the deductible would cover the full charge. That is the way I read it.

Senator MUSKIE. So the question is the extent to which charges under the administration's proposal in the future would rise above the $50 deductible.

Is there any basis on the experience up to now to make a projection, other than this?

Secretary WEINBERGER. I am not certain I understand the question, Mr. Chairman.

Senator MUSKIE. I assume that inflation, you know, would take some of these charges above the $50 deductible. But beyond that, is there any reason to believe that this distribution of 1971 was an elaboration or——

Secretary WEINBERGER. No, I do not think so. As I read it—if I could add up the figures very quickly—about 35 percent of the cases would involve charges, where once the deductible was met, the individual would receive a benefit that he does not now receive under Medicare.

On the other hand, this is a 1971 set of figures, Mr. Chairman, and we are talking about a bill that will be in effect, we hope, by 1976 so there will be some movement of those bars back and forth. I would think, given the kind of inflation in drug prices that we have been talking about—though I would hope our new drug policy would reduce that inflation somewhat—that close to 50 percent of the people requiring drugs would be getting a benefit who do not have it and would not have it under the existing Medicare and Medicaid programs.

Senator MUSKIE. Without a question, you are providing benefits that are not now available.

Secretary WEINBERGER. The point of this chart is that some people would not benefit and, unfortunately, some people would have to pay the $50, but that is the point of insurance; it covers you against unexpected illnesses that may or may not happen to you and some people may not get to use all of the benefits. I would think they would be happier than those who did get to use all of the benefits.

Senator MUSKIE. I understand but let me make this point first. This information is the latest that we are able to get from the Administration. I do not criticize you for that. If we had 1972 figures, I would be delighted to have them but 1971 is the best we have got.

Second, what we are talking about here in this subcommittee is the aged; and most of them do not have supplementary income—they have to depend on their Social Security payments to pay for even these drug costs. We are trying to analyze the extent to which this pro-

gram represents meaningful relief to them and I am not passing judgment on that point. I am simply trying to get the reaction of your experts to the data that we have and its relevance.

Secretary WEINBERGER. As far as we know, the data itself is accurate and the way we read it would be that somewhere between a third and a half of these people who require this particular service would get a benefit that they do not now have. In other words, 100 percent of the people do not get this benefit now and somewhere between a third and I would guess a half would get it under our plan.

That is essentially what the chart means to me. Here again, the point is—if you want to analyze it—that the benefit is literally designed to accrue the greatest advantage to those who have long term and continuing drug costs, high drug costs, and it is consistent with other aspects of the plan.

DEDUCTIBLE REDUCED FOR VERY LOW-INCOME PERSONS

On the other hand, the deductible is reduced for persons of very low income, recognizing the income factor. So that would bring a few more bars into play here as to people who would benefit and on that basis, I would raise that estimate but, essentially, the chart shows that a great many people who currently get no benefit at all would get a benefit under the proposal we have set forth.

Those who do not need drugs would be getting a potential benefit for a year when they might use them.

Senator MUSKIE. Did I understand you to say this deductible does not apply?

Secretary WEINBERGER. It is reduced sharply. It is not $50 for the poor.

Senator MUSKIE. But how much?

Commissioner CARDWELL. For persons with incomes of $1,750 a year or less, it drops to zero.

Secretary WEINBERGER. Below $1,750 they pay no premium or deductible, so it would not be $50 for everybody.

Senator MUSKIE. Could you give us, incidentally, any data on the number of persons represented in each of these income groups?

Now, as I understand it, the first group is from zero to $1,749. The second, $1,750 to $3,499; the third, $3,500 to $5,249; the fourth, $5,250 to $6,999. Are those the four groups?

Secretary WEINBERGER. And the fifth group, $7,000 and above.

Senator MUSKIE. Do you have any data on how many, among the elderly especially, fall into each of those income groups?

Secretary WEINBERGER. We can certainly get it. I would assume the Treasury Department would have it. We do not have it with us this morning but we can get it.*

Senator MUSKIE. Now, with respect to the first group, the maximum liability is 6 percent of income?

Secretary WEINBERGER. Yes, but no deductible for drugs and no other deductible, no contribution and coinsurance is 10 percent with a maximum liability of 6 percent of the income.

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*See table, p. 907.

Ten percent—that means if you have a $15 office visit for a doctor, the patient would pay $1.50 and he would pay that up to the point where he reached $105 which would be 6 percent of his income.

Senator MUSKIE. Well, I have that table here and without objection, I will include that table in the record at this point.

[The table referred to follows:]

COST-SHARING FOR MEDICARE BENEFICIARIES UNDER COMPREHENSIVE HEALTH INSURANCE PLAN (PER PERSON)

Annual income (single person)	Premium	Deductible		Coinsurance (percent)	Maximum liability (exclusive of premium)
		Drugs	Other		
I. 0 to $1,749	$0	$0	$0	10	6 percent of income (to $105).
II. $1,750 to $3,499	0	25	50	15	9 percent of income (to $315).
III. $3,500 to $5,249	[1] 90	50	100	20	12 percent of income (to $630).
IV. $5,250 to $6,999	90	50	100	20	$750.
V. $7,000 plus	90	50	100	20	$750.

[1] Estimated by Administration.

Secretary WEINBERGER. Thank you, sir. That will be good.

Senator MUSKIE. That would be most useful to us. I yield to Senator Mondale.

Senator MONDALE. I would just move that the other appropriate tables be placed in the record also.

Senator MUSKIE. They were put in yesterday.*

Senator MONDALE. Fine. Mr. Secretary, I would like to ask whether my figures are correct here.

Assume a hospitalized illness costing $500—as I understand the administration's plan—you would pay $150 in deductibles, $70 in coinsurance, and $90 in premiums, for $310?

Secretary WEINBERGER. What income level is this person you are talking about?

Senator MONDALE. $5,000. The same person under Medicare, as I understand it, would pay $84 in deductibles, zero in coinsurance and $75 in premiums, if you have part B insurance.

Thus, under the administration's bill, they would pay $310; under Medicare, they would pay $159. Am I correct in that?

Secretary WEINBERGER. I think——

Commissioner CARDWELL. I think you would have to stipulate that under Medicare, as it stands now, the hospital costs would have to be incurred within one benefit period in order to derive the $159 cost-sharing amount.

Senator MONDALE. Yes, I appreciate that.

Secretary WEINBERGER. This is really a hypothetical case because this man has no drug charges and no physician charges.

Senator MONDALE. If he is in the hospital, under Medicare, his drugs are covered, are they not?

Commissioner CARDWELL. Yes, however, in your example, the deductible would be $100 and the coinsurance would be $80.

Secretary WEINBERGER. That is right.

Senator MONDALE. Let's take another example. Consider hospitalization costing $1,000. As I understand it, under the administration's

*See charts 4, 5, and 6, pp. 902–904; see also part 8, "Barriers to Health Care for Older Americans" charts 1–7, pp. 681–683.

bill, there would be $150 in deductibles, $170 in coinsurance, $90 in premiums, for $410.

Under Medicare, it would be $84 in deductibles, zero in coinsurance, and $75 in premiums. Is that accurate?

Commissioner CARDWELL. Could I have that again?

Senator MONDALE. Hospitalization costing $1,000. The administration proposal, as I understand it, would cost $150 in deductibles, $170 in coinsurance, and $90 in premiums, for a total of $410.

Under Medicare, it would be $84 in deductibles, zero in coinsurance, $75 in part B premiums, for $159. Is that accurate?

HOSPITAL PER DIEM COSTS

Commissioner CARDWELL. I was going to speak to two points. One is that the deductible for the Medicare beneficiary would be $100 under CHIP, if he is in the $5,000 income range, as opposed to $84 under present Medicare law. Also, the $84 represents the current level of hospital per diem costs.

Senator MONDALE. At the current level?

Commissioner CARDWELL. Your case hypothesizes that the $84 figure will not change between now and 1976, where in fact, it may.

Senator MONDALE. Let's just talk about if it were in fact now, because if we do not do that, all you have to do is change regulations and make Medicare look worse.

Commissioner CARDWELL. It would be $84 versus $100.

Senator MONDALE. Let me go over the figures and see where I am wrong. Under the administration bill, it would be $150 in deductibles?

Commissioner CARDWELL. $100, sir.

Senator MONDALE. Would there be a $50——

Secretary WEINBERGER. $50 in drug deductibles.

Senator MONDALE. Would the $50 drug deductible apply to hospital drugs?

Commissioner CARDWELL. No, it does not.

Senator MONDALE. So that would be $100. All right, so it would be $100 deductible; $170 in coinsurance, $90 in premiums for the administration's plan. $84 in deductible, zero in coinsurance, $75 for premium for Medicare, so it would be $360 versus $159. Am I right in that?

Commissioner CARDWELL. I believe so, except that the coinsurance would be $180.

Secretary WEINBERGER. Again, there is the strange patient who does not need the doctor while he is hospitalized. That is a problem you simply cannot ignore because it is the problem people face when they are in hospitals. The coverage we have would probably pay a higher proportion of the physician's charge than Medicare now pays.

Senator MONDALE. Does not part B cover it?

Secretary WEINBERGER. It covers it but it does not recognize the physician's full charge for services in more than half the cases.

Senator MONDALE. Let me just get into these costs, and then we will get into that question.

Secretary WEINBERGER. It is not really realistic or in any sense practical to try to separate out just hospital costs.

Senator MONDALE. Let's recognize many patients will have to pay out over the Medicare premiums. Let's take a $3,000 hospital bill.

As I understand the administration's plan, it would be $100 in deductibles, $75 in coinsurance, $90 in premiums. Under Medicare, it is $84 in deductibles, zero in coinsurance, and $75 in premiums. Would that be correct?

Commissioner CARDWELL. No; there would be coinsurance of $580.

Secretary WEINBERGER. But the administration's proposal covers everything else. By that time, you would almost have reached your maximum liability, so that everything else would be covered and you are not just paying your hospital bill when you use these amounts of care you are speaking of, Senator. You are paying for all of the other covered and when you reach that $750 point, or less, if the income is less, everything else is covered in full, so you are paying a great deal more than paying just the hospital bill.

Senator MONDALE. That same point you made the minute before—that they may be paying more for doctor's fees.

Secretary WEINBERGER. You normally do not get a person who goes into a hospital for $1,000 worth of hospital charges who does not have a great deal of other charges.

My point is you cannot isolate the hospital charges and say they cost more under Medicare than they would under our proposal because our proposal pays for a portion of the hospital charges and everything else when you reach that maximum liability figure.

Senator MONDALE. We will return to that argument. I just want to be sure my figures are correct.

Commissioner CARDWELL. Did you finish that example, though? Did you also equate the cost in terms of what one would pay out of pocket under both circumstances? If you did, I did not hear it.

Senator MONDALE. You mean over and above?

OUT-OF-POCKET COINSURANCE AND PREMIUMS

Commissioner CARDWELL. On the $3,000 bill—how much did you indicate that the individual would pay out of pocket in the form of coinsurance and premiums under the comprehensive health plan?

Senator MONDALE. $760, and under Medicare, $159.

Commissioner CARDWELL. It seems to me if you are going to charge the premium on an annual basis, there would be $680—for the coinsurance and deductible—plus $90 (for the premium).

Senator MONDALE. $840. All right. So, $750 is it?

Commissioner CARDWELL. $770, which is the total of cost sharing charges, in addition to the premium.

Senator MONDALE. Consider a $500 medical bill without hospitalization. As I understand it, the cost of the administration bill would be $310. The cost to Medicare would be $60 in deductibles, $88 in coinsurance, $75 in premiums, or $223.

Secretary WEINBERGER. Can you run that through again?

Senator MONDALE. The $500 medical bill without hospitalization would be $310. Under the administration's bill, it would cost $323; under Medicare, part B, as follows; $60 in deductibles, $88 coinsurance, and $75 in premiums. Is that correct?

Commissioner CARDWELL. No; there would be a total $180 under the administration's bill—in addition to $90 in premiums.

Senator MUSKIE. Plus the cost of out-of-hospital drugs?

Secretary WEINBERGER. Plus the cost of drugs and you have to assume this is one of the doctors under Medicare who will take an assignment and not one of the majority of doctors who can charge more.

Senator MONDALE. That is the point you made a minute ago.

Secretary WEINBERGER. Yes.

Senator MONDALE. So, based on my hypothetical case, in the first instance, the person who is sick pays $151 more under the administration's bill; in the second he pays $200 more; in the third, he pays $600 more; and in the last hypothetical case $90 more. Is that correct?

Secretary WEINBERGER. No. Our figures for these examples are $111, $211, $611, and $55. And, again, we have to put those various qualifiers in because I think they are important. I think your hypotheticals are indeed hypotheticals. They are atypical cases.

Senator MONDALE. These are bills they would have to pay. Would the patient be able to say: "This bill is hypothetical; I do not have to pay it"?

Secretary WEINBERGER. He would not be presented a bill of that kind, Senator, is what I am trying to say. You do not go to a hospital without requiring a doctor; you cannot get into a hospital without having a doctor. In the normal bill, you have a great many other charges.

Senator MONDALE. I am talking about the premiums under part B which assumes coverage. Your point is they may charge more. I am trying to talk about this hypothetical and then I will get back to your point.

Secretary WEINBERGER. What you have cited is a case that is a very rare occurrence. That is the point we are trying to make—with the hospitalization, where physician's services are not required and where your whole charge under your hypothetical is doctor only, with no drugs—these are rare occurrences.

Senator MONDALE. You mean to say a $1,000 hospital bill is very rare?

Secretary WEINBERGER. I am speaking about the one you described a moment ago, the one in which no hospitalization is required, and only doctor's visits are involved. Under that kind of circumstances, in most cases, the administration's plan is superior, because it covers these charges and covers the drugs that are normally associated with that kind of a charge which would not be covered by a nonhospitalized patient under Medicare.

Senator MONDALE. Well, I just cannot agree, Mr. Secretary, that a $500 hospital bill is unusual or a $1,000 hospital bill is unusual. I think it happens all the time.

Secretary WEINBERGER. I agree it happens all the time, but not as indicated in your examples.

Senator MONDALE. The question is whether under the administration bill or under Medicare, a person over 65 is better off, under one or the other, and, as I understand your answers to my hypothetical example the answer is they are better off under Medicare.

Commissioner CARDWELL. I think he is trying to say that these examples in terms of the total amounts are recognizable, people actually do incur $1,000 hospital bills.

Senator MONDALE. All the time.

Commissioner CARDWELL. All the time, but people do not incur a $500 annual bill for outpatient visits to physicians as a rule, without also incurring drug charges. One does not incur a flat hospital charge without incurring physicians' charges. I think that is what he is trying to say.

Secretary WEINBERGER. Posthospital treatment and a whole array of charges would be more typical of your example.

FIXED REIMBURSEMENT SCHEDULE

Senator MONDALE. All right. Well, let's look at it then, how you deal with the problems of charges of doctors in excess of fixed schedule. Under Medicare, doctors are permitted to take the payments under the reimbursement schedule and charge more—that is the Secretary's point. As I understand the administration bill, your answer is to simply say, first of all, the States will set the reimbursement and then we will prohibit the doctors from charging in excess of the Government rate for the elderly and those in the Government plan for the poor. Is that correct?

Secretary WEINBERGER. They would be required to follow on that schedule.

Senator MONDALE. But in terms of the employer plans, those covered under employer plans, they could exceed the charges, is that correct?

Secretary WEINBERGER. They could if they wished to assume all of the costs of billing and collections and administration of that kind, of working in their offices.

Senator MONDALE. Something they freely do under Medicare today.

Secretary WEINBERGER. Which they could avoid if they elect to choose the healthcard system and get away from all collections, all bad debts, and all billing and all administration costs which would be transferred to the carrier and which would be a tremendous savings, certainly to hospitals and, to a very considerable extent, to doctors.

Senator MONDALE. Do you fear that a doctor who is told that persons who are over 65 or persons who are poor would be limited by specific reimbursement charges would limit his practice to others?

Do you think this would create an economic situation where doctors would be reluctant to care for the elderly or, if they do, will give what you might call the once-over quick service?

Secretary WEINBERGER. There are two problems with your assumption, Senator. The first is that the only people in the group with whom he would be prohibited from charging more than the reimbursement schedules are elderly. That is not true.

There would be a very substantial mix of people in this group. It would be the group in the assisted plan who might be young and in a very high risk——

Senator MONDALE. Poor—I said that.

Secretary WEINBERGER. And who might be young, in a very high risk industry and not poor. There would be some who would be of low income, some who would be elderly, some who would be part-time workers, but the point is you also are overlooking the advantage to a doctor in using this particular system. The bad debt problems in doctors' offices, particularly in hospitals, the problems of collection, the problems of billing, of deferred payments—a provider would be completely free of all of those problems if he took advantage of the transfer of those functions to the carrier, which he would be able to do under CHIP.

A CHARGE IN ADDITION TO MEDICARE

Senator MONDALE. Well, let's suppose under these reimbursement schedules, the amount paid for the care of those who are elderly was less than the doctor could earn caring for other patients where there is no selecting. Now, the way that is handled today under the Medicare formula is that they add a charge in addition to Medicare.

Secretary WEINBERGER. Yes.

Senator MONDALE. Now, is it your theory that the doctors are so wedded to the hippocratic oath that they will nevertheless care for them or are there economic interests?

Secretary WEINBERGER. I am mindful that before Medicare came in, a great many doctors provided that service to low income category at no charge and when a lot of people speak of doctors having gotten a great bonanza from Medicare, what they mean is doctors are now being paid for work they did free for a great many people.

I am also mindful of the fact that there are some 70 million Americans in this general market who will be served under the two plans we are talking about, the Medicare and the assisted plan. I would be very surprised if many providers, assuming they are aware of the financial advantages of all of these things, would ignore a market of that size, so I think you are talking about a much larger group of people and you are talking about doctors who would be delighted and, certainly, many hospitals that would be delighted to get rid of all of the bad debt problem, all of the collection problems, all of the payments they never do get at all, and turn that whole thing over to an insurance company which would guarantee them payment at a reimbursement schedule that I hope would be reasonable and fair.

Senator MONDALE. So it is your assumption, in this bill, even though doctors under reimbursement formulas may make less caring for the elderly than they could caring for others, they would nevertheless do so. Is it because, historically, they often cared for people without charge or is it that they would get their bills paid?

Secretary WEINBERGER. Senator, your basic assumption that they make less caring for the poor is what I am trying to challenge here.

Senator MONDALE. They cannot charge more than the formula?

Secretary WEINBERGER. They can charge more but they have very much higher collection costs. You do not seem to have heard anything I have said about the amount of loss.

Senator MONDALE. I just said if they do not have any bad debts.

Secretary WEINBERGER. You were not listening to what I said. They would have bad debts.

Senator MONDALE. So you think it is bad debts that make the difference?

Secretary WEINBERGER. I think it is the collection costs; it is having people who have to keep accounts. I think the assumption that physicians would make more money simply because they would like to be able to charge more and have with it all of these administrative costs is a wrong assumption.

Senator MONDALE. I believe in free enterprise. I think people go where the money is, generally speaking. I think doctors are people and I think our experience under Medicare is precisely that. To tell a doctor, yes, you are going to make less if you take care of old people in terms of what you get paid but you will have fewer bad debts, is a very thin argument.

Secretary WEINBERGER. I think most doctors are like the rest of us and are more interested in the net and I would not be particularly interested if I were a doctor or a practicing attorney, again, in how much gross I had on my books. I would like to know what the net was and the net consists of the amount you save from a lot of these charges you do not have to do yourself and that, in effect, is what we are talking about.

"REASONABLE REIMBURSEMENT SCHEDULE"

It is speculative, to some extent, you are guessing and, to some extent, I will be guessing, but I think if you have a system under which a doctor does not have to be concerned in his office with any billing charges, with any collection charges, with any bad debts problems or anything he can not collect, he might very well decide he would use a reasonable reimbursement schedule and turn all of this business over to the carrier to do for him, when he is taking care of low-income or high-risk or of employed people. We do not know but that seems to me to be a very reasonable assumption and so, I do not think you can say he can make more taking care of employed people because he can charge more for them.

You have to look at the net and the net, I think, would bring it down to the point where it would be a substantial inducement for him to use that kind of system.

Senator MUSKIE. Suppose a State sets a reimbursement schedule for a certain type of health treatment of $100 and the doctors traditionally charge $200.

Why would that doctor say, "Oh, my bill will be paid, therefore, I will spend a lot of my time with people to which that kind of ceiling applies".

Secretary WEINBERGER. We have to look at it—at the overall charges. Losses due to bad debts occur in doctors' offices but I would suspect a reimbursement schedule for $100 for a service normally and usually performed for $200 would not be a reimbursable schedule that would be in effect.

Senator MONDALE. So you think doctors would be looking for the patients who could be charged less over those who could be charged more on the grounds that they would not have as many bad debts?

Secretary WEINBERGER. No, sir; what I am saying is that I believe the inducements that are offered to use the reimbursement schedule

would outweigh a physician's motivation to charge prices at a higher rate.

Senator MONDALE. We do not know what the reimbursement schedule is?

Secretary WEINBERGER. No, we do not.

Senator MONDALE. How can you make that statement?

Secretary WEINBERGER. In the same way you can make the statement that a doctor would automatically choose a high income person even though he runs the risk of bad debts.

What I am saying is that removal of this kind of nonmedical work would result in a great many doctors not paying too much attention to whether a person was covered under this plan or that plan, or the other plan.

He would know his advantages, which are that he would be reimbursed without any administrative overhead or risk of loss on his part.

Dr. SIMMONS. I think you have got to remember that every physician lives out in a real world and you are talking about one-third of the Nation's population, covered under these two categories, Medicare and the assisted plan. You really cannot, realistically, ignore them and say you are not going to care for that segment of your community because those people are living with you; there is an ethic to the profession and I do not think that would happen.

It all depends on what is a fair reimbursement rate set by the State and that is something neither you nor I can predict.

Senator MONDALE. Not under this bill; we do not have the slightest idea.

ECONOMIC INCENTIVES

Senator MUSKIE. One of the problems is we are taking a pig in a poke. You are asking the people to believe that the doctors are not motivated by economics. I do not think they are going to accept that, and I do not either.

Secretary WEINBERGER. Senator, you have no bill before you which says an appendectomy charge can only be so much. There is no bill that sets reimbursement.

Senator MUSKIE. We have a bill that does not say anything on that point.

Secretary WEINBERGER. We have a bill that does say something. It requires a reimbursement schedule to be adopted or the various plans do not come into operation at all.

Senator MONDALE. And the higher the reimbursement rates, the higher the premiums?

Secretary WEINBERGER. You have a situation now contrary to the one Senator Muskie faced, when he was speaking of his earlier days, when you had all of these different kinds of policies offered to you, you have now a situation in which insurance companies will all be writing substantially the same policies and I believe very firmly that with the numbers of people involved and the competition involved, you would get your premium costs down considerably under the $600.

Senator MONDALE. I have taken more than my time. I would like to place in the record an article appearing in this morning's paper.

Senator MUSKIE. Without objection, the article* will be included.

Commissioner CARDWELL. In response to Senator Mondale's comments, I think if you do examine this issue, strictly in terms of economic incentives, his starting point is a very valid one: the experience in Medicare and Medicaid shows that economic incentives alone, when directed at an isolated group, are not sufficient to insure that the group will receive adequate care at a reasonable price.

In other words, the physician has, in many cases, been attracted to the source of the greatest dollar. But there is a combination in this proposal—the reimbursement schedules which would be established by the States and the arrangements concerning who will participate and who will not participate.

The practicing physician is given the choice of not participating but he will have to think twice when he looks at the total U.S. population staring him in the face; he no longer can look at just the aged as an isolated group.

If he decides not to participate, he is cutting himself off from the vast majority of workers, young people, old people, high risk, and that is where the economic incentives we believe will change if you just examine them in economic terms. I would suggest that you look at those two things together and not just the reimbursement issue by itself.

Senator MUSKIE. Thank you. I am glad to get that answer. I was going to put the question; it is good to get the answer before we put the question.

Senator Stafford, I yield at this point.

Senator STAFFORD. Thank you, Mr. Chairman. I am sorry another commitment kept me from hearing most of the Secretary's statement this morning. I have been trying to read it as the hearing has progressed.

It happens, Mr. Secretary, that this morning, I received a lengthy letter of inquiry from the Medical Center Hospital in Vermont on the particular matter and I think I would like to ask for your comments on a couple of rather narrow issues here so that I can respond to the inquiry I have received.

CHRONIC DISEASE TREATMENT

These have to do with interim regulations published by the Social Security Administration under Public Law 92–603, dealing with chronic disease treatment. I would appreciate your comment on the regulations and maybe your comments on what CHIP might do in connection with it.

The Medical Center contends that charge ceilings based on all dialyses performed in any institution is too low in all of those institutions that will provide permanent institutional dialysis.

Mr. Secretary, I invite your comment on this and what the situation might be under the CHIP program?

*See appendix 3, item 1, p. 984.

Secretary WEINBERGER. Senator, we have published the preliminary regulations and we are gathering comments on them now in preparation for the final regulations.

This is a new field, this is the first program in which everyone with a disease has been covered, regardless of age and regardless of income. We believe there is great advantage to home treatment for this disease and we also recognize that the treatment is very expensive, wherever it is carried out. We are carrying out the intent of the law to the best of our ability, both with our preliminary regulations and with the use of the comments that are coming in to make it final.

Mr. Cardwell of the Social Security Commission is in direct charge of this program and he might want to respond specifically to this point but I would say this is another of the comments which are going to be used in the drafting of the final regulations.

Commissioner CARDWELL. I think that is a correct answer. We would be glad to take this individual case under consideration. We would also be glad to talk to them and seek an extension of the deadline for submittal of any comments or criticisms of the proposed regulations.

Secretary WEINBERGER. I would say that the renal dialysis program is taken over by and would continue under the Comprehensive Health Insurance Plan so when we do get the regulations in final form, having taken into consideration all of these comments and others, that would be a program which we would continue.

We would not terminate that program or anything of the kind under the Comprehensive Health Insurance Plan.

Senator STAFFORD. I appreciate that answer. I think I will send you a copy of this letter, if I may, for comment. It is from the head of the program at the Vermont Medical Center and one comment is worth putting in the record here. When he says the legislation was designed to encourage more people to receive dialysis and transplantation care in the most economic and efficient manner possible which I guess we all agree is true as far as intent but then he says our first 9 month experience with this law would suggest the opposite in happening so I will send you this whole letter.

Secretary WEINBERGER. A lot depends on the region of the country and whether home care is available and these machines are still not in enormous supply.

Senator STAFFORD. Let me add this. The 3-month waiting period before Medicare coverage of dialysis costs begin remains a problem that discourages people who have the disease. Would you have any comment on how CHIP might remedy this?

Secretary WEINBERGER. That would require change in the existing statute. We have no authority to make any change in the absence of a statutory change.

Senator STAFFORD. Thank you very much. Once I have managed to read the entire statement, I may have some further questions, but for the present, I will yield.

Senator MUSKIE. Senator Percy?

Senator PERCY. Mr. Secreteary——

Secretary WEINBERGER. I am advised, Senator Stafford, with the renal dialysis program, the catastrophic provisions would pick up after the particular number of dollars had been paid, so there would be no waiting period. So, to that extent, it would be improved over the existing system. There is no wait.

Senator STAFFORD. Thank you. That is good to hear.

Senator PERCY. Mr. Secretary, we seem to feel strongly about these matters. I think you recognize that we are in a sense on this committee, although none of us needed an extra committee, because we are advocates for the elderly.

I would like to say at the outset, I believe the administration believes in supporting programs for the elderly. Although I have had fallouts in other areas of relationship with the administration, where the elderly are concerned, I have had nothing but cooperation. For example, former Secretary Flemming, who is in the audience, has been nice enough to go out on field trips with me to see nutrition programs, and we have, in the last few years, worked to develop a multimillion dollar nutrition program for the elderly.

Now, I look with considerable interest on the administration's national health insurance plan and, particularly, to its effect on the elderly. I was pleased that the witnesses from the UAW, the National Council of Senior Citizens and the American Association of Retired Persons/National Retired Teachers Association testified yesterday that this plan would offer some improvements.

Looking at the positives first, I think the administration should be commended for the additional coverage for outpatient drugs, the improved mental health coverage which is so extremely important, and the catastrophic coverage which is the single most important thing I think we have to do.

"THINGS . . . LEFT UNDONE"

Having patted the administration on the back for all of the fine things it has done, it is also our job to look at the things that are still left undone. Obviously, there is an expressed concern about the terminology that I think Senator Muskie rightly referred to the tradeoffs.

In a tradeoff, someone gains and someone loses. We need to find out who is losing what under this and why is it necessary for anyone to actually lose anything.

In your judgment, can you tell us whether all of the elderly would benefit more from your new plan than from Medicare, and if not, what groups among the elderly would lose benefits under the new plan?

Secretary WEINBERGER. We think everybody will benefit greatly by the plan and that the elderly will benefit particularly and that it will be a vast improvement over the existing system of Medicare and Medicaid. The statement I made at the beginning attempts to substantiate this in considerable detail.

I think that we have to start with the basic understanding, Senator, that we cannot provide, in our opinion, everything for everybody. We cannot provide first dollar coverage for everybody and we can-

not take care of every single illness or every contingency that might happen to everybody, aged or not.

I think if you try to do that, you will get into exactly the same problems that they have encountered in many of the countries of the world where they have tried the first dollar coverage—you overload the system—and people who really need care cannot get it. They are lined up, in effect, behind people with needs, that are either imaginary or not as great. You just cannot provide that kind of coverage and serve everybody and when you try to do it, you do not benefit them.

So if you start with that assumption, then I think you have to look at the benefits that are most necessary, most important, and that are lacking in the present system and some of these are the ones you identified a moment ago, those are the benefits we tried to cover in this proposal.

Senator PERCY. Specifically, could we identify in this tradeoff terminology, who did lose as a result of the new plan, and to what extent have they lost?

Secretary WEINBERGER. The tradeoff is the Senator's terminology: not ours. We think the measure of improvement can be seen in the value of the coverage. The value of the benefits for elderly people goes up from $565 under Medicare to $620 under CHIP. Those are some of the measures of the increases that will come.

There will be people who will have different uses for the program. We cannot predict now all of the diseases and all of the hospitalizations and all of the drugs and all of the mental health care and so on that people will need.

GAUGING THE RISKS

What we are trying to do is what every insurance program tries to do and that is to cover in the most effective way the risks most likely to happen or the risks most likely to be an impossible burden to the people involved so we do not think that is in any sense a problem.

We have an improvement in the benefits that are covered and an improvement in the amount of benefits for the people who we believe need them most. We do have cost sharing, we do have deductibles, we made this point at the beginning. This is not a free medical program for everyone, either over 65 or under 65. We believe without that kind of a provision, you will have an overloaded system that can deliver quality services to nobody and so we have made the conscious decision to require some cost sharing of all enrollees.

I do not regard that as a tradeoff. It seems to me that what we have done here is substituted some, or added, I should say, prescription drug benefits that are not present throughout the existing plan. We have added mental health care here. We have added unlimited physician's care. We have postoperative and home health care and a number of other things.

We have required somewhat higher payments for short-term hospitalization but I do not regard that as a tradeoff. I think that will simply require providers to look more carefully at the question of

which hospitalization, which is the most expensive mode of treatment is really necessary, something they are not doing now, and something which has resulted in the enormous increase in hospital costs, above everything else in the Consumer's Price Index.

Senator PERCY. Mr. Secretary, you have indicated that the term "tradeoff" was the chairman's and not necessarily yours.

In your testimony, you say:

> Thus, our proposed program provides somewhat smaller payments at the beginning of the illness, when expenses are budgetable. In exchange for expanded benefits and catastrophic protection when it is most needed. We considered this trade-off to be not only desirable but essential to the guarantee of true protection against catastrophic illness.

Now, we agree with you on catastrophic protection. I think what you have done in this respect is magnificent, and it is certainly what Senator Scott and I proposed in the bill that we put in. In Illinois, we call it the Percy-Scott bill, and in Pennsylvania, the Scott-Percy bill. We never expect to see this piece of legislation enacted, but we were unhappy with everything we had seen; so we worked for months to put our own bill in, just as a means to say that there can be a better way to finance health care. I think the improvements in the new administration plan has pleased both of us immensely, but by your own testimony, you indicate that there are somewhat smaller payments. Now I do not need to tell you, as we all advance in age, that small things become very large for the elderly. From the number of personal cases we handle, I know many people would look upon the taking away of anything from the aging, particularly when they have been bearing the brunt of inflation, living on fixed incomes as a regression. The elderly have more worries and concerns than any single group in this country, for they are a real disadvantaged minority.

The problem, I think, is one of weighing priorities. I hope within the next 2 weeks, we will adopt the budget reform bill in the Senate. You, as a former Director of the Office of Management and Budget, would recognize that we handle priorities in a chaotic fashion up here.

The budget reform bill that Senator Muskie and I have worked on, we hope, will give us a rational basis for evaluating priorities.

Could you give us a figure, a dollar figure, that would allow us to keep all of the advantages that you have built into your national health insurance plan for the elderly at one end of the spectrum, and at the same time not take anything away at the other end. What would that cost us? That dollar figure would give us a chance to weigh the priorities and see whether or not any tradeoffs are necessary. If we decide that there should not be any tradeoffs, then we will have to responsibly find the additional money some place else, or take it away from somewhere else, or consciously go into further debt which none of us would want to do.

Secretary WEINBERGER. I do not have that now but we could try to furnish it. I think you have to bear in mind that you will have a lot more to consider and should consider, if I might say so, a great deal more than the total costs involved.

[Subsequent to the hearing the following was received:]

If Medicare beneficiaries were subject to the same deductibles and coinsurance amounts as under present Medicare law (both parts A and B), and the maximum cost-sharing liability and expanded benefit provisions of CHIP were applicable, the additional cost would be $1.6 billion over the estimated cost of CHIP in the first year.

UTILIZATION OF A HEALTH CARE SYSTEM

You ought to consider what you are going to be doing to the system as a whole and whether or not by adding some x billions of dollars more to the total costs, you will be encouraging either the individuals or their providers in needless usage of the system in a situation in which it is neither required nor desirable. If you are doing that, then you are not talking about a few dollars here or a few dollars there or several billions; you are talking about depriving a great many hundreds of thousands, multitudes of people, of the utilization of a health care system which they may need far more than persons who have first dollar coverage and who thereby feel they might use it, whether they need it or not, because "it is all paid for." I do not think this is the kind of thing you can approach on a straight dollars and cents basis nor do I think you can approach it on a straight basis of looking at one group in a community, however great the needs may be.

I think if you are going to consider it as a comprehensive national insurance plan, you have to consider its effect on the wellbeing and health of the entire Nation, including youth and children and whether or not by overloading it at one end of the scale, you are going to have such an overusage or such an unnecessary usage of certain modes that you are depriving a great many other people in the Nation of the necessary kind of health care that they really need.

Senator PERCY. In principle, I would support a philosophy that everyone should pay what they can.

Secretary WEINBERGER. This is not a question of payment. This is a question of what results in overutilization. That is what happens in systems and we have a lot of examples around the country, where we say everything is free, you go in and take whatever you think you may need and under that kind of a system, you are depriving a large section of that Nation of its proper health care.

Senator PERCY. I do not think we are essentially apart in philosophy. However, I want to be absolutely certain about this language that you use. "Our proposed system provides somewhat smaller payments at the beginning of an illness." I do not want to see an older person concerned about those early payments not get the medical attention which, if gotten early enough, might have prevented a serious illness I don't want to have him feel that his medical care costs will be picked up only at the end of the line if it is really serious.

If we could have the cost figures I asked for earlier, we could then weigh the priorities and see whether or not at this time it would be wise for us to take away anything from this particular group of people who have had to bear a large part of the brunt of inflation.

Present Medical System Unbalanced

Secretary Weinberger. Senator, your phraseology, I think, is very difficult for us to stay with because you talk about taking away benefits and what we have at the present time is a very unbalanced system, a system which does not give the kind of protection that individuals in the over 65 bracket need throughout the country. What we are trying to devise here and design is a system which serves the medical and health needs, the real health needs of the people a great deal better than the present system is doing so we are not taking away anything.

What we are trying to do is to make sure that the portion of the illness that is most difficult for the individual to finance is covered and to make sure that the mode of treatment that is recommended by his provider is appropriate to his needs and is not automatically the most expensive mode, which may be the worst in his case. In any sense, we are not talking about taking away something; we are talking about getting a better balance and better delivered services that can do more for the health of everybody.

Senator Percy. Well, I am just sticking with your own language and your own testimony which states that there is a tradeoff, and the payments are somewhat smaller at the beginning of the illness. Our witnesses yesterday were very concerned that, on balance, S. 2970 would lessen the health care coverage which the elderly now receive under Medicare.

It is to dispel those concerns that I have asked the question that I have. Let us figure out what it would cost to have no tradeoffs and see if that is possible.

Mr. Chairman, if we could ask those figures, I would ask this record be held open to have those figures inserted and I thank you very much for your testimony.*

Secretary Weinberger. I just concluded by saying, Senator, if I may, that dispelling the concern is not necessarily the point. The point is first of all that to attempt to meet a concern expressed, just because it is expressed, would have the effect of worsening the system for the entire population.

Senator Muskie. Mr. Secretary, I would like to pursue some of the points here. Incidentally, I thought I had got that word "tradeoff" out of your testimony. I am glad that I did because I was not trying to inject anything but a useful figure of speech to focus on the issues that concern me and, obviously, the other members of the committee.

One of the difficulties here is that in preparation of the illustrative examples on either side of these issues, we do not necessarily get a representation of the broad impact.

Secretary Weinberger. I think that is true, Senator.

Senator Muskie. That is true of the illustration my staff has prepared and I am sure it is true of what your staff has prepared.

Secretary Weinberger. We have tried to make it as realistic as possible.

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*See appendix 1, item 1, p. 937.

Senator MUSKIE. I would like to send down to you, in case you have not seen it, Mr. Cruikshank's testimony of yesterday and, particularly, the tables, which I would like to have you or your people look at.

Now, what Mr. Cruikshank has tried to do here is to reflect the impact of the administration's proposal upon hospital bills, taking into account medical and hospital services.

To use the language in his statement, he says table 1—there are three tables there—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.

[The tables referred to appear in part 8, Barriers to Health Care for Older Americans, pp. 678–683.]

Now, of course, using these tables, one can pull out illustrative examples of what might be the impact of CHIP compared to Medicare. For example, using table 1 with a medical services bill of $200 and a 20-day hospital stay, the amount that the patient would pay would be $172 under Medicare.

Going down to table 2, that same patient would pay $560 under CHIP which—from table 3—represents an increase of 225.6 percent. This would be for patients with $5,250 of income or more as the tables do not include income testing.

Now, one can find the other side of the picture, too, in this table and I am certainly not going to ask you to respond with an instant analysis of these three tables but I would like to bring them to your attention and then if your technical people want to provide us with an analysis of these tables. I would be delighted to have it because they were put in the record yesterday.

I thought that we ought to have a response and, obviously, you are going to look at it from a different perspective than the people who prepared it.

COST-SHARING—INCOME RELATED

Secretary WEINBERGER. We certainly would be happy to look at them. I think, in this connection, that they are not income related is completely accurate and I think in that connection, it is very important to bear in mind the 1972 census shows the median income for those over 65 is $2,520 so the income related cost-sharing that is in our bill provides very substantial benefits and very substantial differences from these figures, which assume that everybody under these tables has an income of $7,000 or probably more. There is quite a gap between those tables and what would be required under CHIP and we can get a lot of hypothetical cases and put them before you that show that payments under the CHIP program would be less.

Senator MUSKIE. It might be possible for you to construct tables comparable to these for the other two income levels?

Secretary WEINBERGER. There are several income levels but we could try to do that.

[Subsequent to the hearing the Department of HEW submitted comments on the statement of Nelson Cruikshank, president, National

Council of Senior Citizens; and Bert Seidman, director of Social Security, AFL–CIO. Submitted by Frank E. Samuel, Jr., Deputy Assistant Secretary for Legislation (Health). See appendix 1, items 3 and 4, pps. 949, 962.]

Senator MUSKIE. There are five in all but those that are income tested or income qualified, are three.

Secretary WEINBERGER. It is important, I think, Mr. Chairman, to bear in mind that there is a great advantage to the elderly, many of whom have very low income, to have a program in which there is a scale or a sliding scale of payments relating to income and, therefore, getting it within the income ability of people over 65 to pay and, at the same time, there is a tremendous benefit also to enabling them to spread their payments over as long as they wish for whatever amount they may actually owe.

The other point I was endeavoring to make to Senator Percy before he left is the fact that materially the cost of the first few days of hospitalization is something that is budgetable, is planned for in many situations and can be handled.

It is the long continuations, the catastrophic feature, that cannot be provided for by anyone and that is the thing that is not covered now and would be covered under our program but we will be glad to comment on these specific tables and construct some more accurate ones, as we believe they would be on an income related basis.

Senator MUSKIE. All right, it is difficult to bounce an illustrative example back and forth across this table. I can bring up a horror story and you can bring up some.

Secretary WEINBERGER. We have two for every one, sir, if you would like us to spend all morning going over it.

Senator MUSKIE. You can study our example and we can study yours but frankly, what I want to get a picture of is exactly what Senator Percy was talking about. This is the reason I found these charts useful although they might not present the whole picture.

I want to know what the impact is on Medicare patients in the average hospital stay as shown in chart 5.* This will give us the picture of the tradeoff.

Secretary WEINBERGER. I would like to emphasize once more if I could, Senator, the fact that a great deal of the hospitalization at the present time is influenced by the design of the Medicare system and we cannot assume, from all of those black bars, that all of those days of hospitalization, 5 days, and so on, were either necessary or the best method of treatment in many cases. In too many cases it is ordered by the doctor because it is there and this is the thing we do have to keep in mind in the design of any health insurance program.

Senator MUSKIE. I agree with that and that gets me to another point. I would agree with you that one of the reasons hospitalization constitutes something like 60 percent of the health care costs of the elderly is because there is unnecessary utilization of hospital care and I have been an ardent advocate of home health care as a substitute. The administration's plan would cut that, cut it from 100 days——

* See chart 5, p. 902.

Secretary WEINBERGER. No, sir.

Senator MUSKIE. I mean visits, not days. This chart which we have here suggests that the visits would be cut from 200 to 100 and that there would be a coinsurance feature added that does not exist now.

Secretary WEINBERGER. What you need, Senator, is another chart that shows you the incidence of home visits and the vast proportion of those are under 100 visits per year and that is why we cover that proportion up to and including 100 visits, rather than 200 visits.

Senator MUSKIE. Mr. Secretary, I see I have about 2 minutes to get to the floor to cast a vote. I will try to be right back and I will try not to hold you too long.

Secretary WEINBERGER. All right, sir.

[A brief recess was taken at this point.]

AFTER RECESS

Senator MUSKIE. The committee will be in order. Mr. Secretary, I understand you have another appointment?

Secretary WEINBERGER. I do, but we will stay as long as possible.

Senator MUSKIE. There are a lot of interesting questions I would like to pursue but I do not think that they are such as would justify on my intruding on your schedule.

You might want to finish responding to my last question and I might have one or two more before your next commitment.

Secretary WEINBERGER. I have forgotten what it was?

Senator MUSKIE. It was a question about the apparent reduction in home health benefits.

Secretary WEINBERGER. Yes. We believe from our examination of the facts we have that 100 covered visits would cover the great bulk of all of the cases.

I share with you the feeling that home health care is frequently preferable to hospitalization and we believe that the 100 covered visits that we have would take care of the great bulk of the situations rather than the 200 which are rarely utilized, if at all, under the present coverage.

Senator MUSKIE. Well, it is my impression—and I would like your experts or yourself to comment—that one of the reasons why home health benefits are not utilized more is because of the restrictive way in which the law is now written. Is that true?

HOME HEALTH CARE UNDER CHIP

Secretary WEINBERGER. I would not be able to speak to that. I think the home health care we are talking about under the Comprehensive Health Insurance Plan is quite different than the visits covered at the moment.

Commissioner CARDWELL. I think most people would agree there are economic disincentives under the present arrangement. On the other side, there is an area of great unknown—the consequences of an open-ended approach to home health and third-party financing,

could probably be incalculable at this point. We would urge some caution in thinking through on that.

I think the idea here was that the approach to coverage would be essentially the same. One could argue over the difference between the 200 visits and the 100 visits and find an issue.

Senator MUSKIE. You have raised an interesting point. Are you saying that the administration's program would loosen up the criteria or eligibility?

Commissioner CARDWELL. No, we are saying the criteria for eligibility and the general philosophy about the role of third-party financing, under an insurance approach, are essentially the same. We are not changing that philosophy and so the only real issue we see is the one you have drawn: the comparison of 100 visits versus 200 a year.

Senator MUSKIE. I agree the number of visits may, in a sense, be the result rather than the cause of a problem here if the home health care program is too narrowly based in terms of eligibility and encouragement to use it. What we are talking about is the importance of reducing the use of hospitalization for problems that could be solved in other ways. Since we all seem to be philosophically attuned to the notion of home health care, the question is: Should not we provide in legislation such as my bill, S. 2690, for a liberalization of the program in order to provide a stimulus for its use and to reduce reliance on hospitalization? That is really the issue. I am simply trying to define it.

Secretary WEINBERGER. Senator, I guess the question is whether a relaxation or stimulation of its use would occur in place of hospitalization or would occur in cases where it was not required, even in and for itself. If you had unlimited home health care and, assuming you could get someone to make house calls, you would have a possibility of a very substantial use in situations where it was not required.

I think what Mr. Cardwell is saying is that there should be some restrictions and some restraints on it because no one knows what opening it up would do, again, in the way of overloading the system and depriving people who might be more in need, or entirely in need, from getting the care—the kind of care they might not get if people who did not need it were overusing it. I think that is the basic problem we have got.

Senator MUSKIE. I wish you would look at S. 2690 and give us your comments. You should still be subject to physician's supervision under S. 2690.

Commissioner FLEMMING. Senator, I just noted in the Secretary's statement, on long-term care, where we do have that area under intensive study, not only with respect to its health dimensions but with respect to its income security features and social services, that home health services would be encompassed within the framework of that work and looking at the question of institutionalization versus the home health side where, as noted, we are siding with you philosophically on the issue.

HOMEMAKERS SERVICES DEMONSTRATION PROJECTS

Senator MUSKIE. Well, section 222 of the Social Security Amendments of 1972 provided for demonstration projects to test the value of homemakers services as a Medicare postoperative benefit. One of the objectives would be to determine if such coverage would reduce long range cost by reducing the lengths of stay in hospitals and skilled nursing facilities and I understand the demonstrations have not yet begun. On February 12, I addressed a letter to Dr. Charles Edwards on this subject.

I have not yet received a reply and I look forward to receiving one if you could expedite that.

Secretary WEINBERGER. What is the date of your letter?

Senator MUSKIE. February 12 and I will include that in the record * and a reply.

Secretary WEINBERGER. We will get that back to you; that is too long for you to wait.

Senator MUSKIE. I have waited longer.

Secretary WEINBERGER. I feel we should get our mail answered as quickly as possible and congressional mail has a high priority.

Senator MUSKIE. I do not want to be too critical on that point; I might discover my own staff has waited that long to answer mail.

A point Mr. Glasser made yesterday, and I quote from his testimony the following:

> Eye examinations, development of visual care, eyeglasses, ear examinations, and hearing aids are covered under the administration's proposal; the children up to age 13 but the major problems of vision care and hearing and major need of eyeglasses and hearing aids are not among children, it is among the elderly.

My questions are; first, is that an accurate statement? And second, if it is, where will the needy aged go for their noncovered items which will no longer be provided by Medicaid?

Secretary WEINBERGER. I think the reason for the emphasis on well-child care and the other services mentioned is that the greatest benefits we can get in the preventive field will result from providing such services to children in that general age group. In that age group, you have accomplished a very substantial advance on existing preventive medicine. With respect to persons over 65, we——

Senator MUSKIE. Mr. Secretary, I think you must be in league with the floor here. There is another vote to which I must go.

Secretary WEINBERGER. That is the first time anyone has accused me of having any power on the floor of the Senate.

Senator MUSKIE. You ought to reexamine your resources.

Secretary WEINBERGER. I will not hold you. I will complete that answer in writing, if you wish.

Senator MUSKIE. There is one other question I would like to put and have your answer in the record. Then there are some other specific questions we would like to submit. You have said in your statement several times that the total increase in Federal spending for the aged will be approximately $1.8 billion?

Secretary WEINBERGER. Yes, sir.

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* See appendix 1, item 2, p. 948.

Senator MUSKIE. And I wonder if you would submit for the record a breakdown of that so we could identify it? *

Secretary WEINBERGER. We will be glad to do that.

Senator MUSKIE. We will submit other specific questions if others develop in the course of the hearing.

I appreciate your patience and your testimony.

Secretary WEINBERGER. We welcome the opportunity.

Senator MUSKIE. Thank you very much. May I say to our witnesses, I will be back after this vote.

[A short recess was taken at this time]

AFTER RECESS

Senator MUSKIE. The committee will be in order.

I would like to welcome Nelson Cruikshank, president, National Council of Senior Citizens, and Bert Seidman, director of Social Security, AFL–CIO.

Gentlemen, I think we have at least a half hour before we are interrupted by a vote so I will turn the meeting over to you.

Mr. CRUIKSHANK. Mr. Chairman, since I had a good session with you yesterday, may I suggest that Mr. Seidman go first?

Senator MUSKIE. That will be fine. Mr. Seidman, it is a pleasure to welcome you.

STATEMENT OF BERT SEIDMAN, DIRECTOR OF SOCIAL SECURITY, AFL–CIO

Mr. SEIDMAN. I am very glad to be here, Mr. Chairman.

The AFL–CIO has a very great interest in this hearing. The Secretary said this morning that this subject is of crucial significance for the 23 million Medicare and 4½ million aged Medicaid beneficiaries.

I might say it is also of a very, very great significance for the workers and employers who, through their taxes, their Medicare, taxes are helping to finance this program or would help to finance the program that the Secretary is proposing, as well as to the taxpayers who will be paying for the part of it that would have to be paid out of general revenue.

Mr. Chairman, the Secretary said that the program that he was proposing was far superior to that which is presently available under Medicare and Medicaid. Well, I think that you and others, both witnesses and Senators, have shown that there is a very serious question as to whether the program is superior. It may be superior in certain aspects.

It is certainly clear that for most of the people who are now being covered by Medicare and Medicaid, it will be worse but I would like to say that in our judgment, this comparison should not be made simply between what we have and what is being proposed but also between those two things and what we could have. The AFL–CIO supports, as you know, the health security program and, therefore,

* See appendix 1, item 1, p. 937.

in a number of instances, I will be comparing what we have and more particularly, what is being proposed with the health security program.

I was very glad that Senator Mondale introduced into the record the article in this morning's Washington Post.* I commend it to everybody to read because while it describes what can only be called genteel but abject poverty, it describes the condition of people who among the elderly are just probably average.

The article states that the two sisters, aged 82 and aged 79, have a Social Security income of $296.36, and the reporter goes on to say, a pinch-penny budget, that allows them, both of them—not each of them—both of them, $2 a day for food and then he goes on to say—describe what that food is. It is oatmeal, it is a can of beans, it is never any meat. They cannot remember when they last had any meat, and when the Secretary talks about whether people at that level of income and at much lower levels of income, can afford that 10 percent coinsurance, that deductible he says we have decided.

I do not know how many elderly people he has asked who are living at the level of income as to whether they can afford to make those payments.

Well, it just so happens that $296 a month, what these two elderly sisters have as income, is the average income for a couple, man and wife, two people, under Social Security today. So that if we think in terms of what any program, including the administration's program, means and the costs that are involved and whether or not there are barriers to health care, instead of thinking in terms of statistics and charts and so on, let's think about this elderly couple and whether they can afford this.

Mr. CRUIKSHANK. You forgot the Secretary said he was going to give them a credit card. They would have the privilege of going into debt and paying out on an installment basis.

Senator MUSKIE. Under the administration's proposal, what level would the two people come under if they had a joint income of $3,600?

Mr. SEIDMAN. Each one happens to have below average Social Security benefit but it just so happens that their combined Social Security benefits is about the average for a couple under Social Security today.

Senator MUSKIE. I still do not get the impact. As we have it here, the first income level is up to $1,749. There is no deductible and there is a 10 percent coinsurance at that level.

Mr. SEIDMAN. Ten percent coinsurance.

Senator MUSKIE. And the next bracket, there is $25 deductible for drugs. Now, would this couple come under, since their income is $3,600?

Mr. SEIDMAN. In the example—for example, in the Secretary's testimony—they would come in the program No. 2 income class, roughly.

Senator MUSKIE. So they would pay those higher deductibles?

Mr. SEIDMAN. They would pay higher deductibles and coinsurance.

* See appendix 3, item 1, p. 984.

Mr. CRUIKSHANK. And we are not sure what they would mean to include by income. There is no indication whether food stamps would be included or there is no definition of what is income.

Senator MUSKIE. There is certainly none in the bill.

Mr. CRUIKSHANK. I could not find it.

Mr. SEIDMAN. The bill is a very, very hard bill to read, Senator. You cannot get some of these things that are in the testimony out of the bill unless you are a real expert and I am not that expert. So we have taken some of the things they have said more or less on faith.

ROUTINE MEDICAL SERVICES—NOT COVERED

Another point I would like to make is that the Secretary says, in his testimony, that the more routine medical services which can be budgeted should not be covered under a health insurance program which primarily seeks to provide financial protection.

He says that there has been a conscious decision to cover basically the same broad range of services under all three programs. Well, I do not know what he means by routine medical services which can be budgeted for but eyeglasses and hearing aids.

Senator MUSKIE. I was going to ask you that question. I never had the opportunity.

Mr. SEIDMAN. And hearing aids and dental care, things which really, in the case of many of the elderly people, can mean the difference between life and death and certainly between life and a living death, a decent life and a living death.

I wonder whether these two elderly sisters can afford to pay for eyeglasses that they may need or a hearing aid they may need; I doubt it very much. But if they were covered by Medicaid, in most States—it is true that Medicare does not and should cover those items—but in most States, Medicaid does cover those items so the poorest of the elderly, those who are now receiving, let's say Supplementary Security Income, SSI, would have available to them, at no cost, eyeglasses, hearing aids, dental care, and even preventive care.

That would all be taken away by this program and the Secretary says that somehow or other, the States would pay for this. But if you look at the fine print, the cost for the States, under this program, is already greater for the covered items than they are now paying for Medicaid, and I wonder in how many States they are going to cover eyeglasses and hearing aids and dental care in addition for the people who are now getting them.

It is at least a very serious question as to whether many of them will not. So that this program is taking away from the elderly particularly, things which they desperately need, which ought to be available under Medicare and at least are available under Medicaid and would not be available under the so-called assisted programs.

There are so many points in the Secretary's testimony and I really cannot cover all of them but he says that cost-sharing instills cost consciousness. Again, I turn to these two elderly sisters and I wonder whether they have to have cost consciousness instilled in them by cost-sharing; whether they have to make 10 percent or 20 percent payments in order to go to a doctor and that means one less can of

beans; whether they need that kind of cost consciousness. I doubt it very, very strongly.

Impact of Cost Sharing on the Poor and Elderly

The fact of the matter as we get to a more technical level, that there is no technical evidence whatsoever in terms of the impact of cost-sharing on the poor or the elderly, except that is does not take very much intelligence to realize that those who are elderly and therefore living on very restricted incomes and particularly the poorest among them do not have the money to meet the cost-sharing amounts and, therefore, will not avail themselves of the health care that they need, no matter how much they need it.

The Secretary says, well, but on balance the benefit package for the aged will be raised from $565 to $620. Now, what we are talking about here is approximately a 10 percent difference and I frankly wonder how closely the Department can estimate a 10 percent difference on a program which has not even begun yet. At most, we are talking about the possibility that because of this catastrophic feature, and for no other reason, there might be some slight increase in the total benefits to the total group but I think we should be very skeptical about that.

Senator Muskie. We have figures indicating that, of the $1.8 billion he spoke of as the increase in Federal spending for the aged, $1.6 billion is attributable to the drug program alone so that the remaining difference of $200 million is pretty small.

Mr. Seidman. That is certainly correct, but he does make a great deal of this catastrophic element, and I would just like to point out that, as he states, in 33 States, we have in effect a catastrophic program for the elderly because in the so-called spend-down provisions for the medically needy, they can be taken care of.

This elderly couple, living entirely on Social Security, had this hospital bill for 2 weeks. One of them had to go to the hospital for a heart attack and she had her bill paid for by Medicaid, undoubtedly on this spend-down provision, as it works in the District of Columbia, where they happen to live, so this is not giving the elderly very much that they do not have now.

Mr. Cruikshank. Bert, could I interrupt on this catastrophic?

I think it is awfully important to note, while the Secretary made a great deal out of the catastrophic protection that was under his bill, as opposed to Medicare, he left out the fact that that only applies to part A. He was talking about these limitations all the time. There is no limitation under Medicare under part B.

A doctor's bill can run up to $10,000, $15,000, and it is covered presently under Medicare. Nowhere does the catastrophic thing come in under their proposal. It comes in down at the 60-, 70-, 80-, 90-plus days and when does that happen? Only after peer-review has failed, only after utilization review has failed, only after every precaution presently in the program has failed. This tiny, small fraction of 1 percent is to get this so-called great additional protection. It already exists under part B, no limit under Medicare, so it is really

just talking about the very, very long-term hospital stay. That is where the catastrophic protection comes in.

Mr. SEIDMAN. Senator, we think people should have that catastrophic protection but we ought not prevent them from getting the needed care by so-called cost-sharing, which, in effect, for people at that level of income means they do not get the care at all unless they are so desperately sick, they have to go to the hospital. The health security program does contain a catastrophic feature for the elderly as well as for the rest of the population.

The Secretary says that the program would be even more responsive to the health needs of the aged than Medicare because it removes the financial barriers that prevent the elderly from obtaining these necessary medical services of high quality.

NEW ADDITIONAL BARRIERS

Frankly, I do not understand this statement. It seems to me the reverse is true. It builds in new additional barriers to necessary medical services and it is less responsive to the health needs of the aged, particularly if you combine the Medicaid and Medicare and particularly, the kinds of features that I indicated before, the eyeglasses, the hearing aids, the dental care, and so on.

Senator MUSKIE. Do all States provide that?

Mr. SEIDMAN. Almost all States provide eyeglasses, hearing aids, dental care, and preventive care. I am told that 75 to 80 percent of the people now covered by Medicaid would be robbed of some of those services and this applies, of course, with these items, particularly to the elderly.

And while it is true that Medicare ought to and does not cover drugs, there are only four States under Medicaid that do not cover drugs so that drugs are available without cost-sharing under the Medicaid program to many of the elderly.

Senator MUSKIE. What are the income levels in the Medicaid program?

Mr. SEIDMAN. In Medicaid, of course, they are set at different levels in different States.

Senator MUSKIE. What is the range? Is it designed to be the poverty level, by and large?

Mr. SEIDMAN. Now it is the SSI program, all of the people on SSI are generally covered, plus in some States, those that are receiving supplemental SSI, so that those minimum figures are now, for a couple, $210 a month, I believe, under SSI, and they will be going up July 1.

The Secretary says that aged persons with incomes below $1,500 will pay no premium or deductible charges and would pay only a 10 percent coinsurance rate up to a maximum annual liability of 6 percent of their income or $105. He read this very quickly, with no emotion whatever. We are talking about people living at $1,500 in America in 1975, being expected to pay $105 out of their $1,500 for obviously the most desperately needed medical services. How many of them are going to be able to do this?

It seems to me to describe this as being a program which is bringing improvement when those same people now under Medicaid can obtain services without any payments whatsoever and, of course, under the health security program would obtain services with no payments whatsoever it seems to me is a complete distortion of words and meanings.

Well, I could go on, but I do not want to take up any more time. I would like to suggest, and I am not prepared to provide the information myself at the moment, but I think that the examples that the Secretary has given us of his hypothetical examples, I think it would be very interesting if he added just one more column; I think this could be done fairly easily and that is what each of these groups would pay under the health security bill, or any other bill people might be interested in, but our particular interest would be in the health security bill, and you would find that the liability would be very, very much lower.

He gave one example which I think is particularly interesting and that is the short-term hospitalization example of 10 days. Since 12 days is the average for the elderly and for the group at $3,000, it shows an out-of-pocket expense of $270. Now, what we are talking about is an out-of-pocket expense of these two sisters; they are the kind of people who would have to pay that $270 which, incidentally, would be $50 more than under Medicare.

There is the whole question of whether or not the people under Medicare and Medicaid or the replacement program for Medicaid would or would not get second class services.

Now, under the health security bill, you have the same kind of a provision that you do in this bill—that is in this bill for the assisted program and the Medicare replacement program, that is, all doctors would have to adhere to the fee schedule. They could not charge more if they wanted to participate in the program for any services that they gave.

Now, people who did not want to be in the program at all could pay anything they wanted to but if they wanted to be in the program, they would have to do that. Under this program, this is not true. It is clear it is not true for the employer part of the program under which most people in the country would get their medical care, according to the assumption of the Secretary.

Now, if it were true that doctors would find that not being able to charge more was so highly desirable, I should think they would be clamoring for the idea that there should be the assignment as the limitation throughout the program, not just the Medicare and the poor, but throughout the program. That is obviously not the case and because the administration knows it is not the case, it provides this out for the better-off groups in the population. It does not provide it for the Medicare and Medicaid people because they know they cannot pay it anyway.

70 Million People—A Two-Class System of Health Care

Well, now, I am not saying that the doctors will ignore the 70 million people who would be covered by these programs, give no

medical care whatsoever but they are not going to give them the same kind of medical care as they will people who are going to pay them more money so that; there is no question in my mind that, unlike health security, this program would set up a two-class system of health care.

Well, there are other points that could be made but we did a little figuring in advance of this. This is not commenting directly on the Secretary. We looked at the income levels under the Medicare replacement program and we found that the average Social Security beneficiary couple is now getting $296 a month.

Senator MUSKIE. That is almost exactly the same as your two sisters.

Mr. SEIDMAN. That is right, almost exactly the same as the two sisters combined. When the benefits rise by 4 percent in April, they will get an increase of $140 per year. Under the administration's plan, those people, because they will go into a different income group, will have an increase in their premiums of $102 and an increase in their deductibles of $100, an increase in the drug deductible of $50. That means a $330 potential increase in their health costs as compared with $140 increase in Social Security, before any benefits are obtained from this program and once they do begin to get services under the program, plus an increase in their coinsurance, from 15 to 20 percent and an increase in their maximum liability, the drain on their payments from 9 percent of their income to 12 percent of their income so that if they are subject to any illness, to any appreciable extent, their entire Social Security increase will be washed out.

Let me say, by the way, that the bill does provide for escalation of all of these figures of deductibles and premiums and coinsurance and so on so that when the Secretary said in 1976, you might be able to—you might have a different situation, all of these figures would have gone up, if the program had been in effect.

Now, these are just a few of the points it seems to me that could be made in discussing the points that the Secretary made in his statement. In conclusion, Mr. Chairman, if I may, I would like to ask that there be included in the record a statement which the AFL–CIO executive council has just adopted at its midwinter meeting on the administration health program as well as a fact sheet containing a summary analysis of the program.*

Senator MUSKIE. Without objection, so ordered.

Mr. SEIDMAN. Not focusing particularly on the needs of the elderly, although it does mention this, but the program as a whole as well as the statement they adopted on the question of noninstitutional services for the elderly. In other words, home health care, homemaker care, and so on, in which our executive council called for a good, hard look at this so as to develop a comprehensive system of services for the elderly and asked that such a program of services be included in any national health program that may be adopted.

Of course, one of the features of the administration program which is definitely a cutback is that the number of home health services are

*See appendix 2, item 1, p. 976.

cut in half, from 200 under the present program to 100 under this program.

It is very interesting that the Secretary used the catastrophic argument as the reason why they wanted to set the limit, the upper limit for it, all other aspects of the program, but apparently for home health services, he used just the reverse argument. I do not know why he did that but apparently, that was tailored to the program they had, rather than any consistency or logic in the program.

Well, thank you very much, Mr. Chairman.

Senator MUSKIE. Thank you, Mr. Seidman.

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

Mr. CRUIKSHANK. I will be very brief, Mr. Chairman. There are many things that I could say but your committee was very generous with respect to time with me yesterday. Just very briefly, I would point a couple of basic inconsistencies, I think, in the Secretary's statement this morning. One, Bert has already referred to.

In the approach to hospital insurance, he said it was not important to cover the most frequently recurring item because this was budgetable. The administration bill he said provided a tradeoff, namely no protection for the so-called budgetable costs in return protection against the catastrophic, down at the end of the very, very long stay in the hospital.

Senator MUSKIE. He used the word "routine." Can you distinguish between routine and chronic?

Mr. CRUIKSHANK. That is a distinction completely new to me. I do not know what he means by routine. He used the reverse argument on home health by saying we are covering the most frequently recurring costs and argued this is what a program should do.

Another one was brought very sharply into focus by the question and reply of Senator Mondale, where the Secretary was trying to convince the committee that the physician would find such advantage accepting assignments, that he would not charge beyond the reasonable charge amounts because he would be relieved of other burdens, and so forth, but in the earlier part of his statement, the Secretary relied heavily, as an argument for his program, that the assignment method was gradually being cut down under the present Medicare.

Under the present Medicare program, the physician has all of the advantages resulting from accepting assignment that he has under the proposal and if it is true that if it is in few—fewer cases accepting assignment, there must be something to Senator Mondale's argument, that there is an economic interest.

Now, if that economic interest exists, generally among the poorer segment of the population, how much more would it exist as applied to the employed sections of the population. We also know with respect to that assignment question that the incidence falls with very, very widely different degrees.

The Health Insurance Benefit Advisory Council made a study of this and it shows that the doctor accepts assignments much more

generally in the case of the large bill. The small office visit, and so forth, where he feels more free and a greater chance of collecting the bill, that is where the heavy incidence of the direct billing method takes place. He takes the risk there in collecting and the costs of collecting, and so forth, but what I would like to point out is the inconsistency here that the Secretary sees no such incentive; in fact, he tells us there is an incentive the other way in his proposal, but in describing the present Medicare proposal, he describes a move away from assignment to the economic motives and results in the cutback.

Now, yesterday, Mr. Chairman, I spoke at some length about the very basic differences in the philosophy of the approach of these two programs and it seems to me that is apparent, without underscoring it, to the members of this committee, but there was, in last Sunday's Post an article of such discernment and perceptiveness, preceding these hearings, I do not know that the author even knew that these hearings were scheduled but he could very well have been preparing this paper for these hearings because it runs just to these points. It is by Prof. Rashi Fein, who is a medical economist. He is the professor of economics at Harvard Medical School and a faculty member of the Kennedy School.

This runs so much to the point of the issue now before this committee that I would like to ask, sir, it be made a part of the record.

Senator MUSKIE. Without objection, it will be made a part of the record.*

Mr. CRUIKSHANK. Thank you. If you have no further questions, I am finished at this point.

Senator MUSKIE. Well, I think we have touched on the significant points here in this morning's hearing. I find that this bouncing back and forth of hypothetical examples can be very confusing and, of course, the Secretary wanted to steer away from any implication that the program represented any reduction for any significant number of people and anything we would get in the record to illuminate that point is instructive. I think your willingness to respond to his testimony has been very helpful.

I would like to suggest if, upon further reflection, there are other points you would like to make, we would, of course, welcome them for the record.

Mr. CRUIKSHANK. Thank you, sir.

Mr. SEIDMAN. Thank you.

Senator MUSKIE. Thank you very much. We stand adjourned.

[Whereupon, the subcommittee adjourned at 1:15 p.m.]

*See appendix 3, item 2, p. 987.

APPENDIXES

Appendix 1

ITEM 1. LETTER AND ENCLOSURE FROM HON. CASPAR WEINBERGER, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, IN RESPONSE TO QUESTIONS SUBMITTED BY SENATOR EDMUND MUSKIE IN A LETTER DATED APRIL 5, 1974

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., May 21, 1974.

HON. EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly, Special Committee on Aging, U.S. Senate, Washington, D.C.

DEAR SENATOR MUSKIE: In reply to your letter of April 5 requesting responses to questions relating to the administration's comprehensive health insurance proposal, we have prepared the enclosed material, which we hope you will find helpful.

Sincerely,

CASPAR WEINBERGER,
Secretary.

Enclosures.

Question 1. You have said in your statement that the total increase in Federal spending for the aged will be approximately $1.8 billion. Please submit a breakdown of (1) amounts which will be spent for each of the added benefits, such as catastrophic coverage, drugs, mental; (2) the total amount of savings (and extra charges to the elderly) of the cost-saving provisions; and (3) the interrelationships among these items.

Answer.

NEW FEDERAL EXPENDITURES FOR AGED (65 AND OVER) UNDER CHIP FEDERAL HEALTH CARE PLAN

Items resulting in increased Federal expenditures:	*Cost (in billions)*
1. Newly eligible aged persons	$0.3
2. Coverage of outpatient prescription drugs	1.5
3. Coverage of long-term hospital and psychiatric care	0.3
4. Reduced cost sharing for classes I, II, and III	1.2
5. Net loss as a result of the elimination of the SMI premium	0.6
Gross increase in Federal spending	3.9
Items resulting in reduced Federal expenditures:	
1. Increased cost sharing for class IV beneficiaries	—0.6
2. New HI taxes on Government employees and reduced Federal spending in other programs (largely Medicaid)	—1.5
Gross savings	—2.1
Net increase in Federal expenditures for the aged	$1.8

Question 2. To help evaluate the impact of cost-sharing provisions for various income groups of the elderly, could you please submit (1) a breakdown of the elderly population by income level; (2) whatever information is available on present health care costs (total and out-of-pocket) and utilization by income level; and (3) comparative figures for the non-elderly population.

Answer.

ESTIMATED INCOME DISTRIBUTION OF PERSONS 65 AND OVER ANTICIPATED FOR FISCAL 1975

Income	Percent of people	Number (million) of people
$0 to $1,500	0.6	0.13
$1,500 to $2,000	8.7	1.92
$2,000 to $2,500	9.7	2.15
$2,500 to $3,000	20.4	4.50
$3,000 to $3,500	14.3	3.15
$3,500 to $4,000	8.3	1.84
$4,000 to $4,500	5.4	1.19
$4,500 to $5,000	4.7	1.04
$5,000 to $5,500	3.7	.82
$5,500 to $6,000	3.2	.70
$6,000 to $6,500	2.7	.60
$6,500 to $7,000	2.1	.47
$7,000 to $7,500	2.0	.45
$7,500+	14.2	3.14
Total	100.0	22.10

The following tables on present (fiscal year 1973) health care costs (total and out-of-pocket) and utilization of health care services for various age groups will appear, with analysis on age differences in medical care spending, in the May 1974 Social Security Bulletin.

Highlights for fiscal year 1973 reveal that:

—Of the $80 billion personal health care bill in fiscal year 1973, 15 percent was spent for the young, 57 percent for persons aged 19–64, and 28 percent for the aged.

—An aged person had an average medical bill of $1,052, compared with $384 for a person in the intermediate group, and $167 for a youth.

—The average hospital bill for an aged person was 10 times that of a youth and nearly triple that for a person in the intermediate age group; for physicians' services, his bill was three and one-half times that for a youth and double that for the remaining group.

—Public funds paid for nearly three-tenths of personal health care spending for the two younger groups and two-thirds for the aged.

—Medicare met two-fifths (40 percent) of the aged's health bill—slightly lower than the 42 percent figure in 1972. The smaller proportion results in part from the increase in the SMI deductible, which rose from $50 to $60 as of January 1973. The overall proportion met by all public programs was slightly higher in 1973, however, due to an increase in Medicaid spending for the aged.

—All third parties—Government, private health insurance, philanthropy and industry—paid seven-tenths of the aged's health bill and more than three-fifths of the bill for persons under age 65.

TABLE 1.—ESTIMATED PERSONAL HEALTH CARE EXPENDITURES, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FOR THREE AGE GROUPS, FISCAL YEARS 1971–73

[In millions]

Type of expenditure	All ages			Under 19			19–64			65 and over		
	Total	Private	Public	Total	Private	Public	Total	Private	Public	Total	Private	Public
						1971						
Total	$65,662	$42,441	$23,221	$10,678	$7,959	$2,178	$37,332	$28,197	$9,136	$17,650	$6,283	$11,369
Hospital care	29,300	14,383	14,917	3,071	1,723	1,348	17,582	11,244	6,338	8,644	1,416	7,228
Physicians' services	15,086	11,662	3,424	3,592	3,234	357	8,326	7,268	1,058	3,168	1,159	2,009
Dentists' services	4,637	4,402	235	1,027	947	80	3,281	3,156	125	330	299	31
Other professional services	1,516	1,315	201	364	321	43	834	764	70	318	229	89
Drugs and drug sundries	7,602	7,084	518	1,481	1,407	74	4,322	4,089	233	1,798	1,588	210
Eyeglasses and appliances	1,922	1,856	66	317	306	11	1,193	1,142	51	412	408	4
Nursing-home care	3,212	1,239	1,973	80	20	60	402	54	348	2,730	1,164	1,566
Other health services	2,388	500	1,888	746	----------	746	1,392	480	912	250	20	230
						1972						
Total	$72,716	$45,605	$27,156	$11,495	$8,189	$3,305	$41,162	$30,162	$10,997	$20,106	$7,257	$12,851
Hospital care	32,691	15,143	17,548	3,518	1,772	1,746	19,362	11,594	7,768	9,807	1,777	8,030
Physicians' services	16,626	12,882	3,744	3,636	3,221	415	9,332	8,155	1,177	3,658	1,508	2,150
Dentists' services	5,048	4,793	255	1,122	1,030	92	3,572	3,437	135	355	326	29
Other professional services	1,598	1,370	228	351	300	51	895	812	83	352	258	94
Drugs and drug sundries	8,157	7,544	613	1,596	1,499	97	4,643	4,358	285	1,920	1,687	233
Eyeglasses and appliances	2,034	1,957	77	336	323	13	1,264	1,204	60	435	430	5
Nursing-home care	3,480	1,376	2,104	87	44	43	435	82	353	2,958	1,251	1,707
Other health services	3,127	540	2,586	849	----------	849	1,659	520	1,139	621	20	601
						1973 [1]						
Total	$80,048	$49,713	$30,335	$12,367	$8,792	$3,576	$45,240	$32,950	$12,287	$22,442	$7,972	$14,473
Hospital care	36,200	16,951	19,249	3,765	1,884	1,881	21,573	13,063	8,510	10,860	2,004	8,856
Physicians' services	18,040	13,999	4,041	3,938	3,484	454	10,133	8,810	1,323	3,969	1,707	2,262
Dentists' services	5,385	5,097	288	1,199	1,096	103	3,805	3,654	151	381	347	34
Other professional services	1,680	1,439	241	386	336	50	941	849	92	353	254	99
Drugs and drug sundries	8,780	8,110	670	1,713	1,611	102	4,994	4,691	313	2,074	1,818	256
Eyeglasses and appliances	2,109	2,025	84	346	334	12	1,311	1,245	66	452	446	6
Nursing-home care	3,735	1,512	2,223	93	47	46	467	88	379	3,175	1,376	1,799
Other health services	4,119	580	3,539	927	----------	927	2,016	560	1,456	1,178	20	1,158

[1] Preliminary estimates.

TABLE 2.—ESTIMATED PER CAPITA PERSONAL HEALTH CARE EXPENDITURES, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FOR THREE AGE GROUPS, FISCAL YEARS 1971-73

Type of expenditure	All ages			Under 19			19–64			65 and over		
	Total	Private	Public	Total	Private	Public	Total	Private	Public	Total	Private	Public
						1971						
Total	$313.36	$202.54	$110.82	$142.34	$106.10	$36.23	$327.51	$247.37	$80.15	$859.51	$305.97	$553.64
Hospital care	139.83	68.64	71.19	40.94	22.97	17.97	154.24	98.64	55.60	420.94	68.96	351.98
Physicians' services	72.00	55.66	16.34	47.88	43.12	4.76	73.04	63.76	9.28	154.27	56.44	97.83
Dentists' services	22.13	21.01	1.12	13.69	12.62	1.07	28.78	27.69	1.10	16.07	14.56	1.51
Other professional services	7.23	6.28	.96	4.85	4.28	.57	7.32	6.70	.61	15.49	11.15	4.33
Drugs and drug sundries	36.28	33.81	2.47	19.74	18.76	.99	37.92	35.87	2.04	87.56	77.33	10.23
Eyeglasses and appliances	9.17	8.86	.32	4.23	4.08	.15	10.47	10.02	.45	20.06	19.87	.19
Nursing-home care	15.33	5.91	9.42	1.07	.27	.80	3.53	.47	3.05	132.94	56.88	76.26
Other health services	11.40	2.39	9.01	9.94		9.94	12.21	4.21	8.00	12.17	.97	11.20
						1972						
Total	$343.89	$215.54	$128.35	$153.47	$109.33	$44.13	$355.65	$260.61	$95.02	$959.85	$346.45	$613.50
Hospital care	154.51	71.57	82.94	46.97	23.66	23.31	167.29	100.18	67.12	468.18	84.88	383.35
Physicians' services	78.58	60.88	17.70	48.54	43.00	5.54	80.63	70.46	10.17	174.63	71.99	102.64
Dentists' services	23.86	22.65	1.21	14.98	13.75	1.23	30.86	29.70	1.17	16.95	15.56	1.38
Other professional services	7.55	6.48	1.08	4.69	4.01	.68	7.73	7.02	.72	16.80	12.32	4.49
Drugs and drug sundries	38.55	35.66	2.90	21.31	20.01	1.30	40.12	37.65	2.46	91.66	80.54	11.12
Eyeglasses and appliances	9.61	9.25	.36	4.49	4.31	.17	10.92	10.40	.52	20.77	20.53	.24
Nursing-home care	16.45	6.50	9.94	1.16	.59	.57	3.76	.71	3.05	141.21	59.72	81.49
Other health services	14.77	2.55	12.22	11.34		11.34	14.33	4.49	9.84	29.65	.95	28.69
						1973						
Total	$375.41	$233.15	$142.27	$167.15	$118.83	$48.83	$383.67	$279.44	$104.20	$1,052.48	$373.87	$678.75
Hospital care	169.77	79.50	90.28	50.89	25.46	25.42	182.96	110.78	72.17	509.31	93.98	415.33
Physicians' services	84.61	65.65	18.95	53.22	47.09	6.14	85.94	74.72	11.22	186.14	80.05	106.08
Dentists' services	25.25	23.90	1.35	16.21	14.81	1.39	32.27	30.99	1.28	17.87	16.27	1.59
Other professional services	7.88	6.75	1.13	5.22	4.54	.68	7.98	7.20	.78	16.55	11.91	4.64
Drugs and drug sundries	41.18	38.03	3.14	23.15	21.77	1.38	42.35	39.70	2.65	97.27	85.26	12.01
Eyeglasses and appliances	9.89	9.50	.39	4.68	4.51	.16	11.12	10.56	.56	21.20	20.92	.28
Nursing-home care	17.52	7.09	10.43	1.26	.64	.62	3.96	.75	3.21	148.90	64.53	84.37
Other health services	19.32	2.72	16.60	12.53		12.53	17.10	4.75	12.35	55.25	.94	54.31

[1] Preliminary estimates.

TABLE 3.—ESTIMATED PUBLIC PERSONAL HEALTH CARE EXPENDITURES, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FOR THREE AGE GROUPS, FISCAL YEARS 1971–73

[In millions]

Type of expenditure	All ages			Under 19			19–64			65 and over		
	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local
						1971						
Total	$23,221	$15,415	$7,807	$2,718	$1,579	$1,139	$9,136	$4,593	$4,543	$11,369	$9,242	$2,127
Hospital care	14,917	9,742	5,176	1,348	861	487	6,338	2,950	3,388	7,228	5,930	1,298
Physicians' services	3,424	2,586	838	357	241	116	1,058	408	650	2,009	1,937	72
Dentists' services	235	148	87	80	45	35	125	83	42	31	21	10
Other professional services	201	148	53	43	34	9	70	30	40	89	85	4
Drugs and drug sundries	518	276	241	74	44	30	233	119	114	210	113	97
Eyeglasses and appliances	66	35	31	11	6	5	51	26	25	4	3	1
Nursing-home care	1,973	1,196	777	60	32	28	348	196	153	1,566	968	598
Other health services	1,888	1,283	604	746	316	430	912	782	130	230	184	46
						1972						
Total	$27,156	$18,145	$9,010	$3,305	$1,975	$1,330	$10,997	$5,739	$5,258	$12,851	$10,432	$2,419
Hospital care	17,548	11,563	5,985	1,746	1,111	635	7,768	3,791	3,977	8,030	6,660	1,370
Physicians' services	3,744	2,810	933	415	278	137	1,177	452	725	2,150	2,080	70
Dentists' services	255	166	90	92	53	39	135	93	42	29	21	8
Other professional services	228	166	62	51	41	10	83	36	47	94	89	5
Drugs and drug sundries	613	327	286	97	57	40	285	145	140	233	126	107
Eyeglasses and appliances	77	44	33	13	9	4	60	31	29	5	4	1
Nursing-home care	2,104	1,272	832	43	23	20	353	198	155	1,707	1,050	657
Other health services	2,586	1,798	788	849	403	446	1,139	995	144	601	401	200
						1973 [1]						
Total	$30,335	$20,105	$10,230	$3,576	$2,137	$1,439	$12,287	$6,393	$5,894	$14,473	$11,576	$2,897
Hospital care	19,249	12,609	6,640	1,881	1,204	677	8,510	4,104	4,406	8,856	7,300	1,556
Physicians' services	4,041	2,992	1,049	454	301	153	1,323	506	817	2,262	2,184	78
Dentists' services	288	188	101	103	59	44	151	104	47	34	24	10
Other professional services	241	168	73	50	38	12	92	37	55	99	92	7
Drugs and drug sundries	670	360	310	102	60	42	313	161	152	256	140	116
Eyeglasses and appliances	84	48	37	12	8	4	66	34	32	6	5	1
Nursing-home care	2,223	1,350	873	46	25	21	379	217	162	1,799	1,108	691
Other health services	3,539	2,392	1,147	927	441	485	1,456	1,231	225	1,158	722	437

[1] Preliminary estimates.

TABLE 4.—ESTIMATED PERSONNEL HEALTH CARE EXPENDITURES UNDER PUBLIC PROGRAMS, BY PROGRAM, AND SOURCE OF FUNDS, FOR THREE AGE GROUPS, FISCAL YEARS 1971–73

[In millions]

Program	All ages			Under 19			19–64			65 and over		
	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local
	1971											
Total	$23,221	$15,415	$7,807	$2,718	$1,579	$1,139	$9,136	$4,593	$4,543	$11,369	$9,242	$2,127
Health insurance for the aged	7,478	7,478								7,478	7,478	
Temporary disability insurance	68		68				68		68			
Workmen's compensation (medical benefits)	1,095	25	1,070				1,053	25	1,028	42		42
Public assistance (vendor medical payments)	5,997	3,222	2,775	1,050	564	486	2,723	1,463	1,260	2,225	1,195	1,030
General hospital and medical care	3,748	414	3,334	312	112	200	2,321	241	2,080	1,114	60	1,054
Defense Department hospital and medical care (including military dependents)	1,957	1,957		685	685		1,213	1,213		59	59	
Maternal and child health services	403	148	255	275	101	174	128	47	81			
School health	272		272	272		272						
Veterans' hospital and medical care	1,854	1,854					1,421	1,421		433	433	
Medical vocational rehabilitation	163	130	33	33	26	7	127	101	26	4	3	1
Office of Economic Opportunity	187	187		91	91		82	82		14	14	
	1972											
Total	$27,156	$18,145	$9,010	$3,305	$1,975	$1,330	$10,997	$5,739	$5,258	$12,851	$10,432	$2,419

Health insurance for the aged	8,364	8,364								8,364	8,364	
Temporary disability insurance	68		68				68		68			
Workmen's compensation (medical benefits)	1,215	27	1,188				1,171	27	1,144	44		44
Public assistance (vendor medical payments)	7,455	4,003	3,453	1,268	681	587	3,590	1,928	1,662	2,597	1,395	1,202
General hospital and medical care	4,353	619	3,734	474	194	280	2,647	366	2,281	1,231	59	1,172
Defense Department hospital and medical care (including military dependents)	2,341	2,341		819	819		1,451	1,451		70	70	
Maternal and child health services	495	259	236	337	176	161	158	83	75			
School health	295		295	295		295						
Veterans' hospital and medical care	2,233	2,233					1,703	1,703		530	530	
Medical vocational rehabilitation	179	143	36	36	29	7	140	112	28	4	3	1
Office of Economic Opportunity	156	156		76	76		69	69		11	11	
	1973[1]											
Total	$30,335	$20,105	$10,230	$3,576	$2,137	$1,439	$12,287	$6,393	$5,894	$14,473	$11,576	$2,897
Health insurance for the aged	9,039	9,039								9,039	9,039	
Temporary disability insurance	68		68				68		68			
Workmen's compensation (medical benefits)	1,370	30	1,340				1,324	30	1,294	46		46
Public assistance (vendor medical payments)	8,525	4,625	3,899	1,370	743	627	3,896	2,114	1,782	3,259	1,768	1,491
General hospital and medical care	5,050	721	4,329	560	235	325	3,070	425	2,645	1,420	61	1,359
Defense Department hospital and medical care (including military dependents)	2,597	2,597		909	909		1,610	1,610		78	78	
Maternal and child health services	455	221	234	310	151	159	145	70	75			
School health	320		320	320		320						
Veterans' hospital and medical care	2,561	2,561					1,955	1,955		608	608	
Medical vocational rehabilitation	197	158	39	40	32	8	153	123	30	4	3	1
Office of Economic Opportunity	152	152		67	67		66	66		19	19	

[1] Preliminary estimates.

TABLE 5.—ESTIMATED AMOUNT AND PERCENTAGE DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES FOR THE AGED, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FISCAL YEARS 1971–73

Type of expenditure	Amount (in millions)					Percentage distribution				
	Total	Private	Public			Total	Private	Public		
			Total	Medicare	Other			Total	Medicare	Other
	1971									
Total	$17,650	$6,283	$11,369	$7,478	$3,891	100.0	35.6	64.4	42.4	22.0
Hospital care	8,644	1,416	7,228	5,290	1,938	100.0	16.4	83.6	61.2	22.4
Physicians' services	3,166	1,159	2,009	1,859	150	100.0	36.6	63.4	58.7	4.7
Dentists' services	330	299	31	----------	31	100.0	90.6	9.4	----------	9.4
Other professional services	318	229	89	78	11	100.0	72.0	28.0	24.5	3.5
Drugs and drug sundries	1,798	1,588	210	----------	210	100.0	88.3	11.7	----------	11.7
Eyeglasses and appliances	412	408	4	----------	4	100.0	99.0	1.0	----------	1.0
Nursing-home care	2,730	1,164	1,566	223	1,343	100.0	42.6	57.4	8.2	49.2
Other health services	250	20	230	28	202	100.0	8.0	92.0	11.2	80.8
	1972									
Total	$20,106	$7,257	$12,851	$8,364	$4,487	100.0	36.1	63.9	41.6	22.3
Hospital care	9,807	1,777	8,030	6,017	2,013	100.0	18.1	81.9	61.4	20.5
Physicians' services	3,658	1,508	2,150	2,006	144	100.0	41.2	58.8	54.8	3.9
Dentists' services	355	326	29	----------	29	100.0	91.8	8.2	----------	8.2
Other professional services	352	258	94	82	12	100.0	73.3	26.7	23.3	3.4
Drugs and drug sundries	1,920	1,687	233	----------	233	100.0	87.9	12.1	----------	12.2
Eyeglasses and appliances	435	430	5	----------	5	100.0	98.9	1.1	----------	1.1
Nursing-home care	2,958	1,251	1,707	216	1,491	100.0	42.3	57.7	7.3	50.4
Other health services	621	20	601	43	558	100.0	3.2	96.8	6.9	89.9
	1973 [1]									
Total	$22,442	$7,972	$14,473	$9,039	$5,434	100.0	35.5	64.5	40.3	24.2
Hospital care	10,860	2,004	8,856	6,613	2,243	100.0	18.5	81.5	60.9	20.7
Physicians' services	3,969	1,707	2,262	2,094	168	100.0	43.0	57.0	52.8	4.2
Dentists' services	381	347	34	----------	34	100.0	91.1	8.9	----------	8.9
Other professional services	353	254	99	81	18	100.0	72.0	28.0	22.9	5.1
Drugs and drug sundries	2,074	1,818	256	----------	256	100.0	87.7	12.3	----------	12.3
Eyeglasses and appliances	452	446	6	----------	6	100.0	98.7	1.3	----------	1.3
Nursing-home acre	3,175	1,376	1,799	206	1,593	100.0	43.3	56.7	6.5	50.2
Other health services	1,178	20	1,158	45	1,113	100.0	1.7	98.3	3.8	94.5

[1] Preliminary estimates.

38-470—75——5

TABLE 6.—COMMUNITY HOSPITAL UTILIZATION AND EXPENSES, BY AGE GROUP, FISCAL YEARS 1967–73

Fiscal year	Number of admissions (in thousands)			Number of patient days (in thousands)			Average length of stay (days)			Expenses	
	All ages	Under 65	65 and over	All ages	Under 65	65 and over	All ages	Under 65	65 and over	Total (in millions)	Per adjusted patient day
1967	27,048	21,840	5,208	214,454	148,536	65,918	7.93	6.80	12.66	$11,510	$49.22
1968	27,465	21,960	5,505	221,971	148,878	73,093	8.08	6.78	13.28	13,697	56.24
1969	28,027	22,123	5,904	227,633	149,585	78,048	8.12	6.76	13.22	15.965	63.66
1970	29,238	23,101	6,137	231,601	153,120	78,481	7.92	6.63	12.79	18,669	73.14
1971	30,312	23,996	6,346	234,413	155,475	78,938	7.73	6.49	12.44	21,418	82.70
1972	30,706	24,071	6,635	232,892	153,587	79,305	7.58	6.38	11.95	23,925	92.48
1973	31,483	24,513	6,970	235,984	155,623	80,361	7.50	6,35	11.53	26,589	101.05
Percentage change from preceding year:											
1968	1.5	0.5	5.7	3.5	0.2	10.9	1.9	−0.3	4.9	19.0	14.3
1969	2.0	.7	7.2	2.6	.5	6.8	.5	−.3	−.5	16.6	13.2
1970	4.3	4.4	3.9	1.7	2.4	.6	−2.5	−1.9	−3.3	16.9	14.9
1971	3.7	3.7	3.4	1.2	1.5	.6	−2.4	−2.1	−2.7	14.7	13.1
1972	1.3	.4	4.6	−.6	−1.2	.5	−1.9	−1.7	−3.9	11.7	11.8
1973	2.5	1.8	5.0	1.3	1.3	1.3	−1.1	−.5	−3.5	11.1	9.3

Source: "Hospital Indicators," Hospitals, midmonth issues.

TABLE 7.—AMOUNT AND PERCENT OF EXPENDITURES FOR PERSONAL HEALTH CARE MET BY THIRD PARTIES FOR TWO AGE GROUPS, FISCAL YEARS 1966–73

Fiscal year	Total	Direct payments	Third-party payments			
			Total	Private health insurance	Government	Philanthropy and industry
			All ages			
Total amount (in millions):						
1966	$36,216	$18,668	$17,548	$8,936	$7,892	$720
1967	41,324	18,766	22,558	9,344	12,461	753
1968	46,323	18,899	27,424	10,444	16,205	775
1969	52,059	20,316	31,744	12,206	18,714	824
1970	59,127	23,281	35,846	14,406	20,550	890
1971	65,662	24,749	40,913	16,728	23,221	964
1972	72,761	25,968	46,793	18,602	27,156	1,035
1973	80,048	28,127	51,921	20,463	30,335	1,123
Per capita amount:						
1966	$181.96	$93.79	$88.16	$44.90	$39.65	$3.62
1967	205.35	93.26	112.10	46.43	61.92	3.74
1968	227.78	92.93	134.85	51.36	79.68	3.81
1969	253.52	98.93	154.59	59.44	91.13	4.01
1970	285.00	112.22	172.79	69.44	99.06	4.29
1971	313.36	118.11	195.25	79.83	110.82	4.60
1972	343.89	122.73	221.16	87.92	128.35	4.89
1973	375.41	131.91	243.50	95.97	142.27	5.27
Percentage distribution:						
1966	100.0	51.5	48.5	24.7	21.8	2.0
1967	100.0	45.4	54.6	22.6	30.2	1.8
1968	100.0	40.8	59.2	22.5	35.0	1.7
1969	100.0	39.0	61.0	23.4	35.9	1.6
1970	100.0	39.4	60.6	24.4	34.8	1.5
1971	100.0	37.7	62.3	25.5	35.4	1.5
1972	100.0	35.7	64.3	25.6	37.3	1.4
1973	100.0	35.1	64.9	25.6	37.9	1.4
			Under age 65			
Total amount (in millions):						
1966	$27,974	$14,286	$13,688	$7,627	$5,432	$629
1967	31,332	15,085	16,247	8,755	6,815	677
1968	34,222	15,711	18,511	9,786	8,024	701
1969	38,223	16,784	21,439	11,437	9,256	746
1970	43,461	18,720	24,741	13,498	10,434	809
1971	48,010	19,574	28,436	15,708	11,854	874
1972	52,657	19,928	32,729	17,486	14,302	941
1973	57,607	21,488	36,110	19,235	15,863	1,021
Per capita amount:						
1966	$154.96	$79.13	$75.82	$42.25	$30.09	$3.48
1967	171.71	82.67	89.04	47.98	37.35	3.71
1968	185.73	85.27	100.47	53.11	43.55	3.80
1969	205.68	90.32	115.36	61.54	49.81	4.01
1970	231.77	99.83	131.94	71.98	55.64	4.31
1971	254.02	103.56	150.45	83.11	62.72	4.62
1972	276.22	104.53	171.68	91.72	75.02	4.94
1973	300.19	111.97	188.21	100.23	82.66	5.32
Percentage distribution:						
1966	100.0	51.1	48.9	27.3	19.4	2.2
1967	100.0	48.1	51.9	27.9	21.8	2.2
1968	100.0	45.9	54.1	28.6	23.4	2.0
1969	100.0	43.9	56.1	29.9	24.2	2.0
1970	100.0	43.1	56.9	31.1	24.0	1.9
1971	100.0	40.8	59.2	32.7	24.7	1.8
1972	100.0	37.8	62.2	33.2	27.2	1.8
1973	100.0	37.3	62.7	33.4	27.5	1.8
			Aged 65 and over			
Total amount (in millions):						
1966	$8,242	$4,382	$3,860	$1,309	$2,460	$91
1967	9,990	3,681	6,309	589	5,644	76
1968	12,102	3,191	8,911	658	8,179	74
1969	13,838	3,534	10,304	769	9,457	78
1970	15,664	4,559	11,105	908	10,116	81
1971	17,650	5,171	12,479	1,020	11,369	90
1972	20,106	6,045	14,061	1,116	12,851	94
1973	22,442	6,640	15,802	1,228	14,473	101

TABLE 7.—AMOUNT AND PERCENT OF EXPENDITURES FOR PERSONAL HEALTH CARE MET BY THIRD PARTIES FOR TWO AGE GROUPS, FISCAL YEARS 1966–73—Continued

Fiscal year	Total	Direct payments	Third-party payments			
			Total	Private health insurance	Government	Philanthropy and industry
	Aged 65 and over					
Per capita amount:						
1966	$445.25	$236.72	$208.52	$70.71	$132.89	$4.92
1967	532.32	196.14	336.18	31.38	300.74	4.05
1968	633.05	166.92	466.13	34.42	427.84	3.87
1969	709.35	181.16	528.19	39.42	484.78	4.00
1970	785.67	228.67	557.00	45.54	507.40	4.06
1971	859.51	251.81	607.69	49.67	553.64	4.38
1972	959.85	288.59	671.27	53.28	613.50	4.49
1973	1,052.48	311.40	741.08	57.59	678.75	4.74
Percentage distribution:						
1966	100.0	53.2	46.8	15.9	29.8	1.1
1967	100.0	36.8	63.2	5.9	56.5	.8
1968	100.0	26.4	73.6	5.4	67.6	.6
1969	100.0	25.5	74.5	5.6	68.3	.6
1970	100.0	29.1	70.9	5.8	64.6	.5
1971	100.0	29.3	70.7	5.8	64.4	.5
1972	100.0	30.1	69.9	5.6	63.9	.5
1973	100.0	29.6	70.4	5.5	64.5	.4

The only data presently available on nationwide health care expenditures and utilization by income level of selected age groups is in two studies done under contract to the Department by Ronald Anderson, et. al., of the Center for Health Administration Studies of the University of Chicago: (1) Health Service Use: National Trends and Variations—1953–1971 (DHEW publication No. (HSM) 73–3004, October 1972); and (2) Expenditures for Personal Health Services: National Trends and Variations—1953–1970 (DHEW Publication No. (HRA) 74–3105, October 1973). We would assume that the distribution of income contained in these studies has not changed appreciably since 1970 or 1971. We enclose a copy of each study.*

Question 3. In the explanation accompanying the CHIP proposal, there is the statement: "Medicare beneficiaries who are low-income would be eligible for reduced premium payments and cost-sharing. The income testing and income definitions would be tied to SSI."

However, there are graduated income tables in the bill which are not tied to SSI. How would "income" be determined, not only for individuals but for couples and families?

Answer. The quoted statement means that the income definition and income testing for the Federal Health Care Insurance Plan of CHIP would follow the same administrative mechanisms that are currently being used for the Supplementary Security Income (SSI) program established under Public Law 92–603.

The definition of income for individuals and families, which CHIP leaves to the Secretary's regulation, is now being developed by the Department. This definition need not be the same as that used in SSI since it is intended for a health insurance benefits program, not an income maintenance program. We are anticipating that the two government plans in CHIP (AHIP and the Federal Plan) will use consistent definitions.

Under CHIP, income will be determined by a public agency designated by the Secretary.

Question 4. The Social Security Offices now have the burden of administering the SSI program and the income testing for that program. If SSA would administer income testing under the CHIP proposal for Medicare beneficiaries, how much more manpower and additional resources would be needed?

Answer. No decision has been made as to which agency within HEW would administer CHIP. The Department has established a task force to determine the

*Retained in committee files.

administrative functions required by CHIP. However, we cannot offer estimates of manpower and resource needs at this time.

Question 5. What proportion of the aged do not go into a hospital during the course of a year but do require medical care? In effect, these individuals would have their deductible increased from $60 to $100.

Answer. The table below summarizes the general picture for an average year:

Medicare beneficiary category:	*Percent*
Total eligibles age 65 and over	100
Hospitalized during year but do not meet part B deductible that year	1
Hospitalized during year and also meet part B deductible that same year	19
Not hospitalized during year but meet annual part B deductible	31
Receive no Medicare benefits during the year	49

Comment. For those who are hospitalized, the effective deductible for those not eligible for reduced cost-sharing under CHIP would be decreased to $100 from $144 (the $84 deductible under part A in addition to the $60 deductible under part B) under the present Medicare law.

Question 6. Would home health care visits be limited to post-hospital care?

Answer. No. Unlike the skilled nursing facility benefit, prior hospitalization would not be required for the home health care services benefit under CHIP.

ITEM 2. LETTER TO DR. CHARLES C. EDWARDS, ASSISTANT SECRETARY FOR HEALTH, HEW, FROM SENATOR EDMUND S. MUSKIE, DATED FEBRUARY 12, 1974, AND REPLY DATED MARCH 26, 1974

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., February 12, 1974.

CHARLES C. EDWARDS, M.D.,
Assistant Secretary for Health, Department of Health, Education, and Welfare, Washington, D.C.

DEAR DR. EDWARDS: As you may recall, during the July 1973 hearings on home health before the Subcommittee on Health of the Elderly at which you testified there was a discussion of projects to test the value of homemaker services. These experiments were authorized by section 222 of Public Law 92-603.

Dr. Claire Ryder of your staff said ". . . section 222 of Public Law 92-603 provides an opportunity to test out a clearly defined homemaker service as a possible alternative to the present benefits under Medicare part A. It will allow us to establish some demonstrations and experiments designed to test out what kinds of patients would benefit from this particular service, the length of the service that they would need, and the costs and impact of such service. One of the concerns that I see addressed in these projects as a part of this whole area of homemaker-home health aids—and I hyphenate the terms rather than separate them because one person, the homemaker-home health aid, provide both elements of this service—how this service can expedite or even make possible the delivery of professional health services."

It has been over 6 months since the home health hearings, and I understand that the projects have not begun. Since I have introduced legislation which would add homemaker services as a home health benefit, I am very interested in these projects and would appreciate a report on their status including the proposed scope.

With best wishes,

Sincerely,

EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., March 26, 1974.

Hon. EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly, Special Committee on Aging, U.S. Senate, Washington, D.C.

DEAR SENATOR MUSKIE: Thank you for your letter of February 12 in which you asked me about the status of research on homemaker services as authorized

under section 222 of Public Law 92–603. I do recall the subcommittee hearings of last July, and I am pleased to describe the current status of our work in this important area of health services. I regret that we were unable to reply before your hearings with the Department March 13.

Since section 222 authorizes research on homemaker services along with intermediate care facility services and day care services, our plans reflect this wider universe.

Specifically, our research will (1) compare the total cost of providing intermediate care facility and homemaker service under title XVIII, and/or day care service under titles XVIII and XIX with the "traditional" care services now covered under titles XVIII and XIX; (2) determine and compare the extent to which the alternative benefits will enable an eligible person to reach and maintain an optimal functional level or will prevent institutionalization compared to present benefits; and (3) measure the cost and effectiveness of methods of patient assessment, patient management planning, and follow-up as an integral part of a service delivery system compared to the present system of care.

In order to better design this research, the Department is initiating studies to provide a complete inventory of existing homemaker services, as well as intermediate and day car facilities. We believe current information on the nature and extent of these services nationwide is an essential requirement for designing subsequent projects to demonstrate and evaluate alternative approaches. These initial studies will describe the current resources in terms of size, patient volumes, total expenditures, and reimbursement practices and rates. Meanwhile, preliminary planning is going forward in connection with subsequent experiements, although the designs cannot be completed until the results of the survey work are available. As our specific plans crystallize, which we expect will occur before the end of April, we will keep you advised.

We have long been concerned with improving home health services and recently published Homemaker/Home Health Aide Services in the United States. This was written under a Public Health Service project that began prior to enactment of the 1972 Social Security Amendments. The book may be of interest in connection with the work of the subcommittee, since it presents guidelines for establishing high-quality services. A copy of ths publication will be forwarded to the subcommittee under separate cover.[1]

We hope this information is helpful, and will be glad to answer further questions you might have on our homemaker services research.

Sincerely yours,

CHARLES C. EDWARDS, M.D.,
Assistant Secretary for Health.

ITEM 3.—COMMENTS ON STATEMENT OF NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, DELIVERED TO THE SUBCOMMITTEE ON THE HEALTH OF THE ELDERLY OF THE SENATE SPECIAL COMMITTEE ON AGING, MARCH 12, 1974; SUBMITTED BY FRANK E. SAMUEL, JR., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

As requested by the Chairman of the Committee, we have reviewed Mr. Cruikshank's statement and have prepared the following general and specific comments.

GENERAL

Mr. Cruikshank's statement reflects, at best, a misunderstanding of the Administration's proposed Comprehensive Health Insurance Plan (CHIP). At worst, his statement incorporates distortions of fact and is unfortunately very misleading. We will address his observations individually.

SPECIFIC COMMENTS

(1) *Statement.*—"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."

Response.—We do not believe a monolithic Federal bureaucracy is preferable to a pluralistic approach in which States, providers, consumers and the private

[1] Retained in committee files.

insurance industry will have a stake in making the system work. We believe a clearly limited role for the Federal Government, and major roles for State governments and private insurance companies is not only the more desirable but also the more feasible approach. Such a partnership builds on the capabilities of each and reflects a balanced and practical approach that can best resolve the financing and other problems of the health sector. We believe that a significant Federal role such as that envisioned in S. 3 would represent a major step down the road toward complete Federal financing and control of all health care in the United States. We believe the dangers of turning financial control of the health care industry over to an enormous new Federal bureaucracy are considerable. We would run the risk of creating an institution which would be unresponsive to particular needs and would lack sufficient flexibility and innovation. We believe that the fact that CHIP preserves greater choice among private health insurance plans and a major role for State governments is one of its greatest strengths. CHIP would build on demonstrated insurance company capacity—not on the theoretical attributes of a new bureaucracy. It would also increase competition among insurance companies, providing important incentives for improvements and increased efficiency in administration that are lacking in S. 3.

(2) *Statement.*—"I am assuming in this count that all States would wish to cooperate in CHIP. But what if they don't?"

Response.—We believe that the advantage to the States of participating in CHIP is so substantial that all will participate. If the experience of the Medicaid program may serve as a guide, only one or two States at most can be expected not to participate.

(3) *Statement.*—"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."

Response.—A conscious decision was made to retain both the IHS and the VA intact, so as to preserve the traditional benefits reserved for this group by law. Under CHIP, however, Indians and veterans will have dual eligibility for either their own health services program or for CHIP. Many will undoubtedly prefer to continue utilization of their own health care system, but they are under no obligation to do so.

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

Response.—This statement reflects a lack of understanding of the basic approach of CHIP, which does indeed represent a single universal system for all. The administration of the program will be the responsibility of a partnership of the private insurance industry, the States and the Federal Government, but these components will comprise a unified administrative network. The benefit package is, of course, uniform. Cost-sharing rates do vary for lower-income persons because of their inability to pay the higher charges; this, in our view, is an advantage, not a fault.

For the vast majority of Americans who are full-time workers or their dependents, there will be no variation in cost-sharing regardless of whether they move up or down the income ladder. If the worker should become 65, or disabled or unemployed, the only change which would occur is that his cost-sharing liability and perhaps his premiums would be reduced. We do not believe this would create "confusion" but rather see it as equitable treatment of those who are less able to pay full cost-sharing charges.

(5) *Statement.*—"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."

Response.—On the contrary, CHIP excludes no one—every U.S. citizen is eligible to enroll. Some individuals may prefer not to enroll in CHIP or to purchase their own coverage. We estimate that approximately 2 percent of the population will fall into this category.

(6) *Statement.*—"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."

Response.—A family that is basically healthy, and therefore does not meet its deductible, would not "benefit" in that year from the plan to be sure. However,

by providing that the financing of small bills be done by the family, the CHIP plan is able to provide comprehensive coverage against larger bills *at a reasonable premium cost.* We believe the average worker and taxpayer is able to appreciate the fact that "free" medical services are never really free, that he will pay those small bills one way or the other.

(7) *Statement.*—"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 (0.9 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 (0.9 percent of $10,000)	90
Total expenditures before eligibility for benefits under Nixon program	1,255"

Response.—This table is inaccurate in the following respects:

(a) The average family premium is estimated to be $600, not the $475 shown on the chart. The employee contribution will be 25 percent after the first three years, so the 35 percent figure is misleading. This brings the employee share of the premium to $150.

(b) The $450 figure for a family's deductibles is misleading inasmuch as benefits for any single family member begin, not after the $450 limit on family deductibles, but after expenses for that member pass $150. For example, it would be unusual for three members of a single family to be hospitalized in any given year. If such were the case, however, the entire family would meet its three-deductible limit and benefit from the CHIP coverage as soon as that $450 limit were reached; this would be true even if more than three members of the family were ill. More common would be the example of a mother receiving maternity benefits or a child who undergoes a tonsillectomy. In each case, the member of the family receiving services would benefit from the first day of hospitalization.

(c) The $150 listed for the drug benefits is also misleading and inaccurate because it implies that a family must meet $150 worth of drug expenses before it will receive any benefits under CHIP. Actually, any member of the family will begin to receive benefits as soon as one $50 deductible for drugs or one $150 regular deductible has been met.

(d) The entry "Total Family Expenses Before Receiving Benefits under Nixon Program" should read, therefore, $390 instead of $856.

Finally, in concentrating on what a family would have to spend before benefitting from CHIP, Mr. Cruikshank has neglected to discuss what the family's expected cost-sharing liability would be in fact. Based on a projected average utilization of $900 in 1975, the family in the $10,000 income category would have an expected cost-sharing liability of $337.50. This is less than half of the $856 projected by Mr. Cruikshank.

We would also add that the inclusion of the Medicare tax is inconsistent with the "total expenditures before eligibility for benefits" begins concept inasmuch as the tax would continue to be, as it is now, for future protection and is not properly associated with the other immediate expenses.

(8) *Statement.*—"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."

Response.—This statement is extremely misleading as are many examples which are skewed to demonstrate a certain point. As indicated earlier, it is a rare family which would have three members with severe enough illnesses to meet both their drug deductible and general deductible. Secondly, Mr. Cruikshank for some reason has stopped at the point where the family has incurred $1,500 in medical expenses. We believe this is unrealistic, particularly in the example Mr.

Cruikshank uses of a family with three ill members. If the family members were ill enough to incur $1,500 in expenses, it is possible that their true expenses would range much higher. The value of CHIP, of course, increases as the amount of incurred expenses increases.

Thus, it is more likely that a family such as described in the example would incur closer to $4,500 in medical expenses, not the $1,500 in Mr. Cruikshank's example. In this situation, the family would have paid $1,462.50 in cost-sharing (three $150 deductibles plus 25 percent coinsurance on the $4,050 of medical expenses) and the $150 premium, but would have received a benefit of $2,887.50 in covered medical expenses. With but $37.50 more in cost-sharing the family would have reached their annual maximum out-of-pocket liability ($1,500) beyond which *all* covered medical expenses would be fully paid.

This is not a typical family, however, inasmuch as the expected average cost-sharing liability of a family in this $10,000 income category, as previously indicated, would be $337.50. A family in this income category would reach their maximum liability of $1,500 after incurring a total of $5,500 in medical expenses.

(9) *Statement.*—"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."

Response.—Mr. Cruikshank appears to believe that the benefits of insurance protection depend on how much of every dollar of medical expense is paid by the insuror. He would seem to be disappointed that more people would not "benefit," in his sense of that word, from the programs. In fact, one reason for a low number of "beneficiaries" may simply be a result of the fact that (fortunately) relatively few people are sick enough to accumulate $150 in medical expenses in a year. In addition, Mr. Cruikshank has again ignored the income-related features of CHIP which reduce cost-sharing for low-income persons.

(10) *Statement.*—"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."

Response.—We disagree with the last statement. With the exception of extended care, which, because of its social services implications, should not be loaded onto any NHI program, few families are strapped by the cost of physical exams, other physicians' services, and dental and eye care. These are generally items of a routine nature which are predictable medical expenses for which they can budget. Loading them onto an NHI program makes it unnecessarily expensive to the consumer.

(11) *Statement.*—"The Administration recognizes that the time is ripe for National Health Insurance, but it would merely attempt to patch up the present 'non-system' in a half-hearted way."

Response.—We reject the notion that a complete revolution in the financing and organization of medical care is necessary. A carefully designed combination of reforms to existing health delivery and financing arrangements offers the best hope for solving recognized problems.

(12) *Statements.*—"Primary reliance would continue to be placed on the private health insurance industry—the shakiest pillar in the whole structure—thus inviting rising fees and increasing the profit bonanza for the insurance industry." . . . . "In fact, close examination of the Administration proposal indicates that the biggest beneficiaries would not be the sick, but the health insurance industry."

Response.—This is simply not the case. Group coverage is already a highly competitive market with low benefit margins; our plan would increase competition which would further reduce prices. We have attached an analysis of the Economic Performance of Private Health Insurance Plans which demonstrates that concerns about "a bonanza" for private insurance are groundless.

(13) *Statement.*—"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."

Response.—The experience of the Medicaid program has demonstrated that financing alone will not provide access to heath care for all. In spite of the massive

sums of Federal aid which have gone into the training of health manpower and the building of health facilities, many communities—with varied populations—remain without adequate health manpower and/or facilities. We suggest it is naive to believe that any NHI proposal currently before the Congress can guarantee access to health care because workable and effective incentives have not yet been developed which will encourage physicians and other health professionals to practice in medical scarcity areas. These problems are addressed through other legislation proposed by the Administration.

(14) *Statement.*—"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."

Response.—This is not accurate. The Medicare program would remain essentially unchanged except that (1) many aged would pay less in cost-sharing charges; (2) others would pay more, but in no case could the maximum cost-sharing liability exceed $750, a limit which does not exist under the current program; (3) benefits are expanded and improved, and (4) physicians treating Medicare patients would be required to accept as full reimbursement the rates determined by each State instead of selectively accepting assignment as under present Medicare.

The basic purpose of Medicare—to assist in meeting the health care expenses of the elderly—and the basic concept of Medicare—health insurance financed through payroll taxes—will not change under CHIP.

(15) *Statement.*—"That there are weaknesses and shortcomings in the Medicare program I would be the last to deny. But the President's proposals attack these shortcomings by compounding them rather than getting at their root causes and seeking a cure."

Response.—This is a misleading statement. CHIP will attack the following shortcomings in Medicare:

(a) Unlike the present Medicare program with its imbalanced cost-sharing between Part A and Part B and the subsequent incentive to use higher-cost hospital and related care, cost-sharing will be uniform for all services under CHIP. Mr. Cruikshank sees this uniform cost-sharing under CHIP as a limitation of the benefits available to Medicare beneficiaries. In fact, however, CHIP would require cost-sharing on hospital care at the same rate that Medicare beneficiaries are currently paying for Part B services. Mr. Cruikshank objects to this 20% coinsurance rate for Part B only when it is applied to Part A services. This alone would indicate that currently Part A services are overutilized relative to Part B services because of the differential in cost-sharing. It is this overutilization which CHIP seeks to affect.

(b) The higher out-of-pocket costs paid by Medicare beneficiaries because of physicians who do not accept assignment will be eliminated under CHIP because all physicians and facilities treating Medicare patients must accept assignment.

(c) The lack of catastrophic protection which forces more than half of the Medicare beneficiaries to buy supplemental insurance (generally to cover the cost-sharing charges after the first 60 days of inpatient hospital care) will be much less of a problem for Medicare beneficiaries because catastrophic protection through the $750 maximum annual liability would be provided by CHIP.

(16) *Statements.*—"For example, surely one of the major shortcomings of Medicare is the fact that it leaves a significant part of the medical and hospital bill of the older patient to be paid out of his own income.". . . "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."

Response.—Item 15, above, explains why such an assertion is untrue.

(17) *Statement.*—"The accompanying three tables illustrate the impact of these so-called 'utilization control' devices for that portion of the Medicare covered population not eligible for income-related reductions. 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 II shows the out-of-pocket costs for the same services under the Nixon proposal. 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.

"These tables make it clear that only those persons experiencing catastrophic health costs would be better off under the President's proposals."

Response.—Mr. Cruikshank's discussion of the tables ignores entirely the differences in the benefit package between current Medicare and CHIP. This omission tends to present more favorably the less comprehensive, less costly present Medicare program.

Much depends, as is the case with any chart comparison, on the manner in which the charts are drawn up, particularly with respect to their underlying assumptions. In this regard, we note three major points which tend significantly to bias the charts:

(1) Table II ignores CHIP's income-related maximum liability feature, erroneously assuming that all beneficiaries would pay cost-sharing amounts until the $750 limitation is reached. Beneficiaries with low incomes who opt for reduced cost-sharing will pay substantially less than this maximum amount. This significant omission from Mr. Cruikshank's presentation is sufficient to render the chart comparison meaningless for the most part.

(2) Table I erroneously assumes that under present law all charges for covered services are reasonable charges, so that beneficiary liability is limited to 20 percent of the total charges for covered services after the deductible is met. In fact, over 10 percent of the amounts billed to the current Part B program are considered to exceed the reasonable charges. This omission tends to cause the amounts in Table I to be significantly understated.

(3) The charts are terminated at the 80th day of inpatient hospital care, so the substantial cost sharing under the current part A program is omitted. Thus, although Mr. Cruikshank does note CHIP's advantages with respect to catastrophic illnesses in his testimony, the chart presentation is misleading and biased toward the present Medicare program.

As requested by the Chairman, we have developed charts which show the CHIP cost-sharing charges for Income Classes I–III individuals. (See attached Tables IV, V, and VI)

TABLE IV.—CHIP COST-SHARING PROVISIONS FOR THE AGED—INCOME CLASS I (0–$1,749)[1]

	Days in hospital (per year)							
Medical services bill	0	5	10	20	40	80	150	365
0		$55	$105	$105	$105	$105	105	$105
$50	$5	60	105	105	105	105	105	105
$100	10	65	105	105	105	105	105	105
$200	20	75	105	105	105	105	105	105
$400	40	95	105	105	105	105	105	105
$800	80	105	105	105	105	105	105	105
$1,600	105	105	105	105	105	105	105	105
$30,000	105	105	105	105	105	105	105	105

[1] Deductible, 0; coinsurance, 10 percent; maximum liability, 6 percent of income ($105).

TABLE V.—CHIP COST-SHARING PROVISIONS FOR THE AGED—INCOME CLASS II ($1,750–$3,499)[1]

	Days in hospital (per year)							
Medical services bill	0	5	10	20	40	80	150	365
0		$125.00	$207.50	$315	$315	$315	$315	$315
$50	$50.00	132.50	215.00	315	315	315	315	315
$100	57.50	140.00	222.50	315	315	315	315	315
$200	72.50	155.00	237.50	315	315	315	315	315
$400	102.50	185.00	267.50	315	315	315	315	315
$800	162.50	245.00	315.00	315	315	315	315	315
$1,600	282.50	315.00	315.00	315	315	315	315	315
$30,000	315.00	315.00	315.00	315	315	315	315	315

[1] Deductible, $50; coinsurance, 15 percent; maximum liability, 9 percent of income ($158–$315).

TABLE VI.—CHIP COST-SHARING PROVISIONS FOR THE AGED—INCOME CLASS III ($3,500–$5,249)[1]

Medical services bill	Days in hospital (per year)							
	0	5	10	20	40	80	150	365
0		$190	$300	$520	$630	$630	$630	$630
$50	$50	200	310	530	630	630	630	630
$100	100	210	320	540	630	630	630	630
$200	120	230	340	560	630	630	630	630
$400	160	270	380	600	630	630	630	630
$800	240	350	460	630	630	630	630	630
$1,600	400	510	620	630	630	630	630	630
$30,000	630	630	630	630	630	630	630	630

[1] Deductible, $100; coinsurance, 20 percent; maximum liability, 12 percent of income ($420–$630).

With respect to the statement that "only those persons experiencing catastrophic health costs would be better off" under CHIP, Mr. Cruikshank is apparently unaware of the case where an aged person with a chronic condition needs maintenance drugs but few doctors' visits. Such a person is much better off under CHIP because outpatient prescription drugs are not even covered under current Medicare. A second example is that of short-term hospitalization on top of several visits to a physician and surgeon. Under current Medicare there would be a separate $60 deductible for Part B and another $84 deductible for Part A. The CHIP beneficiary, however, would be able to apply all covered services to his total deductible of $100 so that his deductible when he needs inpatient hospital care would be greatly reduced. For example, if the CHIP beneficiary has $90 worth of covered services to apply toward that year's deductible, he need pay only $10 more toward services while hospitalized before meeting his deductible. Under current Medicare, he would have to pay an $84 deductible for Part A services regardless of the amount of Part B services used.

In addition, and much more important, is Mr. Cruikshank's omission of any reference to the fact that CHIP provides for reduced cost-sharing for low-income adults. That such assistance is available under CHIP and not under the current Medicare or Medicaid programs is of tremendous value for those aged whose incomes are not low enough to be eligible for Medicaid but low enough to need assistance in paying medical bills. For example, an aged person with an income of $3,000 would have a maximum liability of $270, a $50 deductible and a 15% coinsurance rate.

It is true that some Medicare beneficiaries could be faced with higher cost-sharing charges under CHIP than they currently pay, due to the 20 percent coinsurance on all covered services above the deductible, but this is more than offset by broader benefit coverage and the maximum annual liability feature. While present Medicare inpatient coverage tends toward first-dollar coverage with limited benefits and open-ended cost-sharing, Medicare under CHIP would emphasize uniform cost-sharing on all types of benefits until a maximum annual liability is reached beyond which the beneficiary pays nothing more for covered services. In addition, out-of-pocket expenses of beneficiaries for physician services will be reduced since physicians will be *required* to accept assignment of Medicare benefits under CHIP.

(18) *Statement.*—"The President has described his program as one which 'improves' Medicare. But its guiding principle to be to take a lot from a great many in order to give a few people very little."

Response.—This, again, is an inaccurate interpretation of the CHIP benefit package. An expansion of benefits cannot be described as a cutback in program value.

(19) *Statement.*—"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 principle 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. . . .

"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, home ownership 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."

Response.—Mr. Cruikshank is evidently under the impression that Medicare would become an income-related program; this is simply inaccurate. Medicare will remain, as it always has, a program of benefits with entitlement based on right. Those aged who choose to take advantage of the lower cost-sharing, subsidized from general revenue funds, not from the Trust Fund, may do so voluntarily, just as approximately 1 out of every 5 aged individuals do so today under Medicaid. No one will be forced, however, to go through a means test; income-related reduced cost-sharing will be purely optional.

With respect to the second point, Mr. Cruikshank is assuming that the subsidized cost-sharing for the low-income aged will be financed out of Trust Fund monies instead of general revenues. His reasoning apparently is that everyone, regardless of income, should be eligible for reduced cost-sharing. CHIP would provide for uniform cost-sharing for all Medicare eligibles, except for those with incomes under $5,250 who opt for reduced cost-sharing. They would receive assistance from general revenues, just as they do under the current Medicaid program, which fills in the gaps for almost 4 million low-income Medicare beneficiaries.

Mr. Cruikshank's third point requires correction. Persons not opting for reduced cost-sharing would be as eligible as all other persons for the basic protections of the CHIP coverage. We believe that the cost-sharing subsidies, drawn from general revenues, should be available only for those with low incomes.

(20) *Statement.*—"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 six 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 five years the inadequacies of this approach together with public awareness of the indignities attached to a means test program 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."

Response.—Mr. Cruikshank's narrative is inaccurate in two respects. First, although a social insurance program was established for both the aged and the disabled, the State-aided programs were not disbanded. Only in January 1974 were the public assistance programs for the aged, blind, and disabled heavily federalized under the SSI program. However, these are still State-aided and are not social insurance programs. In addition, State-aided assistance for the health care expenses of the aged, blind, disabled and dependent children are still operating as Medicaid programs.

We believe that the enactment of the Federal disability insurance and Medicare programs by the Congress (in the belief that at that time existing programs were inadequate) does not mean that enactment of a Federal-State and private industry program such as CHIP two decades later is a "step backward." Mr. Cruikshank's statement reflects a misunderstanding of the Administration's proposal, which will continue to finance Medicare through the payroll tax and the subsidized cost-sharing for the poor from general revenues. In short, the existing financing concepts of the current Medicare and Medicaid programs will continue in place.

(21) *Statement.*—"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."

Response.—The limit of 100 was determined to be reasonable, given the experience under Medicare with the average number of visits utilized by Medicare beneficiaries.

(22) *Statement.*—"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."

Response.—We find this statement puzzling, because Mr. Cruikshank is aware of the Department's policies on drug reimbursement and such policies have received wide-ranging support from consumer groups. Mr. Cruikshank implies that the "lowest-cost at which the drug is generally available" reimbursement policy will mean additional out-of-pocket costs for beneficiaries. This is just the opposite of the anticipated result. Patients as well as Federal and State governments will pay less in costs for drugs and cost savings may be diverted to financing additional benefits. Secondly, it is premature, we believe, to oppose drug benefits because of reimbursement provisions which are not spelled out in detail in the law because there are numerous instances where it is considered inadvisable to write into law mechanisms which need to be carefully developed and continually revised.

(23) *Statement.*—"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. CHIP coverage would depend upon a state electing to furnish coverage."

Response.—These statements are very misleading because: (1) Disabled and ESRD individuals will be covered under AHIP to the same extent as they are covered under Medicare (i.e., no reduction in benefits); and (2) the suggestion that States will not establish AHIP programs is implausible because of the strong financial incentives created to do so.

(24) *Statement.*—"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."

Response.—Mr. Cruikshank persists in misunderstanding the substance of CHIP. CHIP incorporates the following cost-controls:

1. increased competition in the medical marketplace by requiring all employers to offer an HMO option where HMO's exist;
2. a benefit package that removes the present incentive to use the most expensive type of care—i.e., hospital services—as a first resort;
3. a cost-sharing structure that requires a patient to pay up to 25 percent of the cost of his medical care up to his maximum liability;
4. the requirement that all capital investment of over $100,000 be reviewed by a State-designated planning agency;
5. the requirement that all covered health services be subject to Professional Standards Review Organization review to control against unnecessary utilization and poor quality medical care;
6. a reimbursement system for drugs based on the lowest prices generally charged in the area for the same generically and biologically equivalent drug;
7. a payment system for physicians based on a State-established reimbursement schedule and the requirement that such fees be accepted as full payment for persons insured under AHIP and Medicare. Physicians could require addi-

tional payments from those insured under Employer Plans, provided the patient is notified beforehand of such additional charges;

8. the requirement that States establish for hospitals prospective reimbursement systems that are consistent with Federal guidelines.

With respect to his statement on consumers, we would comment that consumers will be free to participate in the development of policy and regulations for CHIP. In addition, they will be free to participate in the development of reimbursement schedules which will be established by each State. We do not believe that advisory councils represent the optimal mechanism for channeling consumer input into the policymaking process.

(25) *Statement.*—"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."

Response.—This may be true; however, we disagree with the implications that they are therefore to be faulted. We do not believe that these functions are properly the responsibility of the private health insurance industry, whose primary mission is to administer the underwriting of insurance.

(26) *Statement.*—"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 counter-productive in controlling the cost of medical care."

Response.—This is an overly simplistic description of physician and patient behavior. The absence of cost-sharing in the health plans of some other countries has led to significant overutilization of services on the part of patients who are only marginally in need of such care, at the expense of patients who have greater need for the services. A system of moderate cost-sharing is designed to deter such unnecessary care which is patient-induced. (See also our response to statements 8 and 24.)

(27) *Statement.*—"The President is on weak ground when he turns to the as-yet-untested, physician-run Professional Review Organizations (PSROs) to reduce unnecessary utilization and cost. It is the proverbial situation of the fox set to guard the chicken coop."

Response.—Mr. Cruikshank's statements are at best premature. We are convinced that the PSRO's will be capable of assuming their peer review responsibilities by the time any NHI plan is effective.

(28) *Statements.*—"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."

Response.—We deliberately did not specify that the CHIP fee schedules apply across the board because this would, in our opinion, represent not only unnecessary interference in the practice of medicine, it would also reduce unnecessarily the range of choice available to enrollees. We consider the mandatory assignment provision under CHIP to be a significant improvement over the current Medicare program where fewer than half of the claims are assigned. We do not believe there will emerge a two-class system of medical care because of the large size of the group under mandatory assignment (73.5 million). This group will include many others besides the aged (22.4 million), such as the disabled, the high risk employee, and the low-wage employee.

(29) *Statement.*—"The Executive Board was quick to recognize that the President's proposal ignores the lessons gained in the eight 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."

Response.—We do not share Mr. Cruikshank's preference for an all-pervasive Federal Government control over medical care.

ATTACHMENT A

ECONOMIC PERFORMANCE OF PRIVATE HEALTH INSURANCE PLANS

Introduction

The efficiency of private carriers in underwriting health insurance coverage as compared with a government-administered program such as Medicare is a major issue in the debate on national health insurance.

There are three categories of private carriers:

Blue Shield and Blue Cross plans, which are nonprofit organizations established for the purpose of selling health insurance coverage.

Commercial carriers, which generally sell a broad line of insurance coverage, including life and casualty.

Independent plans, such as prepaid group practices and special plans administered by employers for their employees or by employer-employee welfare funds.

In 1972, Blue Shield and Blue Cross accounted for 44% of total health insurance premiums, the commercial carriers for 49%, and independent plans for 7%. This paper focuses principally on the first two types of plans and compares their performance to that of Medicare.

Two concerns arise in assessing the economics of private health insurance. The first deals with efficiency. The commonly used measure of efficiency (really, inefficiency) is the retention rate, which is the percent of premium payments going for profits (underwriting gains) and costs of administration, i.e., the percent *not* paid out in benefits. The second issue relates to profitability, typically defined in terms of net underwriting gains or losses, i.e., premium income less benefit payments and costs of administration.

Unfortunately, completely valid comparisons between private plans and Medicare are not possible, for several reasons.

Accounting systems are different. For example, selected costs of administration (e.g., policy review performed outside of the Social Security program) are not charged to the program; Federal construction costs are accounted for differently.

Somewhat different functions are performed. For example, Medicare is more comparable with large group coverage than with individual coverage. Yet, many large employers perform some of the paperwork functions associated with claims processing, including initial claims review.

Medicare has a much more stable enrollment than any privately covered group.

Tax treatment is different. The commercial carriers typically pay the States a tax of 2.0–2.5% of premiums.

The costs of claims administration depend heavily on the specific benefit package. Although hospital claims are more expensive to process in absolute dollar amount than drug claims, they are considerably less expensive to process per dollar of benefits paid, simply because the average size of the claim is many times larger.

The average Medicare claim is higher than that of private coverage because of the different populations covered. (The average Medicare hospital claim is roughly two times that of Blue Cross.) This should result in lower claims processing expense per benefit dollar for Medicare than for private carriers.

Medicare offers a single benefit package and does not bear the expenses of private carriers associated with allowing consumers to select among a wide range of benefit packages.

Medicare Part A (hospital insurance) currently has operating expenses of 3.5% and Part B (principally, physician services) has operating expenses of 12%. Operating expenses overall amount to about 6%.

Profitability of Private Carriers

In 1972, the private health insurance industry collected $22.3 billion in premiums, of which $19.5 billion—or 87.3%—was returned in benefit payments. Operating expenses accounted for $3.1 billion—or 14.0%—of premium income. Thus, there was a net underwriting loss of $300 million—or 1.3%—of premium income.

The losses were concentrated in commercial group policies, as shown below:

	Net underwriting gain	
	Amount (million)	Percent of premium income
Total	−$300.3	−1.3
Blue Cross-Blue Shield	243.4	2.5
Blue Cross	200.7	2.8
Blue Shield	42.7	1.5
Insurance companies	−548.5	−5.0
Group policies	−558.4	−6.7
Individual policies	9.9	.4
Independent plans	4.8	.3

Commercial group policies had a loss rate of 6.7%. In contrast, Blue Cross, Blue Shield, individual commercial policies, and independent plans experienced underwriting gains.

Not reflected in the above data on profitability is investment income from reserves that are held for future claims liability. This claims reserve is typically equivalent to 3 months of premium income. Assuming a return of 4% after taxes, the reserve would generate 1% in premium income.

Retention by Type of Carrier

Major differences in retention rates exist among the various types of health insurance plans. As the following table shows, Blue Cross/Blue Shield have lower retention rates than commercial carriers:

	Retentions (billions)	Retention rates (percent)
Total, private health insurance	$2.8	12.7
Total, Blue Cross/Blue Shield	.93	9.4
Blue Cross	.57	8.0
Blue Shield	.36	12.8
Total, insurance companies	1.79	16.4
Group policies	.56	6.7
Individual policies	1.23	47.4
Total, independent plans	.12	7.8

One of the reasons for the difference is the special treatment of the Blues, namely their exemption from Federal and State premium taxes, which nationally average 2.1% of premiums. However, there are significant differences in retention rates between Blue Cross (8.0%) and Blue Shield (12.8%). This difference reflects hospital claims having lower administrative costs per dollar paid in benefits than claims for physician services.

Group coverage returns a much higher proportion of the premium dollar in benefit payments than does individual coverage. The above table shows that, in 1972, the retention rate was 6.7% for commercial group policies compared with 47.4% on individual policies. These percentages include 2.1% in premium taxes, which should be subtracted in making comparisons with Medicare. The retention rate less premium taxes for group policies is an estimated 4.6%. However, operating expense less premium taxes for commercial group policies were 11.3%. The difference between operating expenses and retention rates reflects underwriting losses. Comparisons with Medicare are difficult for the reasons men-

tioned earlier (e.g., Medicare has a more stable enrollment, a much larger average claim size, and a uniform benefit package). Legitimate comparisons of commercial carriers with Blue Shield and Blue Cross are not possible because of differences in reporting (the "Blues" do not account separately for individual coverage), varying administrative arrangements with providers, and differences in the type of coverage sold (the Blues have more standardized benefit packages, and typically offer the consumer fewer choices).

Trends in Retention Rates

There is no noticeable upward or downward trend for aggregate retention rates. As the following table shows, retention rates for all private health insurance averaged 13.7% from 1960 to 1966 and 11.6% from 1966 to 1972.

RETENTIONS OF PRIVATE HEALTH INSURANCE ORGANIZATIONS AS A PERCENT OF SUBSCRIPTION OR PREMIUM INCOME, 1948-72[1]

Year	Total	Blue Cross-Blue Shield			Insurance companies			Independent plans[2]		
		Total	Blue Cross	Blue Shield	Total	Group policies	Individual policies	Total	Community	Employer-employee-union
1948	29.7	15.6	14.6	22.0	45.8	30.2	61.7	7.9	(3)	(3)
1950	23.2	14.5	12.3	21.6	33.9	22.8	47.4	10.0	(3)	(3)
1955	19.5	11.3	8.6	17.6	27.5	16.1	46.9	8.8	(3)	(3)
1960	14.5	7.9	7.2	9.6	21.1	9.6	47.1	3.5	(3)	(3)
1961	14.7	7.8	6.8	10.3	21.0	10.1	47.1	8.4	(3)	(3)
1962	14.4	7.2	5.7	11.0	20.9	9.4	49.3	9.2	(3)	(3)
1963	13.3	6.5	5.0	10.3	19.4	8.3	46.0	9.7	(3)	(3)
1964	12.8	5.6	3.9	9.7	19.1	8.3	45.5	9.5	(3)	(3)
1965	12.7	6.1	4.7	9.9	18.4	6.9	45.3	9.4	8.2	10.2
1966	13.5	8.1	6.6	12.0	18.1	6.9	45.6	9.3	8.0	10.2
1967	14.0	10.4	8.3	15.5	17.4	6.4	47.2	9.7	8.4	10.8
1968	12.1	6.7	3.7	13.8	16.5	6.2	46.4	8.6	6.2	9.7
1969	10.8	4.1	2.2	8.9	16.7	5.9	49.2	7.9	6.9	8.2
1970	8.4	4.2	2.7	7.8	12.5	3.9	41.9	3.8	4.5	1.6
1971	9.9	7.0	5.3	10.9	13.1	2.3	46.2	5.9	5.3	4.3
1972	12.7	9.4	8.0	12.8	16.4	6.7	47.4	7.8	8.1	6.1

[1] Amounts retained by the organizations for operating expenses, addition to reserves, and profits.
[2] Derived from table 16.
[3] Data by type of plan before 1965 not available.

Conclusion

Despite the difficulties inherent in making comparisons, available data at minimum argue against any *prima facie* case that Medicare is administering more efficiently than private coverage as some advocates of public financing contend. The evidence clearly refute allegations that private carriers would reap windfall profits from CHIP.

An additional concern is the long term dynamics of any proposal that would essentially nationalize private carriers and perform these functions either directly or under cost reimbursable contracts. The Medicare carriers and intermediaries view their non-Medicare business as being of paramount importance, and many operational processes related to Medicare are transferred from their private business. Reducing privately underwritten business to a small proportion of total health insurance business would inevitably lead to the same difficulties in controlling costs as have occurred in other industries—e.g., hospitals, portions of the aerospace industry—that receive revenues principally on the basis of actual mosts. As with hospitals, the inevitable results include the lack of a benchmark to measure efficiency; the generalized feeling that efficiency needs improving; and a sense of frustration in not being able to design effective incentives, despite potentially massive doses of governmental regulation. In contrast, CHIP would increase price competition in an already highly competitive industry by standardizing the benefit package (which will reduce operating expenses) and requiring disclosure to consumers of relevant information, including retention rates.

ITEM 4.—COMMENTS ON STATEMENTS OF MR. BERT SEIDMAN, DIRECTOR OF SOCIAL SECURITY, AFL–CIO, AND MR. NELSON CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, MARCH 13, 1974, BEFORE THE SUBCOMMITTEE ON HEALTH OF THE ELDERLY, SENATE SPECIAL COMMITTEE ON AGING; SUBMITTED BY FRANK E. SAMUEL, JR., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Statement.—"Mr. Chairman, the Secretary said that the program that he was proposing was far superior to that which is presently available under Medicare and Medicaid. Well, I think that you and others, both witnesses and Senators, have shown that there is a very serious question as to whether the program is superior. It may be superior in certain aspects. It is certainly clear that for most of the people who are now being covered by Medicare and Medicaid, it will be worse. . . ."

Response.—Objective analysis of the proposed legislation reveals that, overall, Medicare coverage is significantly improved. It cannot be denied, for example, that an expansion of the Medicare benefit package to include outpatient prescription drugs, comprehensive medical health services, and unlimited hospitalization represents a substantial improvement over existing Medicare coverage. Taking all changes into account, including modifications in cost-sharing arrangements, the actuarial value of the protection offered increases from $565 to $620 per year. Moreover, the structure of the insurance plan provides much better protection against what would otherwise be catastrophic medical bills, a feature absent from current Medicare.

CHIP would eliminate the need for millions of aged persons to purchase insurance supplementary to Medicare. Currently more than half of all Medicare beneficiaries secure some form of private coverage to supplement their Medicare protection. This figure is significant because it underlines the gaps in the current Medicare benefit package. The importance of being insured against such risks is illustrated by the fact that more than 11 million aged insured pay a gross average premium of $120/year for such supplemental protection.

Under CHIP, aged beneficiaries who are low-income would be eligible for reduced cost-sharing. This would particularly help those low-income aged who are currently above the present State-established income standards for Medicaid eligibility.

Overall, Federal expenditures for health insurance on behalf of the aged would increase by $1.8 billion.

Although the current Medicaid program in many States covers some services not provided under CHIP, we strongly believe that implementation of the CHIP plan would represent a basic advance in the provision of medical services to most low-income families and individuals.

Because CHIP is designed to provide all enrollees with the same benefits, current Medicaid beneficiaries will experience gains of benefits in some areas and losses in others. Optional services which are not now available in every State under Medicaid but which will be covered under CHIP include clinical services, prescribed drugs, prosthetic devices, physical therapy and related services, other diagnostic, screening, preventive and rehabilitative services, and emergency hospital services. In addition, many services previously subject to limitations in some States would be provided without limitations under CHIP. For example, at least 21 States limit the number of days of inpatient hospital care under their Medicaid programs from 10 days per admission to 90 days per spell of illness. Under CHIP there would be unlimited inpatient hospital care in all States.

Another example is physicians' services: 14 States limit the number of visits, ranging from two visits per calendar year to one visit per day. Such services, when medically necessary, would be unlimited under CHIP in all States.

Statement.—"The article states that the two sisters, aged 82 and aged 79, have a social security income of $296.36, and the reporter goes on to say, and in a pinch-penny budget, that allows them, both of them—not each of them—both of them, two dollars a day for food and then he goes on to say—describe what that food is. It is oatmeal, it is a can of beans, it is never any meat. They cannot remember when they last had any meat, and when the Secretary talks about

whether people at the level of income and at much lower levels of income, can afford that ten percent co-insurance, that deductible he says we have decided."

Response.—While one can argue with the specific cost-sharing structure that we have instituted, we believe it is reasonable. The CHIP Medicare plan, it should be noted, imposes an absolute limit on cost-sharing beyond which expenses are fully reimbursed, never more than $750 for those 65 and over with incomes of more than $5,249, and down to 6 percent of income for those with under $1,750 a year. In addition, the Healthcard allows an individual to spread the costs over time rather than having to make a lump-sum payment. We believe the advantages to those 65 and over who must obtain health care on credit outweigh the minor disadvantages of incurring debts and carrying charges.

Although it is true that the normal cost-sharing under CHIP would be greater than under current Medicaid, under which States are permitted to impose cost-sharing as a result of the 1972 Amendments to the Social Security Act, the optional reduced CHIP cost-sharing feature would be based on the ability to pay. CHIP's cost-sharing requirements at either the full or reduced level are meant to instill cost-consciousness on the part of the enrollee and reduce the tendency for unnecessary or inappropriate utilization of health services. In addition, through cost-sharing it is possible to reduce total premium costs, expand the beneficiary group, provide a larger range of services than might otherwise be offered, and relate an individual's contributions to his or her utilization of health services. Finally, where cost-sharing broadens the benefit package, there occurs a reduction in financial incentives to use hospitalization rather than outpatient care.

Statement.—(Question from Senator Muskie) "Under the Administration's proposal, the two people, under what level would they come, if they had a joint income of $3,600?"

Response.—Under CHIP each sister's income would be counted separately.

Assuming that each sister had an income of $1,800, each would be responsible for the following annual cost-sharing liabilities:

Drug deductible (if applicable)	$25
Other services deductible	50
Coinsurance on all services above the $50 deductible up to a maximum annual liability of $162 (9 percent of income) (percent)	15

Statement.—(Mr. Cruikshank) "And we are not sure what they would mean to include by income. There is no indication whether food stamps would be included or there is no definition of what is income."

Response.—We purposely did not include in the bill a definition of income because we were awaiting developments of a parallel definition for welfare reform. However, the Department has a preliminary definition of income which can be utilized in regulations or in amendments to CHIP for the income-related optional reduced cost-sharing feature under CHIP.

Statement.—"I wonder whether these two elderly sisters can afford to pay for eye glasses that they may need or a hearing aid they may need; I doubt it very much, but if they were covered by Medicaid, in most states, it is true that Medicare does not and should cover those items but in most states, Medicaid does cover those items so the poorest of the elderly, those who are now receiving, let's say supplementary security income, SSI, would have available to them, at no cost, eye glasses, hearing aids, dental care, and even preventive care.

"That you all be taken away by this program and the Secretary says that somehow or other, the states would pay for this but if you look at the fine print, the cost for the states, under this program, is already greater for the covered items than they are now paying for Medicaid and I wonder in how many states they are going to cover eye glasses and hearing aids and dental care in addition for the people who are now getting them."

Response.—The fact that most eye, ear, and dental care are controllable expenditures (as opposed to medical services for acute conditions) means that most people can generally budget for this type of care. Because of this characteristic, and because of the lower cost of such services, these services are considered as inappropriate for coverage under an insurance program which is designed to provide protection against unexpected and high medical costs. We believe that, given the choice, most persons prefer to insure against unexpected illness.

We agree that it is unfortunate that eye, ear, dental and preventive care are not universally available to the elderly poor under Medicaid today, as the following table demonstrates:

Service:	*Number of States currently providing service under Medicaid*
Eyeglasses	35
Hearing Aids	25
Dental Care	37
Dentures	33
Optometrists	37
Podiatrists	37

But a more serious problem, which is not mentioned, is that Medicaid excludes many millions of poor aged persons whose income is just above the income standard set by the State for Medicaid. In States without spend-down programs, these people are "locked out" of the Medicaid system, regardless of the amount of money spent for medical care. For those in States with "spend-downs," the potential recipient must often spend a sizeable portion of his income before reaching the income standard set by the State. For example, in a State which had an income standard of $2208 for a single person, a person with an income of $3,000 would have to incur almost $800 before establishing eligibility for Medicaid.

Furthermore, Medicaid no longer can assure that these optional services will be provided "at no cost" as is alleged. Section 208 of P.L. 92-603 authorized States to impose cost-sharing charges on all optional services for the cash recipients and to impose income-related premiums on the medically needy (noncash recipients). Finally, preventive care is generally unavailable under State Medicaid programs to persons over age 21.

Mr. Seidman's statement on the costs of CHIP to the States is in error. The States as a whole will save an estimated $1 billion under CHIP. For an analysis of the impact of CHIP on the States, see Appendix A., p. 969.

Statement.—(Mr. Seidman) "That is certainly correct but he does make a great deal of this catastrophic element and I would just like to point out that, as he states, in 33 states, we have in effect the catastrophic program for the elderly because in the so-called spend-down provisions for the medically needy, they can be taken care of. "This elderly couple, living entirely on social security, had this hospital bill for two weeks, one of them had to go to the hospital for a heart attack and she had her bill paid for by Medicaid, undoubtedly on this spend-down provision, as it works in the District of Columbia, where they happen to live, so this is not giving the elderly very much that they do not have now."

Response.—As discussed in our response to the previous question, the spend-down provision of many State Medicaid programs does not provide the same kind of catastrophic coverage as would CHIP. To begin with, there is no maximum liability. An aged person with a $5,000 income might have to spend 60 percent of his income before establishing Medicaid eligibility. Secondly, because many States have limits on both the scope and amounts of Medicaid benefits, a person is not assured of complete coverage of the expenses of comprehensive medical care once he spends down. We would therefore have to disagree with the statement that CHIP is "not giving the elderly very much that they do not have now."

Mr. Seidman also ignores the fact that only 33 States have incorporated spend-down provisions in their Medicaid programs. CHIP would extend catastrophic protection to low-income persons in the 19 States currently without such provisions.

Statement.—"I think it is awfully important to note, while his secretary made a great deal out of the catastrophic protection that was under his bill, as opposed to Medicare, he left out the fact that that only applies to Part A. He was talking about these limitations all the time. There is no limitation under Medicare under Part B."

. . . "Nowhere does the catastrophic thing come in under their proposal. It comes in down at the 60, 70, 80, 90 plus days and when does that happen? Only after per-review (sic) has failed, only after utilization review has failed, only after every precaution presently in the program has failed. This tiny, small fraction of one percent is to get this so-called great additional protection. It already

exists under Part B, no limit under Medicare, so it is really just talking about the very, very long term hospital stay. That is where the catastrophic protection comes in."

Response.—In stressing that "only" Part A coverage was limited under the present Medicare program, Mr. Cruikshank apparently believes that catastrophic protection against inpatient hospital costs is not a high priority item. We believe that the importance of such coverage to the aged is demonstrated by the fact that, of the 11 million Medicare beneficiaries who purchase insurance to complement their Medicare coverage, most insure against the high cost of unexpected hospital stays, in lieu of the lower-cost (Part B) ambulatory care.

He also implies that persons who are hospitalized for more than 60 days are the victims of inadequate peer and utilization review systems. This has simply not been demonstrated by any convincing evidence of which we are aware. Finally, while it is true that only a small percentage of persons ever accumulate catastrophic medical expenses, the need for protection against such catastrophic expenses is universal.

Statement.—"The Secretary says that the program would be even more responsive to the health needs of the aged than Medicare because it removes the financial barriers that prevent the elderly from obtaining these necessary medical services of high quality.

"Frankly, I do not understand this statement. It seems to me the reverse is true. It builds in new additional barriers to necessary medical services and it is less responsive to the health needs of the aged, particularly if you combine the Medicaid and Medicare and particularly, the kinds of features that I indicated before, the eye glasses, the hearing aids, the dental care, and so on."

Response.—As we have tried to demonstrate in some of our previous responses, CHIP would be more responsive to the health needs of the aged than Medicare because of the following reasons:

(1) The imbalanced cost-sharing under the present Medicare program would be eliminated.

(2) The benefit package would be improved to include unlimited inpatient hospital coverage, outpatient prescription drugs, and more comprehensive mental health benefits.

(3) Physicians would be required to accept as full reimbursement for services rendered the State-established reimbursement rates. This should mean substantial savings in out-of-pocket costs for Medicare beneficiaries inasmuch as currently over half of all Medicare claims are unassigned.

(4) Medicare beneficiaries who are low-income would be eligible for reduced cost-sharing. This will particularly help low-income aged persons who are barely above the present income standards for Medicaid eligibility.

(5) Overall, Federal expenditures on behalf of the aged would increase by $1.8 billion under CHIP. Medicare enrollees would have a benefit package having an actuarial value of $620 per year, compared to $565 under the current program.

(6) We believe our proposal offers the aged better financial protection. For the first time, every beneficiary would be protected through the maximum annual liability feature of CHIP which would eliminate the open-ended liability currently facing Medicare (and many Medicaid) beneficiaries.

We have already discussed in our response our reasons for believing that CHIP is a great improvement over Medicaid.

Statement.—(Senator Muskie) "Do all states provide that?

(Mr. Seidman) "Almost all states provide eye glasses, hearing aids, dental care, and preventive care. I am told that 75 to 80 percent of the people now covered by Medicaid would be robbed of some of those services and this applies, of course, with these items, particularly to the elderly.

"And while it is true that Medicare ought to and does not cover drugs, there are only four states under Medicaid that do not cover drugs so that drugs are available without cost-sharing under the Medicaid program to many of the elderly."

Response.—The answer to Senator Muskie's question is in our response to Statement 7. Mr. Seidman's statement about drug coverage is true; however, he fails to realize that such services are not necessarily free, as was pointed out in our response to his statement.

Statement.—(Senator Muskie) "What are the income levels in the Medicaid program?"

(Mr. Seidman) "In Medicaid, of course, they are set at different levels in different states.

(Senator Muskie) "What is the range? Is it designed to be the poverty level, by and large?"

(Mr. Seidman) "Now it is the SSI program, all of the people on SSI are covered, plus in some states, those that are receiving supplemental SSI, so that those figures are now, for a couple $210 a month, I believe, under SSI, and they will be going up July 1st."

Response.—Mr. Seidman is incorrect in stating that "all of the people on SSI are covered." There are 17 States which have opted to use the Section 209(b) (of P.L. 92–603) provision which enables them to set the income standards for Medicaid eligibility at levels below the SSI level ($1,680). These levels in 1972 ranged as low as $900 to $3,000 for an aged person. The current SSI income standard is $140/month ($1,680/year) for an individual, and $210/month ($2,520/year) for a couple. These figures will go up to $146/month ($1,752/year) and $219/month ($2,628/year) for individuals and couples, respectively, in July.

Following is a State-by-State list of States' Medicaid income eligibility standards for the aged, blind, and disabled. Specific dollar amounts are unavailable at this time:

MEDICAID INCOME ELIGIBILITY STANDARDS FOR THE AGED, BLIND, AND DISABLED—JUNE 1974

	All SSI eligibles	209(b)
Total	33	17
Alabama	X	
Alaska	X	
Arizona		
Arkansas	X	
California	X	
Colorado		X
Connecticut		X
Delaware	X	
District of Columbia	X	
Florida	X	
Georgia	X	
Hawaii		X
Idaho	X	
Illinois		X
Indiana		X
Iowa	X	
Kansas		X
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland		X
Massachusetts	X	
Michigan	X	
Minnesota		X
Mississippi		X
Missouri		X
Montana	X	
Nebraska		X
Nevada	X	
New Hampshire		X
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina		X
North Dakota		X
Ohio		X
Oklahoma		X
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming	X	

Following is a table indicating approximate income levels for Medicaid eligibility for the aged as of July 1972, the latest month for which data is available:

APPROXIMATE INCOME LEVELS FOR MEDICAID ELIGIBILITY FOR THE AGED

	Aged person		Aged couple		Income protected for maintenance in States with MN program	
	Payment standard [1]	Adjusted payment level [2]	Payment standard [1]	Adjusted payment level [2]	1 person	2 persons
Total						
Alabama	1,680		2,520			
Alaska	1,680	2,520	2,520	3,840		
Arizona						
Arkansas	1,680		2,520	3,132		
California	1,680	2,604	2,520	4,716	2,208	3,200
Colorado [3]	1,740	1,824	3,480	3,648		
Connecticut [3]	2,172		2,748		2,300	2,900
Delaware	1,680		2,520			
District of Columbia	1,680		2,520		2,100	2,800
Florida	1,680		2,520			
Georgia	1,680		2,520			
Hawaii [3]	1,680	2,484	2,388	3,866	1,668	2,784
Idaho	1,680	1,788	2,520	2,742		
Illinois [3]	2,028	1,745	2,532	2,677	2,052	2,508
Indiana [3]	1,200		2,400			
Iowa	1,680	2,475	2,520	3,823		
Kansas [3]	2,436		2,964		1,600	2,200
Kentucky	1,680		2,520		1,500	1,800
Louisiana	1,680	1,716	2,520	2,899		
Maine	1,680	1,872	2,520	3,744		
Maryland [3]	1,152		1,572		1,600	2,100
Massachusetts	1,680	2,682	2,520	4,083	2,388	2,832
Michigan	1,680	1,914	2,520	2,931	2,160	2,700
Minnesota [3]	2,196		2,940	2,572	1,740	2,424
Mississippi [3]	900		1,800			
Missouri [3]	1,020		2,040			
Montana	1,680		2,520			
Nebraska [3]	2,184	1,757	2,820	3,276	1,780	2,560
Nevada	1,680	2,119	2,520	3,418		
New Hampshire [3]	2,076		2,736		2,280	2,868
New Jersey	1,680	2,138	2,520	3,267		
New Mexico	1,680		2,520			
New York	1,680	2,396	2,520	3,654	2,500	3,400
North Carolina [3]	1,344		1,836		1,700	2,200
North Dakota [3]	1,500		2,280		1,800	2,400
Ohio [3]	1,512		2,544			
Oklahoma [3]	1,560		2,544		1,608	2,400
Oregon	1,680	1,780	2,520	2,730		
Pennsylvania	1,680		2,520		2,000	2,500
Rhode Island	1,680	2,042	2,520	3,123	3,090	4,000
South Carolina	1,680		2,520			
South Dakota	1,680		2,520			
Tennessee	1,680		2,520			
Texas	1,680		2,520			
Utah [3]	1,344		1,800		1,596	2,148
Vermont	1,680		2,520		2,448	3,156
Virginia	1,680		2,520		1,900	2,500
Washington	1,680		2,520		2,240	2,844
West Virginia	1,680		2,520			
Wisconsin	1,680	2,604	2,520	3,960	2,600	3,200
Wyoming	1,680		2,520	2,530		
Guam	1,680		2,520		1,500	2,500
Puerto Rico	1,680		2,520		2,580	3,200
Virgin Islands	1,680		2,520		2,200	2,750

[1] Federal SSI payment is given unless the State has opted to go back to a previous standard.
[2] Data on the levels States will be supplementing to is limited; the information given shows the approximate levels the States supplement to, but is not a comprehensive listing.
[3] States which have indicated that they are going back to a previous standard as provided under sec. 209(b).

Statement.—"He gave one example which I think is particularly interesting and that is that the short term hospitalization example of ten days, since twelve days is the average for the elderly and for the group at $3,000, it shows an out-of-pocket expense of $270. Now, what we are talking about is an out-of-pocket expense of these two sisters; they are the kind of people who would have to pay that $270 which, incidentally, would be $50 more than under Medicare."

Response.—As we indicated in our response to a previous statement, if each sister had an annual income of $1,800, each would have a maximum annual

liability of $162. This is almost $100 below the $270 which Mr. Seidman gives, and it is $60 *less* than a current Medicare beneficiary would have to pay, not $50 *more* than Medicare as Mr. Seidman has stated. The mistakes in arithmetic here are probably due to Mr. Seidman's treating the two sisters as a couple rather than as two individuals, as they would be under CHIP.

Statement.—"There is the whole question of whether or not the people under Medicare and Medicaid or the replacement program for Medicaid would or would not get second class services."

Response.—We do not believe this will be the case for the following reasons:

(1) The floor on reimbursement for physicians participating in all three programs will be substantially the same as reasonable-cost reimbursement. This will induce many physicians to participate in AHIP and Medicare who have not participated in Medicaid because of the very low reimbursement levels set by some States.

(2) The mix of population in AHIP and Medicare will be much more diverse than that in the Medicaid program, which serves only low-income persons. Because of the diversity of this population and its size and disassociation from the welfare program image, it is anticipated that physicians will want to participate in the two programs as fully as in EHIP.

(3) The use of the Healthcard to finance covered health care under all three programs is expected to provide strong incentives for physicians to become full participating providers, which would result in their charging the same rates for enrollees of all three programs, even though they are permitted to charge an additional amount to EHIP enrollees. We believe the assumption of billing and collection functions by carriers will provide a strong incentive for physicians and others to become full participating providers. Our decision to require assignment under AHIP and Medicare and to leave it voluntary under EHIP was based on the following considerations:

(1) Allowing voluntary assignment under all three programs would have unnecessarily aggravated inflation of medical costs, and could have prevented many low-income persons from obtaining needed medical care.

(2) Requiring mandatory assignment under all three programs would in effect substitute national fee screens. We did not believe such a level of government intrusion into the practice of medicine to be desirable.

Statement.— . . . "We looked at the income levels under the Medicare replacement program and we found that the average social security beneficiary couple is now getting $296 a month.

"1. When the benefits rise by four percent in April, they will get an increase of $140 per year. Under the Administration's plan, those people, because they will go into a different income group, will have an increase in their premiums of $102 and an increase in their deductibles of $100, an increase in the drug deductible of $50.

"That means a $330 potential increase in their health costs as compared with $140 increase in social security; before any benefits are obtained from this program and once they do begin to get services under the program, plus an increase in their co-insurance, from 15 to 20 percent and an increase in their maximum liability, the drain on their payments from 9 percent of their income to 12 percent of their income so that if they are subject to any illness, to any appreciable extent, their entire social security increase will be washed out."

Response.—The average social security beneficiary couple was receiving $277 in March of 1973, not $296. The $277 payment increased to an average of $296 in April, and to $305 in June of 1974. Even if the 2 sisters had a total payment of $296 in March, this would have increased by $248.64 per year in April with the 7 percent increase (not $140, as Mr. Seidman has indicated) and another $152.04 in June with the 4% increase then, for a new total annual income of $3,952.68. (Again, we are assuming that each sister is receiving half of the total yearly income, or $1,976.33, which is a $200.33 increase over the previous income of each.) It should be noted that the two sisters are not "the average couple" but rather two individuals, as far as social security benefits are concerned.

We fail to understand how Mr. Seidman has come up with his estimates of increases in the cost-sharing liabilities of both sisters, unless he is considering them as a couple and not as individuals, as CHIP does. Contrary to Mr. Seidman's statement that each sister "will go into a different income group, will have an increase in their premiums of $102 and an increase in their deductibles of $100, (and) an increase in the drug deductible of $50," none of this is true. The sisters

would remain in the same Income Class II category (as their income increases from $1,776 to $1,976.33, which is well below the $3,499 cut-off for Income Class II), their premiums will remain the same as will their deductibles. Thus, the $330 potential increase in cost-sharing liability which Mr. Seidman suggests is a sizeable error.

Mr. Seidman's other references to the increase in coinsurance and maximum liability are also inaccurate; these remain the same. The only change in the sisters' status with respect to cost-sharing is that their maximum liability would be increased from $159.84 to $177.87, an increase of $18.03. Their $200.33 increase in social security benefits will not, as Mr. Seidman states, be "washed out" by the $18.03 in increased cost-sharing liabilities.

Statement.—"In the approach to hospital insurance, he said it was not important, really, in effect, he said to cover the most frequently recurring item because this was budgetable and they were going to be for the trade-off and provided in catastrophic protection, the protection against the catastrophic, down at the end of the very, very long stay in the hospital."

(Senator Muskie) "He used the word 'routine.' Can you distinguish between 'routine' and 'chronic'?"

(Mr. Cruikshank) "That is a distinction completely new to me. I do not know what he means by 'routine.'"

Response.—"Routine" health services are those provided without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury. For example, periodic physical examinations, chest x-rays, diabetes screening tests, high blood pressure detection screenings, would be considered routine services. The term "routine" is also applied to eye examinations for the purpose of prescribing fitting or changing eyeglasses and to services in connection with the care, treatment, filling, removal, or replacement of teeth. Routine foot care includes the cutting or removal of corns, warts, or calluses, trimming of nails and other hygienic and preventive maintenance care. In general, "routine health needs" can be classified as predictable services which are generally budgetable and are, accordingly, not covered under CHIP, except preventive care for children under 13.

We consider "routine" health care needs for adults as inappropriate for coverage under an insurance program which is designed to provide protection against unexpected medical costs.

A "chronic" illness is one which is expected to be of long duration and which may be subject to flareups requiring specific medical attention. Usually, such an illness is not totally curable but can be controlled with medication and periodic medical care. Examples would be high blood pressure, arthritis, diabetes and certain heart condtions. Glaucoma could be an example of a chronic eye disease.

For most people, eyeglasses are used to correct refractive errors which are not the result of acute eye disease. Glasses, other than those associated with treatment following cataract surgery, would generally be classified as a "routine" health need for the purposes of a health insurance program.

Statement.—"Under the present Medicare program, the physician has all of the advantages resulting from accepting assignment that he has under the proposal and if it is true that if it is in few—fewer cases accepting assignment, there must be something to Senator Mondale's argument, that there is an economic interest."

Response.—It is incorrect to imply that the physician has the same inducements to accept assignment under the present Medicare program that he has under CHIP. Mr. Cruikshank completely ignores the Healthcard system which would perform the billing and collecting functions of physicians, and guarantee reimbursement to physicians at the State-established rates, thus eliminating the bad debt losses of physicians. We believe these advantages, which do not exist under the present Medicare program, will persuade most physicians to become full participating providers (i.e., assignment-accepting physicians).

APPENDIX A

IMPACT OF CHIP ON THE STATES

The Administration's Comprehensive Health Insurance Plan (CHIP) has three parts: The Employee Health Insurance Plan, the Assisted Health Insurance

Plan (AHIP), and Medicare. AHIP would replace current State expenditures for virtually all services covered under Medicaid other than long-term care. It would also reimburse for selected health services that are now funded entirely by State and local governments. A residual Medicaid program would be retained for long-term care services—skilled nursing facilities, intermediate care facilities, home health services, and mental health services. The residual Medicaid program is intended as an interim measure pending further Departmental study and recommendations later this year regarding the Federal role in financing long-term care.

Under AHIP, the States would play a major role in cost containment through comprehensive health planning, rate setting, and other regulatory measures. Indeed, the pressures of rising State health budgets have compelled many States to undertake new and innovative health cost and utilization control activities. For the most part, the Federal Government has adopted the better State practices. Furthermore, there are many decisions—such as the assessment of the need for specific medical facilities—that, realistically, can be made only at State or local levels. The Administration does not wish to weaken the incentives for States to contain health care costs. Thus, we believe it imperative that the States continue to participate in the public financing of health care.

State financial participation would amount to 25% of the public costs of AHIP. The aggregate State contribution (at 1975 prices) is estimated at $4.2 billion. In addition, the States may choose to continue to provide services that neither AHIP nor the residual Medicaid program for long-term care would cover, e.g., adult dental services. These are referred to as "State-only services." If States continue to finance all of these services, but without Federal assistance, the estimated FY 1975 costs would be $419 million, of which the Federal Government now contributes $230 million.

State and local governments would, however, achieve budgetary savings from the following programs:

1. States would in 1975 spend an estimated $3.2 billion under Medicaid for services covered by AHIP.

2. More than half of the States have "General Assistance" programs, under which they pay for services for low-income persons who do not qualify for Medicaid because they are not categorically related. FY 1975 expenditures under General Assistance are estimated at $693 million, of which $465 million would be for services covered by AHIP.

3. Many States and local governments provide services through their own clinics and hospitals. An estimated $2.0 billion in hospital services (excluding care in mental institutions) provided directly by State and local governments, would be reimbursable. While the States may not be able to translate all of their reimbursable direct services into actual savings, they would be able to offset a major portion (probably on the order of $1–2 billion) of the $2.0 billion. States could also offset a portion of current expenditures for outpatient clinic services and inpatient mental illness. Unfortunately, available data do not permit us to estimate the resulting savings to the States although in some communities (e.g., New York City), the savings are known to be considerable.

In addition to the above changes, we assume that the States will maintain their current expenditures for long-term care under both the Medicaid ($1,957 million) and General Assistance ($228 million) programs, since these programs would not be changed.

Some States may choose to fill in cost sharing or, alternatively, increase welfare payments for Medicaid eligibles who do not now face cost sharing. We have not estimated the resulting fiscal effect because we believe that, on balance, most current Medicaid eligibles will be better off under AHIP, largely because they will face less physician discrimination than at present, and stringent limitations on inpatient hospital services will be removed. For example, fewer than 10% of private physicians in New York City saw any Medicaid patients last year. In contrast, CHIP would both establish reasonable reimbursement rates under all plans and forbid providers from discriminating against AHIP enrollees. Moreover, many States limit hospital benefits to fewer than 20 days per admission or per year. It should also be borne in mind that most of the $5.9 billion in new Federal spending as a result of CHIP is for low income persons.

In summary, the aggregate fiscal impact of AHIP on the States is:

	Billion
Expenditures excluding direct hospital services:	
AHIP	$4.2
Residual Medicaid (long-term care)	2.0
State-only services	.4
Residual general assistance	.2
Total	6.8
Less offsets from current programs:	
Medicaid	5.1
General assistance	.7
Total	5.8
Subtotal	1.0
Less savings from direct hospital services programs	1-2
Fiscal savings to States	0-1

The first year of participation in CHIP, the State contribution would be the sum of:

1. State expenditures in FY 1975 under Medicaid except for long-term care services—i.e., skilled nursing facilities, intermediate care facilities, home health services, and care in mental institutions—and dental services, and

2. Ten percent of the product of (a) the ratio of State per capita income to U.S. per capita income and (b) the difference between total expenditures in the State under AHIP and total (State and Federal) FY 1975 Medicaid expenditures for services covered by CHIP.

The first component would raise $3.2 billion in State revenues, and the second component $1.0 billion.

In the second and subsequent years, the State share would be:

1. The amount it paid in its first year of participation, plus

2. Twenty-five percent of the product of (a) the ratio of State per capita income to U.S. per capita income and (b) the difference between total public AHIP expenditures in that year and total public AHIP expenditures in the first year of participation in the program.

The formula is designed to:

Avoid massive sudden budgetary shifts among States;

Reflect relative ability to pay among States through the per capita income adjustment; and

Encourage the States to control medical costs by having them contribute 25% of the increase in public expenditures (adjusted for relative per capita income) over the first year of the program.

Table 1 displays the fiscal effect of CHIP on each State relative to the existing Medicaid and General Assistance programs. The fiscal relief from savings in direct services programs is discussed subsequently. The first four columns show, respectively, total State fiscal effort for:

1. AHIP.

2. The residual Medicaid program for long-term care services.

3. State financing of services not covered by AHIP or residual Medicaid (State-only services).

4. The residual General Assistance program (primarily for long-term care services).

Total expenditures would amount to $6.8 billion (column #5). The offset from Medicaid and General Assistance for services covered by AHIP would be $5.8 billion (column #6). This yields a net increase of $1.0 billion (column #7), but does not reflect savings from directly provided services.

Table 2 provides estimates of State and local expenditures for hospital (excluding mental hospital) services that would be reimbursable under CHIP. These data are displayed separately from those in Table 1 because the uncertainties in the estimates are much larger. The aggregate estimates are understated, reflecting the use of conservative estimating procedures, the exclusion of acute care in penal and long-term care institutions and, for some States, data not being available.

Tables 3 and 4 attempt to display the potential net effect of AHIP. Table 3 assumes that State and local governments realize 50% of the savings shown in Table 2. In most States, we would anticipate actual savings of at least 50%. Table 4 assumes that State and local governments achieve the full potential savings.

Tables 3 and 4 also show the per capita burden or savings within each State—i.e., the net fiscal effect divided by the State population—and the percent change relative to total current State expenditures for Medicaid, General Assistance, and direct hospital services. The per capita change is intended as a proxy for fiscal relief or burden. The per capita changes in Table 4 range between an increase in expenditures of $7.38 (Alaska) and a savings of $46.66 (District of Columbia). The percentage changes range between a 59% increase in West Virginia to a 66% savings in Maryland.

TABLE 1.—ESTIMATED STATE EXPENDITURES UNDER AHIP, EXCLUDING SAVINGS FROM DIRECT HOSPITAL SERVICES, FISCAL YEAR 1975

[In millions]

State	AHIP	Residual Medicaid (long-term care)	State only services	Residual general assistance	Total	Current Medicaid and general assistance	Total minus current Medicaid and general assistance
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total	$4,204.9	$1,956.9	$419.0	$228.4	$6,809.2	$5,806.2	$1,003.0
Alabama	37.7	14.4	2.4	0.2	54.7	34.8	19.9
Alaska	4.1	2.2	.5	----	6.8	4.1	2.7
Arizona	23.9	----	----	----	23.9	----	23.9
Arkansas	19.1	9.5	1.6	.2	30.4	18.6	11.8
California	608.7	183.0	55.7	55.4	902.8	849.6	53.2
Colorado	45.4	20.1	5.3	.6	71.4	51.6	19.8
Connecticut	46.3	39.1	2.3	.4	88.1	68.2	19.9
Delaware	10.4	4.0	----	----	14.4	11.1	3.3
District of Columbia	41.8	7.5	5.5	.1	54.9	42.5	12.4
Florida	103.1	18.2	3.1	3.3	127.7	78.5	49.2
Georgia	71.0	27.2	12.0	.3	110.5	80.8	29.7
Hawaii	15.3	5.4	2.5	1.8	25.0	23.0	2.0
Idaho	8.6	2.7	.7	----	12.0	7.0	5.0
Illinois	271.0	102.1	27.1	----	400.2	338.9	61.3
Indiana	62.4	31.6	6.6	.4	101.0	72.3	28.7
Iowa	32.4	15.9	4.0	.3	52.6	34.0	18.6
Kansas	40.1	14.6	3.8	2.9	61.4	49.1	12.3
Kentucky	43.4	11.3	5.3	----	60.0	39.3	20.7
Louisiana	40.1	18.8	1.6	.4	60.9	38.6	22.3
Maine	11.8	7.5	.3	----	19.6	16.2	3.4
Maryland	84.8	19.7	10.2	4.7	119.4	128.7	—9.3
Massachusetts	155.3	112.8	18.9	10.2	297.2	266.9	30.3
Michigan	237.0	107.1	29.5	----	373.6	323.1	50.5
Minnesota	87.7	48.1	19.0	----	154.8	121.9	32.9
Mississippi	25.3	6.4	2.3	.1	34.1	21.7	12.4
Missouri	58.9	16.5	1.2	2.5	79.1	48.8	30.3
Montana	8.3	3.6	1.2	----	13.1	8.1	5.0
Nebraska	20.4	13.2	1.7	----	35.3	24.7	10.6
Nevada	10.9	3.0	1.0	----	14.9	10.1	4.8
New Hampshire	8.6	4.8	1.3	----	14.7	10.6	4.1
New Jersey	146.8	66.2	13.9	4.3	231.2	208.2	23.0
New Mexico	12.9	3.5	.8	0	17.2	9.6	7.6
New York	806.2	545.4	83.5	83.4	1,518.5	1,504.5	14.0
North Carolina	66.6	16.4	8.1	.6	91.7	61.4	30.3
North Dakota	7.5	3.5	.8	----	11.8	7.0	4.8
Ohio	154.4	53.8	12.1	1.5	221.8	168.7	53.1
Oklahoma	46.5	17.3	9.1	----	72.9	48.2	24.7
Oregon	26.4	13.2	2.9	----	42.5	27.3	15.2
Pennsylvania	189.0	106.6	11.4	49.9	356.9	333.8	23.1
Rhode Island	25.3	9.6	1.4	----	36.3	30.3	6.0
South Carolina	20.4	7.6	.7	.3	29.0	18.5	10.5
South Dakota	7.9	3.6	1.3	----	12.8	7.3	5.5
Tennessee	43.5	21.5	4.8	.4	70.2	51.5	18.7
Texas	178.8	99.6	2.6	----	281.0	199.7	81.3
Utah	8.8	4.2	2.3	0	15.3	9.9	5.4
Vermont	7.9	5.8	.8	----	14.5	11.3	3.2
Virginia	67.8	21.0	9.2	.9	98.9	72.8	26.1
Washington	54.9	29.1	6.1	3.2	93.3	75.7	17.6
West Virginia	18.9	2.2	2.1	----	23.2	13.7	9.5
Wisconsin	77.7	55.2	18.0	.1	151.0	121.4	29.6
Wyoming	2.9	1.3	.4	----	4.6	2.6	2.0

TABLE 2.—EXPENDITURES FOR STATE AND LOCAL HOSPITAL SERVICES REIMBURSABLE UNDER CHIP, FISCAL YEAR 1975

[In millions of dollars]

State	Direct hospital expenditures	State	Direct hospital expenditures
Total	2,041.4		
Alabama	13.5	Mississippi	17.5
Alaska	.3	Missouri	55.8
Arizona	33.2	Montana	[1]
Arkansas	7.4	Nebraska	15.0
California	105.4	Nevada	[1]
Colorado	29.7	New Hampshire	.2
Connecticut	8.6	New Jersey	53.3
Delaware	8.7	New Mexico	1.8
District of Columbia	47.3	New York	586.1
Florida	72.2	North Carolina	29.9
Georgia	61.2	North Dakota	.7
Hawaii	7.8	Ohio	63.5
Idaho	.7	Oklahoma	7.6
Illinois	84.0	Oregon	22.8
Indiana	26.4	Pennsylvania	61.0
Iowa	13.1	Rhode Island	1.5
Kansas	25.8	South Carolina	8.1
Kentucky	17.8	South Dakota	[1]
Louisiana	108.7	Tennessee	53.2
Maine	[1]	Texas	188.2
Maryland	38.0	Utah	3.5
Massachusetts	32.5	Vermont	.1
Michigan	38.8	Virginia	27.4
Minnesota	34.3	Washington	19.7
		West Virginia	.9
		Wisconsin	5.1
		Wyoming	3.0

[1] Not available.

TABLE 3.—ESTIMATED STATE EXPENDITURES UNDER AHIP—FISCAL YEAR 1975

[Assumes savings of 50 percent in direct expenditures for State/local hospitals]

State	Fiscal burden from table 1, col. 7 (millions)	Assumed savings for direct hospital expenditures (millions)	Net fiscal effect (millions)	Per capita change	Percent change
Total	$1,003.0	$1,020.7	−$17.7	−$0.09	−0.2
Alabama	19.9	6.8	13.1	3.72	27.0
Alaska	2.7	.2	2.5	7.69	57.0
Arizona	23.9	16.6	7.3	3.75	
Arkansas	11.8	3.7	8.1	4.10	31.0
California	53.2	52.7	.5	.02	0
Colorado	19.8	14.9	4.9	2.08	6.0
Connecticut	19.9	4.3	15.6	5.06	20.0
Delaware	3.3	1.7	1.6	2.83	8.0
District of Columbia	12.4	23.7	−11.3	−15.11	−13.0
Florida	49.2	36.1	13.1	1.80	9.0
Georgia	29.7	30.6	−.9	−.19	−1.0
Hawaii	2.0	3.9	−1.9	−2.35	−6.0
Idaho	5.0	.4	4.6	6.08	60.0
Illinois	61.3	42.0	19.3	1.72	20.0
Indiana	28.7	13.2	15.5	2.93	16.0
Iowa	18.6	6.6	12.0	4.16	25.0
Kansas	12.3	12.9	−.6	−.27	−1.0
Kentucky	20.7	8.9	11.8	3.58	48.0
Louisiana	22.3	54.4	−32.1	−8.63	−7.0
Maine	3.4	.1	3.3	3.21	46.0
Maryland	−9.3	19.0	−28.3	−6.98	−39.0
Massachusetts	30.3	16.3	14.0	2.42	17.0
Michigan	50.5	19.4	31.1	3.42	40.0
Minnesota	32.9	17.2	15.7	4.03	22.0
Mississippi	12.4	8.8	3.6	1.59	11.0
Missouri	30.3	27.9	2.4	.50	1.0

TABLE 3.—ESTIMATED STATE EXPENDITURES UNDER AHIP—FISCAL YEAR 1975—Continued

[Assumes savings of 50 percent in direct expenditures for State/local hospitals]

State	Fiscal burden from table 1, col. 7 (millions)	Assumed savings for direct hospital expenditures (millions)	Net fiscal effect (millions)	Per capita change	Percent change
Montana	5.0	(1)	(1)	(1)	(1)
Nebraska	10.6	7.5	3.1	2.03	8.0
Nevada	4.8	(1)	(1)	(1)	(1)
New Hampshire	4.1	.1	4.0	5.19	37.0
New Jersey	23.0	26.7	−3.7	−.50	−1.0
New Mexico	7.6	.9	6.7	6.29	59.0
New York	14.0	293.1	−279.1	−15.19	−13.0
North Carolina	30.3	15.0	15.3	2.93	17.0
North Dakota	4.8	.4	4.4	6.96	57.0
Ohio	53.1	31.8	21.3	1.98	9.0
Oklahoma	24.7	3.8	20.9	7.93	37.0
Oregon	15.2	11.4	3.8	1.74	6.0
Pennsylvania	23.1	30.5	−7.4	−.62	−2.0
Rhode Island	6.0	.8	5.2	5.37	61.0
South Carolina	10.5	4.1	6.4	2.40	24.0
South Dakota	5.5	(1)	(1)	(1)	(1)
Tennessee	18.7	26.6	−7.9	−1.96	−8.0
Texas	81.3	94.1	−12.8	−1.10	−3.0
Utah	5.4	1.8	3.6	3.20	27.0
Vermont	3.2	.1	3.1	6.71	27.0
Virginia	26.1	13.7	12.4	2.60	12.0
Washington	17.6	9.4	8.2	2.38	9.0
West Virginia	9.5	.5	9.0	5.05	62.0
Wisconsin	29.6	2.6	27.0	5.97	21.0
Wyoming	2.0	1.5	.5	1.45	9.0

[1] Not available.

TABLE 4.—ESTIMATED STATE EXPENDITURES UNDER AHIP—FISCAL YEAR 1975

[Assumes savings from direct expenditures for State/local hospitals]

State	Fiscal burden from table 1, col. 7 (millions)	Assumed savings for direct hospital expenditures (millions)	Net fiscal effect (millions)	Per capita change	Percen change
Total	$1,003.0	$2,041.4	−$1,038.1	−$4.99	−13
Alabama	19.9	13.5	6.4	1.82	13
Alaska	2.7	.3	2.4	7.38	55
Arizona	23.9	33.2	−9.3	−4.78	
Arkansas	11.8	7.4	4.4	2.22	17
California	53.2	105.4	−52.2	−2.55	−5
Colorado	19.8	29.7	−9.9	−4.20	−12
Connecticut	19.9	8.6	11.3	3.67	15
Delaware	3.3	8.7	−5.4	−9.56	−27
District of Columbia	12.4	47.3	−34.9	−46.66	−39
Florida	49.2	72.2	−23.0	−3.17	−15
Georgia	29.7	61.2	−31.5	−6.67	−22
Hawaii	2.0	7.8	−5.8	−7.17	−19
Idaho	5.0	.7	4.3	5.69	56
Illinois	61.3	84.0	−22.7	−2.02	−5
Indiana	28.7	26.4	2.3	.43	2
Iowa	18.6	13.1	5.5	1.91	12
Kansas	12.3	25.8	−13.5	−5.98	−19
Kentucky	20.7	17.8	2.9	.88	12
Louisiana	22.3	108.7	−86.4	−23.23	−19
Maine	3.4	.1	3.3	3.21	5
Maryland	−9.3	38.0	−47.3	−11.66	−66
Massachusetts	30.3	32.5	−2.2	−.38	−3
Michigan	50.5	38.8	11.7	1.29	15
Minnesota	32.9	34.3	−1.4	−.36	−2
Mississippi	12.4	17.5	−5.1	−2.25	−15
Missouri	30.3	55.8	−25.5	−5.37	−14
Montana	5.0	(1)	(1)	(1)	(1)
Nebraska	10.6	15.0	4.4	2.89	11
Nevada	4.8	(1)	(1)	(1)	(1)

TABLE 4.—ESTIMATED STATE EXPENDITURES UNDER AHIP—FISCAL YEAR 1975—Continued

[Assumes savings from direct expenditures for State/local hospitals]

State	Fiscal burden from table 1, col. 7 (millions)	Assumed savings for direct hospital expenditures (millions)	Net fiscal effect (millions)	Per capita change	Percent change
New Hampshire	4.1	.2	3.9	5.06	36
New Jersey	23.0	53.3	−30.3	−4.11	−12
New Mexico	7.6	1.8	5.8	5.45	51
New York	14.0	586.1	−572.1	−31.15	−27
North Carolina	30.3	29.9	.4	.08	1
North Dakota	4.8	.7	4.1	6.49	53
Ohio	53.1	63.5	−10.4	−.96	−4
Oklahoma	24.7	7.6	17.1	6.49	31
Oregon	15.2	22.8	−7.6	−3.48	−15
Pennsylvania	23.1	61.0	−37.9	−3.18	−10
Rhode Island	6.0	1.5	4.5	4.65	53
South Carolina	10.5	8.1	2.4	3.53	9
South Dakota	5.5	(1)	(1)	(1)	(1)
Tennessee	18.7	53.2	−34.5	−8.56	−9
Texas	81.3	188.2	−106.9	−9.18	−28
Utah	5.4	3.5	1.9	1.69	14
Vermont	3.2	.1	3.1	6.71	27
Virginia	26.1	27.4	−1.3	−.27	−1
Washington	17.6	19.7	−2.1	−.61	−2
West Virginia	9.5	.9	8.6	4.83	59
Wisconsin	29.6	5.1	24.5	5.42	19
Wyoming	2.0	3.0	−1.0	−2.90	−18

1 Not available.

Appendix 2

ITEM 1. STATEMENT BY THE AFL-CIO EXECUTIVE COUNCIL ON THE ADMINISTRATION HEALTH PROGRAM

BAL HARBOUR, FLA., *February 19, 1974.*

President Nixon's so-called national health insurance proposal would do little to solve this Nation's health care crisis.

He has designed a system to protect the financial well-being of doctors and insurance companies, not to meet the health needs of the American people. By ignoring the compelling need to reform the health care delivery system, President Nixon's proposal would be the threshhold for a further outrageous escalation of medical costs.

We believe the Nation must develop a national health insurance program based on the principle that quality health care is a right of all Americans.

That is why the AFL-CIO is supporting National Health Security—the Griffiths-Kennedy bill. It is the health consumers' program.

The Griffiths-Kennedy bill would help transform the present outmoded health care delivery system from one dedicated to the financial interests of doctors, hospitals and insurance companies to one dedicated to meeting the health needs of the American people.

The administration bill would perpetuate the present system. Wherever the Nixon administration was faced with a choice between the needs of the people and the selfish interests of the doctors and insurance companies, it came down on the side of the doctors and insurance companies.

Accompanying this statement is a detailed analysis of the administration bill. Briefly, we find these glaring differences between the Health Security program, which we support, and the Nixon program, which we oppose:

(1) Health Security would provide quality health care to all Americans as a right; the administration bill would not. Despite its claims, the Nixon program would leave many Americans unprotected against the high cost of medical care. The poor and near-poor, under the Assisted Health Insurance Plan, would have no guarantee of treatment by a physician. Additionally, the administration program would require costly and demeaning means tests.

(2) Health Security would provide strong quality and cost controls throughout, but the administration bill would not. Its quality controls are almost nonexistent. The administration relies on high deductibles and coinsurance paid by patients to control cost, despite evidence that financial barriers to health care only delay effective treatment of illness and, thus, ultimately increase costs.

(3) Health Security would provide full benefits to all Americans, including all necessary hospital and physician services with the exception of certain costs for mental health care. According to the administration's own estimates, at least three out of every four persons would receive no benefits under the Nixon program in any given year. These people would have to pay for all of their medical care out of their own pockets.

(4) Health Security provides for effective consumer representation at all levels to protect the patients' interests: the Nixon bill would provide none. The only role for consumers that we can find in the Nixon bill is to pay sizable premiums and high deductibles and coinsurance.

(5) Health Security would provide a single, comprehensive standard of benefits covering all Americans; the administration bill would not. It has proposed different plans for the employed, the poor and the elderly, with varying premiums, deductibles and coinsurance. This can only further fragment the health care system.

(6) Health Security would be financed by the proven and accepted method of Social Security taxes, matched by general revenue funds, with proper and

essential Government control over the expenditure of funds. While this would mean a greater tax burden, it would eliminate all other medical costs to the average American.

In contrast, the President's bill would not eliminate medical costs and it would increase taxes, despite the President's patently false declaration. The Government would compel employers to purchase private health insurance policies for their employees, and this Government compulsion would cost employers at least as much as if they were taxed.

These billions of dollars and the billions paid by employees would be turned over to private insurance companies, with only the barest minimum of governmental supervision.

(7) Under Health Security employers and employees would pay far less money for far more health protection than under the Nixon plan. Under the administration plan, according to Commerce Department estimates which the administration has not released, employers would pay between 4.1 and 4.5 percent of payroll for health insurance for their employees. Under Health Security, employers would pay 3.5 percent of payroll.

The Nixon plan would require employees to pay about $150 a year for health insurance premiums for themselves and their families, plus up to $1,500 in deductibles and coinsurance, plus up to $118.80 for Medicare taxes. Under Health Security, employees would pay a maximum of $150 a year—what most are paying now just for Medicare—for complete health care coverage for themselves and their families with no deductibles, no coinsurance and no added premiums.

(8) Health Security would begin the long-overdue process of reforming and modernizing the nation's health care system. The administration bill would do nothing to improve the health care system.

(9) Health Security would remove the profit motive from providing health care; the administration bill would not. Indeed, the President cites free enterprise competition as one of the "cost control" features of his proposal; thus ignoring the facts of the runaway inflation in medical costs.

(10) Health Security would improve benefits, cut medical expenses and eliminate the fear of the cost of catastrophic illness for America's elderly citizens. The President's bill would increase the costs for Medicare beneficiaries, except for catastrophic illness.

Thus, in every major area of concern to Americans—coverage. reforms, benefits, quality, cost and cost controls—the administration proposal falls far short of meeting the needs.

Therefore, we call on the House Ways and Means Committee to hold early hearings on national health insurance and move for early enactment of the Griffiths-Kennedy bill.

The AFL–CIO executive council agrees with President Nixon that "comprehensive health insurance is an idea whose time has come in America." But his bill would not accomplish that goal. His bill would further enrich doctors and insurance companies without improving the health of the American people.

Enclosure.

SUMMARY OF THE ADMINISTRATION'S COMPREHENSIVE HEALTH INSURANCE PLAN (CHIP)

The proposal will establish three programs: An Employee Health Insurance Plan (EHIP); an Assisted Health Insurance Plan (AHIP) and a modified Medical plan. Medicare would be converted from a social insurance program to a partial means test welfare program.

EMPLOYEE HEALTH INSURANCE PLAN

The Employee Health Insurance Plan would require every employer to purchase a mandated minimum benefit package from private insurance companies. Small employers, with less than 50 employees and average individual wages of less than $7,500, would have the option of buying the Government program.

The scope of benefits is broad but very shallow. No benefits would be paid until the insured person had incurred substantial out-of-pocket expenses. Only then would the program pay for most types of medical expenses, including mental health and prescription drugs, but preventive care for adults would not be covered. Children would be eligible for well baby care up to age 6 and vision, hearing and dental care up to age 13.

Employees would have to pay an annual deductible of $150 per person ($450 for a family) and 25 percent of covered medical bills up to a maximum of $1,500 a year per family. The per person deductible would increase as the cost of living rose. There is a special deductible of $50 per year per person (up to $150 per family) for drug expenses. These limits would apply only to covered benefits. Noncovered items, such as extended nursing home care not preceded by hospitalization, would not be counted toward meeting the deductible or $1,500 maximum expenses. Families could, therefore, incur medical expenses of substantially more than $1,500 per year which would not be covered.

The following types of medical expenses are not covered:

(1) Supplementary charges by physicians over the fee schedule established by the various states.

(2) Physical examinations for adults.

(3) Dental and eye care for persons over 13.

(4) Mental health services in excess of 30 days hospitalization or 15 outpatient visits except when provided by a community mental health center in which case 39 outpatient visits are allowed.

(5) Extended care over 100 days.

(6) Skilled nursing home care provided without prior hospitalization.

(7) Home health services of more than 100 visits.

The premium cost of Employee Health Insurance would be shared between the employer and employee. Initially employers would have to pay a minimum of 65 percent of the premium cost and employees 35 percent. After 3 years, the minimum employer contribution would be 75 percent of premium. If the cost of the insurance increases an employer's payroll by more than 3 percent of payroll, the Government would subsidize the employer payments. The subsidy would be phased out over 5 years.

ASSISTED HEALTH INSURANCE PLAN

The Assisted Health Insurance Plan (AHIP) is intended to supplement the employee plan by providing coverage for all other persons, also through private insurance companies. It would cover, in the main, part-time and seasonal workers, the unemployed, low-income persons, employees and dependents of small low-wage employers and individuals.

Benefits under Assisted Health Insurance would be identical to the minimum benefits of the employee plan. The benefits would be subsidized by the Federal Government and by state governments as well.

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.

FINANCING

The Employee Health Insurance Plan would be financed primarily from employer-employee contributions. The Assisted Health Insurance Program would be financed partly by premiums, partly by a transfer of funds from other gov-

ernment programs, i.e., Medicaid, OEO, neighborhood health centers, maternal and child health services, public health hospitals, etc. The net additional cost to the Federal government from general revenues would be $5.9 billion. State and local government expenditures for health care would be increased by $4.5 billion—$1 billion for health care for the poor and $3.5 billion to provide insurance for employees.

States would contract with private insurance companies to offer the Assisted Health Plan to all residents of the State, except those with family incomes of $7,500 or more who have the option of obtaining an Employee Plan.

The premiums for the Assisted Health Insurance Program would be based on an individual or family income, with a graduated scale of premium payments and cost-sharing related to income. The income scale is structured to encourage working families with income between $5,000 and $7,499 to purchase the Employee Plan.

While families with incomes below $2,500 per year would not have to pay any insurance premium nor any deductible, they would still be required to pay 10 percent of their medical bills up to $150 per annum. Probably the cost of collecting this 10 percent would exceed collections.

CRITIQUE

The Administration's Comprehensive Health Insurance Plan is designed to: (1) Placate the American Medical Association and other providers of health care, (2) assure the profits of the insurance industry, and (3) meet the problems of small business. It is not designed to meet the health needs of the American public.

The President claims his program would not increase taxes. Of course the premiums both employers and employees would be forced to pay are a mandated cost, exactly like taxes.

In addition, the deductibles and coinsurance are costs to the consumer. In fact, 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. The administration admits that three out of four persons in any given year would not have medical expenses exceeding the deductibles and would not receive any benefits from the program that year.

CHIP is designed as an insurance program against the risk of illness. By excluding preventive care for adults and by including a sizable deductible that would deter patients from seeking early treatment, President Nixon has ignored the very benefits he hailed in health maintenance organizations.

The Nixon Administration claims its bill would provide broad, comprehensive benefits. *The fact is* that the Nixon plan would not provide any benefits until a family has made substantial out-of-pocket payments.

For example, a family of four with an annual income of $10,000 would spend the following for health care in a year before receiving any benefits from the Nixon program:

Premiums (35 percent of average premium of $475 a year)	$166
Medicare tax (0.9 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 (0.9 percent of $10,000)	90
Total expenditures before eligibility for benefits under Nixon program	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 has 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.

Even at that, not everything is covered. Specifically uncovered services under the Nixon plan are physicians' charges in excess of fee schedules, physical

examinations for adults, dental and eye care for persons over 13. These costs alone would strap the budgets of many families.

By comparison, under the Health Security program, which we support, a worker would pay 1 percent of his income up to $15,000 a year as his share of the Health Security tax. The Medicare tax would be abolished; so, most workers would only pay a few dollars more for Health Security. The worker and family would then receive all their necessary health care services, including preventive care and dental care for children up to 15, without having to pay one dime more. Health Security would have no deductibles and no coinsurance.

The employer's share of the Health Security tax is 3.5 percent of payroll. According to Commerce Department statistics as yet unreleased by the Nixon administration, this would be less than employers would be mandated to pay in private insurance premiums for their employees under the Nixon plan. The administration bill would require employers initially to pay an average of 4.1 percent of payroll for health insurance premiums. This would rise to an average of 4.5 percent of payroll after 2½ years.

While the President has been quick to criticize the cost of the Health Security program, he has been reticent about releasing the true cost of the administration proposal. The AFL–CIO staff, using available data, has estimated the cost of the administration bill if it were in force in fiscal 1974:

[In billions]

	Present expenditures for personal health care	Nixon plan	Health security
Government (all levels)	$34.5	$39	$75
Consumer out-of-pocket	34.5	30	18
Private insurance	24	32	0
Total	93	100	93

Thus, the Nixon program would increase the amount spent in the Nation for personal health care, largely due to added profits for private insurance companies. Only Health Security would get a handle on costs and hold future increases in medical costs to a minimum. Because the Nixon plan has no effective cost controls, it would touch off a new escalation in medical costs.

The Nixon plan would cover only about 40 percent of the Nation's health care expenditures. Health Security would cover about 70 percent.

In his health message, President Nixon said that the added government cost of his program would only be $6.9 billion. But to consider the true cost of the Nixon proposal, the mandated insurance premiums must be included as well as federal and state health care expenditures. Thus, the true Government or Government-mandated cost of the Nixon bill is closer to $71 billion. The high deductible and coinsurance required increases the cost of the Administration bill even further.

And because it lacks cost and quality controls, the Nixon program is certainly no bargain.

The Nixon administration claims that rich and poor will be treated alike under this bill. *The fact is* CHIP would establish a double standard of care.

(1) The poor would receive minimum benefits. Insurance companies can offer, and the rich can afford, better health insurance policies which would pay the deductible and coinsurance charges and also cover the exclusions in the minimum benefit package.

(2) CHIP requires physicians to accept a State-negotiated fee schedule for services provided to beneficiaries of the government assisted plan and Medicare. The Nixon bill specifically permits physicians to charge higher fees to EHIP beneficiaries. Employee plan patients would inevitably receive more favorable consideration by physicians, because doctors would make more money.

The administration claims every citizen would be able to purchase health insurance at a cost he can afford. *The fact is* that the Nixon bill falls far short of the universal coverage of the Griffiths-Kennedy bill. For example:

—Employers would not be required to offer EHIP to their employees until they had completed 90 days on the job. While employers would be required to

pay health insurance premiums for their former employees for 90 days after they lost their job, continuity of coverage would be interrupted unless the unemployed worker paid the full premium—or about $40 a month—or applied for the Government-assisted welfare plan. The unemployed worker would still have to pay the deductible and coinsurance.

—Self-employed families, if they are unable to buy private insurance, would have to pay 150 percent of the average group rate in their State of residence or about $900 a year. Poor health risks, the so-called uninsurables, could only obtain coverage under AHIP.

—Migrant works with only temporary ties to one employer and only temporary residence in one state could not be readily insured under either EHIP or AHIP.

President Nixon claims his program would control costs and quality. *The fact is* that cost and quality controls are virtually non-existent.

The President says cost-sharing by the patient would control utilization of services and, therefore, cost. However, it is the doctor and not the patient who makes those decisions. To the extent that people are deterred from seeking early treatment, deductibles increase the total cost of medical care.

The President says that Professional Services Review Organizations (PSRO's) would reduce utilization and cost. But PSRO's are controlled by the medical profession, and physicians cannot be expected to act adversely to their own economic self-interest.

The administration's cost controls depend in part upon developing prepaid group practice plans throughout the country, but the benefit provisions of CHIP are incompatible with these plans because of the high deductibles and coinsurance. The Nixon program would, therefore, inhibit the growth of prepaid group practice plans and health maintenance organizations.

The Nixon plan would rely on the States to establish prospective budgets for hospitals and other health institutions. But the states have not demonstrated sufficient competence in this area and would have virtually no clout with recalcitrant institutions because the states would not control any funds. The insurance industry would have all the money for health services.

Under the Nixon plan, states would negotiate fee schedules with the medical profession. But physicians would only be required to accept the fee schedule for Government-assisted and Medicare beneficiaries. Physicians could require additional payments on covered benefits for those on the employee plan; but these payments could not be counted toward meeting the $1,500 ceiling on expenditures by the beneficiary.

By contrast, Health Security would control costs and quality through much more stringent provisions. For example, Health Security would establish minimum standards for physicians; the Nixon plan would not. Health Security would require that surgery only be performed by board-certified surgeons; the Nixon plan would not. Health Security would require consultation before surgery; the Nixon plan would not. Health Security would require physicians to accept the fee schedule as 100 percent payment for everyone; the Nixon plan would not.

The Nixon administration claims its program builds on the strengths, capabilities and experience of the health insurance industry; that private enterprise can do the job better and with less red tape. *The fact is* that the escalation in medical costs was the result of the present outmoded system which relies on private insurance.

The worse features of private insurance would be continued by the Nixon program. Experience rating would be an integral part of the program. Poor health risks would have the option of paying 50 percent more for their insurance or buying into the welfare program. If insurance companies refused to cover high-risk individuals for 150 percent of the average rate, these people would be left with the option of no insurance or the welfare program.

CHIP would leave regulation of insurance companies to the states. State regulation of the insurance industry has been ineffective in the past, and there is no reason to believe state administration would be improved by passage of the program. In addition, the cost of administering an income-related program based on experience rating would build an immense insurance industry bureaucracy between the providers and the patients.

CHIP conforms to the insurance industry practice of "skimming." That is, the insurance industry would sell insurance to low-risk and profitable employed

groups, leaving the poor, the unemployed and other unprofitable high-risk groups and individuals to the Government program.

The Nixon plan would require a complicated system of income-testing—a more polite name for "means" tests—to determine eligibility under AHIP. Additionally, insurance companies would have to keep records on the income changes of their subscribers in order to adjust the individual's deductible and coinsurance requirements.

Income testing is, per se, repugnant to American workers. It dilutes the principle of health care as a right of all Americans into a thinly disguised welfare program. As the States have found out in administering their welfare programs, income testing escalates administration costs, further reducing benefits. The paperwork that would be required for insurance companies to bill and collect deductibles and coinsurance would threaten to swamp the health care system in a flood of red tape.

As with welfare, when administrative costs exert pressure on limited budgets there is the temptation to reduce costs by cutting benefits. This happened under Medicaid, and must not happen under national health insurance.

President Nixon claims consumers would have an important role in his program. *The fact is* that the only role for consumers is to pay high deductibles, coinsurance and premiums. A particularly distressing role for consumers in the administration proposal is the procedure whereby insurance companies could charge patients an unspecified amount of interest on their share of doctor and hospital bills. Credit cards and interest charges are no substitute for comprehensive benefits with no deductibles and no coinsurance. The Nixon program is for the doctors and the insurance companies, not the consumer.

SUMMARY

The Nixon administration national health insurance proposal falls far short of the minimum standards for national health insurance established by the AFL–CIO executive council on February 17, 1970:

- Universal coverage as a matter of right.
- Comprehensive single standard of benefits.
- Financed like Social Security.
- Encouragement of prepaid group practice plans.
- Strong cost and quality controls.
- Reform of the health care system.

The Nixon program would not provide universal coverage as a matter of right. It would not provide a single standard of comprehensive benefits. It would be financed through the private insurance industry and not like a social insurance system. It would not encourage prepaid group practice plans. It would not effectively control costs and quality. It would not reform the health care system.

Only National Health Security—the Griffiths-Kennedy bill meets the goals of the AFL–CIO.

ITEM 2. STATEMENT BY THE AFL–CIO EXECUTIVE COUNCIL ON NONINSTITUTIONAL SERVICES FOR THE ELDERLY

BAL HARBOUR, FLA., *February 19, 1974.*

Many older people are confined in expensive nursing homes and other institutions for relatively minor health conditions only because the range of community services that would enable them to remain at home are not available.

This problem is not insurmountable. All that is needed is a greater national and community commitment to development of these services.

Unfortunately, noninstitutional services for the elderly are given little or no priority in most communities. Even where such services are to some degree available, they are usually provided on a fragmented basis from a variety of agencies. These services should be brought together in a coordinated, general service program.

They would cost the community far less than it now pays for nursing home care and would provide the elderly greater satisfaction by enabling many of them to remain in their own homes. Successful programs will require a wide spectrum of services ranging from home health services and visiting nurses to homemakers and housing for the elderly.

Of course, elderly persons should not be denied care in a nursing home or other appropriate institution when such care is the best for their condition. The objective should be what is best for the health and well-being of elderly people.

The core of any noninstitutional service system should be an effective home health services program—a complex of services which may be brought into the home to sustain individual health and independence. But there has been a glaring inconsistency between stated public policy and what has actually happened to home health services programs. In many areas, home health services are not available at all. Where such programs are operating, they are generally underfinanced, unable to adequately cover the target population, and deficient in essential elements which would make them an effective resource.

Both Medicare and Medicaid authorize home health services but with such tight restrictions that they have created roadblocks to the development of such services. Less than 1 percent of Medicare expenditures now go to home health care and even that small portion appears to be decreasing. Some health service agencies have shut down and many others still operating appear to be in financial jeopardy. A good first step toward more effective health service programs for the elderly would be greater emphasis on such services in the Medicare and Medicaid Programs.

But more than this is needed. What is needed is a program of noninstitutional services that is capable of being a major component in a comprehensive health care system such as the National Health Security Act would establish.

The AFL–CIO urges the development and passage by Congress of a comprehensive system of services for the elderly, and that such a program of services be included in any national health program that may be adopted.

Appendix 3

ITEM 1. NEWSPAPER ARTICLE SUBMITTED BY SENATOR WALTER MONDALE, ENTITLED "AGING SISTERS IMPRISONED BY POVERTY," FROM THE WASHINGTON POST, MARCH 13, 1974

[From the Washington Post, Mar. 13, 1974]

AGING SISTERS IMPRISONED BY POVERTY

(By John Saar)

Imprisoned by poverty and hounded by inflation, two elderly sisters are closing out their lives in a Massachusetts Avenue apartment in a constant state of anxiety and depression. Mary Smith, aged 82, and her younger and sicker sister Elsie Sager, 79, survive, and not much more. Rising prices have stolen even the smallest of life's material pleasures from them.

The sisters' lives provide a frightening case study of life in inflationary times for many of this city's 103,000 people over 60 years of age.

Too old to work, with no close relatives, the sisters depend on a Social Security income of $296.30 and a pinchpenny budget that allows them $2 a day for food.

Penury has forced an almost total divorce from the outside world upon the sisters. Only the buzz of traffic and their own suppressed longings remind them, they say, of a normal life. They have one another and all the comfort an antiquated and flickering television can bring.

In the course of a long interview, the suspicion of tears misted Mrs. Smith's spectacles just once as she was saying, "Sometimes I see women in this building all dressed up for a swell lunch at Woody's or Garfinckels and I almost burst out crying."

They lack sheets for their beds, shoes for their feet. Rising prices lay constant siege to their diminished diet, making one sacrifice after another—fresh fruit, then milk, then meat . . .

Stoic by nature, Mrs. Smith says their situation is "laughable." But she does not laugh. In fact the once jolly person whose pleasant face bears imprinted smile lines rarely laughs these days.

For the two sisters, the closing out of their lives is proving a bleak ordeal replete with depression, indignity and suffering by deprivation.

Inflation continually threatens their precarious existence on an already inadequate fixed income. And inflation, in a remorseless progression, has canceled the few pleasures from their lives. Mrs. Smith, for instance, "an avid reader" used to devour the morning paper cover to cover. She had to cancel it a while back.

The women worked a combined total of 39 years to earn their right to the monthly social security checks—Mrs. Sager as a beautician in Richmond, Mrs. Smith as timekeeper in a now defunct Washington laundry. They are single. Mrs. Smith was divorced in 1925 and her sister has been a widow for 44 years.

"Every night," says Mrs. Smith, "I thank God for what we have, but it's mighty little." Her dress was a gift from the manager of the building. The print flowers have been laundered to a pallor, so that the dress matches her indoor complexion—notepaper-white. Her shoes are a work of artistry—15 years old, the many slits and holes carefully welded shut with glue.

"In the past year or so," she says in her usual firm and unself-pitying manner, "it looks like I'm really getting crushed. I shouldn't and I'm trying to get out of it."

But her sister Elsie is depressed most of the time—"what we've been through is enough to tear the heart out of anyone," Mrs. Smith explains.

Asked to comment on how the sisters' situation could be equated with that of thousands of other elderly people in the city, social workers with various

voluntary agencies and a spokesman for the District government's services to the aged office agreed it was typical. "These people are almost among the affluent aging," said George Robey, acting chief of the social services division.

In 1973 food prices soared by 25 per cent, placing a specially heavy burden on the fixed income poor like the two sisters. In January this year, grocery prices in the Washington area went up another 3 per cent.

"Inflation has had a tremendous impact on the elderly here," said Geraldine Brittain, a social worker with the private Family and Child Service who has helped the sisters. "There are relatively few social workers and it's a big population of elderly. We just touch the tip of the poverty iceberg. I think there's lots of real suffering."

Defenders of the Social Security system are quick to point out the payments are intended to supplement, savings, pension or other retirement income. The two sisters were left with no savings when they retired due to ill-health in their early 60s—Mrs. Sager because from the small profits of her beauty shop she had to look after her mother and two nephews and Mrs. Smith because her $60-a-week salary permitted no savings.

Although the sisters are receiving their full entitlement, they are skeptical and disappointed: "All those years," says Mrs. Sager, "they kept telling me my social security was building up, building up, and then when I got where I couldn't work but half a day that's what they based it on."

The grim reality of the sisters' cheerless life is worsened by the contrast with their falsely optimistic anticipation of how "the golden years" would be. The absence of forethought to retirement is cited by experts as one of the contributory causes to distress in the aged. Arguing for more community concern in treatment of the vulnerable and powerless aged, they like to gently threaten that as a multitude advancing to through life. We should pay heed when distress falls on those in front.

Mrs. Sager, a stocky invalid figure in a white nightrobe had seen her retirement as a chance to go to the zoo, the Smithsonian, the Washington scenes she never got around to seeing while working. Now even those limited ambitions are beyond reach: "I was going to have myself a ball," she says in a voice huskily wistful with the memory.

"I thought when I got to be in my old age," remembers Mrs. Smith, "I'd have enough to eat, a place to sleep, plenty of time to read and nothing to worry about. And having a lunch out or something like that once in a while."

Her life now is, she says, "certainly nothing like that. We can't afford to buy a bus fare and if we got downtown we could not afford lunch. You couldn't do it for less than $1.50 or $2—we can manage for a day on that—it's out of the question for us."

In a splitting of financial responsibilities common among elderly roommates, Mrs. Sager uses her check to pay the $140-a-month rent on their two-room apartment and Mrs. Smith cashes hers to buy food and other essentials. Anxiety over making ends meet is a constant for them, incalculable to the outsider: "All the time you're figuring out 'can I buy this, or buy that' and you're scared to death something will happen and you won't have the money," says Mrs. Smith.

The telephone, for instance, is an oft-discussed but finally indispensable necessity that costs a precious $10.50 a month. The sisters seldom leave the dingy-walled apartment—"if they whitewash it the rent goes up"—except for their once-monthly shopping trip.

The telephone is a link to the outside world, with richer friends who call from Florida, New York or California—and for two old women with fragile health, a protection. Several weeks ago Mary picked up the red handset and called a doctor when her sister had a 3 a.m. heart attack.

The episode put Mrs. Sager into George Washington Hospital for two weeks under the Medicaid program and emptied the sisters' slender cash reserve. Mrs. Sager was too sick to ride buses. Hiring a friendly car-owner to transport her cost $5 each way and then Mrs. Smith had to come up with $3 a day to visit her. They dug into their loose change and used the last nickel before the hospitalization was over.

Lunch would be a can of beans Mrs. Smith said. How long since they last ate any meat?

Mrs. Sager: "Four weeks."

Mrs. Smith: "No. it was about six weeks ago we had some hamburger. So far as buying lamb chops or a roast of beef, we never do it."

Their diet now consists of eggs, oatmeal, hominy. grits, fruit juices, crackers and vegetables. They see no way of economizing further.

Outright hunger is not a problem said Mrs. Smith: "If I get hungry I go and eat a couple of crackers." Until a third sister died four years ago, Mrs. Smith and Mrs. Sager lived in relative prosperity and ate heartily because rent and overheads were shared three ways. "We used to eat a full-course meal then but we've been cutting down, cutting down, so now we're small eaters."

Asked if she was constantly aware of rising prices Mrs. Smith gave an outraged "Oh!" and snapped her head away. The prices have hounded them relentlessly, she said. When fresh milk went out of their price range they replaced it with condensed milk. A can of condensed milk that used to cost 18 cents, now costs 35, she said. "It seems to be getting worse all the time. Every time you buy something, it's so much more than it was before."

The two sisters are white. The significance of that is that in a city with an over-all population 71 percent black, whites are in a disproportionate majority among the elderly. Of 72,000 people over 65 in the District, 57 percent are white.

The imbalance is attributed to the reluctance that settled whites of advanced age felt about joining the general white migration from the city in the 1950s and 1960s. Another critical factor is the shorter life expectancy of blacks usually believed to result from poorer health care in youth.

Nationally, life expectancy for a white female is 74 against 68 for a black female. In males the difference is even more striking with whites averaging 67.9 years and blacks 60.

The 103,000 people over 60 are distributed fairly evenly over the District's nine service areas with one striking exception. In the area west of Rock Creek Park, 26,411 are concentrated and 99 percent of them are white, according to David Brooks of the District's office for the aged.

Exact income figures are unavailable, but Brooks and other experts see thousands of aged whites caught between low limited incomes and rising prices with an abundance of hardship and psychological suffering.

The sisters are luckier than most because their apartment, though taking half their income, is a bargain by current standards. "One of the most dramatic problems," according to Mrs. Brittain, the social work "is the inability to pay rent. Old apartment buildings are being turned into condominiums, the residential hotels are being torn down right and left and the problem of finding these people somewhere to live is very, very serious."

Brooks goes further. The waiting time for a subsidized apartment in National Capital Housing Authority projects is 2- to 4-years, with no emergency capability at all: "There is no housing available for the elderly," Brooks said flatly.

As viewed by the sisters, their situation could scarcely be worse. Social Security is due to go up by 11 percent between now and July, but they expect a rent rise to more than take care of that. Whatever the increase is, they will have to pay it. The costs of moving, deposits, a month in advance are way beyond them, they say.

The experts do not agree on whether whites or blacks suffer most. Being black and old "is a double jeopardy," Mrs. Brittain belives. It makes for many more problems. They were usually in lower paid jobs so they rarely have as much income as whites and their health needs are more severe. The effects of discriminatory education and health care are really exaggerated as they grow older.

On the basis that elderly blacks generally are paying lower rents and therefore have more money than aged whites, George Robey contends they may be better off. Besides, "people on the lower end of the scale manage better than those who are used to something better."

"The ones who seem to suffer the most are those numerous people—mostly women. who worked in government or business for years and years and retired with what seemed a good income. The little place on Massachusetts or Connecticut Avenue which might have cost them $60 in 1948 is $160 or $170 now. Everything else has gone up and they're still trying to hold on."

Holding on is what Mrs. Smith or Mrs. Sager have become very proficient at. With a ticking clock. paper flowers. fading photographs and a daguerro print of their father—a handsome man with stiff white collar and walrus moustache—the sisters pass their time in genteel poverty.

Just before Christmas the nephew Mrs. Sager brought up as her son died at 45. The funeral was in Richmond. They could not afford bus fare.

"Being too proud to borrow from somebody," Mrs. Sager related, "we didn't go"—

"Well you can't borrow if you can't pay it back," her sister interrupted.

"Well, I'll tell you. It's a hard thing."

Of the two sisters Mrs. Smith is commanding, determined to exercise her responsibilities to the last. Her sister wants to make a trip to Richmond—"my mother and brother and everyone is buried there. She wants to go home so bad it's pathetic and by hook or crook I'm going to see she does it."

The inability to meet familial standards of respectability is a source of understated shame to the sisters. Mrs. Smith calls her derelict shoes "perfectly awful, embarrassing" and says she ceased going to church when she could no longer dress properly for the Methodist pews.

In the view of another social worker, Lillian Teitelbaum, indignities await those aged who seek help from District and federal agencies: "Sometimes they are treated miserably. Wherever they go there are roadblocks and if they are uneducated they passively retire."

David Brooks, supervisor of information for the District's services to the aged, agrees there is a problem. "When they reach me, most old people are very, very frustrated. They've been calling and not finding any agency which can help them."

The aged service is limited in function—it finances certain programs undertaken by voluntary organizations and makes referrals to other agencies. "Sometimes our agency can't help," says Brooks. "Either we don't have the clout or there is simply no mechanism."

The plight of the two sisters and unknown thousands of their 60-plus peers leaves social workers angrily helpless.

"In this day and age $300 a month for two people is obviously inadequate. They and others are being deprived of essential living needs."—Mrs. Teitelbaum.

"I see them as having come to the ends of their lives and having to struggle. It's damn hard when you come this far and life doesn't offer any opportunity for enjoyment."—Mrs. Brittain.

With her ailing sister in the other room, the obvious question could be asked of Mrs. Smith. She stood still and delivered a bravely honest answer: "We've talked about it a lot. I just don't know what would happen to the one who was left."

ITEM 2. NEWSPAPER ARTICLE SUBMITTED BY NELSON CRUIKSHANK, ENTITLED "THE NIXON Rx FOR HEALTH CARE: COMPLEXITY, CONFUSION, INEFFICIENCY, INEQUITY," FROM THE WASHINGTON POST, MARCH 10, 1974

[From the Washington Post, Mar. 10, 1974]

THE NIXON Rx FOR HEALTH CARE: COMPLEXITY, CONFUSION, INEFFICIENCY, INEQUITY

(By Rashi Fein[1])

President Nixon has sent Congress his blueprint for a national health insurance program that, if written into law, would represent a significant improvement in meeting the medical bills of many Americans. But that says more about the size of the problem than about the wisdom of the proposed solution. For the administration's system would be one of complexity, confusion, inefficiency and inequity.

Under the administration's plan, millions of Americans would remain without protection. And even for those covered, medical care would continue to be rationed on the basis of income.

This is so because of a series of policy decisions made for ideological reasons. Faced with public concern over rapidly rising health costs, the President chose to stress *voluntary* enrollment, largely private financing (with funds flowing from employers and employees to private insurance companies), a minimal impact on the federal budget, and supervision by state rather than federal officials.

The administration's plan has three major components:

First, under the Employee Health Insurance Plan, employers would be required to offer their employees a health insurance plan with a federally defined

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set of covered services (the basic plan), coinsurance, deductibles and maximum liability provisions. If the employee elects to be covered, 75 per cent of the premium costs would be paid by the employer.

Second, under the Assisted Health Insurance Plan, states would contract with carriers to offer the basic plan of covered services to persons who are not working, who fall below defined income levels, or who are high medical risks (for instance, the disabled now covered by Medicare). Individual premium payments, out-of-pocket expenditures for medical care and annual maximum liability would vary with income. Program costs would be met by contributions from employers (where applicable), those insured, and state and federal funds. This plan would replace most of the exisitng Medicaid program.

Third, the Federal Health Care Benefits program would replace Medicare. The services covered would be identical to those provided in the basic employee plan. Premiums, out-of-pocket costs and maximum liability, again, would vary with income.

Americans would sort themselves (or be sorted) into one of the three programs and move between them as their socio-economic and demographic characteristics changed. In recognition of "voluntarism," each of the plans would provide "the opportunity . . . to obtain coverage" rather than the coverage itself. In recognition of "pluralism," each of us might face a different insurer as we changed employers or moved from one state to another.

EMPLOYERS AND EMPLOYEES

First, consider the Employee Health Insurance Plan. This part of the program would require that employers offer those employees who qualify, based on hours and weeks of work, a defined health insurance plan, and that, usually beginning about two months after the onset of employment, the employer contributing 75 per cent (65 per cent in the first three years of the program) of the premium expense for the covered employees. The employee would pay the rest.

The administration estimates that the benefit package defined in the plan would require a total premium of approximately $600 for a family and $240 for an individual. Recognizing that the $450 employer contribution to the premium might significantly increase payroll expenses, the plan provides for a federal subsidy (declining over a five-year period) to employers for a portion of the premium costs in excess of 3 per cent of total cash wages.

What might all this mean to the employer, to the employee, to the labor market? Some general answers are clear. Small, marginal and low-wage employers would find that, if the employee has a family and elects to be covered, the mandated premium expense would lead to a significant increase in costs. Even with the maximum subsidy, an employer whose employees elected coverage for themselves and their families and who had average annual wages $7,500 would find the wage bill increased by over 3.5 per cent in the first year. By the sixth year, with the decline in federal assistance and the increase in employer's contribution rate, premium costs would add a full 6 per cent to payroll expenses. While these percentages are reduced if the average annual wage is higher, there surely can be little doubt what kinds of workers employers would prefer: employees who elect to do without coverage, ineligible part-time rather than full-time workers, single individuals rather than heads of families, and temporary rather than permanent help.

Whether any of these factors would have a significant impact on, say the Ford Motor Co.'s hiring policy is not the point. The program the President offers is not really addressed to UAW members (whose coverage, in a number of respects, is already better) but to employees not now protected by an adequate health insurance program—people who are now and, in many cases would remain, in difficulty. It would make it more difficult for low-income heads of families to obtain regular, full-time employment.

Of course, it can be argued—and with considerable merit—that the impacts on employees are in part illusory; that premium would be shifted from employer to employee through the wage determination process (and to the consumer through inflation). But if that be the argument, we can question whether premiums of $600 permit us to say, as the President does, that the program "will cost no American more than he can afford to pay." This is surely not the case for those with low income.

Regrettably, too, the program has regressive characteristics: A premium that is a fixed dollar amount is a higher percentage of low incomes than of high.

Thus, married employees with annual income of $7,500 would face a 2 per cent "tax" to meet their share of premium costs. For those with incomes $75,000 the "tax" would be 0.2 per cent.

The adverse labor market and regressive tax impacts would be mitigated—though at a price—as some employers induce their employees to reject coverage. Though the bill prohibits such actions, there are subtle (and not so subtle) ways of accomplishing that objective. Again, those affected would be the economically most valuable, those who need coverage the most. Presumably, however, we who have coverage would feel better by having erected a fiction that the failure to obtain coverage was a matter of free choice.

The difficulties were known but not correctable. The decision was in favor of voluntary enrollment, employer-employee cost-sharing and minimal federal contribution. These are incompatible with progressivity and universal coverage.

COSTS AND BENEFITS

The basic benefit package that the program mandates includes a long list of "covered" services: inpatient hospital service, physicians' services (though not including routine checkups), home health services, outpatient drugs, dental and vision care for persons under age 13, and more. Close examination of the nature of the program suggests, however, that the President's advisers use the term "covered services" loosely.

First, we would face deductibles, the dollars we must spend for covered services before insurance provides any assistance. In the Employee Health Insurance Plan these deductibles would equal $150 per person for covered medical services (but with no additional deductibles after three members of the family have *each* reached the $150 level) plus an additional per-person deductible (without a family limit) of $50 for outpatient drugs. A family of five—in circumstances where only two members have satisfied the deductible—could face expenditures of almost $1,000 on covered (and additional amounts on uncovered) services over and above the premium contribution *before any insurance benefits were paid.* A family of two would need to spend only $400 before receiving cash benefits.

After the deductibles have been satisfied, coinsurance would enter the picture: The plan would pay 75 per cent of the approved charges; the insured person would pay the remaining 25 per cent (and any charges in excess of those approved). There is, however, a limit to these "cost-sharing" expenditures by the insured: a "maximum annual liability" provision. For a family under the employee plan, this maximum liability (not including premium costs, payment for noncovered services, and of unapproved charges for covered services) would be $1,500 ($1,050 for an individual). The maximum expenditure for medical care would, of course, be greater since some services are not covered at all or have limits placed upon them (for instance, routine physical examinations including well-baby care, dental care, services to the mentally ill).

Certainly many Americans would benefit from such protection. Though the deductibles and cost-sharing rates would be quite high, many of us lack even those protections today. Millions more lack the plan's maximum liability protection. While few persons or familes would reach the maximum—an individual would have to receive at least $3,600 worth of covered medical services before reaching the $1,500 liability limit—the presence of such a maximum would offer a measure of security that has real value. The more then the pity that the basic structure of the plan—the choice not to have a system that could relate benefits or premiums to income—creates a ridiculous situation: A working family with income of $7,500 would have a maximum liability of 20 per cent of income, while one with income of $15,000 would have a 10 per cent ceiling, and one with income of $75,000 would have a 2 per cent ceiling. Nor are the ceilings adjusted in any way to take account of family size and thus of other demands on income.

PAYING IS GOOD FOR YOU

That the administration has proposed a system with high deductibles and cost-sharing is no accident. Given the desire to utilize employer-employee funding and on a voluntary basis, premium charges cannot be tied to income in a progressive (or, for that matter, even in a proportional) manner. Lowering deductibles and cost-sharing rates would significantly increase premiums since more Americans would receive cash benefits. In the absence of progressive funding, such premium increases would quickly price many employers and

employees out of the market and would make the regressive impact of medical costs so explicit as to call the entire approach into question.

The administration, however, does not view the consequences of the deductible and cost-sharing as undesirable. In the past, the President's advisers have often argued that the introduction of deductibles and cost-sharing would: 1. reduce the utilization of medical care (though, in some unexplained way, not interfering with necessary care); 2. increase price consciousness on the part of consumers who would have to pay for care out of their own pockets. Both of these effects would help contain inflation.

In his message to Congress, the President stated: "By sharing costs, consumers would have a direct economic stake in choosing and using their community's health resources wisely and prudently." Furthermore, such sharing—a "sharing" in which the consumer pays 100 per cent of a significant deductible—clearly fits the ideological thrust of the administration: the need to stand on one's own two feet, not to be pampered.

These are interesting arguments even if based on erroneous facts and faulty theory. The chief difficulty relates to the belief that deductibles and cost-sharing, as constructed, can serve the same purpose for families with different incomes, tastes and medical needs. Clearly a family of six with income of $7,500 facing a premium of $150 and, say, $600 expenses which it must meet out of pocket without *any* insurance assistance is likely to behave differently in deciding whether to seek medical care than would a family of three with income of $27,500 facing the same premium and deductible. If costs to the consumer do make a difference—and the administration believes they do—then surely they don't make the same difference to all. Could deductibles have varied with income to help mitigate the problem? Not within the game plan chosen.

The consequences of the administration's decision are apparent: Medical care would continue to be better for those with higher incomes. Cost-sharing would discourage many from using preventive and early detection care. This is a necessary consequence of the administration's desire to have the payment system stay outside the federal budget and remain voluntary and private. It is a consequence of the desire to erect a system that reflects the administration's assessment that the issue is financial protection against high expenditures rather than a system that reflects the need to remove economic barriers to care at all levels.

WHO'S ELIGIBLE FOR WHAT?

In recognition of the fact that many Americans would not have an opportunity to enroll in the employee plan, a second program, Assisted Health Insurance, with the same set of covered benefits, is proposed. This insurance would be developed through state contracts with insurance carriers. Thus we have a series of state programs meeting federal standards and guidelines rather than a federal program.

In general, the plan would enroll families with incomes of less than $5,000 ($3,500 for individuals); nonworking and very high-risk working families with incomes between $5,000 and $7,500; nonworking families with unusually high medical risks—such as the disabled—regardless of income; and unusually high-risk employer groups. Premiums, deductibles, cost-sharing rates and maximum liability provisions would all be income-related. Carriers would derive their income in part from employers (where applicable), in part from those enrolled (where income is sufficiently high to require payment), in part from state contributions with significant federal assistance to the states.

And thus the sorting and sifting begins. Persons would not be eligible for *the* program but for a particular program, and their eligibility would change with changes in employment status, income, health risk and state of residence. In a mobile society, this program structure would provide benefits not only to sick people but to the data processing industry as well. Yet unnecessary costs are not all that is at stake. The greater difficulty is that in systems of such complexity some individuals—again, those least educated and most vulnerable—are the ones most likely to fall between the cracks, to find themselves without coverage.

The Assisted Health Insurance Plan would replace the present Medicaid program (except for certain services not covered). No one can differ with the conclusion that the state Medicaid programs, with varying benefits and eligibility standards, need replacement. Uniformity is desirable. But the lesson of the need for uniform benefits and eligibility was not the only lesson that the administration should have learned from the Medicaid experience. Some of us

have been impressed by the inability or unwillingness of many states to provide for efficient administration and review—problems that remain with the heavy emphasis on state rather than federal program development and control.

We have also come to recognize the need to reduce economic barriers to care. Yet the Assisted Health Insurance Plan offers some Medicaid recipients fewer benefits than they now have and sets significant economic barriers for many—barriers that would reduce the utilization. While a family with income of $4,000, for example, would not have to spend more than 9 per cent of income for *covered* services, the problem in meeting the initial deductibles and cost-sharing payments, the first $360, cannot be overlooked. Clearly, these out-of-pocket expenditures would represent important economic barriers to care for those who, above all others, need assistance: those with few cash resources.

INSTEAD OF MEDICARE

The President also proposes that the Medicare system (though not including the disabled) be integrated into the new plan. The list of Medicare-covered services would be altered to conform to the mandated health insurance plan. As a result, certain services not covered at the present time would be covered—for instance, outpatient drugs, subject to cost-sharing—and all beneficiaries would be protected by a maximum annual liability (ranging up to $750, depending on income). These benefits are real, and they help address some of the inadequacies of Medicare.

It is unfortunate, however, that the administration's proposals would require additional payments for medical care on the part of many elderly. Deductibles, cost-sharing rates and maximum liability limits would vary with income, with a maximum $100 deductible and 20 per cent share of the costs above $100. This deductible would be greater than the $60 deductible for physician services that now applies, and the cost-sharing rate would be extended to cover hospital care where it is found only to a limited extent today.

Thus, the changes would provide greater benefits to some elderly, particularly that very small number with unusually high medical expenses, while reducing cash benefits to the many whose medical expenses are more limited. These proposed changes surely need to be seriously debated.

So, also does the departure from the Medicare social insurance principles. Medicare would be transformed into an income-related program as it is replaced by a plan that would introduce income tests and vary the cash value of benefits with income. This, too, is the result of policy makers' preferences. Can we believe that the introduction of income tests into the social insurance system represents the preferences of the people?

In both these programs, with premium costs and benefits that are income-related, attention must be paid to the creation of "notch effects": situations in which small increases in income result in large increases in costs to the covered person. These difficulties are illustrated by a simple example: In the Assisted Health Insurance Plan, an increase in family income of $500 (from $4,500 to $5,000) would lead to an increase of $300 in premium costs, of $50 in per-person medical deductibles, of $25 in drug deductibles, and of almost $200 in maximum liability. Though the dollar amounts differ, a similar situation is found in the Medicare-replacement program. It is even possible to find that a $1 increase in income could lead to an increase in premium and other medical care costs of over $400. At low incomes, *and only at low incomes*, the plan would severely penalize persons whose income increases enough to move them from one income class into another.

These deficiencies could not be eliminated. Once the package for the employees' health plan was determined, other parts of the program fell into place.

FACTS AND FICTIONS

In his message to Congress, the President stated: "My proposed plan differs sharply with several of the other health insurance plans which have been prominently discussed. The primary difference is that my proposal would rely extensively on private insurers." Indeed, the President would provide for major participation by private carriers, though without the federal regulation he had called for in the 1971 version of his plan and without addressing the issues of privacy and confidentiality of income data made available to the carriers under this program.

The President justifies his approach on the basis of the pool of talent that exists within the private sector in administering and designing health plans and on the basis of the belief that competition in the health insurance industry would reduce premium costs to the employers and employees. Thus, "if the government were to act as the insurer, there would be no competition and little incentive to hold down costs." The myth that competition among the private health insurance companies results in greater efficiency than is found in the Social Security Administration is simply not supported by the facts.

Nor do we face a choice only between public insurance with the demise of the private carriers and private insurance with their survival. Other alternatives are available. Medicare, after all, is a public program that utilizes the private sector in the role of fiscal intermediary. The desirability of that alternative needs examination. It is clear, however, that the issues are considerably broader than the administration suggests.

There is, however, one difference that the President chooses to stress that is nonexistent and fictitious. Three times in his message he stated that his plan would "insure that doctors work for their patients, not for the federal government." This incantation was repeated a week later, just after his checkup at Bethesda Naval Hospital, where he was examined by a team of federally employed physicians.

It is a disservice to the quality of the debate to erect a fiction about the relationship of physicians to the government under other national health plans before the Congress. None of the major plans would create a National Health Service (and does the President really believe that British physicians don't work for their patients?) or would alter the relationship between physicians and patients. A publicly financed program does not equate with government employment any more than the President's privately financed program means that doctors will be working for insurance companies. The real issues are sufficiently important to provide ample room for honest debate, without trying to create differences where they don't exist.

The President has called his plan "the very best way . . . to assure all Americans financial access to high quality medical care." It is not the best way. Perhaps the Congress could improve it here and there, but its time would be better spent if it considers other paths. It is time for debating policy, not for refining details.

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