BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

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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.

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

MONDAY, MARCH 5, 1973

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

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 6226, Dirksen Building, Hon. Edmund S. Muskie, chairman, presiding.

Present: Senators Muskie, Kennedy, Moss, Eagleton, Percy, and Stafford.

Also present: William E. Oriol, staff director; Kenneth Dameron, Jr., professional staff member; John Guy Miller, minority staff director; Robert M. M. Seto, minority counsel; Gerald Strickler, printing assistant; and Phyllis Balan, clerk.

OPENING STATEMENT BY SENATOR EDMUND S. MUSKIE, CHAIRMAN

Senator MUSKIE. The hearing will be in order.

This morning the Subcommittee on Health of the Elderly begins its study of "barriers to health care for older Americans."

Last year major congressional actions improved the economic well being of the Nation's elderly. A 20-percent Social Security raise, the largest dollar increase ever, became law.

Social Security is now inflation proof with provisions for automatic cost-of-living adjustments.

Enactment of H.R. 1 meant further advances for the aged, including increased benefits for more than 3 million widows and dependent widowers, liberalization of the retirement test, a new special minimum for persons with low lifetime earnings, and the establishment of a floor under the income of every older American.

But if our Nation is to assure true economic security in retirement, we must resolve the serious medical cost problems which now impose an intolerable drain upon the limited incomes of the elderly. This point was underscored very eloquently by the delegates at the White House Conference on Aging, who said in December of 1971, "This Nation can never attain a reasonable goal of income security so long as heavy and unpredictable health costs threaten incomes of the aged."

That message is as relevant today as it was 15 months ago.

In fact, their warning may be even more appropriate now because of escalating medical costs and threatened slashes in Medicare protection. Our leadoff witness today, Secretary Weinberger, will explain the nature of these new proposals, as well as the reasons for them.

One fundamental question that I will ask is: How can many of our elderly realistically expect to receive adequate medical care, in the face of these proposed Medicare cutbacks?

This question takes on added significance when we recall that more than 3 million older Americans live in abject poverty, most elderly single persons subsist on less than $40 a week, in this, the wealthiest of all nations, and health care expenditures for the aged averaged $861 in 1971, well over three times that for those under 65.

Despite Medicare's valuable protection, the threat of costly medical expenses is still all too real for millions of older Americans. Medicare now covers only about 42 percent of the total health bill for persons 65 or older. Serious gaps in protection include such major items as essential out-of-hospital prescription drugs, and effective provision for long-term care.

The net impact is that the elderly paid out of pocket in fiscal 1971 almost as much for health care as they did the year before Medicare became law.

Improvement, not retrenchment, should be our goal.

Few would dispute the need for trimming unnecessary Federal spending, but certainly a better target could have been chosen than the Medicare program.

Clear evidence of this was revealed in a recent poll conducted by Louis Harris. An overwhelming 92 percent of those surveyed opposed the Nixon proposals to "Make older people pay more than they now pay for Medicare." Only 5 percent supported the President.

Once again, this reaffirms that Medicare is a program enthusiastically supported by all Americans, not just older Americans.

That point was made very well in a letter to me, which I will submit for the hearing record, from the National Council of Senior Citizens. The NCSC believes that Medicare could not have been enacted without the wholehearted support of our younger working population, and that the population of all ages can, in 1973, be expected to fight the battle against Mr. Nixon's proposed cutbacks.

The NCSC also makes this important point:

> Mr. Nixon, while urging massive cutbacks in Medicare benefits for the workers' elderly parents, made no recommendation to cut back on the taxes the worker pays to support the Medicare program. By maintaining the Social Security tax as it is, the President is making available as a paper surplus in his unified budget another $1.6 billion a year which is now going to support benefits that he proposes to abolish.

Another sharp protest has been sent to me from the American Association of Retired Persons/National Retired Teachers Association. This statement, which I also submit for the record, describes the President's proposal as "ill timed, based on myth, and harsh to older Americans."

It adds:

> The recommendations of the President only make it more obvious that our Nation must now find a comprehensive solution to the problems of delivering and financing health care and must reform substantively the present health care system. Attention must be paid to the inadequacies of the present health care system; inadequate funding, maldistribution of services, insufficient personnel, inappropriate delivery systems, and inattention to preventive care are the real difficulties in providing older Americans with quality care.

Opposition to the President's proposals has been forcefully expressed by the AFL-CIO, through its executive council, meeting in Miami on February 23; by a representative of the National Association of State Units on Aging; and by other organizations.

In short, the President's proposals are not only unpopular, they are perceived as unwise and unjust.

Our opening round of hearings today and tomorrow will help us determine where we are and where we should be headed in removing barriers to health care.

Of particular interest to the subcommittee will be these issues:

How spiraling health care costs are crippling Medicare and Medicaid;

Why adequate alternatives to needless institutionalization are not being developed, and why home health care resources are dwindling;

How fragmentation of medical services in intensifying the health care dilemma, especially in inner cities and rural areas;

Whether coinsurance and deductibles, in fact, serve a socially desirable purpose;

How can Medicare and Medicaid costs be controlled, while assuring equitable treatment for those served by the programs; and

How the elderly should be served in whatever national health security program finally comes into being.

These questions will require intensive analysis. We are committed to this task. We want facts and opinions from Government officials, health care personnel, elderly consumers, spokesmen for national aging organizations, and others. Our inquiry will not be limited to the hearing rooms of our Senate Office Buildings. We also plan to take testimony in the field. We want to find out what is happening to people; we want our facts firsthand.

A major focus of these hearings, especially today, will be to determine how basic policy decisions affecting the health of millions of Americans are made.

With the growing concentration of power in the Office of Management and Budget, Americans are entitled to know who is making these judgments and how.

Are they conceived by statistical technicians not elected by or accountable to the people?

Are appropriate agencies and others with specialized expertise being consulted or ignored?

Our first witness today, a former Director of the Office of Management and Budget, is uniquely qualified to shed light on these fundamental questions.

One major policy decision—of paramount concern to the subcommittee—is the proposal to subject Medicare beneficiaries to additional out-of-pocket payments.

Specifically, the subcommittee wants to know how and why the administration decided to make Medicare patients pay for:

Actual hospital room and board charges for the first full day plus 10 percent of all subsequent charges, instead of the present $72 deductible and nothing thereafter until the 61st day;

The first $85 of doctor bills, instead of the current $60; and

Twenty-five percent, as opposed to the existing 20 percent, for physician services after the part B deductible is met.

What factors, other than cost cutting, were considered in reaching these decisions? Did these policymakers take into account the impact that these proposals would have on the lives of 23 million elderly and disabled Americans? Were they aware that about 9 out of every 10

persons who reach 65 can expect to be hospitalized at least once during their remaining years? And do they know that approximately two out of three will need hospital care more than once after age 65?

These questions, I think, underscore a very crucial fact: Illness strikes with far greater frequency and severity at a time in life when those victimized are least able to afford it.

If the administration's decisionmakers are aware of this, then why do they offer these major changes in the Medicare program? If they are unaware of these basic facts, then how could they make these decisions?

These questions ring within the walls of this hearing room. They were asked last Thursday in the Senate Chamber by 13 Senators, including myself, in an extended colloquy.

They are being asked all over this Nation. To our forthcoming witness, Secretary Weinberger, I ask for answers.

I think it is highly appropriate at the beginning of these hearings that we should have Senator Kennedy with us this morning, author of the national health proposal which is pending before this Congress.

He of course is conducting the comprehensive hearings in the whole field of health care. Our hearing is more limited, although focused on the needs of a segment of our population which especially earns our compassion and understanding, so I would call on Senator Kennedy at this moment to say a few words at the outset of these important hearings.

STATEMENT BY SENATOR EDWARD M. KENNEDY

Senator KENNEDY. Mr. Chairman, I appreciate the opportunity to join with you at these hearings of the Subcommittee on Health of the Elderly of the Senate Special Committee on Aging.

I believe these hearings will be a valuable addition to the work that this committee has done in the past. And as chairman of the Senate Health Subcommittee, you can be sure that this subcommittee's work will be a welcome aid as we work on this year's slate of health legislation.

This series of hearings on barriers to health care for older Americans is of particular importance now when the Federal budget throws up new hurdles to the access of elderly Americans to adequate health care.

The budget recommendations to increase both deductibles and coinsurance seem to reject the general pattern of Federal action in the last Congress, action designed to improve the conditions of life of the Nation's 20 million elderly.

We were successful in passing a nutrition for the elderly bill; we were successful in making major changes in Social Security including a 20 percent increase in Social Security benefits, increased benefits for widows, and an expansion of earnings exempt from the retirement test.

OPPOSITION FROM THE ADMINISTRATION

But we were faced at each step of the way by the steadfast opposition of the administration.

The most frustrating confrontation came over the Older Americans Act in which the Congress extended and upgraded the Administration

on Aging, provided a new jobs program for older workers and took a first step toward rationalizing social services for the elderly.

Despite the overwhelming support of all elderly groups, the President pocket-vetoed this measure. The Senate has reaffirmed its commitment to providing adequate services to the elderly by overwhelmingly repassing this measure, S. 50, 2 weeks ago.

And now in the field of health care, we find a confrontation once again. The Congress is moving toward expanding health care services available to all citizens, including the elderly.

The Nation as a whole clearly supports such action. Yet this budget abdicates Federal responsibility to deal with the Nation's health needs. It cancels the mental health centers program. It cancels ambulatory care facilities under the Hill-Burton law. It eliminates dental services for adults under Medicaid. It reduces aid to schools of nursing. It eliminates construction grants for medical and dental schools and it holds other Federal support to these health professional schools at two-thirds of the amount authorized and needed.

And the budget saves its sharpest sting for the elderly. For despite the eloquent recitation of the seriousness of health costs to the elderly contained within the President's Message on Aging to the Congress a year ago, this budget will make health paupers of millions of older Americans.

The President said last year:

> Growing old often means both declining income and declining health. And declining health, in turn, means rising expenditures for health care.
>
> Per capita health expenditures in fiscal year 1971 were $861 for persons 65 and older, but only $250 for persons under 65. In short, older Americans often find that they must pay their highest medical bills at the very time in their lives when they are least able to afford them.

After saying that, I cannot imagine how the present budget could have been submitted to the Congress. For it proposes, by increasing deductibles and coinsurance, to require the elderly and disabled to pay between $700 million and $900 million more out of their own pockets for health care.

How many older Americans will find their savings wiped out by new health bills?

How many older Americans will refuse to seek medical aid until it is too late because they cannot afford preventive care?

I find this a disturbing and callous proposal which may, in fact, save the Government money; but only at the cost of needless suffering by millions of older Americans.

The budget special analysis seeks to justify this proposal as one which will help those with prolonged hospitalizations and one which will cut down on unnecessary utilization of hospital services.

On the first alleged justification, I have found out that a patient has to be in the hospital over 100 days in order for the new provisions to help him save money.

Only seven-tenths of 1 percent of all Medicare hospitalizations are for more than 100 days. In other words, only 7 patients out of every 1,000 who enter the hospital under Medicare will save money under the new provisions.

The other 993 will pay more, up to $1,000 more in some cases. In fact, Medicare only covers 90 days of hospitalization a year without dipping into lifetime reserves.

On the second alleged justification, it has been nowhere demonstrated that you keep doctors from putting people in the hospital by charging the patient more money. In fact, Blue Cross and Blue Shield argue that sizable deductibles and coinsurance are punitive, and keep people away who need health care.

The best that can be said of the administration's proposal is that it is an experiment and an unproven one.

White House Conference Recommendations Rejected

Experimental or not, unproven or not, it is clear that the administration has decided to reject the compassion contained within the President's own Message on Aging, to reject the recommendations of the White House conference for an end to all Medicare out-of-pocket payments, and instead to adopt a punitive policy that raises new barbed-wire barriers to adequate health care for the Nation's elderly.

Ultimately, the only answer to the removal of all barriers and the guarantee of good health care for the Nation's elderly rests on a system that controls health care costs and offers quality health care for all Americans.

Until that happens, the Nation's older Americans will continue to reap the whirlwinds of inflation in health costs that result from our failure to control the health care system.

Despite all that we have done since the passage of Medicare, we still cover less than half of the costs of health care for older Americans. It is only through national health insurance that we will fully serve the health care needs of the elderly.

The health security program, S. 3, which I have introduced, is the only proposal before the Congress which couples comprehensive and universal coverage with comprehensive and universal reform of the health system.

And Nelson Cruikshank, president of the National Council of Senior Citizens, told this committee last month, S. 3 "would give more than lip service to our now generally accepted premise that good health care is the right of every American."

In addition to covering all hospital costs from the first day until the last, this program would cover all health services for the prevention and early detection of disease, the care and treatment of illness, and medical rehabilitation, and it would do it without deductibles or coinsurance of any kind.

Also, it would provide:

Full coverage for hearing aids and eyeglasses and foot services;

Full coverage for drugs required for the treatment of chronic or long-term illness;

Full coverage for health care in nursing homes so long as the nursing home is operated in connection with a hospital and more generous coverage than is currently available under Medicare for other nursing home care;

Home health services for chronically ill or disabled men and women.

Now, you will find as the chairman pointed out, that the elderly people are paying more for health costs than they were at the time of health care.

Fundamental Reform Needed

What we are going to need is some real fundamental reform.

Mr. Chairman, I believe the 93d Congress will pass a comprehensive program of national health insurance that encompasses the basic principles of the health security program. And I am sure that this series of hearings will help provide the data and information to support speedy approval of that legislation so that we can finally fulfill our pledge to make good health care the right of every American, young and old.

Senator Muskie. I would like to repeat the point you emphasized, Senator Kennedy, the rationale for the administration's cuts appears to be a shift of benefits for those who overutilize short-term care, those who are bearing the burden of long-term care, but when you add up the mathematics, the only people who save are the Government's budget, that $700 to $900 million a year.

That does not look like a shift in benefits, but rather a cut in total benefits to me.

Senator Kennedy. Mr. Chairman, we could suggest, the administration, just by requiring under Medicare, the buying of drugs under generic names rather than brand names, would save that $700 million right now without cutting out the services to the elderly people.

If they are interested in saving money, all they have to do is start taking on the big boys, the pharmaceutical companies.

Finally, one of the great myths in the health area is the overutilization for health services by middle-income or low-income elderly people. The people that overutilize health services are rich people.

The first thing required is outreach programs to go out and tell the elderly people that we have some services. They don't know how to utilize it. I don't find elderly people sitting in doctor's offices because they like to.

This is one of the great myths we hear over and over again from the administration. I hope this panel may comment on my impressions afterwards.

I want to thank the Chair for having these hearings.

I think these hearings are being held on a very significant subject, and I look forward to hearing the witnesses.

Senator Muskie. Thank you.

I would like to insert the statement of Nelson Cruikshank; a letter from Commissioner Ball, with the tax studies, including the Blue Cross-Blue Shield study on the utilization; and other letters, as well, in the appendix of the hearing record.*

May I say, also, that Secretary Weinberger was scheduled to be the first witness, but asked to testify later.

I welcome that, because I think it is just as well to have a foundation laid by the witnesses we now have before we put questions to the Secretary.

Now, may I present the panel for this morning. We have Miss Alice M. Brophy, director, New York City Office for the Aging, New York, N.Y.; Mrs. Marjorie H. Cantor, director of research, New York City Office for the Aging, New York, N.Y.; Leslie S. Libow, M.D.,

*See appendix 1, p. 81-95.

FACP, director, geriatric medicine, Elmhurst General Hospital, Queens, N.Y.; and Mrs. Mae Laufer, senior citizen health consumer, New York, N.Y.

I will reserve questions until you have all testified so that we can be sure to get the full impact of your testimony before Secretary Weinberger appears, and then if we have time for questions, we will get into it.

Miss Brophy, welcome; your complete biographical data will be entered at this point in the record.

BIOGRAPHIC SKETCH OF ALICE M. BROPHY, DIRECTOR, OFFICE FOR THE AGING AND HOSTESS, "THE SIXTH AGE", WNYC RADIO

One of the two recipients of the Mayor's Medal for "Distinguished Performance in the Services of the City", 1967.

Member, President's Advisory Commission to the Department of Housing and Urban Development on Housing the Elderly.

National Council of Senior Citizens Award of Merit recipient. 1970, for Outstanding Work on Behalf of Elderly Citizens.

Board of Directors, National Association of Social Workers.

Board of Directors, Karen Horney Clinic.

For the last twenty years, has been in the field of housing as Director of Social Planning and Social Services in the New York City Housing Authority and Coordinator of the West Side Urban Renewal Area.

In recent years, an instructor on urban planning at New York University and a guest lecturer at the Columbia School of Architecture.

Former Assistant Deputy Administrator of Program Planning and Director of Model Cities for the Human Resources Administration.

Administrator of public assistance in Rhode Island, Binghamton, New York, and New York City Department of Social Services.

Graduate of Pembroke College in Brown University and Columbia University School of Social Work.

Appointed September 30, 1968, by Mayor Lindsay as Director of the New York City Office for the Aging.

STATEMENT OF MISS ALICE M. BROPHY, DIRECTOR, OFFICE FOR THE AGING, NEW YORK CITY, N.Y.

Miss BROPHY. Thank you very much, Senator Muskie, Senator Kennedy, and I thank both of you for your statements. I hope we can answer some of the very substantive and critical questions you raised.

I am Alice Brophy, director of the office for the aging. I am also chairman of the urban coalition that represents some 8 million elderly throughout the country, elderly having difficulty in securing adequate medical care.

As you know, the New York City Office for the Aging, since its inception in 1968, has been charged with carrying out four major goals: advocacy, coordination, research and identification of need, and initiation of innovative programs to meet these needs.

In the course of our experience with older people, the constant reiteration of problems relating to the costs of medical care and the difficulties in obtaining health services has convinced us that, if income is the No. 1 problem of older people, health care is a close second.

As a result, in the summer of 1972, the New York City Office for the Aging undertook an indepth study of the barriers to adequate health care for older New Yorkers. This study is the basis of our testimony today.

Although the study concerned itself primarily with the structure and delivery of medical care in times of illness, the health needs of older people were viewed in the broadest perspective.

The kind of environment in which a person lives out his retirement years, the level of income and the opportunities for constructive use of leisure time are as essential to positive physical and mental health as are the number and quality of doctors, hospitals, nurses, et cetera.

Older people, given a decent income and a range of supportive services in the community, have shown that they can live with chronic illness and still function positively as members of society.

Dignity and equality of medical opportunities, and avoidance of charity must be the foundations on which any health care delivery system for older people is built.

Facts About Older New Yorkers

Before we get into a description of the health care system of New York City and the problems faced by older people in obtaining quality health care, I would like to share with you a few brief facts about older New Yorkers and the kind of lives they lead.

In New York City at the present time there are approximately 950,000 persons 65 and over, comprising 12 percent of the city's population.*

Older New Yorkers, you may be interested to know, are close to 10 percent of all older people in the country. In New York City, as elsewhere, older women outnumber men. For out of every 10 older persons, 6 are women, 4 are men. During the last decade the city's older population has grown 16 percent at a time when the population growth among younger people is leveling off.

The fastest growing segment of the elderly population is the frail elderly, that is those 75 years old and over. At the present time one out of every three older New Yorkers, is 75-plus.

Although 91 percent of older New Yorkers are white, the proportion of blacks and Spanish speaking elderly is increasing rapidly and this group will constitute a significant segment of the population of most cities in the future.

Contrary to popular conception, most older people maintain their own homes as long as possible. In New York City only 14 percent have moved in with children or relatives.

This desire to continue to live independently is an important underlying motivation for most older people, even after the death of a spouse.

Approximately one-third of all older New Yorkers live alone, with no one immediately available in the household to assist them during periods of illness, recuperation, or other crisis periods.

By and large, most older New Yorkers and their compatriates across the country are poor. Living principally on Social Security, occasionally supplemented by meager pensions or small savings, elderly households suffer from relatively fixed incomes in this period of sharply rising prices.

Although 1970 census income data for New York City is not yet available, a special 1 percent sample of New York City households conducted by the Census Bureau in 1970 provides us with a picture of incomes of older people.

*See chart 1, appendix 2, p. 111.

Over half of the households headed by persons 65-plus have incomes of $3,500 or less, as compared with 20 percent of younger households.

Thirty-one percent have incomes of $2,000 or less. At the higher end of the income scale only 17 percent of the elderly households reported incomes of $10,000 or over as against 37 percent of younger households.

Females living alone suffer the most.

Although only 4 percent of the elderly are institutionalized and another approximately 8 percent are incapacitated enough to be homebound, older people have frequent need of medical services.

They have a greater incidence of impairment, are more inclined to chronic illness, use hospitals more frequently and stay longer than do younger people.

Steady Rise in Chronic Illness

As age increases the incidence of acute illness declines, but there is a steady rise in chronic illness. More than three-fourths of the population over 65 suffer from at least one chronic illness and about half have two or more illnesses.

In New York City, the incidence of chronic conditions among the elderly was almost double that found among middle-aged adults 45 to 65.

The chronic conditions most associated with older age are arthritis and rheumatism, heart and circulatory conditions, and diabetes. Although few older people are bedridden, enforced limitation or prevention of normal activities is a principal consequence of chronic health problems among the aged—nationally about 40 percent suffer some limitation on activity because of chronic illness.

As it is well known, there is a direct relationship between income and amount of illness both chronic and acute. As family income declines illness increases.

The national health survey of 1959 (and we have no reason to think the picture with respect to prevalence of chronic illness has altered) showed that 86 percent of older people in the lowest income bracket suffer from chronic illness, while at the higher income levels only 76 percent reported such illness, still a high figure but significantly below the poorest older people.

At the present time, 22 percent of New York City's elderly live below the poverty threshhold while half of all elderly households have incomes insufficient to allow them to live at a moderate standard of living as defined by the Bureau of Labor Statistics.

It must be remembered that these older people were not always poor. Most worked hard all their lives in the garment shops, retail establishments, and small businesses of New York City. Never rich, they were not a welfare population. Yet today, in retirement, far too many are faced with radically reduced incomes, a situation fraught with psychological as well as financial tragedy.

How much mental stress and interacting physical symptomatology is engendered by the sharp discontinuity in life styles arising from this income reduction in old age we will never really know.

The exceedingly low incomes of too many older New Yorkers, the high proportion of elderly women, the large number of individuals

living alone, the increasing number of elderly in the 75-and-over age cohort, and the high incidence of chronic illness have important implications for health care.

In our presentation today on barriers to health we will emphasize what we know best—the health plight of older New Yorkers. But the health care picture in New York City is not *sui generis*—it reflects, perhaps to a greater extent, trends occurring throughout the country and much of the existing health statistics to be presented are on a national rather than regional basis. What we say today therefore mirrors the needs and difficulties faced by most older Americans whether they live in the inner cities of our large metropolises, in suburbia or in rural America. As you will see, it is not a picture we Americans have much to be proud of. Seven years after the passage of Medicare older people are little better off with respect to adequate medical care at a price they can afford than prior to Medicare and the health delivery systems around the country are too often chaotic, fragmented and depersonalized. I would like at this point to introduce Marjorie Cantor, who is going to target in on health costs for the older person.

[Statement by Miss Brophy continued on p. 29.]

Senator MUSKIE. Mrs. Cantor, your biographic sketch will be inserted at this point in the record.

BIOGRAPHIC SKETCH OF MARJORIE H. CANTOR, DIRECTOR OF RESEARCH, OFFICE FOR THE AGING

Mrs. Marjorie Cantor has been Director of Research of the New York City Office for the Aging since its inception in 1968. She is a graduate of Hunter College, New York City, is a member of Phi Beta Kappa, and has a Masters Degree in Developmental Psychology from Columbia University. Prior to coming to the Office for the Aging, she has directed and been associated with a wide variety of Research Projects, including Senior Fellow at the Metropolitan Applied Research Center; Director of the Vista Research Project, Columbia University School of Social Work; Research Director, Phoenix Project in the Westside Urban Renewal Area of Manhattan, and Research Methodology as a faculty member of both the Columbia School of Social Work and the Fordham University School of Social Work. Her publications, in addition to the *Health Crisis of Older New Yorkers,* include *The Elderly in the Rental Market of New York City; Elderly Ridership and Reduced Transit Fares; The New York City Experience; A Study of Vista in Urban Poverty; Vista Volunteers and the Poor; A Special Type of Helping Relationship;* and *Sweatshops in the Sun,* etc.

Mrs. Cantor is a member of the Society for the Psychological Study of Social Issues; the Gerontological Society; and has served on governmental and public task forces in the field of health care for the aging, as well as numerous committees concerned with the problems of older New Yorkers.

STATEMENT OF MARJORIE H. CANTOR, DIRECTOR OF RESEARCH, NEW YORK CITY OFFICE FOR THE AGING, NEW YORK, N.Y.

(CHARTS TO WHICH MRS. CANTOR REFERS APPEAR IN APPENDIX 2, PPS. 111-116.)

Mrs. CANTOR. The advent of Medicare in 1966 was heralded as the opening of a new era. Older people would no longer be worried about medical costs in time of illness and rich and poor alike would receive quality medical services from doctors and hospitals of their own choice. Second-class medicine for the old and poor was to be a thing of the past. The issue was not what you could afford in the way of care, but what you needed to help you stay well.

Seven years later to what extent are these predictions true? It is our contention that in spite of greatly increased public expenditures

for health services for the elderly, the barriers to adequate and comprehensive care are still formidable. Rising medical costs have outpriced all but the most affluent elderly, lack of coverage under Medicare denies needed services for millions of older people ineligible for Medicaid, but too poor to pay for such services out of their own pockets.

Fragmentation and depersonalization of health services continue, particularly in the central cities where so many older people live out their last years.

In short, Medicare and its promise are, for far too many older New Yorkers, still a mirage.

As Miss Brophy has noted, older people suffer from many serious health problems usually of a chronic nature which require considerable, often constant, medical care.

In line with this increased incidence of illness particularly chronic, utilization of physician's services increases with age.

Even before the advent of Medicare, older persons visited doctors on an average of 7.2 times per year, compared with 5 visits yearly among those 45–64 years of age.

In 1970 among older persons insured under part B of Medicare, 4 out of 5 had used medical services averaging 6.5 visits to doctors offices, about the same level as Medicare.

Similarly, the rate of those elderly who are hospitalized far exceeds the average of the total population. At ages 45–64 about 1 person in 7 is hospitalized each year—at 65 and over about 1 in 4.

Furthermore, older people tend to spend a longer time in hospitals. Nationally, in 1970 a patient over 65 stayed almost twice as long as a younger patient—averaging 12.7 days per stay as compared to 7 or less for those under 65.

Length of Hospital Stay

Length of hospital stay tends to differ regionally. In New York City, the average stays are longer than the national average for both young and old alike.

Thus, in 1970, patients 65 and over in the municipal hospitals average 38.6 days of hospital care as compared with 13.6 days among younger patients.

In voluntary hospitals the average stay for older persons was 20–21 days and for persons under 65 approximately 11–12 days.

Lest the length of the hospital stays of elderly New Yorkers surprise you, it must be remembered that approximately 30 percent of all older New Yorkers live alone, as compared with 22 percent nationally.

While among elderly in the poorest neighborhoods of the inner city, almost 4 out of 10 have no one else living in the household with them.

Undoubtedly the incidence of chronic illness and the assistance of Medicare may contribute to longer hospital stays among older persons; but the fact that so many older people have no one at home to care for them, and that home health aides and homemakers in New York City are in exceedingly short supply, keeps older people in hospitals longer.

This lack of available care in the community, rather than the availability of Medicare to cover hospital bills, is an important contributing factor to the seemingly excessive stays of some older hospital patients.

Who Pays the Medical Bills?

Let us now turn to the question of costs and who pays the medical bills of the elderly.

In 1971, the total bill for personal health care for older Americans was $15.7 billion. This was 27 percent of the aggregate health care cost of the country, although the elderly were only 10 percent of the population.

Breaking this down on a per capita basis we find that the average health bill for each older person was $861, approximately 3½ times that of persons under 65.

As indicated in the chart, the largest amount, $440, was for hospital care, while next in magnitude is the $151 allotted to nursing care, followed by $144 on the average for physician's services and $87 per person for drugs per year. It should be remembered that average figures are somewhat misleading as to actual amount spent by individuals since they include persons with no medical expenses and those with catastrophic bills. But the breakdown gives us some idea of the relative importance of various categories of medical services in the total cost picture.

The older person, of course, does not carry the full burden of these medical expenses. The passage of Medicare in 1965 and Medicaid in 1966 completely changed the ratio of public and private expenditures for health care for the elderly.

As can be seen in chart 3 (see appendix 2, page 112), outlays for personal health care soared (due to the purchase of more service as well as an inflationary price rise), and there was initially a dramatic shift from private to public funds to pay for these expenditures.

Thus, in 1966 with total cost of $7.8 billion for elderly health care, 69 percent came out of private sources (mainly from the pockets of older people with private insurers, particularly the Blues contributing a small proportion) while 31 percent came from public funds.

Within 1 year the proportion had begun to change to 40 percent private and 60 percent public. By 1969 the total bill had risen to $13.5 billion with the public share running 72 percent.

At the present time, there appears to be some leveling off of the dollar amount, as well as the proportion assumed by public funds.

In 1970 and 1971 public sources contributed 68 percent of the total amount spent for the elderly, leaving 32 percent to be paid by the older people themselves.

However, public funds do not pay equally for all types of services and the cost of some important services under Medicare as presently constituted lie wholly or substantially within the province of older people.

While Medicare and Medicaid combined in 1971 covered most of the hospital bills and three-fourths of doctor's bills, older people had to assume, mostly from their own pockets, 40 percent of the costs of nursing home care, and virtually almost all the costs of dental care, drugs, eyeglasses, hearing aids, home nursing, and therapy as well as many types of preventative health care.

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Chronic Care Expenses Not Covered

Since many of these uncovered items are connected with chronic care, such expenses tend to go on unremittingly year after year.

Furthermore, it is really misleading to lump together all public expenditures for health care (that is, Medicare, Medicaid, Veterans' Administration, the military, et cetera) in considering how much of the health care bill is publicly funded. With Medicare, Medicaid, and public programs considered together it would appear that public funds currently cover approximately 86 percent of hospital bills and 72 percent of all doctor's bills. However, this is not really the case. Althouhg Medicaid pays virtually the entire hospital and doctor bills, in New York City only 130,000 out of 950,000 older people are covered by Medicaid.

The vast majority of older New Yorkers depend primarily on Medicare and the amount absorbed by the Government under Medicare alone is considerably less than when expenditures for all public programs are considered together.

In New York, for example, the moneys reimbursed to all institutions, hospitals, nursing homes, home health agencies, et cetera, for hospital related care under part A of Medicare are estimated to represent only 70–72 percent of the cost of such services to the elderly leaving 30 percent at least to be borne by older people themselves.

And in the case of doctor's bills, the proportion borne by older people is even higher. Most New York doctors do not accept Medicare assignment, but bill their elderly patients directly.

Their fees in too many cases far exceed their profile allowances under Medicare. As a result, it is estimated that supplementary medical insurance reimbursements to doctors, outpatient clinics, et cetera, represent only 60 percent of the actual cost to the elderly individuals, leaving 40 percent to be covered by the elderly out of their own pockets.

Without question Medicare and Medicaid have resulted in a dramatic increase in the proportion of health costs assumed by public programs, but I would like to underscore that there is still a substantial proportion left to the older population, particularly to the vast majority covered only by Medicare.

Not only do individuals continue to bear a significant portion of their health care expenses, but the dollar amounts have risen sharply as well. Unfortunately, the steadily increasing amount spent for health, whether by the Government or older people themselves, does not reflect only an increase in the purchase of service. It also mirrors skyrocketing medical prices. In the 5 years since the passage of Medicare, the medical care price index rose at a rate of 6 percent or more per year and in 1970 it rose 7.3 percent. In New York City the spiral was even sharper with a rise in medical prices of 10 percent during the single year 1970–71. The greatest increases were in hospital costs—17 percent, and in doctor's fees—13 percent.

40 to 50 Percent Cost-Increase in New York City

Thus as your committee itself has noted, "an aged person in 1966 who was spending 21 days in the hospital and 60 days in an extended care facility following an operation that cost $400 in surgeon's fees

would have spent $396 out-of-pocket including his part B premium. As of January 1, 1972, a similar patient could expect to pay $611.60 as well as whatever increase there might be in the surgeon's fees," New York City probably might have increased 40 to 50 percent.

It is particularly in the area of doctor's fees that older poorer people have been hurt the most. As I previously noted, most older people are expected to pay the fee rendered and collect later from Medicare. Faced with doctor's bills that far exceed Medicare reimbursements, older people have several difficult alternatives—use up their meager savings, turn to children for help, or simply give up going to the doctor as often as needed. In our recent study of the elderly in New York City, the major reason given for holding back from not going to the doctor was simply not enough money.

Although the price stabilization program appears to be having some slowing effect on rising medical costs, it is important to note doctor's fees were frozen at the already inflated 1971 level. Should controls on doctor's fees be lifted, there is no reason to expect that the vicious cycle of spiraling costs would not resume.

But it is not only the costs of doctors' visits, drugs, nursing, and other medical services which have risen sharply in the last 5 years. The cost of Medicare itself to an older person has more than doubled since 1966. As you can see on the chart, the premium for part B doctor's insurance has gone from $36 to $69.50 annually or an increase of 93 percent, while the hospital deductible has risen 80 percent from $40 in 1966 to $72 at the present time.

In many cases the 20 percent doctor's coinsurance alone paid by the older person may more than exceed the total payments of an individual for all health services prior to Medicare.

Thus we find that, on every side, costs of health care have sharply risen. Early expectations that Medicare would solve all the health problems of older people and bring financial security in time of illness, have been discarded as costs have spiraled. And the realization has grown that older people with their low incomes may indeed have lost ground in the battle to cover their medical expenses.

Five years after Medicare, the elderly are faced with average out-of-pocket expenditures of $225. When Medicare premiums of approximately $70 per year are added to this amount the medical expenses of an individual can run at least $300 or $600 for a couple.

We estimate that in spite of the recent 20 percent Social Security increase, half of the elderly households in New York City have incomes at or below $4,000. Therefore, an average couple facing out-of-pocket medical expenses of $600 would be using nearly 15 percent of their total income for health. In addition at the present time in New York half of the elderly households pay one-third or more of their income for rent. Thus between a rent bill of $1,284 per year and $600 medical bills, our average couple might have only $2,116 a year or $176.33 per month left for food, clothing, and all other expenses of living. Hardly a large amount in days of sharply rising food costs.

Is Medicare A Mirage?

But what is particularly cruel about the present situation with respect to Medicare is that most older people are totally unprepared for medical costs they must incur. To them Medicare has been held

out as an insurance program that will cover all or virtually all costs in time of illness. Thus they are confused and angry when they receive a Medicare reimbursement of only $453.80 for an $861 surgeon's bill for a fractured hip—an actual case in our files—or they find that assistance in the home after an operation is neither available nor covered by Medicare. Is it any wonder that many people are beginning to ask if Medicare is not really a mirage?

While the failure of Medicare to cover the cost of health services is the most burdensome and frightening aspect of the program for older people, the fact that many health services are not covered under Medicare, or under the private insurance plans is another important area of concern.

Medicare does not cover drugs. Yet the per capita cost of drugs and drug sundries paid by the elderly in 1971 was $87 and for those with more than one severe illness the expense can rise to over three times that amount.

And as the HEW task force on prescription drugs pointed out in its report, costs fall heavily on those least likely to be able to bear them. Women, often the poorest of the elderly, have 50 percent more drug acquisitions than men and spend over a third more. Individuals with severe disabilities spend almost three times as much as those with none.

The task force further stated that:

> There are many elderly men and women who have some income and some savings—who may also have sufficient Medicare or other insurance to protect them against the bulk of the hospital and medical costs of a brief illness—but who cannot pay for the out-of-hospital drugs and other costs of a long continuing chronic illness without seeing their financial assets eroded or totally dissipated.

Medicare does not cover dentistry. So it is not surprising that the National Health Survey found that over 50 percent of the elderly had not seen a dentist in more than 5 years. With only 1 percent of the elderly having private insurance for dental care, neglect is the only option.

Eyeglasses and Hearing Aids not Covered by Medicare

Medicare does not cover eyeglasses and hearing aids despite the fact that almost 2 out of every 10 older persons have impaired vision and 1 out of 6 partial or total deafness.

Medicare does not cover out-of-hospital podiatry. And yet with age, foot problems become extremely important. It is impossible to estimate the extent to which functional well-being for many elderly is limited by uncared-for podiatric problems.

Medicare does not begin to adequately cover home health care needs. Reimbursement for home health aides is bound by restrictive interpretation of need while homemaking and housekeeping services, which can often mean the difference between an older person remaining in his own home or having to have hospital or nursing home care, are not at all reimbursable under Medicare.

Nonwelfare elderly must carry the complete cost of such services themselves. On meager incomes, few older people can afford long-term housekeeping assistance. In some cases, faced with no alternative, families are forced to turn to public assistance to get this vitally needed care. In other cases, families turn to institutionalization. It is estimated that at least 10 percent of the nursing home residents in New York

City are institutionalized for lack of home care. And many hospital stays could be reduced by days, and even weeks if home care could be provided.

Medicare barely covers mental health care. Provisions for mental health care are so minimal as to be almost nonexistent. As the Group for the Advancement of Psychiatry points out, "This system not only affords inadequate coverage but promotes hospitalization rather than care in the community, often contrary to sound psychiatric practice." To say nothing of economic practice!

Finally, Medicare does not cover preventive care at all, although this essential health service would, as has been proven, actually reduce the number of hospitalizations required by older persons.

So far today I have purposely dwelt on the deficiencies and lack of coverage in the Medicare program as it is presently constituted. Far from fulfilling the promises outlined at its inception Medicare today falls short of meeting many of the basic health needs of older people.

The price they must pay for the services they receive too often severely depletes their limited incomes. The President, in his 1974 fiscal budget message, has suggested still further changes in Medicare and Medicaid aimed at escalating costs for older people and further reducing services.

Proposed Change Violates Original Intent

Let me state categorically, in the opinion of the New York City Office for the Aging, the proposed change would further violate the original intent of the Medicare legislation and would represent a severe blow to the health care of older people, particularly the chronic and severely ill, most in need of Medicare protection.

To illustrate the impact of the President's proposals, we have taken two typical examples—the costs involved in a typical hospitalization and the doctor's bills incurred by a chronically ill woman with a common ailment of old age—congestive heart failure.

First, let us look at the cost picture for a 21-day stay of an older person in a New York City hospital. Twenty-one days is about the average length of time older people remain in our hospitals and with semiprivate room-and-board charges in New York City's hospitals running from $95 to $125 a day, we have chosen an average cost of $110 per day for this illustration.

We have not included laboratory fees, drugs, nursing care, et cetera, since these costs are generally completely covered by Medicare in a New York City hospital and no change in these provisions is proposed.

I would like to say there has been difficulty in defining what the President's proposal meant, so we assumed 10 percent of all the room costs after the first day. Now we find out he means 10 percent of all costs in the hospital after the first day, so your cost estimate is underestimated if anything.

Twenty-one days is about the average length of time. He would pay $110 for that first day and 10 percent for the remaining 20 days, resulting in out-of-pocket costs of $330.

This is more than 4 times as much as previously, or to say it another way, a 358-percent increase in out-of-pocket costs for a typical hospital stay.

If an older person who is hospitalized can expect a quadrupling of out-of-pocket expenses connected with a hospital stay, what will be the effect of the President's proposals on out-of-pocket costs for doctor's services?

According to physicians we have consulted, a chronically ill, 78-year-old woman with heart trouble would visit her private physician, an internist or general practitioner, about once every 3 weeks.

Approximately every other visit, cardiographs and lab tests might be given and it is likely that she would be referred to two consultant specialists during the course of a year, one for a related disease such as hypertension, and the second, perhaps a cardiologist.

It is quite likely that such an older person might be hospitalized once during the year and it is customary for a doctor to visit his patient at least once per day during the course of hospital stay.

The fees quoted for these various services are fairly standard in New York City and in order to not be accused of overstating the case, we are assuming that the doctor's fees are within Medicare reimbursement schedules and that the patient would not have to assume any additional costs over and above the 20 percent coinsurance. An assumption which we know is far from the case in most situations in New York City and elsewhere.

We are assuming the following: $140 per day for the regular doctor's visit; specialists for related conditions, 2 visits for $110; laboratory tests, 6 times per year at $330; and doctor's visits during hospitalization, once per day for 21 days for a total of $315 per year; for a total cost of $885.

Under present Medicare provision, the patient would be required to pay a total of $225 in doctor's fees for the year. If the President's proposals were enacted into law, the out-of-pocket doctor's bills would increase to $285, or close to a one-third increase in doctor's bills. Considering the low incomes on which so many older people live you can well see that such increases might be catastrophic.

Experts have noted that with the recent increase of 20 percent in Social Security benefits, older people's retirement payments for the first time are within a respectable range. We personally question this, but in any case let me say that according to our estimates, the President's proposed Medicare changes would probably wipe out half of more of the recent 20-percent increase in the case of older persons with any reasonable degree of illness. If these proposals are enacted into law, Congress will be in the position of having given with one hand and taken away with the other. And most important, older Americans will be left with vastly increased medical bills and will be still farther away from the Medicare promise of adequate and equitable health care for all in old age.

Miss BROPHY. I would like to present Mrs. Laufer, who will talk from the standpoint of the consumer.

Mrs. Laufer, about 7 years ago, decided she would like to have a health center in the Bronx, and she contacted individuals at the Federal, State, and local level.

I am very happy to tell you, what Mrs. Laufer wants, Mrs. Laufer gets, and there is a health center in the Bronx called the Mae Laufer Health Center opened in October of last year.

She is president, vice president, and every other officer you can think of. Mrs. Laufer is in constant communication with the more than 400 members of the Senior Citizens Health Center who come to her with questions about all kinds of problems they are having.

I am happy to present Mrs. Laufer.

STATEMENT OF MRS. MAE LAUFER, SENIOR CITIZEN HEALTH CONSUMER, BRONX, N.Y.

Mrs. LAUFER. Senator Muskie, and all affiliated with the Special Committee on Aging, although none of you people have ever met me, I believe, but you have mail in your office constantly from me.

I have written to most of the members of the Special Committee on Aging, and picked those that I thought cared and would help.

I am very pleased to be here this morning because I never expected that I could speak freely and tell you how we feel and what the needs are and how important it is.

When we were at the White House conference, our President said we must have special health services for the elderly.

We must not charge the Medicare fee. He should pick up the tab. Not only should he pick up the tab, but we shall see that all of the goodies that he promised become a reality.

As of today, I have written a letter to the President and I enclosed—Senator Muskie, you have one, Senator Kennedy has one, I have written it a long time ago into your office on how I felt, you have a copy.

You have it in the office, and so have other Senators for the Special Committee on Aging——

Senator MUSKIE. We will include that in the record.*

Mrs. LAUFER [continuing]. Including the chairman, Senator Frank Church, and a few others.

Medicare is not what we thought it would be. When Medicare came through, I felt that at least I would be covered when I got sick. It is not so.

Medicare has its loopholes. We pay for this insurance, but what do we get, $40 deductible, $50 deductible, $60 deductible, $70. It escalates time and time again. Now, to me it is a most important thing that since we pay for our insurance, we should have the same services that Medicaid has, the fringe benefits.

You know what I mean. When a senior citizen of 74 goes into a drugstore with a prescription the doctor gave her, and the drug is so expensive, $14, and she looks at the drugstore man, and she says, can't you give me a little less? I only have $4; can't I have a smaller amount? And she does not get the drug, unless she pays $14.

So he has a change of heart, and he said, well, if you come back with $12, I will give you the drug.

Our senior citizens are suffering more with the 20-percent increase on account of the inflation.

I got $25, so my landlord took $20. I am left with $5, and also the Medicaid out of all my members, which is a porverty pocket area, 53-percent are without Medicaid, because they have anywhere from $4 to $7 to $8 a month more.

* See appendix 3, p. 122.

This should never be, therefore it is a must and immediately the Special Committee on Aging should get together to see that the Medicare program gives us the services that the Medicaid program gives to the welfare recipients.

We are not on welfare, we are not getting any funds from the Government.

We want what is coming to us, because in 1929, upward until now, we had worked, we had a trying time, and we have worked to the present.

Our senior citizens, to go into the supermarket and pick an article from the counter and put it in the basket, but when she gets to the cashier, she has to put everything back, because she does not have enough money.

Every time you go in, the prices go up, up, up. I have an article here, but I am telling it as it is. My senior citizens keep coming in every day and asking, Mrs. Laufer, I lost my Medicaid. Mrs. Laufer, I lost my Medicaid. This goes on, and with membership of people upward of 94 years old, it is sad.

Somebody is responsible for us, and our fate is in the Special Committee on Aging, and they have to do something, and do it fast. If you think we could live on $2,000 a year that Medicaid allows, I would like you to just take a figure, and put it all together. I have done it myself, which I will read later on, and find it very difficult to live on $2,295.80, let alone $2,000 which Medicaid allows.

We helped to build America with muscle, not with machines. Our children went to college, not with scholarships, and not with loans. We went to work and paid for their tuition so they could be educated.

We never had anything as the people of today. We had to carry a cake of ice to the fourth floor for 10 cents, and we lived through five wars and I could go and on, and I feel our priority is health.

I want to go to the doctor, I want to go to the drugstore, I need a pair of glasses, I need my teeth fixed, I need podiatry.

Shortchanged and Forgotten Generation

Our needs are the same as your needs. The only thing is we don't have that much to go into the future, because after all, I am 70 years old, a younger person could get ill, but an older person must go soon. I feel we have much to say, but I know that the Special Committee studies and knows in dollars and cents that we are shortchanged, and we are the forgotten generation.

I have worked with officials time and time again way back, and the fact that the clinic has been accomplished has been the best thing in our area, because our doctor went home many, many nights and could not eat his dinner, to see how the elderly people were suffering.

They had no doctor to go to, they did not have Medicaid, and now those that had Medicaid lost their home care.

I have a senior citizen who is partially blind, and has $136 income, and a very small pension. She lost her home care, she lost her Medicaid, and she has nothing left.

We all suffered when the 20-percent income on Social Security, and I know that I am not telling you anything new, because if you are studying the situation, you have it well at hand.

I hope that you will try your very best to revive the most needed program.

Federal Government, city, and State government must step in to see that senior citizens have a share of the revenue sharing.

We want the same goodies awarded to the welfare recipients. We all hope that our officials will study this situation, so that our elderly will not have to carry the prescriptions in her bag because there are no funds for drugs.

I can give you many examples, but I would only repeat myself, you all know our problem, as I said before.

I will speak for myself. I have an income of $2,295,80.

The maximum Medicare income, $2,200. The surplus, $95.80 per year. Per month, $7.98. My rent is $1,104 per year. My telephone is $110 per year. My Medicare is $74 per year. I have a Blue Shield-Blue Cross policy because I am afraid they would put my bed in the hall by the elevator, so I pay $70.06. I have fire insurance, $14. I have transportation, $60 for the year. I have to go to the washing machine, it costs me 60 cents for each wash, and twice a week, I have $62 for wash.

This is approximate round figures. I allowed myself $15 a week for food including meat, groceries, and produce, which amounts to $780.

At the end of the year I got $2,274.46. I have $20.54 to buy special food if I want it for social, for the drycleaner, for clothes, for drugs, for furniture, for household items, for shoes, for house furnishings, for extra, for electric applicance, for electricity and gas, and also for the doctor's fee, the $60 that I will be allowed to go to the doctor. Therefore, I feel in closing that if I were an addict, and I had to have a fix, or I had to have prescriptions of special foods and everything, there would not be no problem because I would be on welfare, and I would be entitled to all those goodies.

Since I am not a drug addict, I am not entitled to only what statistics show. I am not a statistic. I am a senior citizen, and I want the needs that everybody else would like to have.

I cannot go to the cimena for $4.50. I have to be satisfied with what I see on television, whether it is 1949 or 1930.

I try my very best to help all elderly, and I want you to know, even though we live in a poverty pocket area, the prices are much higher than if you live in Connecticut, or lived in White Plains, and did shopping in suburban stores.

We paid upward to 3 weeks ago, 81 cents for a dozen eggs.

Thanks, you all, for listening attentively. I hope I did not say anything that was not right, but that is how I feel as a senior citizen. I am very dissappointed, both the White House conference and both the Government, what they are doing to all our elderly in this country, God bless America.

Senator MUSKIE. Mrs. Laufer, thank you very much.

I cannot think of anything you said that is wrong.

Miss BROPHY. Now, I would like to introduce Dr. Libow, Mount Sinai City Hospital, a major division of the Mount Sinai School of Medicine. Dr. Libow is a consultant on medicine. He will talk about the health delivery system.

STATEMENT OF LESLIE S. LIBOW, M.D., FACP, CHIEF, GERIATRIC MEDICINE, MOUNT SINAI HOSPITAL, NEW YORK

Dr. LIBOW. Mr. Chairman, Senator Moss, it is a privilege to appear before you and to have the opportunity to state my views on the health care system in New York City as it affects the elderly.

The observations in this presentation derive from my experience as chief of the geriatric medical division at a public hospital in New York City (the Mount Sinai City Hospital Center at Elmhurst), where our geriatric medical program deals with community residing elderly as well as with hospitalized or nursing home patients. The 15 problem areas discussed are all interrelated and no one problem will tell the entire story. Without doubt, these problems in the health care system, taken together, represent as serious a threat to the older person's state of body and mind as the classical problems of heart disease, cancer, and stroke.

1. TIME

It requires increased time to interview an elderly individual as well as to explain the problems and the treatment suggestions. The physician often needs help from others, such as family members, nurses, and neighbors, to be sure of the carrying through of the planned program. With the shortage of physicians that exists to render care to the elderly, the additional need to allow increased time produces an impossible situation.

2. LIVING ALONE OR WITH FRAIL SPOUSE

Approximately 35 percent of older women and 20 percent of older men live alone. Those who are not alone often live with a frail spouse. Of course, many live with their children. Frequently, the key to preventing hospitalization or to an early return to their homes from a hospital is the presence of someone to help out at home. The homemaker and the home health aide are costly, essential, and in small supply. Though minimally trained, they exert maximum effect in reducing hospital and nursing home admissions.

3. MEMORY

Fifteen to twenty percent of all elderly people have diminished memory to varying degrees. Will they remember the instructions for their diets, for their schedules of medication administration, for their next office of clinic appointment? In fact, is their memory adequate so that their symptoms are actually reliably stated to the physician?

4. AMBULATION

One of the two major reasons for permanent nursing home placement in our city is diminished ability to walk (the other major reason is mental impairment). Often, the problem is frequent falls without clear-cut medical explanation. Can the individual be left at home in a secure fashion? Can they walk well enough to get to the market, to the drugstore or to the doctor's office? Here, the availability of home health aides or even less trained people, again, may make the difference between living at home and being institutionalized.

5. ISOLATION

(*a*) *Telephone.*—Many of our elderly patients cannot afford telephones. Offsetting some of the isolation and decreased ability to walk is the availability of the telephone. Here, the individual can communicate with the physician, hospital pharmacy, friend and family. Very often, we see unnecessary transfers of individuals to hospitals via ambulance in response to the frightened telephone call of a neighbor who has found the elderly in a state of illness and where the elderly individual has no opportunity to describe his difficulties to a physician. Often, too, they are very tardy in being able to obtain renewals of prescriptions or proper home care because of the absence of this communication line.

(*b*) *Transportation.*—Will the individual be able to get to and from the physician's office, clinic, hospital and their homes? We are never sure of this and much is left to chance. The cost and the physical difficulties of transportation are barriers. I have previously presented a suggestion for financing health related transportation and have called this transicare.[1]

(*c*) *Boredom.*—Diminished ability to walk, absence of friends and family, and income, as well as other changes lead toward a monotonous existence. The impact of monotony on health has been more clearly than ever demonstrated in the recent National Institute of Health study entitled, "Human Aging II,"[2] in which it was revealed that two health parameters, when coupled were more able than insurance tables or any other parameters to accurately predict mortality in healthy elderly people. The two parameters were chronic cigarette smoking and variability and complexity of a typical day's activity. The less variable and complex, and therefore more routine and monotonous, the greater the mortality. Very few remedies now exist to counter the boredom of late life.

6. INCOME

We see poverty in approximately 20 to 40 percent of our elderly people. This poverty serves as a barrier to health via diminished transportation, diminished food intake, diminished ability to purchase medications, to pay for home health aides and physicians' visits and, in general, to almost every aspect of health and life.

7. MULTIPLE ILLNESSES

In the era of the specialty practice of medicine, our elderly patients are particularly in difficulty. They usually have multiple illnesses and this leads to multiple physicians, which leads to multiple and simultaneous medications, which leads to multiple trips and costs. Obviously, increasing confusion and diminished health care are often the results.

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[1] Libow, L. S. "Older People's Medical and Physiological Characteristics." Some implications for transportation, pp. 14 to 18 in "Transportation and Aging—Selected Issues." Edited by Cantilli, E. J. and Shmelzer, J. L. U.S. Government Printing Office, Washington, D.C. 1762-0042, 1970.

[2] Bartko, J. J. and Patterson, R. D. "Survival among healthy old men: a multivariate analysis," pp. 105 to 117 in "Human Aging II"—an 11-year follow-up biomedical and behavioral study. Edited by Granick, S. and Patterson, R. D. U.S. Department of HEW, PHS, HSMHA, DHEW Public No. (HSM) 71-9037, 1971.

8. PREVENTIVE CARE

Preventive care is not part of the American health industry for any age group, let alone for the elderly. For example, flu vaccinations, screening for glaucoma or for brittle bones or for early mental changes, are not covered by Medicare insurance. A better example is the absence of any organized health care system in most communities.

9. DOCTOR'S OFFICES AND CLINICS

It is rare to find a clinic or office specially geared to the needs of the elderly. Instead, we have a mixture of all age groups seeking help. Many have optimistically, and I believe naively, stated that such mixture is better since we should not isolate the elderly individual. Our experience has proven quite to the contrary. Matters such as the speed of interviews, the need for special instructions, the need for special transportation arrangements, the need for specially trained personnel, all point to the requirement for special health personnel and special clinics to deal with the needs of the elderly.

10. LONGER STAY IN HOSPITALS

The elderly do not enjoy their stay in the hospital. The strangeness, the fear, the diminished contact with friends and family, the worries about cost and life, the mysteries of the unexplained, usually serve to promote a strong desire to return home as quickly as possible. However, the extra days of hospitalization for the elderly compared to middle-aged persons—as presented previously by Mrs. Cantor—result not from malingering nor from the physician's desire to perpetuate hospitalization, but rather from the obvious uncertainties accompanying early discharge. The many previously listed essential problems all can be seen affecting the physician and patient in such a way as to require more time in a hospital until the patient has further increased his physical and mental strength, his ability to handle his home situation, and until such time as what community help there is available, can be pieced together from its splintered setting. A premature discharge without the foregoing requirements being met may inevitably lead to worsening of illness and recurrent hospitalization, if not permanent nursing home institutionalization.

11. MEDICATIONS

Our ill elderly are each taking three to six medications. If they are not Medicaid recipients they must pay out of their pockets. Additionally, they often have difficulty carrying out instructions for multiple, simultaneous medications since the appearance of the medications and the schedules are both confusing. Obtaining renewals of medications is a significant problem, both at the local pharmacy and at the hospital since matters such as money, transportation, and even physicians' renewal forms are often not easily obtainable. Simply stated, there is no system for the obtaining, the delivery of, the continuation of, and the self-administration and teaching of medications and schedules.

12. NUTRITION

From 10 to 20 percent of the elderly border on malnutrition and this frequently leads to institutionalization in a hospital or nursing home. There is minimal, if any, ability to improve the delivery and availability of food for our elderly.

13. HEARING AND VISION

Decrease of these senses is well known in late life, and yet, our present Medicare system does not allow payment for eyeglasses or hearing aids. Obviously, decline of sensory input worsens problems such as isolation, falls, accidents, and mental decline.

14. TRAINED PERSONNEL

In addition to the well known shortage of physicians, nurses, health aides, and other paraprofessionals in our entire health system, there is a particular shortage with regard to the elderly. Health professionals have not been attracted in large number to working with this age group. More than that, health professionals, as any other citizen, often deny their own aging and thus prefer to work with younger individuals. As mentioned earlier, doctors' offices and special health clinics geared for the elderly are necessary and somewhat nonexistent. Increased training of special personnel to work with the elderly and to lead the nonspecially trained health personnel in caring for the elderly, is an urgent matter. Few medical schools teach geriatrics to their students. There are only enough funds for one residency-fellowship position in geriatric medicine at the Mount Sinai City Hospital Center at Elmhurst, though nearly 40 applicants have sought training in the past 12 months. Shockingly, this is perhaps the only formalized program in this country where a graduate physician can receive post-graduate training in both community and institutional aspects of this special field. A similar need for special training exists in nursing. The number of home health aides and homemakers in our city fulfills 25 to 50 percent of the actual need.

15. MEDICARE

Medicare has been a wonderful step forward with regard to some of the previously unmet needs. In particular, it has been a great help with the costs of acute hospitalization. To a lesser extent, it has been helpful with meeting doctors' bills. It has been of least help, we have found, with regard to nursing home payment. Medicare is only a financial relief vehicle. Increasing the patient's responsibility for his health bills, as suggested by the present administration, and thereby decreasing the Government's responsibility, might—and this is very uncertain—diminish the rate of hospitalization because the elderly individual may be so fearful of these additional expenses that they will either not seek help or refuse the suggestion for hospitalization.

Even the physician might diminish his tendency toward hospitalizing his elderly ill patients because of his awareness of increasing costs to them. However, the question remains, what alternatives exist for the physician to render care and for the ill elderly to receive care? There

are few existent alternatives in this city. Physicians' offices and hospital clinics are not geared to render the kind of diagnostic and therapeutic care which the ill elderly would need as an alternative to hospitalization. Our communities in New York are not geared to the transportation, medication, homemaker, nurse, physician, medical supply, and social service needs of the home residing ill elderly. Thus, what is necessary is to first form health systems in each community which could attend to the needs of the ill elderly as an alternative to hospitalization, and then increase the patient's responsibility as well as adding other deterrents to hospitalization. Simply stated, this would be putting the horse before the cart rather than what is now proposed.

The second part of this presentation will deal with the health system for the elderly we have developed as a result of encountering the aforementioned problems in health care.

The previously mentioned essential problems faced by physicians and other health professionals have led to the establishment of a geriatric medical system at the Mount Sinai City Hospital Center at Elmhurst, Queens, N.Y. This system is based on the idea that the cornerstone to the preventive care as well as continued care is a tightly knit, coordinated health system including hospital, outpatient care [clinic], nursing home involvement, and most essentially, a community health team. The base of operations for this system is our public hospital. From the hospital we have stepped into the community and collaborated closely with the Visiting Nurse [Public Health Nurse] Service which is comprised of nursing, home health aide, homemaker, social worker, physical therapist and other health workers. .We focus on the "marginal" patient; that is, those elderly who are least able to remain at home, or return to their homes from the hospital, without additional organized support of many kinds. The less frail, more self-sufficient elderly have also come to derive the benefits from the existence of such a system.

This marginal patient is usually physically and/or mentally frail, living alone or with a frail spouse, and with the severe financial limitations quite typical of this group and described earlier by Mrs. Cantor. The goal is to permit such individuals to remain at home either after an acute medical, surgical, and psychiatric illness brings them to the hospital or to prevent them from ever needing to enter the hospital by making available coordinated diagnostic, therapeutic, and community supportive measures.

Potentially, the well-known 20 to 30 percent of nursing home patients in our community who are not in need of lifelong nursing home care could also utilize this system.

The system will be further described with regard to its component parts.

1. THE HOSPITAL UNIT

This is an 80-bed convalescent type unit within a 1,000-bed general hospital, a major teaching division of the Mount Sinai School of Medicine. The patients admitted to this unit have the characteristics of frailty and "marginality" described previously. They come to us mostly from the other units within this hospital following a reasonably brief stay for their acute illnesses. Many also come directly from the community referred to us by the home care division of this hospital or referred to us by the closely collaborating visiting nurse service. We

admit approximately 7 to 10 patients per week and discharge approximately two-thirds of these patients back into the community within 4 to 6 weeks. One-third of these patients never adequately improve in a physical and/or mental sense to avail themselves of our community support system and are placed in nursing homes for what will probably be the remainder of their lives. The two major reasons, in addition to diminished financial resources, leading to nursing home placement, are diminished ambulation and/or diminished mental function. The inhospital unit program includes the following items:

a. Combined medical, nursing rounds for diagnostic, therapeutic, and planning purposes.

b. Reambulation efforts by both trained physical therapists and lay people assisting the elderly with walking.

c. Teaching of self-administration of medications in preparation for a similar responsibility at home.

d. Participation with social service in group sessions focusing on the forthcoming needs leading to discharge as well as those necessary for maintaining oneself at home.

e. Training of physicians as specialists in geriatric medicine (this is probably the only such program in the United States) and training of other health personnel including community health workers.

f. The staff conference is the focus for our coordinated team approach to care. There are 15 to 25 health professionals attending this 1½-to-2 hour session including visiting nurse personnel as well as hospital and geriatric clinic personnel such as social workers, nursing aides, head nurses, recreational therapists, physical therapists, unit administrator, physicians in training, physicians in charge, and home care physician. The meeting focuses on reviewing the weekly experience in the geriatric outpatient clinic, where those of our community residing patients who came in for care are discussed from the point of view of the community nurse, social worker, and physicians. We then proceed to a report from the visiting nurse with regard to problems encountered during their home visits in the community within that week. The focus then turns to one patient newly admitted to our unit. A brief presentation of the case is forthcoming from the physician, nurse, recreational therapist, physical therapist, and social worker, followed by an interview with the patient with or without family members present, and concluded by a summary of our plans for both inhospital and home maintenance care. The visiting nurse and home care physician comment on necessary community support plans.

The conclusion of the staff conference focuses on a review of 5-to-10 inpatients who have been discussed at previous meetings or who present new problems with regard to their return and maintenance at home.

These conferences serve to produce a strong feeling of coordination and solidarity within our health system as well as permitting patients to benefit from an integrated approach. An additional benefit, obviously, is teaching of geriatric care.

2. THE GERIATRIC CLINIC

A significant number of our discharged patients do not have their own physician to return to. We continue their care indefinitely in our geriatric clinic. Those who are not ambulatory enough to return to

our clinic are seen at home regularly by either the home care physicians of our hospital and/or the visiting nurse service. Other patients are referred to our clinic by the visiting nurse or other community sources, though these are small in number in comparison to our own inhospital based referrals. The clinic is staffed by physicians in training (two resident fellows) and by geriatricians in charge as well as a nurse from the visiting nurse service who has been specially trained at another medical school in the role of a nurse practitioner and is now specially training with us in the role of nurse practitioner in geriatrics. Her insights into community problems faced by patients have served to further advance our abilities to render care. During the clinic session, 8 to 12 patients are seen by physicians, nurse practitioner and social workers. Transportation arrangements are made by clinic personnel for all those who are Medicaid eligible. Prescriptions are often given for long periods of time, a departure from hospital policy, but only in an effort to reduce unnecessary return trips for the appropriate patients.

3. NURSING HOME

Our staff regularly visits a community nursing home in an effort to learn more about their problems, to help them with their problems, and to improve both their understanding of the hospital and clinic and our understanding of their institution. This is a new program and thus far has led to significant forward strides.

Every community needs such a system particularly geared to the elderly. This system need not use a hospital for its base, though this seems preferable because of the following reasons: (1) The extensive interdisciplinary experience of a hospital, and (2) its respected position within the lay and health community. This system could use as its base a geriatric clinic in the community. The clinic could organize all of the aforementioned skills including a closely affiliated hospital and nursing home.

This approach allows the patient or the family or the nurse or the social worker or the physician to turn to an already organized system, geared appropriately to the special needs of the elderly in terms of health maintenance, in terms of diagnostic study and therapeutic efforts, and in terms of alternatives to institutionalization. Most of all, it provides a potential alternative to hospitalization for those problems which the physician is likely to encounter in his dealing with the elderly patient and which leads the physician to often throw up his arms in despair or turn to the modality of hospitalization where, at least, he is sure that extra personnel, special tests, and treatments are readily available. He further is able to more adequately cope with the problems of transportation, memory impairment, nutrition, medications, and most of the other earlier mentioned essential problems.

This system in this community is far from perfect. Many patients are not reached and many patients and families are seriously burdened with heavy financial responsibilities.

It is obvious to anyone that the cost of health care, with or without such a system, is very high. It appears to be much higher without a system such as the one herein described. Mrs. Cantor's presentation made clear the several hundred dollars per year increase in cost to an elderly individual under the administration's proposed Medicare increase. To seriously consider further increasing the cost of health

care to the patient in an effort to control the expensive Medicare program, the expanded national budget and inflation, is to turn the intended beneficiary of Medicare into a victim.

Miss BROPHY. Thank you, Dr. Libow. I have a closing statement.

Senator MUSKIE. I say, Secretary Weinberger is scheduled for 11. We have a commitment to hear him. We will use the 10 minutes remaining, but then I would hope you would be able to stand by for possible questions when he is through.

Miss BROPHY. We would be glad to.

Senator MUSKIE. So bear that in mind as you continue.

Miss BROPHY. Just let me make some points, because you have the closing testimony for the record.

STATEMENT OF MISS ALICE M. BROPHY—Continued

Miss BROPHY. The testimony you have heard here this morning has illustrated and documented many serious barriers faced by older people in obtaining the quality health care they need so vitally.

There is one other, however, that needs to be added. I refer to the fact that in large urban areas fragmentation and depersonalization of health care of the poorer elderly is sharply on the rise.

Although New York City has more doctors than any other city, recent years have seen a marked changed in the doctor's role.

The general practitioner is fast disappearing from the scene. In 1966 in New York City there were fewer than 4,000 general practitioners left among more than 22,000 doctors. Although our recent study of the elderly in New York shows that many elderly still use a private doctor, in the poorer neighborhoods and particularly among minority groups, the outpatient clinics and emergency rooms of municipal and voluntary hospitals have tended to become the neighborhood doctors.

Older people in such circumstances go from clinic to clinic and are, handled by everchanging teams of doctors, nurses, social workers, and medical technicians. No one doctor is theirs alone, responsible for them as a whole person—no one is available to present the older person with a total evaluation of his or her situation.

Although our great hospitals offer the best of medical science, the manner in which health care is dispensed is often overwhelming, confusing, and totally impersonal. It is a little wonder that older people frequently fail to keep clinic appointments or refuse to be taken to the hospital until they are near death.

The "laying on of hands" so important a part of the healing process, so vital in strengthening the patient's will to live, seems a thing of the past in too many large city hospitals.

Each organizational deficiency causes financial, social, and moral problems for the elderly. Until these deficiencies are resolved, the economic problems of older people will be needlessly intensified and their physical suffering neglected.

Some method must be found to convert the vastness of the giant medical centers into human-scale, neighborhood-based geriatric clinics where quality medicine can be dispensed in surroundings which enhance the personal dignity as well as the health of the older American.

96-688—73——3

Five Major Barriers to Adequate Medical Care

In closing, I would like to summarize what we have all been trying to say today. As we see it there are five major barriers to adequate medical care for older people which desperately call for action.

First, an incredibly rapid rise of medical costs in the last decade has virtually undermined Medicare and has outpriced all but the very rich from quality medical care.

Second, Medicare as presently constituted fails to cover important medical services required by older people—drugs, dentistry, podiatry, appliances, mental health care, and home health services—despite the fact that this lack of coverage too often results in far more expensive alternatives for city, State, and Federal governments.

Third, medical services are fragmented and hard to locate.

There are serious gaps in both facilities and personnel in almost every community. These gaps and the fragmentation of the present health delivery system prevent an older person from receiving the broad and comprehensive medical care he requires.

Fourth, the older patient currently has little or no input into the policy of the health care delivery system. Too often, he has little recourse when he is unhappy about the care he receives and, in many cases, the whole process of health care delivery is thoroughly confusing and depersonalizing to him.

Fifth, we must face the fact honestly that, with few exceptions, the older person who seeks health care is the unwitting victim of society's prejudice against old age. Young doctors tend to be impatient with the elderly, find them difficult to treat, and have little interest in the illnesses of old age, since most of these hold no promise of reversibility.

And finally, in the face of all these existing barriers, the President is proposing to further undermine Medicare and Medicaid through increasing costs to older people. These proposals will make a mockery of the economic benefits gained by the recent 20-percent increase in Social Security and will put older people almost back where they were before. This is not only a financial blow but it is psychologically a cruel and inhuman hoax. At the very point at which an older person can look forward to having more money on which to live, we are now proposing to vastly increase the medical bills which he himself must pay.

Inflationary Rise in Hospital Charges

The high cost of medical care resulting principally from the inflationary rise in hospital charges and doctor's fees must not be used as an excuse for increasing the costs to older people. Forcing older people to pay more money is not the way to get older people to leave the hospital sooner. Comprehensive services awaiting them in the community, so that they can be cared for in their own homes, is the best and least expensive answer to shortening hospital stays.

Therefore, our first and most overriding recommendation for the welfare of older Americans is that the President's proposed changes in Medicare be rejected.

Furthermore, the present Medicare program must be brought back to its original goals to remove the crushing burden of medical costs from the shoulders of older people and make access to quality medical care available to all older people regardless of their ability to pay.

Specifically, we want to see Medicare benefits expanded to include prescription drugs, dental services, eyeglasses, prostheses, podiatry and expanded home health care. Reimbursable home health care should be defined to include homemaking services for situations where skilled nursing care may not be needed but homemaking support is imperative. And the present option that enables doctors to accept or refuse assignment from Medicare should be eliminated.

Health care must be taken into the community not as an experiment but as an integral part of the health care delivery system. The expansion of ambulatory, neighborhood-based geriatric clinics, especially in areas with a scarcity of private doctors, would provide a first-line of comprehensive health care for older people. Geriatric clinics should be evaluated against family health clinics to determine which best serve elderly people. The attachment of diagnostic screening and selected health services to existing nonmedical community programs for the elderly, such as the projected nutrition programs, offers an unusual opportunity to link social services and medical care.

There must be a sharp increase in community-based health services, such as homemakers and home health aides, which enable people to remain independent longer in their own homes and which await them when they return from the hospital.

But all of these changes are only short-term solutions. In the long run what is really needed, for young and old alike, is a comprehensive health security bill, such as the Kennedy-Griffiths bill, which will take care of all medical needs from the beginning to the end of life. Only with such a comprehensive plan can we be sure that needed medical services are available to all and that the health care delivery system is rationalized and its present chaotic state eliminated.

If these recommendations seem visionary or impractical, let us just remenber that ill health at any age is a frightening experience. In old age, bound up with fears of being unable to obtain or afford health care, illness can become a virtual nightmare.

Surely, we can find the resources to protect our elderly population from such fears by providing them with the best medical care possible for rich and poor alike.

Thank you very much.

Senator MUSKIE. Thank you, Miss Brophy, and I thank all of you for your testimony. We were certain you had zeroed in on the issues, you have done that very well.

Your testimony of course raises questions, many questions that go beyond the present budget proposals, nevertheless those proposals are on the focus of our attention right now, and the focus will be sharper within the next hour.

In any case, what we are concerned about is whether or not the President's proposals will result in an improvement of medical care or health care for senior citizens, or whether it will mean a retrogression, and that is the specific question we want to get into this morning, even though your testimony suggests many other questions in areas that we would like to inquire about.

I am going to ask Senator Moss, who was not present at an earlier part of the hearing, if he would like to make a statement, and then if you could, some of you, to stand by until after Secretary Weinberger's testimony, we might well want to put some questions to you at that point.

Senator Moss?

STATEMENT BY SENATOR FRANK MOSS

Senator Moss. Thank you, Mr. Chairman. I am sorry I was not here when the hearing was called to order, but I have heard the witnesses with great interest over a long period of time, for about 10 years, I have been chairman of the Subcommittee on Long-Term Care, of this full committee, and over that period of time, I had held hearings in many, many parts of the country, as well as here in Washington, so I could relate very well to the things that were testified here this morning, and especially the charts that illustrate it so well, and what the cost factor is, and how it has gone up.

The same is true for people who are in rest homes, in intermediate care facilities, and it applies to those on welfare as well as those who are self-sustaining. I enjoyed Mrs. Laufer's testimony from the point of view of a person who does not have to depend on welfare, but finds the costs all but overwhelming, and the thing that Dr. Libow brought out so well has come through again and again, that we really don't have any preventive medicine in this country, especially for older people. This is perhaps one of the greatest deficiencies that we have now; a person has to be ill before he can get any kind of help at all, and if he had preventive medicine of some sort, we could undoubtedly make it much more comfortable and productive for people, but we could actually save much in costs and time if we had that.

Now, our failure to train personnel for working with the elderly, both medical personnel, and nursing, and people who care for elderly people, we do nothing in training people of that sort.

It is sort of out of the area, so I don't care to launch this to any question at this time. We really don't have time for it. I did want to commend all of you who testified this morning, I thought your presentation was outstanding, it shows preparation, and great concern for the problems, and you have stated them very well, and with this as a background I am sure that we are going to have a great many questions of the representative of the administration as to why under these circumstances the costs have gone up, and the burden increased for elderly people who already were handicapped for funds to meet the costs of medical care, and I, therefore, commend all of you.

Thank you.

Senator MUSKIE. Thank you very much, Senator Moss. I understand the Secretary has not arrived yet, so I would like to get into one or two questions.

Miss Brophy, you say that 22 percent of your elderly population live below the poverty level. I believe that was in your statement.

Now, let's say that is approximately 205,000 persons, if my mathematics is correct, an yet only 130,000 are covered by Medicaid below the poverty level. I wonder how many of those are eligible for Medicaid, and why there is this gap.

Miss BROPHY. I don't think we know how many are eligible for Medicaid, although we presume there are a great many. I think it is just possible some older people do not know about this entitlement, although we think it is a very minimum number.

Exposed to Means Test

No. 2. Older people have a great feeling of degradation in going to a setting where they have to be exposed to a means test. We had older people in the office this week who felt they just could not stand it, they would rather starve or not eat rather than go through this kind of intensive questioning which is essential when they apply for Medicaid.

The third reason is that they have some limited savings, it is their crisis money, it is the money they have put aside for the great events of life, and they don't want to dip into this modest savings, so they don't apply for Medicaid.

Senator Muskie. Chart 6,* you introduced this morning, shows about $2,116 is left for income for most elderly New Yorkers after rent and medical costs are paid.

How much higher are living costs in New York City than elsewhere in the Nation, how far does that $2,116 go?

Mrs. Cantor. There is no question that New York City is probably one of the highest, if not the highest area in terms of living costs One way of judging is the BLS moderate standard of living. A retired person in the country needs about $5,400, and in New York City, to maintain the same moderate standard $5,600 is required.

I don't know if it is really that much, but there is some difference. As far as what is left for them to use, $176 a month, I think Mrs. Laufer in a sense really answered what it does cover, that once you get through with food, and a few small clothing items, transportation, there is nothing left, so that I can say that we in New York feel that anybody, in any city of the country or rural area, any person trying to live on $176 a month is down to absolute rock bottom.

Senator Muskie. I understand Secretary Weinberger is in the hallway. I would like to ask you one more question which I think will be a good preface to his testimony.

Average Hospital Stay

Mrs. Cantor, you say that the average hospital stay for an older person in New York City is about 30.6 days. The overwhelming majority of elderly persons never reach the 60th day of hospitalization, and thus never have to pay anything beyond the initial $72 deductible.

Secretary Weinberger is reported as having said that Mr. Nixon's reported medical care increases are desirable, and they will not impose financial hardships on the program's beneficiaries. He said further that Social Security benefits have risen about 60 percent since 1966.

Now, how far do you think Social Security benefits would go, or should go, toward paying the proposed Medicare increases.

Mrs. Cantor. I think the answer to that is there are a number of factors. First of all, when you talk about a 60 or 70 percent Social Security, we have to remember the base. We are talking about $2,000, so it sounds much larger than it really is.

Second, the Social Security increases have been increases which constantly followed rises in the cost of living, so they in a sense never caught up with the previous rise in cost of living for older people.

Many people feel today maybe for the first time we are beginning to approach a reasonable standard of benefits under Social Security

*See appendix 1, p. 114.

law, therefore to come right around and take it, and literally take half or more of it away under the new proposals on changes in Medicare, seems to us to make no sense at all, because it completely violates the very reason for giving the 20 percent increase, which is the catch up for the past rise in costs. I think your point is very well taken, it seems to me in terms of who it is going to hit. It will not hit the long termination as much; it will hit the short term hospital stay, because the costs start on the second day.

We have here a bill of the kinds of auxiliary costs that apparently will be now covered under the proposal.

(See p. 66 for bill.)

They will pay 10 percent of room and board and auxiliary costs. This is a heart case, in New York City, Roosevelt Hospital. The lab fees, $746; X-ray, $112; infusion, $21. Most of these undoubtedly did not take place on the first day, so that under the new proposal, 10 percent of these costs that took place on the succeeding days will be part of the bill, and therefore the amount will be much greater than the 350-percent increase that we first noted.

Senator MUSKIE. The first item on deductible figure would be much higher than $110.

Mrs. CANTOR. Yes, definitely. The 10 percent would be much higher. The 10 percent could be $200, $300, depending on the kind of auxiliary costs that are now going to be figured in.

Senator MUSKIE. Thank you very much. If you would stand by, maybe we can get into some interesting questions later.

Thank you.

STATEMENT OF HON. CASPAR W. WEINBERGER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY JAMES B. CARDWELL, ASSISTANT SECRETARY, COMPTROLLER; STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION; JOHN S. ZAPP, D.D.S., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION; MARIE CALLENDER, PH. D., SPECIAL ASSISTANT FOR NURSING HOME AFFAIRS; AUTHUR E. HESS, DEPUTY COMMISSIONER SOCIAL SECURITY ADMINISTRATION; HOWARD N. NEWMAN COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Secretary WEINBERGER. Mr. Chairman and members of the subcommittee, thank you very much.

I am appearing in response to your request to review for the subcommittee the President's 1974 budget requests for the Department's health programs and their importance to the health status of our Nation's senior citizens.

Since the turn of the century, the number of Americans 65 and older has risen from 3 million to over 21 million, from 4 percent to 10 percent of the national total.

One of the major factors that has produced this largest number and highest proportion of older people in our history is the better health care that has been available to our people.

Improvements in the field of medicine, along with those in nutrition and sanitation, have contributed toward the achievement of one of man's most ancient goals—a longer life.

I should like to stress at the outset that the administration is committed to addressing the problems of the elderly, not just in health, but across-the-board in the area which impact on health is perhaps a more lasting, if less dramatic way, such as income security and nutrition.

I believe the extent of commitment as well as progress in efforts to improve the lot of the elderly will become apparent in this statement.

I think it is also important to recognize at the outset that aging per se is not a disease which can be eliminated by medical science or increased expenditure.

It is rather a process that involves changes in relationship in society and in the family as well as in one physical well-being and must be viewed in context if we are to improve the quality of life for the elderly.

Because the Nation has dealt fairly adequately with many acute and contagious diseases, many more Americans have had their lives extended. Often, their later years are characterized by a high prevalence of chronic conditions, diseases and impairments, which are often not curable and require varying degrees and kinds of long-term care, which must be continued for the life of the individual.

This situation is often further complicated by the fact that the rising need for health services occurs simultaneously with decreases in earnings. At a time when the number of family members and friends are shrinking, chronic conditions make it increasingly difficult for the aged to provide for themselves.

Personal Health Care Expenditures

Personal health care expenditures for older persons in the United States increased by 117 percent (from $8.2 to $17.9 billion) during the 5 years following the enactment of Medicare and Medicaid, while expenditures for the under 65 population were increasing by 69 percent (from $28 to $47.3 billion) and the Consumer Price Index for medical care was increasing by about 40 percent.

Older persons constitute 10 percent of the population but account for more than 27 percent of the Nation's personal health care costs, up from less than 23 percent in fiscal year 1966.

In fiscal year 1966, the per-capita personal health care expenditure for older persons was $441, of which only 30 percent or $132 came from public programs. In fiscal year 1971, the per-capita expenditure had almost doubled to $861 but the amount from public programs was about 4½ times as large ($583) and accounted for almost 70 percent of the expenditures for health care for the aged.

As a result, private per-capita expenditures actually declined by nearly 10 percent from $309 in fiscal year 1966 to $279 in fiscal year 1971 despite rapid inflation in medical care cost and substantially greater use of health services by the aged.

This was a period in which the aged's financial position improved substantially.

Three areas of care for older persons were responsible for most of the expenditures incurred in fiscal year 1971 and showed the highest rate of increase during the fiscal year 1966 to 1971 period.

On a per-capita basis, hospital care expenditure increased by 133 percent to $410; physicians' services went up 63 percent to $144; and nursing home care rose by 123 percent to $131.

These were also the three areas in which public programs met a majority of the costs in fiscal year 1971—86 percent of the hospital care costs, 71 percent of the physicians' services costs, and 60 percent of the nursing home care costs. About 78 percent of the public funds were Federal funds.

In summary, older persons benefited from more than twice as much health care expenditures in 1971 than in 1966 and the portion of these expenses paid by public programs more than doubled during the period.

Medicare and Medicaid are serving their important purpose of improving financial access to medical care for the elderly.

Nevertheless, these figures underlying the necessity and importance of our continuing effort to stop inflation in health care costs for all ages.

Before proceeding to address in detail our budget and legislative proposals, I would like to review for you the conceptual framework within which these decisions were made.

At this point in the history of our Nation, I believe it is essential that we carefully reexamine the roles of various kinds of individual and collective action appropriate for solving social problems.

We need to understand more clearly what responsibilities should most properly be exercised through individual action, voluntary group initiative, or action by government at the Federal, State or local level.

Federal Role in Social Programs

In the last decade, this sense of a proper allocation of responsibility has become very confused. A tacit assumption, I believe, behind much of the social legislation that was enacted in the 1960's is that if something is worth doing, it should be done by the Federal Government.

The question of the proper Federal role often received very little attention. The result, all too frequently, was that Federal tax dollars were ineffectively or inefficiently used in attempting to exercise responsibilities that could not be carried out well by Federal agencies.

Apart from the consideration of overall budget constraints, it is essential to clarify the Federal role in social programs.

The 1974 budget is an important step toward doing just that. We have not just made a series of reductions in the budget to meet a spending ceiling determined by a responsible fiscal policy.

We have made changes, both up and down, in order to define a more rational Federal interest and responsibility and a more effective use of Federal resources.

In broad outline, I would describe the Department's role in health as follows. First priority should be on reducing financial barriers affecting access to health care through the financing of health services.

The principal vehicles for accomplishing this at present are Medicare and Medicaid which supplement the income of persons who otherwise could not afford to purchase the medical care they need and which allow individuals to pay for health protection during the working years.

We will shortly, however, be presenting proposals to Congress for a new and more comprehensive approach to national health insurance.

Many people seem to say that Medicare and Medicaid are not really health programs. I would say not only are they health programs, they are the Nation's most important health programs and national health insurance will be our most important health initiative.

There is also a valid Federal interest in supporting health and medical research. These kinds of activities have very broad national benefits, but the high investment costs make it difficult for the private sector or State and local governments to make an adequate annual investment.

Preventive health and consumer protection activities also have very significant benefits which can only result from collective action.

Private individuals cannot and should not be expected to carry out all these activities on their own, even if assisted by national health insurance.

The hazards to the public presented by new drugs and food processing and handling must be addressed at the Federal level. Likewise, traditional public health activities, such as the control of epidemics across State lines are properly a concern of the Federal Government, though we see a very large role for State and local government as well as the Federal Government in this area.

Limited Federal Role

We believe a more limited Federal role is appropriate with respect to special financing for structural changes in the system, either by providing new facilities or demonstrating new types of delivery systems.

The role here typically should be confined to technical assistance and providing special startup funds to demonstrate ideas.

The direct provision of medical care by the Department should only be undertaken as a last resort. Wherever possible, these activities should be carried out by local government or private organizations.

Moreover, we see this as a separate issue from assuring financial access to health services.

With regard to the education of health manpower, principal reliance should continue to be placed on existing private and public education institutions.

Federal involvement should be centered on the general student assistance programs administered by the Office of Education.

Limited Federal programs may be necessary to overcome especially difficult supply problems, assure a proper geographic distribution of health workers, or demonstrate the role of valid new types of health professionals.

HEW's Health Budget Highlights

I would now like to present the highlights of the Department's 1974 health budget in terms of this conceptual framework.

Overall, HEW's spending for health programs has been increasing rapidly in recent years. Total health spending in 1974, proposed in the President's budget, would reach $21.7 billion, $35 billion more than our current estimate for 1973 and nearly double the amount spent in 1969.

The principal factor in this increase has, of course, been rising health benefit payments through Medicare and Medicaid.

In 1974, nearly 60 percent of health outlays will go to finance health care for older Americans, the disabled, and the poor, through these programs.

However, many other aspects of the Department's health programs, which affect the health status of the elderly, have also been increased significantly.

Biomedical research, health manpower training, mental health programs, and food and drug safety are the principal areas of expansion since 1969.

Estimated outlays for Medicare and Medicaid will reach $17.3 billion in 1974, an increase of $3.5 billion over our current estimate for 1973.

Currently, more than 20 million elderly aged 65 or over are covered by Medicare. Beginning this July, another 1.7 million people who have been receiving cash benefits under the Social Security and railroad retirement programs because they are disabled will have Medicare coverage.

Many of these are also older Americans. Their average age is 57 and their average health care expenses are more than twice as great as those age 65 or over.

They will now have the same degree of protection against the cost of health care as the over-age 65 group. It is estimated that benefit payments for the disabled will be $1.6 billion in the first year.

Also, beginning in July 1973, nearly all workers and their families, whether or not they are of retirement age, will be able to qualify for Medicare protection if they suffer from chronic kidney disease.

Medicare Benefit Outlays

In fiscal year 1969, when this administration took office, total Medicare benefit outlays were $6.3 billion. By fiscal year 1974, we estimate these expenditures will be almost double that amount, $11.4 billion.

Indeed, Medicare benefit outlays in fiscal year 1974 will be $2.3 billion more than in 1973. About $1.6 billion of that increase is to cover the cost for newly covered beneficiaries; $700 million represents increases in payments which will be made on behalf of people age 65 and older.

We are also now in a better position to assure that full value is derived from each program dollar expended. Included among the over 50 Medicare changes in last year's Social Security amendments are several provisions, which we are now moving to implement, that are designed to improve Medicare protection and help the program operate more effectively and economically.

These provisions include limits on costs that will be recognized as reasonable, limits on reimbursement for capital expenditures not approved by health planning agencies, tightened utilization review controls, and expanded authority to demonstrate prospective reimbursement and new coverages, all of which should help to slow the rise in costs of health care which has eroded the intended value of Medicare protection.

Some other important changes for Medicare beneficiaries are the health maintenance organization option, which will allow older Americans to take full advantage of this type of health care delivery system; the liberalization of extended care coverage in skilled nursing facilities; and assurance that future increases in the monthly premium for the supplemental medical insurance program will not exceed the proportion by which Social Security cash benefits increase.

Medicaid provides an important complement to Medicare for the poorest of the elderly. Medicaid will cover an estimated 5.2 million persons over age 65 in fiscal year 1974.

The elderly, although constituting only one-fifth of the eligibles, will continue to receive nearly 40 percent of the $4.9 billion in total Federal matching outlays.

The total Medicaid outlays for fiscal year 1974 will be more than double those of 1969, and the numbers of persons served will have increased from 12 to 27 million.

As with Medicare, the Social Security Amendments of 1972 do much to assure that Medicaid funds are well spent and that the care paid for is the high quality.

In addition, the States have been given more latitude over the scope of services to be offered, and the means to better control expenditures, without jeopardizing quality.

As I mentioned earlier, we will again be submitting a national health insurance proposal to this session of Congress.

In addition, we believe it is essential to modify our current health financing programs. We will be submitting legislative proposals to revise Medicare cost sharing, require Medicaid coverage for free-standing clinic services, and eliminate Federal matching for adult dental services under Medicaid.

As you know, the administration has been examining the question of cost sharing in Federal health programs for several years.

We have now concluded that consumers of health services, including providers such as doctors, hospitals, et cetera, should become more aware of their role in cost and utilization control.

There has been cost sharing in Medicare since its inception. Looking critically at how it operates in the hospital insurance portion of the program, however, we believe that present cost sharing does the wrong things at the wrong time.

Except for a first-day deductible equal to the national average cost of 1 day's hospitalization, Medicare requires no cost sharing during the first 60 days of hospital stay—when overutilization of services is most likely to occur.

High levels of cost sharing are imposed at the end of a long hospital stay—one-fourth of the deductible for the 61st through the 90th day and one-half deductible for the 91st through the 150th day—when the beneficiary is least able to afford it.

Moreover, the amount of deductible and copayment the beneficiary now pays bears no relationship to actual costs incurred and services used.

Cost Sharing for Health Care Costs

We are now proposing that the law be revised to provide for cost sharing for lengthy hospital stays, and to base the amount the beneficiary pays on the charges for actual services used.

Under the proposed system, the beneficiary would pay daily amounts equal to 10 percent of actual hospital charges for that day, after having met an initial deductible equal to 1 day's room and board charges.

By increasing beneficiary awareness of the cost factor from the very beginning of a hospital stay, the change should help to increase consumer awareness and participation in efforts to control health care costs.

Legislative proposals will also be submitted to reform cost-sharing the supplementary medical insurance part of Medicare in order to relate these amounts more closely to rises in Social Security cash benefits.

We believe that these Medicare reforms are desirable and that they will not impose financial hardship on the program's beneficiaries.

As you know, Social Security cash benefits have risen about 70 percent since 1966. We now estimate that only about 15 percent of the aged now have incomes below the poverty level, a percentage quite similar to the nonaged population.

It is therefore now feasible to make greater, although still quite limited, use of cost-sharing provisions in order to improve the design of the program.

For the average Medicare beneficiary who is hospitalized, the cost of our proposed changes to the patient would increase from $84 to $189.

Also as set forth above, other benefits have increased for most beneficiaries so that such an increase in cost is more than matched by an increase in benefits.

Such cost-sharing features are typical of private health insurance policies where their value in curbing overutilization of services is recognized.

In addition, of course, Medicaid will continue to pay the full amount of cost sharing for that portion of the Medicare population with low incomes participating in the Medicaid program, and the amount paid by the beneficiary who has to undergo the very long hospital stay would be substantially reduced by these proposals.

The proposal to mandate States to cover services in the free-standing clinics is designed to assure that the Medicaid population has access to effective alternatives to inpatient care and will enable such federally initiated facilities as neighborhood health centers to receive a a steady flow of funds for services rendered to the poor.

Terminate Dental Services for Adults

The proposal to terminate Federal matching for adult dental services under Medicaid is a result of our desire to target Federal resources on the highest priority health needs. In this instance, we believe that the dental needs of children are clearly more critical than those of adults.

The early childhood screening regulations place a high priority on the identification and correction of dental problems, especially those which have potentially long-term effects.

This proposal would not affect the Federal matching for emergency dental services to adults; that is, oral surgery and related hospitalization.

Yet, increased financing of health care services does not assure better health, or a better life. Our assistance to the elderly involves much, much more.

This administration seeks also to improve physical access to health service, assure quality of care in the services delivered and the institutions where they are delivered, fight the inflation in health care costs and search for remedies of diseases.

We have also worked with Congress to assure a higher and more reliable income for elderly, improved nutrition, and a better environment in which to live.

Better cash benefits through OASDI and SSI, and through the nutrition and social service programs aimed at needs of the elderly also have a real health payoff that must not be overlooked.

In particular, the administration has submitted a bill to the Congress that would extend and improve the current Older Americans Act of 1965.

We join Congress in the belief that through the Professional Standards Review Organizations (PRSO), the quality of care provided the elderly, and all Americans, will be increased.

The President is requesting $33 million in the 1974 budget to begin the establishment of a nationwide network of PRSO's. It is our intention that PRSO's will utilize professional developed standards for health care in a method intended to make each physician and institution accountable for the quality and appropriateness of the care they provided.

We are also concerned that proper administration of the PRSO program will result in health care cost reductions.

It can and should also be an important part of our attempts to reduce inflation in health care costs generally.

Of special importance to the elderly has been the President's continuing commitment to improve the safety and quality of life in nursing institutions.

Improve Standards for Long-Term Care

A great deal of time and effort has been spent by the Department to significantly improve the enforcement of our present standards for long-term care, and to develop and implement new ones.

One of the major efforts undertaken under the past year or so was an intensive program of Medicaid standards enforcement.

During this effort some 7,000 surveys of long-term care facilities were made by the States; and by July 1, 1972, 6,479 had been properly surveyed and certified.

An important result of this activity was a significant increase in the States' capabilities to perform their function of inspection, certification, and technical assistance to skilled nursing facilities.

This was accomplished in part by stepped up 4-week training programs, the closely monitored intensive certification effort, and close cooperation and assistance provided by the regional offices.

Since the nursing home improvement program was in a large part their responsibility, constituent HEW agencies have learned to share and cooperate in order to fulfill their role in the decentralization of activities from the central office.

They are now prepared, with increased staff, to accept more and more responsibility for program development and implementation.

This includes the regional capabilities to monitor grants and training, the development and implementation of new standards, and increased ability for policy formulation.

Progress has been made in achieving better administration and quality controls in long-term care programs for the elderly.

We now feel that we are in a good position to assure that Federal funds no longer flow for substandard care in substandard facilities.

Departmental staff are also working to develop new unified regulations for skilled nursing facilities under both Medicare and Medicaid.

They will reduce much confusion on the part of the public, and eliminate the need for duplicative State agency functions under Medicare and Medicaid.

In these important areas, we have strived to achieve greater involvement of the provider and professional community. Their contributions and opinions have been solicited at every step.

The result has been a real uplift in the safety and quality of nursing home care.

Skilled Nursing Facilities

Finally, we have developed regulations for public disclosure of survey and related information of skilled nursing facilities under Medicare and Medicaid.

This is an effort to assist the public in evaluating and choosing long-term care facilites. We believe this information will enable older Americans and others to receive the proper care when they need it.

Since the enactment of Medicare and Medicaid, heavy emphasis has been placed upon providing institutional care.

With few or no alternatives available, many elderly people find their way into institutions although their needs might be better met by other arrangements.

Although alternatives to institutional care might well be of benefit to many people, we still do not know how many or whom, these services can benefit.

Therefore, we have funded a number of demonstration projects in home health day care, and rehabilitative services to tell us not only whether they are feasible but how much they cost, how many and what kinds of people they can help, and the most appropriate ways to delivering these services.

We are continuing to fund some 100 neighborhood health centers, and encourage all federally assisted facilities for which the Department has responsibility to aggressively seek available third-party payments, both public and private.

National Health Service Corps

I would also mention that the National Health Service Corps will be serving an estimated 204 communities in 1974 in areas where there is a scarcity of health professionals.

Moreover, other existing health care demonstration activities will continue to be available to the elderly as they are for the general population.

Cancer, heart and circulatory diseases rate as the leading killers and cripplers of older Americans.

In 1969 more than three-quarters of the one-half million deaths of older persons were caused by three conditions: Heart (46 percent), cancer (15 percent), and cardiovascular disease (14 percent).

As you know, the President initiated a major quest to conquer cancer in 1971. For 1974, the President has recommended devoting nearly 50 percent of the Federal biomedical research funding to the National Cancer Institute and the National Heart and Lung Institute.

Task forces are being emphasized to concentrate research on cancer sites that cause greatest mortality, including the lungs, breast, large bowel, prostate, bladder, and pancreas.

Further support will be given to cancer centers where concentrations of scientific talent can aid in translating research results into clinical practice.

Special emphasis in the heart disease area is being given to investigations relating to arteriosclerosis, the major cause of heart attacks, and to hypertension, another major contributing factor.

Since 1969 Social Security cash benefits per beneficiary have been increased by 51 percent. Expenditures from the Social Security trust funds for retirement, survivors, and disability insurance benefits have nearly doubled from $26.2 billion in 1969 to an estimated $47.6 billion in 1973.

More importantly, as President Nixon recommended, Social Security cash benefits have been protected from inflation.

Under the provisions of the legislation enacted last July, Social Security benefits will be increased automatically in the future each time the cost of living goes up by 3 or more percent.

In addition, most older widows, whose benefits on the average have been lower than those of any other beneficiary group, will receive additional increases under the 1972 Social Security Amendments.

This legislation also liberalized the provision of the law generally referred to as the retirement test, an made some improvements in Social Security disability protection.

Under the recent changes made in the test, the more a beneficiary works and earns, the more spendable income he will have. This also was a recommendation of the President.

The amendments also provided numerous other changes to improve the protection afforded under the program.

Not only have Social Security benefits been increased substantially in the last few years, but under the new Social Security amendments the Federal Government will assume the responsibility of assuring a minimum level of income for aged, blind, and disabled individuals.

Supplemental Security Income

The new program of supplemental security income, embodying many of the welfare reform principles which President Nixon sought will become effective in January of 1974 and will provide a Federal floor of income of $130 a month for an eligible individual and $195 for an eligible couple.

Almost one-half of the States now make payments to these individuals in amounts below the new Federal payment levels.

For individuals in these States the new program will mean increased income. The new law also encourages States presently paying about the Federal level to supplement the Federal payments.

The new Federal SSI payments combine with optional State programs of aid to the aged, blind, and disabled. Under the new program, Federal outlays for cash payments to the aged will double from an annual rate of $1.2 billion for 2 million recipients in the first half of 1974 to an annual rate of $2,4 billion for 4.6 million recipients in the second half of fiscal year 1974.

Compare this with the fiscal year 1969 outlays of $1.2 billion for 2 million aged recipients.

We have tried to see that this increased income for the aged can buy as much health care as is needed. As President Nixon stated in his message on human resources of March 1:

> Strong measures have been taken to ensure that health care costs do not contribute to inflation and price the aged and others out of the care they need. The rate of increase in physician's fees was cut by two-thirds last year alone, and hospital price rises have also been slowed.
>
> If physician's fees had risen at the same rate in 1972 as they had in 1971, the elderly's medical bills would have been $113 million more than they actually were for the same services.
>
> Similarly, if hospital cost increases had not been reduced, the hospital bill for the elderly would have been $110 million higher.
>
> To build on these gains, controls on the health services industry have been retained and will be strengthened under Phase III of the Economic Stabilization Program.

In summary, this administration has fought to secure a better life for the elderly, by marshaling needed resources and intervention into areas of greatest need and encouraging methods of assistance which are cost effective, yet respectful of the dignity which our elder citizens deserve.

In fiscal year 1974, over $52 billion of the $94 million HEW budget would support older Americans. We are pledged to continue the attack on the basic barriers of financial and physical access to health care, rising costs, variable quality, and insufficient alternatives.

Maintenance of Income for the Elderly

A basic element in our strategy is maintenance of the income of the elderly at a level which allows exercise of personal choices in a dignified manner.

We want to improve the effectiveness of health financing protection for the elderly, and at the same time seek to improve the overall quality of life and opportunity for the elderly.

My colleagues and I would be glad to try to answer your questions.

Senator Muskie. Thank you very much, Mr. Secretary.

First, a few points, your testimony covers a lot of subjects that probably we will not get into unless we kept you here all day.

We would like to submit written questions to cover those areas, and we would appreciate responses in due course.

Secretary Weinberger. We would be glad to do that. We will cover that as expeditiously as possible, bearing in mind you would like to have your record printed as quickly as possible.

Senator Muskie. Second, there are a number of Senators here, and your time is limited, as well as those of the Senators' time, so if there is no objection, I will invoke the 10-minute rule so that we each might have an opportunity within the next 45 minutes or an hour for questions.

You mentioned the administration's intention to submit a national health insurance program to this Congress.

Senator Kennedy may want to get into that area, but I would like to ask one question on it.

National Health Insurance Program

I note that the budget for fiscal 1974 makes no provision for funding of a national health insurance program for that year.

I expect that is by design, and indicates you do not expect a national health insurance program to be in effect during that fiscal year, is that correct?

Secretary Weinberger. Senator, I think the scope of the problem of that kind is such that that of costs would not begin to be incurred during that fiscal year.

We would have a lot of start-up activity. We would certainly have a lot of things in place. We would like to try to fund that part of it as part of the normal planning function of the Department.

The actual expenditures under such a program envisioned would start beyond fiscal 1974.

Senator Muskie. In any case the program would not be available to makeup for whatever gaps you included in needed medical services that may have been eliminated with the elimination of programs until some time after fiscal 1974.

Secretary Weinberger. I think the elimination of programs we are talking about, or the reduction in them are not those that would be reached by a national health insurance plan.

What we want to do with the national health insurance proposal, and we regard it as the most important administrative initiative we have, is to get it to Congress as quickly as possible in such shape that we have tried to reach and cover all of the areas we possibly can, and to have it prepared so that it can be presented in a way that you can consider it as quickly as possible.

I do not see any way in which any program of that scope could be actually in place within fiscal year 1974.

Increasing Costs of Medicare

Senator Muskie. Moving directly to the subject I suspect is at the forefront of the committee's interest this morning, and that is the question of increasing costs of Medicare to our elderly citizens.

Secretary Weinberger. Yes, that is correct.

Senator Muskie. Would that program of national health insurance in any way offset the impact of those proposed changes on elderly citizens?

Secretary Weinberger. I rather hesitate to get into a piecemeal discussion of what the proposal might or might not cover.

We would certainly hope it would be adequate. We would expect it to build on the programs that are in place now to cover any gaps that may exist in those programs.

I think it would be premature and not particularly helpful to the committee for me to speculate on various bits and pieces of the proposal we hope and expect will be comprehensive, and we hope to have before you very shortly.

Senator MUSKIE. Would it be accurate to suggest the elderly cannot rely on that program to make up for what they see as shortcomings?

Secretary WEINBERGER. No. I would say that is an option that is open.

Senator MUSKIE. So that is a possible option?

Secretary WEINBERGER. Yes.

Senator MUSKIE. Zeroing in on these changes of the Medicare program, and especially as they relate to increases in deductibles and copayments, and coinsurance, is it true of the administration that elderly citizens are now overutilizing Medicare for unnecessary health requirements?

Secretary WEINBERGER. Senator, I think the best way to phrase that is in this way, it is the administration's view, and the view of a great many other people, that many of the doctors and providers of health care services, because of the way the system is now designed, have much more of an inducement to use higher priced facilities than is strictly necessary, and that this has a bad effect from all points of view, most obviously by increasing the demand pressure on those institutions, it tends to push up the price which has a bad effect on the health care of the entire Nation.

We are not making the statement nor the charge that there are a lot of elderly people who are pushing their way voluntarily into hospitals, and that they should not be allowed to do this.

What we are saying is the way the system is presently designed, there is an inducement upon the people who order hospital care, and this as you know is the medical advisor to these people, the inducement is there to the medical providers that tend to push up the demand for unnecessary elaborate high-priced or expensive facilities, whereas the same or indeed for their particular situation better care might well be obtained in any institution that does not have these characteristics, and for that reason it is necessary to get some kind of overutilization practices, discouragement against it built into the system.

"OVERUTILIZATION"

If you just use the phrase "overutilization," you get the impression everybody is talking about desire to prevent elderly people from doing something potentially of their own choice that is wrong. That is not the case at all.

Senator MUSKIE. No, but the impact of the proposal is to take the money out of the pockets of the elderly people.

It does not bring pressure on the doctors and the hospitals.

From what we have been told, it is something like $600 million to $900 million that comes out of the pockets of the elderly who need to go to the hospitals. The pressure is on them.

Secretary WEINBERGER. I think that is the key to the whole thing, is the necessity of going to hospitals.

It does not take that amount out of the pockets of the elderly. That is the overall total of the savings, and differences in costs that would be achieved by these recommendations, and those are not all coming from required additional payments from the elderly.

It is the belief of the administration and many of the people who were consulted in the design of this, that you will have better medical

care, better care in total for the elderly, without the required, or without the use of the expensive facilities that is now the case.

Your question is directed toward taking money out of the pockets of the elderly for medical or hospital services they now use, and it is the belief of many that a lot of the services that are now being provided in hospitals might well be provided in different institutions that do not have this kind of cost increase factor in them, and that is the intention of the changes.

Home Health Agencies Declining

Senator Muskie. Mr. Secretary, the committee has just received a report that a number of certified home health agencies, which is one of the alternatives, that that is a declining one, not a going one.

Second, we had testimony this morning from Mrs. Marjorie Cantor with respect to the situation in New York.

The average municipal hospital stay for an older person in New York City is about 38.6 days.

Are you saying that persons averaging 38.6 days will not have to pay more out of pocket as a result of the changes proposed by the administration than under the present program?

Secretary Weinberger. If the person had that kind of a stay, the total charge would be considerable.

Under the provisions proposed, people who do not have to stay over 60 days, a large part of the increase, if not all of it—all of it in cases of the most needy—would be picked up by an increase in benefits or would be picked up by Medicaid, so you do have a situation in which you are trying to change some of the utilization or overutilization pattern, and at the same time are making provisions for the people who do still need hospital stays of shorter duration to have the increased costs paid for them.

Senator Muskie. Now, you are not suggesting that the increased payments for those who stay less than 60 days are being shifted now to those who stay longer than 60 days?

Secretary Weinberger. No; I am saying those who stay longer than 60 days will not have nearly as high charges as they do under the present system, and those who stay longer than 60 days are, I would say, universally less able to pay, so it is desirable to reduce the charges in this category.

Senator Muskie. Let us look at that in the first place.

I think statistically less than 5 percent of those elderly, that they require hospitalization stays over 60 days, but secondly, looking at the motivation of the present law and those of the administration's, I notice that the increase in costs under the administration's proposal goes right through to the 5 percent.

At 60 days, under the present law, the payment is $72 compared to $463 under the administration's proposal, and when we talk about a stay of 95 days, there is a reduction of costs for the patient, but you are talking about increases in costs for patients up to 95 days, which is, I suspect, when it goes over 95 days or even less than 5 percent of the total, so it seems to me you are building a very heavy burden on a very small case.

Secretary Weinberger. I do not believe so, Mr. Chairman, and we do believe the benefits to the system as a whole will be realized from

this change of what now appears to be more of an inducement for the provider to utilize the hospital during the early or diagnostic days than the individual requires.

Increasing the Burden for the Elderly

Senator Muskie. How does increasing the burden for the elderly provide a motivation for providers of the service to hospitalize them less?

Secretary Weinberger. Because at the moment, exactly what happened in England, it made them change the whole fundamental base of the system.

The doctors, confronted with a situation in which it cost virtually nothing to send a patient directly to the hospital whether there is any need or not, and he does that on the ground that it is simpler, and it will not cost anybody anything, and, therefore, we will do it that way.

And then when that takes place, you do have, not through the patient's fault, but through the doctors' fault, an overutilization of the services, and because there is this increased demand, you have the changes being built up as a demand for the service is being built up in a way that has effected the price, the cost increase of health care has gone up more rapidly than any other item of the consumer price index, and we are, I think, contributing substantially to that by this kind of system, and what we are trying to do is to insure where hospital care is needed, it will be provided. But to insure it is actually hospital care, the most important part of this whole arsenal of health care services is really required where it is ordered, so we do have this as one of the goals, as you know, in England, where we have this completely free type of service in all services, it was heavily overutilized, and as a result, they had to make this kind of change, and there is nothing new about cost saving. That concept has been in there from the start.

Senator Muskie. Let me say I think the evidence is very mixed, very mixed on the benefits of cost sharing, but my 10 minutes are up.

I would like to get back later.

Senator Stafford is next, and then Senator Moss.

Senator Stafford. Thank you very much, Mr. Chairman.

I want to join the chairman, Mr. Secretary, in expressing our appreciation for your coming up here, and testifying before this committee this morning. I understand, and I think the committee does, you have a difficult job in what you are doing here, and indeed a difficult job in administering the whole Department of HEW. We wish you well.

Secretary Weinberger. Thank you.

National Health Insurance Proposal

Senator Stafford. I have just one or two questions for you this morning. You did refer to a national health insurance proposal.

I am not going to go into detail on that, simply to inquire of you, if you could tell me and the committee, when we might expect this proposal or these proposals to reach Capitol Hill.

Secretary Weinberger. It is a perfectly reasonable question.

The reason I hesitate to give you a date is that there are large numbers of people, both inside and outside the Government, who think it is proper to discuss these proposals so they will be in the best shape possible when they reach the Hill.

We are cognizant of the passing of time and the need to get it up here, but I can answer you in saying I do not have a specific date. I suspect there is no one in the Department that wants to get it up here more rapidly than I do.

I also want to be sure it is in good condition, and that it is a proposal we can present to you with confidence and defend with vigor when it comes up, and that is what we are trying to do.

I just do not know what the number of days that are still left to produce that, but it is something we are working on. We have previously had proposals that were enacted, and we will build on those proposals, and we hope to get it up just as soon as we possibly can; certainly in time to be enacted in this session.

Senator STAFFORD. I hope you will, Mr. Secretary, because one of the problems up here is that, and it seems to me all too often, the administration's proposals for specific legislation reach here so late, that even those who might want to help with them are not sure what the administration's alternatives may be.

TRANSPORTATION PROBLEM

Mr. Chairman, I have one other question. This has to do with the problem of transportation on the part of the elderly, especially in their accessibility to medical and hospital care.

In rural parts of the country, the elderly often not only have no cars, but no public transportation in their vicinity.

In other legislation, the Older Americans Act, which I think was vetoed, there was a requirement for a study of the transportation problems of the elderly. I wonder if the Department has been giving any attention to this particular problem.

Secretary WEINBERGER. Senator, it is a very good point, and we now think we have an ability, which we are trying to increase, of taking an overall approach to problems, even though they might affect several departments of the executive branch, and our administration on the aging has been working hard and certainly will continue to work hard with the Department of Transportation in this field, because since our first priority, as we said here in this segment, is reducing any financial barriers affecting access to health care, and that would include the most fundamental access, transportation. So if there are problems of that kind, I agree that they are in the rural areas and that is certainly something we would want to address ourselves to, and we are addressing ourselves to them in this joint way.

Senator STAFFORD. Thank you, Mr. Secretary.

I will yield as much time as possible to my colleagues, so I will yield now.

Senator MUSKIE. Senator Moss.

Senator MOSS. Thank you, Mr. Chairman.

Mr. Secretary, I welcome you before the committee, I have listened with care to your testimony.

I am going to confine my questioning to the area of institutional care which has been largely a field that I have been working on in this committee over the years.

Intermediate Care Facilities Regulations

HEW's regulations and standards for intermediate facilities have just been published in the Federal Register, and I just had a chance to take a brief look at them.

They have raised several questions that I would like to propose to you with this opportunity we have here this morning.

Many States, of course, have been rapidly transferring a great many of their patients from State mental hospitals into nursing homes. I see where the mentally retarded, those with epilepsy, cerebral palsy, and tuberculosis, and those with developmental disabilities, under some conditions are eligible to participate in the intermediate care facilities program, and it looks to me as though the ICF's may soon become the universal receptacle of the unwanted.

Only one LPN is required in ICF's generally and sufficient additional staffing, whatever that means.

In ICF's for the mentally retarded, there are some ratios. The highest ratio for these residents, who are aggressive, insultive, or security risks, or who manifest hyperactive or psychotic-like behavior require the minimum ratio of one staff member to every two residents.

Since this is less than the average staffing pattern for nursing homes generally, don't you agree this is inadequate personnel for these hard-to-handle individuals?

Secretary Weinberger. Senator, let me say just something preliminarily about those regulations, and I will try to answer many of your specific questions on the technical details of the ratios, if I can.

Dr. Callender, from our Office of Nursing Home Affairs, is here to try to help out in such areas. I do not have the technical skill on such matters, but let me say as far as the purpose of the regulations, they are designed to insure additional progress toward the President's desire to secure an improvement in long-term care facilities.

He has toured some of them, he has received a great deal of comment, and as you know, some 39 States were found deficient back in 1971. We think we have made substantial progress since that time, and there is yet some distance to go.

These regulations are published as a part of that general program of upgrading that seems to be required.

Regulations—they were all of the Department's regulations—and they were published with the idea that additional comments and changes to the proposals will be made.

We are trying to improve, and there is a comment period that is provided for that purpose, and it is certainly not unknown to extend the comment period, to get additional comments and criticisms and suggestions.

We are trying through the procedures such as those that I started in other Government posts to try to make sure that the State and local governments that are directly concerned with these regulations, are consulted ahead of time.

As a result of that policy, there will be a lot of premature discussing going on, as to what many people will perceive as actual HEW regulations, whereas what we are actually trying to do is have consultation as to the reaction that will be built into particular ideas or put into regulation form, and so on.

On this particular ratio you have mentioned, obviously regulations were in draft form long before I got to the Department.

I am not trying to chuck off responsibility for them, because they are published, and we take full responsibility for their publication, and I do specifically.

Some of the factors that went into the development of those ratios, I am sure, were matters that were of consultation and subject to consultation with the medical profession, and with people familiar with the operation of long term of an intermediate care facility.

I would like to ask Dr. Callender to reply.

Personnel Requirements

Dr. Callender. The personnel requirements were not dreamed up by the regulation writers, but rather they were offered by the provider and professional community as being the best estimate of the kind of regulation that could be expected at this time.

If you look into the regulations, you will see we are recommending that at a later point a more rigid standard be imposed with reference to the intermediate care facility. On extensive advice from the professional and provider community, we felt that was a most reasonable kind of expectation that could be made of these facilities at this time in bringing them into the program under regulations and giving them an opportunity over time to increase their staff ratios or any of the other standards that seemed necessary.

Senator Moss. Mr. Secretary you indicate that these regulations are published to solicit comments from the States and others. However my experience has been that the States have been remiss generally in regulation of the ICF's, permitting many of them to exist that were inadequate. Many providers are motivated by the economic incentive and so they, too, many of them have been lax. Isn't it logical then that their comment would be negative? Don't you think that these regulations ought to be more exacting, setting forward-looking goals to be approximated rather than low requirements established out of the neglect and indifference that in the past has gone for reality?

Dr. Callender. First of all, we have to recognize that this is the first time there have been regulations for these facilities.

Prior to that, there was a great deal of variation from one State to the other.

How great that variance was, and how adequate the care, we do not have information about at this point.

We will have the opportunity through these new regulations to make this kind of information available to ourselves and to you.

I think there has been a mixed reaction about the strictness or laxness of the regulations. I think in general, the response from Government agencies, provider groups, and the professionals feel that they are equitable, that it is a fair assessment of what can be expected from this point in time from those facilities.

Levels of Care

I think what we have tried desperately to do in these regulations, is to recognize that there are several levels of care, that there is good, and that there is bad, and that there are persons who would require

institutional care with some health component to it, but also a very strong supportive social services component. I think you will notice this in the regulations. It is our feeling that by providing this level of care we will be able then to prevent the kind of disability and disorientation that occurs when these components of care at that level are missing.

Secretary WEINBERGER. Let me say, the comment period is not just for States and local governments to comment, or for institutions themselves, it goes to the entire public. The sort of comments and motives we will take into account would be other things than I am sure everybody would have in mind before we proceed to try to draft the final regulations.

There also seems, I have encountered two or three times recently, a feeling that the regulations take effect immediately on the comment period.

You know that they don't. I thought I should emphasize that the comment period is for a real purpose, and we do not start working out changes in response to comments during the 30-day period, so obviously the regulations do not affect anyone at the end of the 30-day period.

We desire to have the views of people on this throughout the country, and we hope very much we will get them.

There is a dilemma here also, the higher the standards required, the higher the costs, the more difficulty of getting in and all the rest, so that all of these are an attempt to strike a balance between the number of factors.

Senator Moss. I appreciate that.

Let me ask a question on just one point then. It fits in with something that has concerned us a great deal.

We have had a number of very serious fires, and a great loss of life in nursing homes, especially in intermediate care facilities recently, and my subcommittee held a hearing on many of those.

FIRE SAFETY STANDARD

Now, in these proposed regulations, the Life Safety Code of the National Fire Protection Association 21st edition is mandated as the fire safety standard, and this is very good.

In fact, I introduced the bill more than 2 years ago to require this, but I am distressed at the generous waiver provisions. The standard may be waived, and I am quoting now from the proposed regulation, "if it causes unreasonable hardship to the facility". Whatever that means.

Can you comment on the waivers of the Life Safety Code authorized in the regulations?

Secretary WEINBERGER. I would first like to say that this matter is one I am concerned with, and have been for many years, and I became aware of the very good work and the extensive knowledge your committee has developed with respect to flammable fabric and other things that go into these homes. We became extremely concerned about the problems involved in this kind of material used in these homes, particularly with people who naturally would have a very difficult time in getting out, in the event of a fire.

This kind of waiver provision generally has been felt desirable in other situations, because I think you do need a degree of flexibility, I think you do need to recognize that some local situations may have different facts surrounding them, and different conclusions should be drawn, but certainly in a matter of this kind, it would obviously be used very sparingly if at all.

Dr. CALLENDER. I think the important thing to look at in reference to the waiver on the basis of unnecessary hardship is that any waiver of any requirement of the Life Safety Code was adopted for the ICF's from the same provisions as for skilled nursing facilities. They are the same codes. Most important, they further require that waiver cannot be made if that waiver represents a hazard to the health and safety of the patients.

Senator Moss. And just one final thing.

Speaking of the mentally retarded, the regulations allow waiver of the Life Safety Code, I quote, "for residents who are in the opinion of competent medical authority capable of exercising average judgment in taking action for self preservation under emergency conditions."

I wonder what an average judgment would mean to the mentally ill.

Dr. CALLENDER. The section you are referring to, with regard to the Life Safety Code, was a part of the section that took cognizance that certain persons who are mentally retarded might benefit by a sort of a halfway house, or a small community housing unit, rather than being in a larger institution for a longer period than necessary.

We tried to strike a happy balance and a safe balance for these persons recognizing that this might be better care, and recognizing these kinds of facilities might not, if we were going to make that kind of facility available, meet the conditions of the life safety codes, that language is for safety factors for those persons who might benefit by that place of care.

Senator Moss. Let me express my compliments that you are finally moving in this long neglected area of promulgating regulations for intermediate care facilities. The regulations on balance I feel are reasonable, they could have been worse.

ICF's have been the focal point, the major part of our difficulties recently, with elderly people must be housed in institutional living, but, and I am just concerned that it seems to me the regulations are still pretty loose, and with a lot of exceptions in them; that concerns me, and we will want to make some comments.

Secretary WEINBERGER. We hope you will, sir.

Senator Moss. Thank you, Mr. Chairman.

Senator MUSKIE. Senator Eagleton.

Senator EAGLETON. Mr. Chairman, I want to commend you for holding this series of hearings on "Barriers to Health Care for Older Americans" and extend my welcome to Secretary Weinberger and the other witnesses.

Medicare in its early days paid approximately 50 percent of the total health care bill of our elderly citizens. Left uncovered were such major items as prescription drugs and long-term care.

Today, as a result of ever larger deductibles and coinsurance payments and of increases in doctors' fees not recognized by Medicare, this program covers only about 42 percent of the health care costs of the elderly.

President's "Cost-Sharing Reforms"

Now we understand that President Nixon will propose that Medicare beneficiaries pay a still greater share of their hospital and doctor bills.

Referred to euphemistically in the President's budget as "cost-sharing reforms," these proposals would in 1974 shift $1 billion in health care costs from Medicare to those elderly and disabled persons who need medical care.

Rather than 60 covered days of hospital care after the payment of a $72 deductible, the President will propose that an elderly person pay the full cost of his first day in the hospital and 10 percent of the cost of each day thereafter.

With respect to doctors' bills, where there is now a $60 annual deductible and 20 percent coinsurance payments for all remaining bills, the President will propose an $85 deductible and 25 percent coinsurance payments.

Mr. Chairman, all too many senior citizens are now hardpressed to pay for the health care they need.

Before they ever see their Social Security check, the part B medical insurance premium has been deducted from it. This now amounts to $5.80 each month; beginning July 1, it will be $6.30.

Yet Medicare pays nothing toward the cost of the drugs many of these elderly people require on a continuing basis. And every time they see the doctor, they must pay at least 20 percent of the bill. Where fees exceed those charges allowed by Medicare, they pay an even larger share.

Mr. Chairman, in my opinion the responsibility of this Congress is to find ways to decrease—not increase—the share of health care costs that the elderly must pay out of their own pockets.

We should, at the earliest possible time, extend Medicare to cover the cost of those prescription drugs required by the chronically ill.

We should eliminate the requirement that Medicare beneficiaries pay a monthly premium for their supplementary medical insurance.

And we should take a hard look at the role of deductibles and coinsurance requirements under Medicare.

Mr. Chairman, this series of hearings beginning today should be very helpful in identifying ways in which Congress can act to lower economic barriers to the health care older people need and deserve to have.

I do have a few questions for the Secretary.

Mr. Secretary, some people now pay more than 20 percent of their doctors' bills.

Allowable Charges Under Medicare

What percentage of claims for physicians' fees are in excess of charges allowed by Medicare?

Secretary Weinberger. I would have to get that information for you. I am told by Mr. Cardwell he thinks about half.

Senator Eagleton. How are allowable charges arrived at?

Secretary Weinberger. Mr. Hess has the detail on how this is done with reference to the standards, and so on.

Mr. Hess. Allowable charges are arrived at by considering the customary charges of physicians in an area, taking into account the

charges for specific types of comparable services, and determining on a statistical base what the prevailing charge is.

Briefly, what we try to do in determining the allowable charges is first of all to say that if the doctor's customary charge is such and such, and if this amount he charges for the service is no more than the prevailing charge in the locality, then we pay 80 percent of his actual customary charge.

If, however, his customary charge is more than the prevailing charge—say 75 percent of all charges that the doctors in his area charge for this service—then the prevailing charge becomes the ceiling on the allowable charge for this particular physician. There are provisions in H.R. 1 which now translate into law this method of determining prevailing charges which we have been doing for a couple of years by regulation.

Also, these same amendments provided for keeping increases in prevailing charges within reasonable limits by specifying that actual changes in the charges over any given period of time will be recognized only to the extent that they conform approximately to the general price increases for comparable services.

Secretary WEINBERGER. Senator, may I make one additional supplement to that.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

In the statement I made at the beginning, we referred to the professional standards review organization, and also the fact that health care costs generally remain under controls without the changes that other items in the consumer price index will be subject to in phase III.

The PSRO constitutes in my mind a major effort to try to insure not only that we do get proper quality control, and proper quality of medical care, and quite properly that is something that will be considered and discussed and worked on by the physicians themselves, since the Government is not an expert in delivering medical care, but the other thing about it is that it will try to establish standards so that it will give us a lot more relevant and effective and up to date information, so that we will be in a position, I think, to spot overcharges as well as overutilization, by the providers much more quickly than we are now. That is one of the goals I have.

Some people seem to think it is just designed to improve quality and therefore will shoot costs up. That is not the way we look at it. We think it has a very real set of hopes and goals which are much broader.

Mr. HESS. Senator, if I may just say, I answered your question with the thought that you were asking about physicians' fees under part B. Perhaps there was a misconception, or perhaps I only partially answered it.

If you are talking about hospital costs, about how we reimburse hospitals, this is on an actual cost basis, under a reasonable cost formula, not on a charge basis.

Senator EAGLETON. With respect to physicians' fees, what incentives are there to doctors to limit their fees to those actually allowed by Medicare?

Is there any incentive built into the law?

Mr. HESS. There is an incentive. There is a provision in the law, that if the doctor wishes, he may take an assignment.

I have to go back one step. Basically, the concept behind the medical insurance plan of Medicare is that we can indemnify the individual for charges incurred. Therefore, the individual gets his services and presents his bill and receives indemnification for 80 percent after the deductible amount.

If the physician wishes he may take an assignment, and many of them do, especially if it is a large bill. I think we get about two-thirds of all bills on an assignment basis. When the physician takes assignment, payment goes directly to him instead of the patient.

If he takes an assignment, then he commits himself not to charge the patient any more than the 20 percent of the allowable charge. Thus, he must adjust his customary fee downward if it is over the allowable charge if he wishes to take an assignment.

Senator EAGLETON. And you say about two-thirds of the bills are handled on an assignment basis?

Mr. HESS. Yes, sir.

Senator EAGLETON. Thank you very much, Mr. Chairman.

Senator MUSKIE. Senator Kennedy has some questions.

Senator KENNEDY. Mr. Secretary, I hope you will excuse me for having stepped out. I was meeting with a mayor from the Commonwealth of Massachusetts, Mayor Topier, about the impact of these very programs we are discussing this morning.

Some time ago, Mr. Secretary, we asked you for information about the basis of some of your proposed budget cuts.

For example, we asked for the level of spending to be expected in this fiscal year whether it would be the same as the last year in which an appropriation was passed, and you said yes, sir, and I asked at that same level; and you said that is the intention, that is what is set forth in the proposal. The only changes are those proposed in the budget for certain decisions and certain budget amendments, for which the Congress will have an opportunity to act.

PROPOSED TERMINATION OF REGIONAL MEDICAL PROGRAMS

Now, we have seen how you are phasing out the regional medical programs, which are aimed primarily at heart, cancer and stroke and affect the elderly people to a very considerable extent.

Secretary WEINBERGER. That is one of the problems. They are not targeted in the areas of greatest need at all, and that is one of the reasons the President has proposed termination for them.

Senator KENNEDY. Tell that to Dr. McBride in Maine, he has 8,000 patients; he has a small program up there tied into coronary care. He came down and testified very eloquently. What are we going to tell him?

Secretary WEINBERGER. I do not know what his point is. Does it affect the elderly very specifically?

Senator KENNEDY. Yes.

First tell us what you are going to do about the program.

Secretary WEINBERGER. With respect to the program itself, a very large proportion of the fund, of the regional medical program is going into providing what turned out to be continuing education courses for doctors well able to take care of their own expenses.

We feel there is nothing wrong with a continuing educational program.

Senator KENNEDY. Why not just eliminate that part of it?

Secretary WEINBERGER. Why not let me finish, and then I can go into some of the other points.

We do feel that would be a very desirable form of activity, but it is one the Government particularly insisted on in its desire to use fiscal resources in areas of greatest need, so if anybody wishes to continue the regional medical program, the portion of it that is covered by continuing education, that would be entirely up to doctors to start setting fees for time exactly as other professions do, that is a portion of it.

The other part of it is that the program initially in the heart, cancer and stroke areas was supposed to get into the communities of the country, in the regions of the country, a lot of information, material, and research activity on a regional basis, and that unfortunately has not worked out.

It has worked out so that regional medical programs for the most part, and I believe in Maine, have boundary lines that are exactly coincident with the State lines, and, therefore, there is an inevitable duplication and overlap which again results in wasting of Federal resources which the President would like to see corrected, and would like to see a better development in the area of greatest need.

Senator KENNEDY. Do I understand that doctors are taking advantage of the educational program?

Secretary WEINBERGER. I am not saying that. I was simply saying the doctors should pay for the continuing educational portion of it.

Senator KENNEDY. Why don't we amend it to provide that?

Secretary WEINBERGER. Then there is no need for Federal participation.

Senator KENNEDY. Do you know what Dr. McBride is doing with electrocardiograms in his project?

Secretary WEINBERGER. Then that is a direct-service project. That is not education.

Senator KENNEDY. What are we going to tell the doctor?

DUPLICATION OF FUNDING

Secretary WEINBERGER. I am going to tell him since his program is primarily covered not by the regional boundary, but by the State, that there is ample opportunity for him to apply for other kinds of funding that the Federal Government has.

Senator KENNEDY. What funding?

Secretary WEINBERGER. There are other kinds of funding throughout the Department that do not require the 40-percent wastage that goes into the administrative costs in the regional medical program. This is the kind of duplication we are trying to overcome.

Senator KENNEDY. Where should he go?

Secretary WEINBERGER. He can come to various areas.

Senator KENNEDY. Tell me specifically.

Secretary WEINBERGER. The mental health services.

Senator KENNEDY. Where within the health services?

Secretary WEINBERGER. The best thing for him to do is to drop me a note, and we can direct him. That gets the fastest service, Senator, and that is what I suggest he do.

The other thing I think is important to bear out; he has other State programs, and you have a high degree of wastage when you have 40 percent going into administrative costs.

Senator KENNEDY. I do not understand why we do not eliminate the administrative costs. You can cut the administration, but why cut the program?

Secretary WEINBERGER. You cut the program, because it covers areas that doctors should pay for themselves, rather than having the Federal Government pay for it.

Senator MUSKIE. If I may interrupt, and since you are talking about Maine, perhaps it might be appropriate for me to make a comment.

RURAL HEALTH CARE DELIVERY

In the first place, what this program is focused on in Maine is development of ways to provide health care delivery in a sparsely populated rural area of the State which has a shortage, if not a total absence, of doctors. I do not know what doctors are being educated up there in this program. There are none in most of these places.

Second, they have developed some imaginative ways of providing delivery for health care.

It is a relatively new program. Some good people have been assembled for the purpose, but the critical point to me is that early this year, they were told to dismantle this program before the Congress could even look at it, before there could be an evaluation of the kind you are talking about, and an evaluation of the program by the Congress, by the people served, by the area, by the doctors, as well as by HEW, so that any opportunity to build on what has been constructive—and my impression is there is a great deal more constructive in this program than your response suggests—rather than giving us the time and the opportunity to build, legislatively as well as administratively, on the constructive potential of this program, they are told to dismantle it, and they have no choice but to do so, because to continue payrolls beyond this fiscal year on the chance that somehow the Congress can find a way to reverse this Executive mandate, it is difficult for them to continue, under threat of continuing the burden themselves. They are just unable to continue if the Congress does not find a way to reverse your orders.

FUNDING NOT REQUESTED FOR PROGRAM

Secretary WEINBERGER. Senator, if I may respond to all of those points, in the first place, the notification was one in the President's budget that he was not going to request funding for this program, and certainly prudent administration requires——

Senator MUSKIE. Your notice was more specific than that, Mr. Secretary. It was a direct communication.

Secretary WEINBERGER. The direct communication communicates the decision reached in the President's budget and advises the participants that he is not seeking funding for the continuation of this program.

Senator MUSKIE. And then you dismantle the program.

Secretary WEINBERGER. The question of what you do when you know the President is not requesting funding for a program is certainly open to the recipient of that benefit.

Senator MUSKIE. It was accompanied by the positive advice to dismantle the program, Mr. Secretary.

Secretary WEINBERGER. I have not seen that specific notice. But he was told, and I am sure, everybody else was told, as to what the request to the Congress is, and under those circumstances, it is the Department's suggestion that there will be no funding for this program, because this is what the President has requested.

Now, in respect to the second point there has been——

Senator MUSKIE. Let us not leave that point so hastily.

The notification of the President's decision not to seek funding is accompanied, administratively, by a positive order to dismantle, definitely an order, a compulsion and pressure and a simple newspaper advice, the President is not asking for continuing funds.

Secretary WEINBERGER. The administrative arrangements that have to be made when a program is stopped are well known to you, Mr. Chairman, and they simply involve the requirement of advising people that a particular program is terminated.

Senator MUSKIE. That is the point. You advised them it is terminated. You are not even interested in whether or not the Congress confirms the administrative decision of the President.

Secretary WEINBERGER. Mr. Chairman, you have to do exactly the same thing, and we do it every time the Congress fails to pass an appropriation bill in time, so we have to notify everybody involved. I had to do it 2 years ago when I was at the Budget Office, because the Congress did not pass an appropriation bill, and I had to tell them they were working on grace and favor.

Senator MUSKIE. You issued your notification before the Congress is even given a crack in providing the funding you are speaking of.

Secretary WEINBERGER. I do not know of the wording of these specific notices, but I know generally, a program where the President had decided not to seek new funding, he may appropriately give notification to people participating in the program so they could make their arrangements accordingly.

Senator MUSKIE. I doubt that either you or I received the wording, because it was an oral notification over the phone so there is no way of reviewing what was said.

I know these people who run these programs. I have known them for a long time, and when they tell me something was said to them over the phone, I believe them, but what they were told is something far different from a warning, that since the President is not asking for this funding, and since the Congress has not had a chance to act, you have to take that into account in planning.

They were told to dismantle. That is a far different kind of a communication.

Secretary WEINBERGER. As I said, I have not seen any such notice.

Senator MUSKIE. Of course, I said you will not see it, because I have an idea this is oral, if my memory serves me correctly.

Secretary WEINBERGER. I gather you have not seen it either.

Senator MUSKIE. I do not have to see it to believe the man who told me he heard it.

Secretary WEINBERGER. Senator, I am not disposed to spend the morning arguing about the form of a notice.

No Congressional Review of Program

Senator MUSKIE. I am not talking about the form. I am talking about the very substantive question of whether you take a program like this, that is developed, with positive results, and by executive fiat, cut it off, without any adequate chance for congressional review, accompanied by pressure upon those who administer the program locally to dismantle, that is something far more arbitrary and final and compulsive than a form of notice. I am not quibbling about words, Mr. Secretary.

Secretary WEINBERGER. I also am not quibbling about words, Senator.

What was told those people, I am confident that they were told the same thing that everyone else involved in the other programs were told.

It is simply that the President had not requested funding for these particular programs, and it would be appropriate for them to consider that in their future planning.

You made one other point that I would like to comment on, that is the point that there would be no HEW evaluation of this program, and that is slightly wrong.

Senator MUSKIE. I said there is no congressional evaluation.

Notice was issued before there was a chance for congressional evaluation.

Secretary WEINBERGER. I had made a note that you included HEW.

Senator MUSKIE. The record will speak for itself.

But if I did, that is inadvertently said.

What I was concentrating on was an evaluation by the people up there so that they could make their plans, by the Congress, by the appropriate committees.

I am sure, as Secretary of HEW, you made whatever review you thought essential for your decision.

There is no doubt of what your decison is, what I am talking about is the responsibility of the right and the duty of the Congress and the people of the area to make evaluation.

You cut these things off, you do not give the State governments a chance to respond, nor the regional governments, you do not give the Congress a chance to respond and HEW does not satisfy these imperatives.

Secretary WEINBERGER. Nevertheless there is an HEW evaluation, and there are other evaluations within the executive branch, and three was a proposed funding to complete commitments made under tehse programs. The problem that we have been going over for some months now is simply that the President has not requested a continuation of this program.

If the appropriation process takes a different form, that will set a different set of circumstances. But the only way the President can indicate his desires in the required way by requesting funds of the Congress and the various activities is to indicate that he does not request them for the program. Measured against the long-term needs of the country, this has a lower priority, and the legislation expires on June 30.

The other point made earlier, as to where will these people go, if the patients of course are Medicare patients they will be covered by such things as the Medicaid program.

If they are elderly, they will be covered by the Medicare program, and then there are numerous authorities under the PHS Act, the Comprehensive Health Manpower Act, the National Health Institutes Act, the National Institute of Medicine, where various grants, applications can be received for specific things done by these regional medical programs.

One of the things that went into our thinking was that there are programs which, unfortunately, have not developed as we had hoped, when they started many years ago. We should have a true distribution on a regional basis of the latest technological skills in the medical profession.

We also think it is proper to note in this connection that the National Library of Medicine is doing very valuable work on a national scale of getting this latest information and technology out directly to the individual physicians without the necessity of going through a network, and at the same time losing 40 percent of the costs and all the rest of it.

President's Recommendation

Senator Muskie. Mr. Secretary, I just want to make two points briefly.

First of all, I am not talking about conforming to what we come to regard around here as the appropriation process, in which the President makes a recommendation to the Congress, and Congress follows on with its own review of the President's recommendation, and then a decision is made.

What I am talking about is what is set by this, as a very deliberate and sophisticated and well-aimed effort to short circuit that project administratively, so you have a telephone communication instead of a piece of writing that can be evaluated for this purpose. I am talking about what was received by this Senator as a deliberate process to shortcut the traditional appropriations, to put these decisions beyond effective reach of the Congress by having these programs dismantled before the Congressional appropriation process can be completed, and I have seen this in more than one instance. That is my first point.

Second, what we are talking about in this regional program in my State, is not simply the organizers of the admittedly scarce health resources in sparsely populated rural areas in my State and other parts of the country.

In areas where transportation is available to people who may live on islands, either islands in the ocean, or islands in the wilderness, to get that care and have it delivered to them, and that is the way people in Maine were approaching their responsibility, to find imaginative new ways to deal with that problem, and now you have pulled their feet out from under them.

Those are the points I wanted to make. Your position is on record.

Secretary Weinberger. I totally disagree with the first point you made, and, secondly, with respect to the second one, the purpose of the regional medical programs may have been something totally different.

The way it is working out, it is not to provide, or produce direct care to people who live in the rural areas. It is to provide a continuing education for doctors, in various areas of the country, and over 60 percent of the program went into education courses of less than 1 full day. So while it undoubtedly does have some general benefit in that area, it is not a service we feel the Government should provide for those participating.

Those are the only two points I want to make.

Senator MUSKIE. I suggest regional medical programs suggest broadness.

Secretary WEINBERGER. The point is it did not result——

Senator MUSKIE. My point is it was working that way in my State.

Perhaps you should have paid more attention to the Maine program and transferred its lessons and experience to a national basis rather than simply pulling its rug from under it.

Senator KENNEDY. Mr. Chairman, we might include this telegram at the appropriate place in the record, which in effect ordered the termination of not only the Maine program, but of other similar programs around the country.

Senator MUSKIE. Without objection, so ordered.

[The telegram follows:]

[Telegram]

DHEW,
Rockville, Md., February 1, 1973.

MANU CHATTERJEE, M.D.,
Program Coordinator, Maine's RMP, Augusta, Maine:

The President has submitted his budget proposals to the Congress. While the amount for fiscal year 1973 for RMPS grants and contracts is shown as $125,100,000, the actual amount available to the program for grants and contracts during the present fiscal year is $55,358,000. The actual reduction in the amount available is detailed on *page 384 of the appendix* to the official submission.

You are aware that we have been operating under a continuing resolution. Early in the fiscal year, 17 RMPS were funded for another year with start dates of September 1, 1972. This was followed by awards at the end of December to 18 RMPS with start dates of January 1, 1973. There remain 21 RMPS with May 1, 1973 start dates. By telegram on December 29, 1972, I advised the 18 RMPS with January 1 start dates that *because of the limited funds available, their awards were authorized only through June 30, 1973 funded at only half the amount established for one year. Similarly* with the limited funds available we have determined that *the 21 remaining awards with May 1 start dates can be extended only through June 30, 1973.*

No grant funds are included in the President's budget request for RMP in fiscal year 1974. Therefore, with no additional funds proposed to be made available in fiscal year 1974, and with the limited funds available this year, the above funding decisions were made to avoid the possibility of overobligating fiscal year 1973 funds. Further, in order to treat all 56 RMPS as equitably as possible and attempt to provide funds for the most critical situations, all of fiscal year 1973 grant awards will terminate on June 30, 1973. It follows, then, that the 17 grants awarded as of September 1, 1972, will receive amended awards reducing the budget period by two months with appropriate prorated funds. As stated above, all RMP grants will be terminated on June 30 1973.

It is our intention to permit grant extensions beyond June 30 but to no later than February 15, 1974. Additional funds will not be awarded except as determined necessary to adhere to the principle of equitable treatment. This would be to accommodate only those activities and program staff identified by the RMPS as requiring support beyond June 30, 1973 that cannot be terminated by that date due to need to finalize.

Necessary reports, publish findings, etc. Upon receipt of your plans by March 15, 1973, for terminating grant support, we will announce on April 15, decisions regarding redistribution of any grant funds available through adjustment of awards which can be used to phaseout RMPS support. It may well be that we will not be able to support much of what is considered essential by you because of the limited

funds available, your plan. Then, for beginning an immediate phaseout of RMPS support to be complete no later than February 15, 1974, should be developed and submitted to us no later than March 15, 1973. The plan should reflect the following requirements:

1. Do not enter into any new contracts or agreements for activities or personnel which commit RMPS funds.

2. Request continued support for only those activities requiring RMPS funds that will produce a predictable result justifying the Federal investment, or

3. Request continued support for those essential activities where a mechanism has been established to continue without interruption support of the activity from other resources.

It is requested that your plan be submitted in writing, accompanied by pages 1, 6, 15 and 16 of the application form 34–1, for phasing out all RMPS support by June 30, 1973, and a separate plan and set of forms for activities proposed for continuation beyond June 30, 1973, but in no event beyond February 15, 1974.

May I also remind you that your plan for phasing out operations must involve the grantee official and the rag in accordance with their responsibilities delineated in RMPS-NID dated August 30, 1972. Staff in the division of operations and development are available to consult with you in the preparation of your plan.

It is expected that all expenditure reports under this procedure will be received in RMPS by no later than June 15, 1974.

I am sure each of you recognize that in the light of the President's recommendations we need to proceed with the development of phaseout preparations in an orderly and prompt manner.

Senator KENNEDY. Secretary Weinberger, during your appearance before the Labor and Public Welfare Committee, you indicated increased coinsurance under Medicare was necessary to control utilization of service, and that this would not keep the people away who need care. We asked for studies to support this view, but have never received these studies.

Do they exist?

Secretary WEINBERGER. What was the question?

Senator KENNEDY. I am referring to the unnecessary utilization of medical care.

Secretary WEINBERGER. I think those were transmitted on March 2, in a letter to Chairman Muskie.*

Mr. HESS. Hand-delivered to the committee on Friday.

Secretary WEINBERGER. They will also be delivered to the other committees.

Senator KENNEDY. What are they?

Secretary WEINBERGER. This document that Mr. Hess just mentioned, and maybe Mr. Hess would like to go into more detail about it.

Mr. HESS. We have three published studies which we made available by hand-delivery to the committee staff on Friday evening, with a cover letter, in response to a request by this committee, and this information should of course be made available for the record of any other committee at this point.

Senator KENNEDY. We have not gotten it.

COST-SHARING PROVISIONS

You also indicated, in your appearance before the House Public Health and Environment Subcommittee, that cost-sharing features are recognized by private insurance carriers as effective means of utilization control. Can you tell me what insurance companies you include?

*See appendix 1, item 2, p. 88.

Secretary WEINBERGER. I believe the Blue Cross-Blue Shield study. This is the one cited in the paper a month ago.

Senator KENNEDY. Blue Cross-Blue Shield says it is not effective. They said if the coinsurance and deductibles are small enough not to create any financial hardship, then the two provisions of the coinsurance are nothing more than administrative nuisances and will hardly act as a control to overutilization.

Mr. HESS. The Blue Cross-Blue Shield study was a survey of some 50 to 60 plans, and their testimony was equivocal in the sense that there were some plans that recorded both statistical results and——

Senator KENNEDY. It was equivocal?

Mr. HESS. Yes.

Senator KENNEDY. What is the basis of your statement?

Mr. HESS. You asked what is the experience of insurance companies.

If you ask actuaries and people who sell both for commercial companies and Blue Cross, you will find many who will testify from their experience—and the fact they continue to sell these policies with deductible and coinsurance—they do think they serve a purpose.

Senator KENNEDY. What is the purpose?

Mr. HESS. The purpose is to cause the individual to be conscious of the costs that are incurred in connection with either an institutional admission or a physician's service, that may have some election to it, in terms of whether to get the service. Or more frequently, it is not a question of whether to get the service, but under what circumstances they will get it.

Senator KENNEDY. Does your program distinguish between elective and non-elective?

Mr. HESS. No; it does not. Our program, however, covers a broad spectrum of out-of-hospital services, so as to discourage in-patient hospitalization, it has provision for outpatient diagnostic procedures, posthospital care and outpatient procedures that help keep the costs down.

Senator KENNEDY. Does it have some effectiveness in keeping the premium down?

Mr. HESS. That is one of the factors.

BLUE CROSS-BLUE SHIELD STUDY

Senator KENNEDY. Can you quote the Blue Cross-Blue Shield; that is, bring me evidence to the contrary, where they say that this is a matter where they feel it is effective in terms of overutilization?

Secretary WEINBERGER. It is one that is quoted in the letter.

Senator KENNEDY. This is a major change.

Secretary WEINBERGER. This quotes the Blue Cross study.

Mr. HESS. Senator Kennedy, it is quoted in there; that is, a policy which the Michigan Blue Cross said that they sold.*

Senator KENNEDY. They said the beneficiary did not need the care, or that it just cut down on the demands for care?

Secretary WEINBERGER. All it said was that the system in effect without any kind of cost sharing had led to what amounted to unnecessary admissions, and when they put in a cost sharing, the admissions decreased, and when they removed the cost sharing, the

*See appendix 1, item 2, p. 88.

admissions and the length of stays increased, leading them to the conclusion that hospital stays did not have any relationship to medical need, but that they could be traced back to the free nature of the service which was then overutilized by the provider, not by the individual himself.

Senator KENNEDY. What is the basis?

Secretary WEINBERGER. This summarizes a study of considerable length which you have. The chairman received it by hand delivery, and it can be put in the record if you wish.

Senator KENNEDY. That was last Friday night?

Secretary WEINBERGER. Yes.

Senator KENNEDY. Is that the letter itself?

Secretary WEINBERGER. This is a letter to Senator Muskie.

Senator KENNEDY. Have we got copies of that?

Secretary WEINBERGER. That responded to a request from Senator Muskie of February 8.

Senator KENNEDY. That is the basis?

Secretary WEINBERGER. These are some of the studies. You asked for some of the studies. We have a lot of other studies and information gathered by our own people, which are summarized by indications that length of stays decrease when the cost-sharing program goes into effect, and when there is some kind of comprehensive utilization review. When these are imposed, there is a substantial reduction in the number of requests for hospitalization, made by the doctors themselves, and that is what I had in mind when I spoke about my hopes for the professional standards review organization.

Senator KENNEDY. No one is disagreeing you can keep people away.

Secretary WEINBERGER. No one is trying to keep people away unless there is a lack of necessity.

Senator KENNEDY. We are not questioning the ability of keeping people away. It is a question of who you are keeping away, and whether they have need which indicate they should not be kept away.

Now, does your study, or the study you submit get into that?

DOES UTILIZATION DECREASE WITH COST-SHARING?

Secretary WEINBERGER. Yes, it does, and it also emphasizes the fact that the utilization decreases when there is a cost-sharing feature, and when you take that cost sharing off, it increases, so there is a clear indication that there is need for a design of the program to meet the needs of the beneficiaries, but also to eliminate overutilization.

Senator KENNEDY. What about the kinds of sicknesses that those people have? Does your report say that not only does it reduce the numbers, but that the nature of people's sicknesses who are kept away are such that they should not be treated. Does it get into that?

Secretary WEINBERGER. I think it looks at all the forms of illnesses.

Senator KENNEDY. Do you consider this a major change in the whole Medicare program?

Secretary WEINBERGER. No, it is not a major change.

Senator KENNEDY. It is for the elderly people.

Secretary WEINBERGER. No, sir.

The cost-sharing features have been part of both private and public programs from the beginning, and what we are proposing is a continuation of the cost-sharing feature with a clear idea now of focusing Federal resources on those most in need, and of trying to remove

design features that are presently there, that encourage overutilization by the doctor.

Senator KENNEDY. By the doctor?

Secretary WEINBERGER. By the doctor, since they are the ones who order the care.

Senator KENNEDY. But it is the patient who will be paying for it, so you are blaming the patient?

Secretary WEINBERGER. We are not penalizing the patient at all. We are trying to insure the doctor sends the patient to the hospital when it is medically necessary, and not when it is not.

Senator KENNEDY. So you crack down on the patient.

Secretary WEINBERGER. There is no cracking down on anybody.

Senator KENNEDY. You are making him pay for it.

Secretary WEINBERGER. The Government is picking up a great deal of it, in the increased Social Security benefits, and in the other recently enacted provisions.

PATIENTS WILL PAY MORE

Senator KENNEDY. The patients will pick up more than they had before.

Secretary WEINBERGER. No; the patients will pick up a slightly larger amount on net, but we feel that is covered by the increase in monthly benefits that has been put in.

Senator KENNEDY. So the Congress gave it to them, the administration has taken it away.

Secretary WEINBERGER. No; not at all, but it will be a better program, a better medical system, a better hospital, and there will be the inducement to use it, when there is a real medical need.

Senator KENNEDY. Earlier this morning, we had a group down from New York that testified, and they did not complete their testimony, but one of the witnesses mentioned Mrs. Berthold Weiler's bill, from New York City. She quoted her, and they submitted this bill for about 4 days under special care.

[The bill follows:]

THE ROOSEVELT HOSPITAL
428 West 59th Street
New York, N.Y. 10019

Berthold Weiler
New York, N.Y.

Admission, No. 407152.
Code No. 122.

Admission, June 22, 1971.
Discharge, June 25, 1971.

For services rendered to: Self Amounts $——

(Please detach and return this stub with your remittance)

If Blue Cross, Approval is——Full and——Discount days Pr. Rm. Allow. $——

Posting date	Description	Date service rendered	Charges	Credits	Balance
	BALANCE BROUGHT FORWARD				
	4 days special care unit	$155	$620.00		
	30 days at $95.00 per day		2,850.00		
	Laboratory		746.00		
	Liver scan		90.00		
	X-rays		112.00		
	Infusions		20.00		
	Medical supplies		21.50		
	Drugs		57.20		$4,516.70
	Senior care coverage: Blue Cross			$60.00	4,456.70
	Medicare allowance			4,456.70	0

Senator KENNEDY. Do you know what the elderly people pay in intensive care when they go to the hospital?

Secretary WEINBERGER. No; I don't.

Senator KENNEDY. That happens to be $55 per day.

Secretary WEINBERGER. The average stay for the elderly is about 12 or 13 days.

Senator KENNEDY. Not according to the witnesses this morning.

Secretary WEINBERGER. Our national data indicates that the average stay would indicate intensive care is clearly the exception rather than the rule.

Senator KENNEDY. Well, they testified this morning, they said it was 22 days average in New York.

Secretary WEINBERGER. I might say perhaps fortunately New York is not the national average.

Senator KENNEDY. Well, what are you going to tell the elderly people in New York?

Secretary WEINBERGER. We are going to try to encourage doctors not to use hospitals, when the hospitals—the most expensive part of the system—are not required medically.

Senator KENNEDY. How does paying the actual first day's cost make sense? If you go to a hospital in Fall River, it is $56, and then in another place it is much higher, how does the patient distinguish between the two?

The people living in those communities do not have a choice necessarily: They must go where they live. What is the equity in that?

REIMBURSEMENT INEQUITIES

Secretary WEINBERGER. The inequity in that is one of the reasons we are seeking to change the system, because what we are seeking to do is to base the reimbursement on actual charges, not on some kind of national average. At the present time, some of the inequities you speak of, or your witnesses testified to, do occur, and we are trying to get a system where we get away from that, based on reimbursement on the actual cost involved, for the particular patient, not on the lump sum of a lot of figures, but rather on how it looks for that person.

Senator KENNEDY. Looking at the figures here, in New Bedford they would pay $56, and in New York Mrs. Wilder would pay $155. That is the way it looks to me.

Secretary WEINBERGER. That is not the way it works.

We will have a system which we believe will result in a far better type of situation for people who actually do need hospitalization, and we will not get these averages as badly as they are now.

Right here in Washington, D.C., the charges range from something like about $65 a day to $130 a day just within one metropolitan area, and what we are trying to do is look at it from the individual patient's point of view and the point of view of his actual medical needs.

Senator KENNEDY. Why should it be that when an ambulance brings you to one place, you pay more than if it brings you to another place?

Secretary WEINBERGER. In the Washington, D.C., area——

Senator KENNEDY. Under your formula.

Secretary WEINBERGER. Under the formula that we have, when you take the combination into effect, you will have a situation where

people will not needlessly be hospitalized, or even have to pay the amounts they have to pay now under the present system, but these will be shared in a way that will encourage less hospital utilization. In unnecessary situations we will have to rely on the people who actually make the decision when you ought to go to a hospital. We do not decide where we go or when. It is up to the doctor, and what we are trying to do is get a system that goes to the doctor, and indicates to him the desirability of using hospitals only when strictly necessary and looking at the patient's point of view in trying to get some kind of individual approach.

Senator KENNEDY. I understand, but we did make a request for supporting studies—and we have not seen these yet.

DRUG COSTS

Why did you not recommend under Medicare that they be required to give generic drugs instead of brandname drugs, and with that you could use that $700 or $800 million and devote it toward elderly people?

Secretary WEINBERGER. Senator, one of the problems, when you make statements to me, that such things to me are insignificant, since it involves a statement of what I think, I would strongly attempt to interrupt you at that point so the record would be clear.

These things are not insignificant to me. They are important. They are important in the way we have had abuses of the system which make it very difficult for a beneficiary who is really in need to get the best advantage of the program, and that is why I propose to make changes.

With respect to the generic drug term, that is a matter of detail with which I think the people who are instrumental in drafting some of these proposals can help you more properly than I can, but there is no desire to force the higher cost of anything.

There is a strong desire to secure a lower cost, and that is why we wish to have all health-care costs including drug costs under strict control.

Senator KENNEDY. I do not understand why you think these spokesmen for the elderly groups would be any less interested in making sure the programs directed toward the elderly will benefit them.

They quite clearly indicate to the contrary.

Secretary WEINBERGER. I found that a lot of people who are familiar with existing programs are very reluctant to consider any changes at all, because they have great worries of changes that may involve some disadvantage, and I do not think that is or should be the case, but it is understandable, and as I say, I do not attack anybody's motives or anything anybody has said.

We have a proposal of our own which we are presenting in a way we think is proper, and for the best possible motives.

Senator KENNEDY. Well, this hospital bill that was introduced this morning, under Medicare, this woman did not have to pay any of the expense; which she would have to pay under your program.

Under your program, under your formula, and it would come to quite a sum.

Secretary WEINBERGER. I would have to know more about that.

SIGNIFICANT JUMP IN COST

Senator KENNEDY. You can analyze it. It was zero for her under the present program, and taking your approach, it is not very complicated, it is $95 for the first day, and 10 percent of the difference for the rest of the stay, which is $435 for a total of $530. Under the present system, it would be zero.

Now, that is a very significant jump just for her.

I thank you, Mr. Chairman.

Senator MUSKIE. Senator Percy.

Senator PERCY. Mr. Secretary, sometimes I know when you appear before a committee, there is a majority and a minority, and you think you can rest when you get to the minority, you will have some friends.

This committee is organized as an advocacy committee for the aging. There is no divided opinion. There is no one on this committee that I know of who takes a position against the aging, or who tries to find ways to cut down their benefits.

Everyone is an advocate for more benefits for the aging.

Secretary WEINBERGER. Without interrupting, Senator, let me say the concern you expressed is fully shared by people on this side of the table.

There are different ways of reaching the same results, and we may differ from that point of view, but I do not think anybody here is against the aging. I am getting too close to it myself to be against it.

Senator PERCY. Because some of my questions may sound critical in nature because of the way cuts are being made, I think it is most appropriate to preface those questions with a statement.

I believe this administration has been doing and has accomplished a great deal for the aging.

Certainly in the area of nutrition, Senator McGovern stated that no administration has ever done more to close the hunger gap in America than this administration has, and you yourself, when you were Director of the Budget, have seen the escalating costs of nutrition feeding, a large part of which has been for the elderly, and we are trying to totally close that gap.

Secretary WEINBERGER. That is correct, Senator. All of those things are mentioned in the opening statement.

Senator PERCY. And some of the things done in the nursing homes, I have personally seen.

The crackdown has been made; uniform regulations have been ordered, and many of the bills we put in have been implemented by Executive order, long before we were required to put them into law. And the Office of Nursing Home Affairs headed by Dr. Callender has done important work in this area. So we have had a very sympathetic approach.

I have enjoyed my experience on this committee, because we have had a sympathetic attitude by the administration.

I think we also agree on the need to put a ceiling on the budget. Whether it is imposed by the executive branch, or by the Congress, is the only dispute.

I hope we take the initiative. I hope we put a congressional ceiling on the budget. Then of course, we will still have the problem of staying within that ceiling and of deciding priorities. The question this morning is: Can we afford to take anything out of this particular field of health care for the aging? And I think this is where we have our difference.

Increasing Health Manpower

In general, could you tell us what is being done about the overall health problem of having an adequate delivery service by increasing the number of doctors and nurses?

Do not the high hospital and medical costs really reflect our shortage of health manpower? What is being done to improve health delivery and to increase the supply of doctors and nurses, which is critically short, and also for dentists?

Secretary Weinberger. We do have a substantial number of programs, and our request is for that purpose. There is no doubt that one of the factors in the steep rise in costs is one of the reasons for the shortage of medical personnel and paramedical personnel, and we have programs designed to try to overcome that.

There are a couple of points which should be noted. This was not the only cause of the rapid rise in health care costs generally.

One of the other reasons is the point that I tried to make earlier this morning, about the overutilization that seems to be encouraged by many of the portions of the programs that are now in place.

Another reason, I think that should be noted in all of this, is that the operative here has to be needed. Every sick person does not need the most expensive form of care in the sense panoply of doctors, specialists, high-cost care and all of the rest.

This is not talking about quality. It is a matter of going to the needs of a particular person at a particular time, and so you do have a lot of factors that go into it.

On some estimates of needs at any time anyone would like to do so, he should have a doctor to consult.

You could produce figures showing a shortage of medical personnel. I am sure you could. I think you have to look at all of these factors. In trying to do that, what we are still satisfied with is that there is a need for an increased number of medical and paramedical personnel, and we have tried to do quite a bit about that. We have increased the number of medical schools through Federal assistance, we have added an increase in the number of first-year medical students from 10,000 to 15,000 in 1968, and the 1974 budget calls for $222 million, and grants for institutions training people in certain areas of shortage, capacitation grants, and what we prefer more perhaps is to help people in a massive way as we are trying to do so that those who wish to do so and are encouraged to do so, can continue on in the medical school and can at least get the college foundation that is necessary.

The new budget I think emphasizes as we try to do with a lot of other things, both new and flexible matters of training and utilizing personnel, thinking of their training through service and through scholarships, in trying to stimulate students into serving the public in underserved areas, that is important.

We have also made a further attempt to keep costs down, which is a big part of it, health care costs, and at the same time we are increasing the supply of doctors, we have held the costs down in phase III, we have exempted health care costs from any loosening under phase II.

We have the PSRO I talked about before you were able to come in, and those were organizations which we very much hope by going into these quality and necessary areas of treatment, will result in substantially lower costs.

We have $60 million in the budget to enable us to demonstrate whether or not health maintenance organizations, where they have preventive aspects, will be a significant factor in this, in producing the number of personnel necessary, and it can be cited that restrictions on Federal encouragement for unnecessary or duplicate construction of facilities is clearly in this category of trying to hold costs down.

The need for more personnel is recognized. We think we are doing something about it that will be effective.

Shortage of 22,000 Doctors

Senator Percy. Mr. Secretary, I have the figures here as to shortages, something like a shortage of 22,000 doctors, and there is a tremendous shortage of nurses.

Would it be possible to have more accurate figures for the record, a projection of estimated needs for the next 5 years, and an estimate of what programs the administration will bring forth, to give us an idea as to when in the future the gap will be closed?

Secretary Weinberger. We will be glad to do that. We will have the problem that there will be different people with different ideas of need, and there will undoubtedly be differences in the figures because of that, but we will get that together; projections as to what our increased requests are for both capitation grants as well as for student aid.

We have the further program, while there are shortages perceived now, there is a danger that we do not want to get into, that we get into with the training, specialized training for the space scientists, and for engineering, and for certain advanced graduate degrees, where we continued the Federal encouragement too long and not recognizing the gap that was required before the people are actually on line, we got ourselves into a situation where we have rather serious surpluses.

Senator Percy. I could not agree with you more.

We clung to these programs where they were not needed, we kept turning out young men and women for jobs that did not exist.

It is the same thing for teachers. I think we have to take a look at that kind of program and see whether or not we can develop a program that will give us the manpower that we need, and match it with the program. And I think if we could hold the record open for this information, it would be appropriate to insert at this point.

Secretary Weinberger. We would be glad to give it to you.

(A study of the health manpower needs is currently in process within the Department. As soon as this activity is completed, the information developed which is relevant to the committee request will be furnished.)

Overuse of Emergency Facilities

Senator Percy. Mr. Secretary, in another area, and in meeting with hospital operators, as administrators, I have heard one of the great complaints they now have is the tremendous overuse of emergency facilities. There are emergency rooms which are really being used as a substitute for family doctors who no longer will take home calls.

Could you give us any ideas as to what could be done here to reduce

this kind of pressure, turning it around? It is adding a tremendous cost to our hospitals, and it is a constant cause of complaint for them.

Secretary WEINBERGER. I think, Senator, it is all part of the motivation that went into our request for redesign on some of the reimbursement programs.

We found what apparently conforms with our concerns and findings, there have been a large number, too large a number of situations in which the doctor or the other person providing health care would turn to hospitals as the first line of treatment as opposed to the last or ultimate area for treatment. If you take a person who has some complaint, and the doctor feels he does not have time to make a local call, but knowing the system takes care of everything, he said you go to the hospital for a few days, and when I get around to it, I will see you there. You do have a system which does involve a very substantial overutilization of the most expensive kind of care, and in many cases the necessary kind for the people who really need a health facility.

I do not mean it in any way as criticism of the doctor. I mean it as criticism of the system which seems to encourage us turning to the hospital as an area of first resort rather than as last, and we believe and hope that some of the changes proposed will discourage that kind of overutilization.

Now, we also have a lot of the comprehensive incentives and various family and neighborhood health centers which we hope can take the place of that as an area of reference for cases of that kind.

DUPLICATION OF RESOURCES

Senator PERCY. One last question; I wonder if HEW is helping to develop a program to encourage—and here the Government can act as a catalyst—to encourage hospitals to pool certain resources. For example, where they each have a heart unit, but are close to each other, can they combine and pool those resources? And is there any program underway to help hospitals in their administrative procedures which seem so costly, cumbersome, and duplicative, to help give them better management?

Secretary WEINBERGER. It is a major point. It is one I happen to be specifically interested in. I served for a time on a comprehensive planning agency in California, and in a private capacity on health facilities planning groups, and we ran into many situations in which hospitals there were each trying to make themselves specialized in areas of treatment for a wide range of diseases and illnesses, and as a result there was a substantial amount of duplication and unnecessary high costs because a lot of hospitals were all providing things as obstetrical care within a very short area, and a lot of the units were half empty. Whereas we were finally able to persuade them to concentrate on specialties and operate on first a local and then a regional basis, and you had a welcome change in this kind of situation. I think it is a very important point, and we are trying to do it through the comprehensive health planning review. We are trying to do it through the amendments which came in last year, which will disapprove of certain expenditures for hospital facilities not recommended by local comprehensive health planning and other groups, and I think we have to do it.

I think we have to say, we are well beyond the point where every hospital in every city can be a specialist, and can be an expert in the treating of such disparate types of illnesses and injuries as burns, heart, pediatrics and obstetrics, and things of that kind.

We have to get individual hospitals that tend to specialize in these cases and through proper arrangement with the medical professions and the hospitals and all of the rest which we worked out in San Francisco, to get an ability to treat patients at these single specialty hospitals to a greater extent than we are now.

We are doing a lot, because we recognize this is one of the principal causes of the skyrocketing cost of hospital care.

Senator PERCY. Mr. Chairman, with your permission, I would like to summarize the remaining questions that are in my mind, and the Secretary can submit answers to them for the record if he chooses, so I can yield back to you. I thank you for this time I have had.

Mr. Secretary, I can just simply reflect back to you as a catalyst, and I suppose serve as an advocate for the elderly and to convey their deep concerns to you, and I know you are just as interested as I am in having their viewpoints.

The administration has reconsidered cutbacks in one area—veterans' benefits—because more facts were brought to bear on this situation.

There is going to be some give and take in the budget cuts.

I fully support many cuts that have been made in this budget. I support the concept of a ceiling, and a responsible budget, and I would like to suggest other cuts that I think can be made and should be made, because I do not think it is wise for us to, say, add $800 million to the budget when we would like to see a ceiling. We have to suggest where the money can be taken out of someplace else to be responsible, and I will certainly do that.

NINETY-TWO PERCENT OPPOSED TO MEDICARE CUTS

In the area of reasons why cuts should not be made to this extent in this area, I have had presented to me a Harris poll where 92 percent of all people indicated that they opposed a cut in Medicare benefits.

That is not just the elderly people. Those are young people also, who feel the extra costs should not be thrown on the shoulders of the elderly. They just cannot see that.

Secretary WEINBERGER. The Harris poll that you cited is one that gave me deep concern from the point of view of accuracy. That is the same poll that asked the question, as to what people thought of the administration's plan to cancel the Head Start program, whereas in fact we are increasing the funding for the Head Start program and have no intention of canceling it.

So when I am faced with a poll that asks a question like that and then reports the results of the kind you report to me, my worry with regard to that poll goes to the misinformation being spread around the country by those pollsters and by the announcement of that result rather than the substance of their findings.

Senator PERCY. I agree with you on that one particular point on the Head Start. I brought in to work every single morning a suitcase of mail—somehow my address at home got out in connection with this issue—a suitcase of mail comes in every morning on that issue. I

answer the people right back, saying they are misinformed about Head Start cuts, but here in the case of Medicare, they are not really misinformed: There are some cuts. I think everybody pretty well understands the nature of those cuts.

I have had many people say we appreciate the 20-percent increase in Social Security, but as we anticipate our health-care costs, this will wipe out that increase.

Others have made the point that the doctors, not patients, really control admissions to hospitals, lengths of stay, and the services provided. And generally speaking, I hear people say, "I do not want to go to the hospital, I do not want to stay in there any longer than I have to. But if I have to go then I must go. I fear being wiped out by these additional costs." And those are the kinds of people that are writing letters on this particular issue.

Secretary WEINBERGER. We are concerned, and we do not want them to be ordered to the hospital.

As you say, many times it is against their will, simply on the assumption that the easiest remedy for the provider is to send them to the hospital.

INCREASE IN ADMINISTRATIVE COSTS

Senator PERCY. Others have pointed out, Mr. Secretary, that if this Medicare cutback goes into effect, it will result in a transfer of money out of one pocket into another. Private insurance will have to be resorted to. It will merely result in a transfer of expenditures in this case. Also, the increased deductibles coinsurance features may add to administrative costs, and sometimes result in dual coverage. So for that reason, people feel the savings that have been shown in the budget are not really true savings.

I certainly do appreciate your responses, Mr. Secretary. I am sympathetic with the problems you face, but I think you know it is our duty to try to see that these cuts do not come out of the hides of those that have been discriminated against.

A tremendous amount has been accomplished in helping the elderly in recent years, but there is serious concern on our part that this is not the right place to cut. So we appreciate your being here this morning.

Secretary WEINBERGER. Thank you, sir.

Senator MUSKIE. Thank you, Senator Percy.

Mr. Secretary, we held you a long time. I still have points I would like to see covered by this testimony. I will try not to hold you too much longer.

First of all, I agree with you, there are times between witnesses and committees, where they seem to deteriorate into a challenge upon motives and that no purpose is served.

Those elderly citizens who believe the administration's proposals will mean an additional squeeze on their incomes, the quality of the motives are certainly there.

For those who believe as you suggest, what is involved is an improvement with respect to their incomes also, it is irrelevant that we go into those things, but what we do try to get are the facts, and I would like to mention a couple of facts that have been presented to the committee today, and to give you a chance to comment clearly on them.

We did have testimony from people in New York City, and we felt they had extensive experience in this field that was appropriate, and they gave us their experience in their testimony in these hearings, so among other things, we were told the costs, given the impact on the average length of stay of older people in New York City, that figure is 21 days, and the net impact of the administration's proposals is that under the present provision, they would pay for the hospital, $72 out of their own pocket.

Under the changes proposed by the President, in his 1974 fiscal message, the same stay would cost the older patient $330.

This is more than four times as much as previously, and to say it another way, 358-percent increase out-of-the-pocket costs for the typical hospital stay. That is fact No. 1.

Fact No. 2, I refer to it, I was referring to it when my time ran out before.

You expressed concern in your statement for the patient who stays longer than 60 days, from 60 to 90 days, and then for 90 days, and above that.

According to your analysis, up to 90 days, the administration's proposal means an increase in costs over the present program as indicated earlier.

I will put that chart in the record. **[See chart 9, p. 116.]**

I take it that you are also concerned about the long stay, the effect of the administration's proposal, and that it is not just limited to those who stay beyond 90 days, not to those who stay beyond 60 days, and I understand with respect to those who stay beyond 90 days, they are only one-tenth of 1 percent of the Medicate patients, of those that go into hospitals, so that seems a fairly small target for such a massive change in benefits.

Secretary WEINBERGER. I think the one point should be made here——

Senator MUSKIE. May I finish my presentation?

That would be involving a very small percentage.

The third point is what is the rationale.

Now, I do not think that has been pinpointed very sharply. You say its purpose is to reduce overutilization. You hasten to add that you are not meaning to suggest that elderly citizens go to hospitals more than their health requires. You are suggesting that you are not being critical of the doctors who tend to overutilize, you suggest that really, in some undefined way, this will result in less utilization and less costs to the patient, and then you refer among other documents, to the documentation sent to this committee by the Commissioner of Social Security, dated March 2, referring in part to Blue Cross-Blue Shield surveys.

The paragraph in that letter referring to the Blue Cross-Blue Shield study reads as follows:

> The Blue Cross-Blue Shield study indicates in part that imposition of a 25 percent coinsurance on hospital stays by one plan which previously had no cost sharing was accompanied by a 10 percent decrease in hospital admissions and a slight increase in length of stays, suggesting that the admission reduction was in the shorter stays. When this coinsurance was removed subsequently, admissions and length of stays increased.

Now, that paragraph very inadequately portrays the substance of that Blue Cross-Blue Shield survey, so I would like to call to your attention, or to make clear in the record that the poll's major points have not as yet been referred to in this hearing.

Five Major Points

These are the poll's major points, as described:

1. High deductibles and coinsurance have a definite effect on utilization but the extent of the effect is hazy.
2. A deductible or coinsurance feature could be large enough to prevent a person from seeking needed care. (It also was noted that these features could restrict utilization on some elective cases. Postponement of treatment on these elective cases could, of course, lead to complications that could result in more expensive treatment plus more physical discomfort.)
3. If the coinsurance or deductible is small enough not to create any financial hardship, then the two provisions are nothing more than administrative nuisances and will hardly act as a control on utilization.
4. When offered the opportunity, the public will select more and more comprehensive coverage over those plans that include deductibles, coinsurance or copayments—even if the latter cost less. (A dramatic illustration of this is in the Federal Employees Health Benefits Program where 90 percent of the Blue Shield and Blue Cross enrollees in the program chose the high option contract with broader benefits and lower deductibles and coinsurance rather than take the low option plan.)
5. More Blue Cross than Blue Shield Plans offer contracts containing deductibles, coinsurance and copayment.

Now, those points, those five points, and there is much more to this, and I have included the whole survey, suggests that the case for what you are doing may deny needed care to those income groups that need it the most, and it is for that reason that this committee has chosen to focus on this administration's proposals, and I am persuaded at this point that I just think when you talk about the program, which covers only 42 percent of the health care costs of the elderly, that the argument by reducing that figure, you can somehow create a motivation on the part of providers of service, doctors, hospitals, to further reduce hospital stays at the cost of the elderly is not a very credible argument.

How do you plan to reduce that 40 percent, is it to zero, before you finally persuade doctors that the patients they are sending to the hospital cannot afford it?

How much must you reduce it before you can persuade hospitals that they ought not to receive patients, because they cannot afford it. Then another point that I think was very hazy, as a result of this morning's testimony, is the alternative, you said over and over again, that you are trying to reduce utilization, overutilization of hospital care, because in many, many cases, this is not the answer to elderly citizens' health care needs.

Escalating Costs Beyond Ability To Pay

We heard testimony this morning describing this in human terms. There are no alternatives for many of these people, so what do you do, leave them at home, by escalating the costs beyond their ability to meet it, and persuading the hospitals and doctors that they ought to be left at home, because they cannot afford it?

These are the issues. We are concerned about the impact on these people. Maybe I have not listened to you closely. I do not know. It

seems to me that what we are arguing here is that by increasing the burden on the senior citizen, that you increase the motivation on doctors and hospitals to send these people to hospitals, even though that may be the only place that anything approximating the health care they need can be gotten.

Now, with that long question, I will yield and let you answer it.

Secretary WEINBERGER. Senator, our time ran out, I guess about a half hour ago, but let me be as brief as I can on it.

The figures you cite about the numbers, the small numbers of people that have long hospital stays, and the large number of people that have short hospital stays, are figures that actually show, I think, some of the reasons why it is felt that changes of the kind we have made should have been proposed.

I do not think those figures reflect anything at all about hospital needs or medical needs.

What they reflect is the knowledge of the fact that the first days are at zero or low cost for most individuals, and after lengthy stays as is indicated, the costs rise, and I think you will find, in many cases, the doctor is aware of it, and others aware start moving people out of hospitals, at the point where it starts to cost something to the individual. For that reason, we think that a system which recognizes the true medical needs of these people is a far better type of system than one that encourages overutilization. You and I can argue and discuss about the nuances of various reports, some of which are made up by some of the Blue Cross-Blue Shield people, who have some interest in this, and some of which are made up by others who have other interests, and all of the rest. But the simple fact of the matter is, I think, the whole picture, that we have of hospital utilization, and hospital costs that have gone up since the Medicare and Medicaid programs came into effect, demonstrated that there has been a much too easy turning to the hospital for the first resort, rather than using the hospital as an area of service, as a last resort. The fact that these figures show that some few people stay longer than these 60 days does not bear at all on whether there is any medical need to do that. These are just naked figures.

What we are interested in is the actual medical needs on both sides, hospitalized or nonhospitalized, and we want to get away from a system that encourages the providers of health services to order a hospitalization at a time when it is not needed, and then be forced by the economics involved to move a person out of a hospital at a time when he may urgently need it, far more so than in the other situation.

I am glad you made the point about the motives. That is certainly an important point to have in these situations where there are a lot of differences as to which is the best way to reach the same goal.

Senator MUSKIE. Let me close with just this, you say that you are for a system that recognizes real medical needs, and that is an objective we all share.

I just do not believe your proposal will lead to that.

Second, we are talking about more than just figures. We are talking about human beings, and they are not just statistics.

They are people charged with administering the needs of the elderly, and they know them in human terms, not statistics.

Finally, let me say with respect to utilization, I think the statistics show that the people who overutilize hospitals are not the people of these low-income categories; they are the affluent. It is their doctors that encourage them to use hospitals when they do not need them, and as a result use up hospital beds, drive up costs to the detriment of those low-income people.

I have simply not been given anything by this administration or anybody else that persuades me that there is an overutilization by the poor, the elderly poor, in such a massive scale, and that we have got to cut $700, $900 million.

Five Hundred Million Dollars Saved?

Secretary Weinberger. The figure is $500 million. We have had that misstated three times.

Five hundred million dollars is the amount that is supposed to be saved if the changes in utilization are passed.

The other is changes that do not affect the individual.

Senator Muskie. I will then take the $500 million figure.

It is still excessive, and I do not think it is justified, and it is not worthy, the $500 million does not go under your program to those who are going to be in hospitals 60 or 90 days or longer, but it goes to the budget.

Secretary Weinberger. Going to the people in general, I think, is the way to save.

Senator Muskie. It does not go to those individuals in hospitals.

Secretary Weinberger. It is a method of doing better at less cost to the taxpayers as a whole, and that is the purpose of it.

Senator Muskie. I thank you, Mr. Secretary, and I apologize for taking you a half hour longer than your commitment, and I appreciate your generosity in staying that much longer.

Secretary Weinberger. Thank you, Mr. Chairman.

Senator Muskie. We now call back Miss Alice M. Brophy, director of the New York City Office for the Aging.

CONTINUED STATEMENT OF MISS ALICE M. BROPHY, DIRECTOR, NEW YORK CITY OFFICE FOR THE AGING, NEW YORK, N.Y.

Miss Brophy. Thank you very much, Mr. Chairman.

Senator Muskie. Miss Brophy, I promised you that we would hear from you and your group again, and I wanted to so much, but I guess the fact is that time has sort of run out on us, but there are one or two points that you may like to emphasize, and now that you have heard the Secretary's testimony, that may help you to sum up your reaction to this morning's proceeding.

Miss Brophy. Mr. Chairman, I would like to respond to the issue of overutilization, which I think is the principal point made by the Secretary.

The point is that there are no such things as alternatives to either the doctor or the patient with respect to hospital care.

There are no diagnostic facilities in the community. Doctors do not make home visits.

In New York City, we have 200,000 home health aides, where we need 400,000 home health aides.

There are no alternatives so that the patient goes to the hospital, and when you consider what that person has to pay he will not go to the hospital unless it is absolutely essential.

I also think, Senator Muskie, the attempts to provide alternatives as was described in the situation in Maine which was terminated, that that certainly indicates that overutilization is certainly not a problem of the older people.

Thank you very much.

Senator MUSKIE. Thank you, Miss Brophy.

Mrs. Laufer, I believe you have a statement to make.

CONTINUED STATEMENT OF MRS. MAE LAUFER, SENIOR CITIZEN HEALTH CONSUMER, NEW YORK, N.Y.

Mrs. LAUFER. Thank you, Mr. Chairman.

I am going back to my area, because we have two senior citizen buildings that houses only the seniors.

Our senior citizens do not want to go to the hospital, and when taken quite ill and brought to the hospital, and I have specifics, I have names, they are sent home within three-quarters of an hour, 2 hours, 4 hours, the housing police have to come in and find them deceased on the floor, on the bed, or anywhere else.

This practice is going on all over the country.

I was aching to ask the Secretary what percent of the HEW funds go to the senior citizens. I can assure you it would not be more than 5 or 10 percent. I assure you, and I want you to know that senior citizens do not want to go into a hospital, including myself.

We want to do whatever we could, unless there is no alternative, and for a hospital to have 30 percent of the beds vacant and not accept elderly people, this should be investigated in this country. It has to be done every day.

Senator MUSKIE. May I say, Mrs. Laufer, I have an 83-year-old mother, and I know how difficult it is to persuade her to go to a doctor's office, let alone to a hospital, so there is no disposition on the part of senior citizens to go to a hospital as a way of getting a vacation, especially in view of the costs you have to assume.

May I express our appreciation for your testimony and your patience. I am sorry we did not get more time at the close, but I think we have a useful record, and we will build on it in the days and weeks ahead.

With that, this hearing is recessed. Thank you very much.

[Whereupon, the hearing was recessed at 1:40 p.m.]

APPENDIXES

Appendix 1

LETTERS AND STATEMENTS FROM NATIONAL ORGANIZATIONS

ITEM 1. LETTER AND STATEMENT FROM NELSON CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

NATIONAL COUNCIL OF SENIOR CITIZENS, INC.,
Washington, D.C., March 1, 1973.

DEAR SENATOR MUSKIE: Thank you for giving the National Council of Senior Citizens an opportunity to present our views concerning the Administration's proposed Medicare cutbacks.

The Subcommittee on Health of the Elderly is to be highly commended for speedily focusing on this formidable proposal as an initial step in its study of "Barriers to Health Care for Older Americans."

Attached are our comments—which we hope will not only be made a part of the formal record for the initial hearings but will be useful material from which you may wish to quote or draw upon in preparing questions for the witnesses.

In order to make this material available in time for the March 5 hearing, we have not attempted to respond specifically to your invitation to outline our views on subjects which your Subcommittee might explore at future hearings or in reports. I would call your attention. however, to my statement before the full Committee on Aging at its January 22, 1973, hearing on "Future Directions in Social Security." Focusing as I did on health programs, my statement encompasses the National Council's goals for health security for all the population and our recommendations for immediate improvements in Medicare and Medicaid. As one line of inquiry for your Subcommittee, I would recommend the proposal I made on pages 12 to 16 under the heading "Improving Medicare-Medicaid pending National Health Security."

You ask also in what ways the National Council of Senior Citizens might wish to participate in the Subcommittee's undertakings. We stand ready to help in whatever way we can in all future hearings and reports. Just let us know how we can be helpful in this important undertaking.

Sincerely,

NELSON H. CRUIKSHANK, *President.*

[Enclosure.]

COMMENTS OF THE NATIONAL COUNCIL OF SENIOR CITIZENS ON ADMINISTRATION'S PROPOSED CUTBACKS IN MEDICARE

The 3,000,000 members of the National Council of Senior Citizens reacted with dismay to President Nixon's budget message. We were shocked to learn that rather than improving the Medicare program along lines proposed by the White House Conference on Aging, the President proposes extensive cutbacks in the existing program.

After studying the President's proposal, the 50-member Executive Board of the National Council of Senior Citizens expressed the serious concern of the Council's membership in a resolution denouncing the drastic Medicare cuts "as an attempt to win favor with the well-to-do at the expense of the defenseless sick elderly of the nation."

Noting that President Nixon seeks to require Medicare patients to pay about three times as much as they now pay for an average hospital stay and a substantial increase in the personal payments required under Medicare medical insurance

(Part B), the Executive Board warned: "This means denial of needed health services to a vast number of men and women who can barely meet the present Medicare out-of-pocket payments."

We strongly believe the enactment of the President's proposal would constitute a most serious barrier to health care for older Americans!

NCSC'S VIEWS ECHOED BY THE NATION

This nation's elderly are not alone in their opposition to the President's proposal; they are joined in opposition by their sons and daughters who are currently making the payroll contributions for Medicare.

The National Council of Senior Citizens has always taken pride in the fact that its membership is concerned with the welfare of people of all ages, members or not. We have often said in testimony to this Committee and other Committees that our members place their responsibility as parents and grandparents before their own self-interest.

Medicare could not have been enacted without the wholehearted support of our younger working population who saw this program as protection badly needed by their aged parents now and by themselves in their own old age. Just as the population of all ages won the battle for the enactment of Medicare in 1965, the population of all ages can be expected to fight the battle against Mr. Nixon's proposed cutbacks. As evidence, we would cite the recent Harris Survey that showed that 92 percent of all people questioned about Mr. Nixon's various proposals for major changes in federal spending disagreed with his proposal to "make older people pay more than they now pay for Medicare"; only 5 percent agreed.

Of the various proposals, this was the one on which the population most strongly disagreed.

Although agreeing 2 to 1 that inflation cannot be controlled unless federal spending is cut to the bone, the public's response to cutbacks in Medicare and other needed social welfare programs indicates the President is very out of step with his spending priorities. In a related question, Harris also found an almost 3 to 1 public agreement with the recently increased Social Security payments. Clearly, President Nixon does not have a mandate to maim and kill basic social welfare programs!

The National Council of Senior Citizens is therefore counting strongly on the support of all our people in defeating the drastic cutbacks in Medicare sought by Mr. Nixon.

A "PAPER SAVING" FOR THE PRESIDENT'S BUDGET

But the public is not upset only by the proposed cutbacks; they are also upset because the elderly sick and the workers are being used by the President to effect a paper reduction in the budget deficit.

Mr. Nixon, while urging massive cutbacks in Medicare benefits for the workers' elderly parents, made no recommendation to cut back on the payroll taxes the worker pays or the premium the elderly pay to support the Medicare program. By maintaining the Social Security tax as it is, the President is making available as a paper surplus in his unified budget in effect, another $1.7 billion a year which is now going to support benefits that he proposes to abolish.

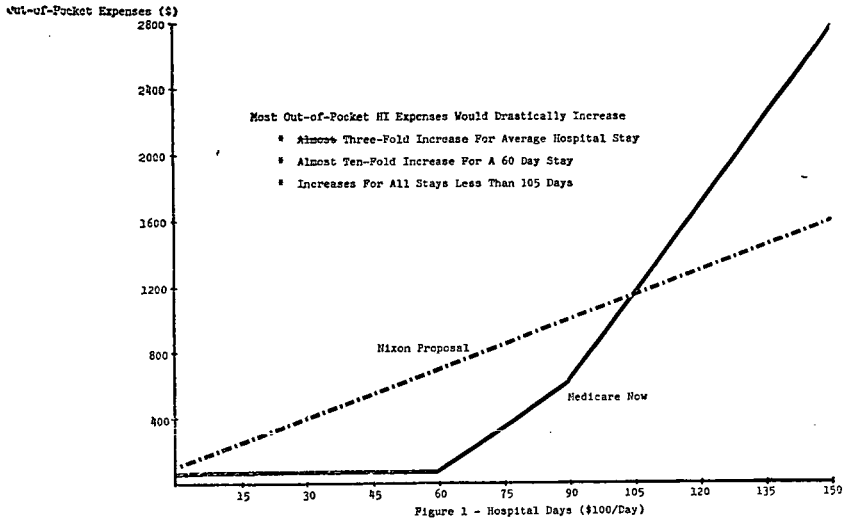
To be sure, Mr. Nixon cannot expend this money for anything else. But it is not being spent for the purpose for which Congress imposed the tax—and is therefore a deceitful misuse of the Social Security trust funds. It releases other money the administration can use to boost the Pentagon budgets.

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

THE PROPOSED CUTBACKS

As you know, under the guise of reducing what is termed "unnecessary utilization of hospital services," the President proposes that the present deductible of $72 for the first day under hospital insurance be increased to the actual first day charge for room and board. In addition, each Medicare patient would be required to pay a "co-insurance" amount equal to 10 percent of his subsequent hospital bill. In contrast there is no additional charge currently under Medicare for the first 60 days, $18 per day for days 61–90, and $36 per day for "lifetime reserve days" from 91–150.

The financial implications of such a change would be grave. This change would shift an additional burden of an estimated $345 million in hospital costs, during the last six months of Fiscal Year 1974, onto the backs of an estimated 5.4 million hospital insurance beneficiaries, or an average out-of-pocket increase of $64. Figure 1 further displays the incidence of this proposed cutback.



It is very significant to notice (Figure 1) that there is a sharp increase in out-of-pocket expenses for almost all hospital stays. (The great majority of hospital stays are well below 60 days in duration; only about 5 percent of the hospital insurance beneficiaries report total annual hospital days in excess of 60). Using the rounded-off current average hospital charge under Medicare of $100 per day, the President's proposal would provide relief for only the handfull of patients requiring hospital stays of 105 days or more. But for most stays the out-of-pocket costs would soar:

—three-fold increase for an average hospital stay, from $72 to $220 for a 13 day stay.

—almost ten-fold increase for a 60 day stay, from $72 to $690.

While providing relief to an extremely small number of patients, the Nixon proposal would have the accompanying disadvantage of removing the financial disincentives to utilize a hospital as a long-term care facility. This situation would occur because of the change from the progressively higher out-of-pocket per diems currently under Medicare to the President's flat rate of 10 percent.

Another criticism of the Nixon proposal is that the out-of-pocket hospital costs would vary across the country, in accordance with local hospital charges. In other words, in those areas where hospital charges are high, such as California, Northeastern States, and large central cities, a patient would have to pay significantly more for his hospital care than a patient in Wyoming or a rural area. The effect of various hospital charges on the patient's out-of-pocket expenses is illustrated in Figure 2.

Medicare patients currently pay the same rate for identical care, regardless of the hospital's normal charge. But under the President's proposal the out-of-pocket charge would vary among hospitals for identical care, since it would be always one-tenth of the hospital's normal charge. The President's proposal could result therefore, in a disparity between out-of-pocket expenses of as much as 150 percent for identical care in two different hospitals. The burden of this hospital coverage cutback would fall much more heavily on the elderly in high hospital cost areas than in low cost areas.

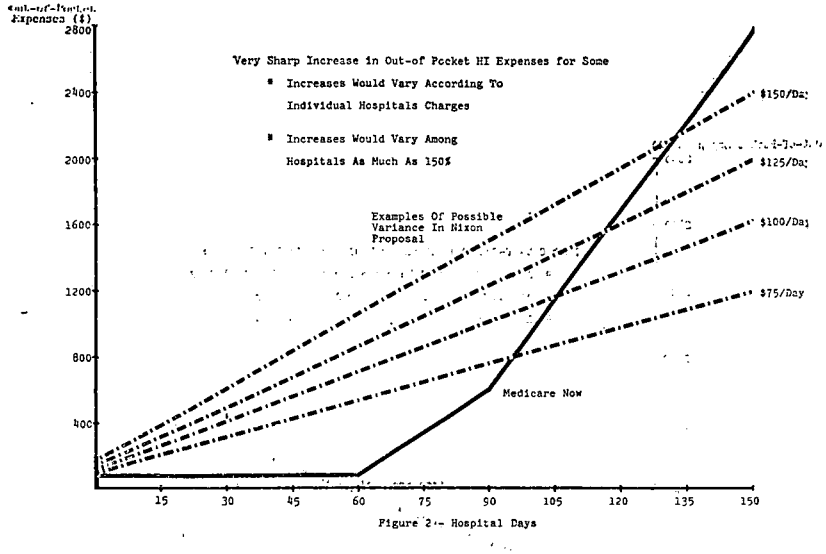


Figure 2 - Hospital Days

The budget message also includes less severe proposed cuts in the Supplementary Medical Insurance Program (Part B). The proposal would increase the deductible by 42 percent, from $60 to $85, and the coinsurance of the subsequent cost to the beneficiary by one-fourth, from 20 percent to 25 percent. The increased burden due to this change during the last 6 months of Fiscal Year 1974 is estimated to be $171 million for 11.6 million SMI beneficiaries, or an average out-of-pocket increase of about $15.

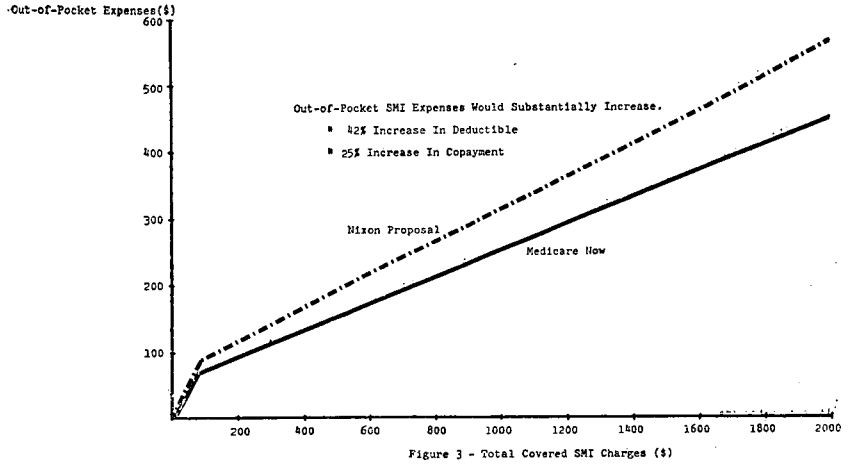


Figure 3 - Total Covered SMI Charges ($)

Figure 3 depicts the increasing personal burden which would be shifted to the elderly sick under the Nixon proposal for SMI. For example, a person with a $200 bill of covered medical expenses, now only has to pay $88, whereas with the Nixon proposal he would have to pay $113.75, an increase of 29 percent. Figure 3 clearly indicates that under SMI everybody would be a loser with Nixon!

THE RELATED PROBLEM OF ASSIGNMENT

A related problem is apparently not touched in the President's budget message—the erosion of SMI coverage due to the increasing refusal of doctors to take "assignment." Under the "assignment" method of payment the doctor agrees to accept the "reasonable charge" as payment in full. The proportion of doctors taking assignments has decreased in the last few years from some 60 percent to 41 percent and can be expected to decrease still further if Medicare is weakened.

Table 1 illustrates progressive erosion of Medicare coverage as the doctor's bill moves from "reasonable charge" (or assignment charge) to 10 percent above "reasonable charge," and to 20 percent above "reasonable charge."

TABLE 1.—MEDICARE NOW, ILLUSTRATIVE PERCENTAGES OF TOTAL CHARGES FOR COVERED MEDICAL AND HOSPITAL SERVICES REIMBURSABLE UNDER MEDICARE, BY SIZE OF MEDICAL BILL AND DAYS IN HOSPITAL (AT $100 PER DAY)

A—CASES WHERE THE MEDICAL CHARGE DOES NOT EXCEED THE "REASONABLE" CHARGE

Medical charges	Days in hospital					
	0	5	10	20	40	80
$50	0	77.8	88.4	94.0	97.0	94.0
$100	32.0	76.6	87.3	93.3	96.6	93.8
$200	56.0	77.1	87.6	92.7	96.2	93.7
$400	68.0	77.7	85.7	91.7	95.5	93.3
$800	74.0	78.5	84.4	90.0	94.2	92.7
$1,600	77.0	79.0	83.1	87.8	92.1	91.7

B—CASES WHERE THE MEDICAL CHARGE IS 10 PERCENT ABOVE THE "REASONABLE" CHARGE

$50	0	77.8	88.4	94.1	97.0	94.0
$100	24.7	75.5	86.6	93.0	96.4	93.7
$200	48.7	75.1	85.5	92.1	95.8	93.5
$400	60.7	74.5	83.6	90.5	94.8	93.0
$800	66.7	74.0	81.7	87.9	93.0	92.1
$1,600	69.7	73.5	78.6	84.6	90.1	90.5

C—CASES WHERE THE MEDICAL CHARGE IS 20 PERCENT ABOVE THE "REASONABLE" CHARGE

$50	0	77.8	88.4	94.1	97.0	94.0
$100	18.7	74.4	86.1	92.7	96.3	93.7
$200	42.7	73.3	84.5	91.5	95.6	93.3
$400	54.7	71.9	81.9	89.4	94.2	92.7
$800	60.7	70.3	78.5	86.2	91.9	91.5
$1,600	63.7	68.9	74.9	81.9	88.3	89.4

The reduction of Medicare coverage due to the lack of control over medical charges can be exemplified by the hypothetical case of a man who has received 5 days of hospitalization and $800 of Part B medical care. If the $800 is billed under "assignment," Medicare will pay 78.5 percent of his total bill. However, his coverage is eroded if that medical bill is 10 percent above "reasonable charge" to 74.0 percent, and only 70.3 percent if 20 percent above "reasonable charge."

The table also displays:

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

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

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

The disastrous combination of President Nixon's proposed Medicare coverage reductions and the increasing refusal of physicians to accept the "reasonable charge", that is to take "assignment", for medical care is graphically outlined on Table 2. Using again the hypothetical case of the man with 5 hospital days and $800 medical bill, under "assignment" in Nixon's proposal he would get further reductions to 68.9 percent coverage, 64.8 percent if 10 percent above "reasonable", and 61.3 percent if 20 percent above reasonable.

TABLE 2.—NIXON PROPOSAL, ILLUSTRATIVE PERCENTAGES OF TOTAL CHARGES FOR COVERED MEDICAL AND HOSPITAL SERVICES REIMBURSABLE UNDER MEDICARE UNDER TERMS OF CHANGES PROPOSED IN NIXON BUDGET BY SIZE OF MEDICAL BILL AND DAYS IN HOSPITAL (AT $100 PER DAY)

A—CASES WHERE THE MEDICAL CHARGE DOES NOT EXCEED THE "REASONABLE" CHARGE

Medical charges	Days in hospital					
	0	5	10	20	40	80
$50	0	65.5	77.1	83.4	86.7	88.3
$100	11.3	61.9	74.7	82.0	85.9	87.9
$200	43.1	63.8	74.7	81.7	85.6	87.8
$400	59.1	63.3	74.7	81.1	85.1	87.5
$800	67.0	68.9	74.8	80.2	84.3	86.9
$1,600	71.0	71.3	74.9	79.1	83.0	85.9

B—CASES WHERE THE MEDICAL CHARGE IS 10 PERCENT ABOVE THE "REASONABLE" CHARGE

$50	0	65.5	77.1	83.4	86.7	88.3
$100	4.4	60.7	74.0	81.6	85.7	87.8
$200	36.3	61.8	73.6	81.0	85.3	87.6
$400	52.2	63.2	72.8	80.0	84.5	87.1
$800	60.2	64.8	71.8	78.7	83.2	86.3
$1,600	64.2	66.1	70.7	76.0	81.0	84.8

C—CASES WHERE THE MEDICAL CHARGE IS 20 PERCENT ABOVE THE "REASONABLE" CHARGE

$50	0	65.5	77.1	83.4	86.7	88.3
$100	0	60.0	73.6	81.4	85.6	87.8
$200	30.6	60.2	72.6	80.5	85.0	87.5
$400	46.6	60.7	71.2	79.0	84.0	86.9
$800	54.5	61.3	69.2	76.7	82.2	85.8
$1,600	58.5	61.7	67.2	73.5	69.4	83.8

THE REAL EFFECTS OF DEDUCTIBLES AND COINSURANCE

Many studies have been conducted on the utilization of health services under deductible and coinsurance provisions. Common conclusions cited by these studies are that the only circumstance which leads to reduced utilization is when the deductible and coinsurance are set high. But at high levels they are found to create a financial hardship and discourage prudent health service utilization. On the other hand, smaller rates are nothing more than administrative nuisances and will hardly act as a utilization control.

PRESIDENT NIXON'S RECORD ON PART B PREMIUMS

Mr. Nixon, after repeated promises to eliminate the Part B premium for doctors insurance—a premium that will increase to $6.30 in July—now proposes to retain this premium while simultaneously making deep slashes in Medicare benefits.

Part B premiums bear heavily on the low incomes of older people who are attempting to insure against some portion of their medical costs. Since January 1, 1966, when the program began, premiums have more than doubled, an 110 percent increase. Coupled with the recent raise in the Part B deductible to $60, the new increase means participants in the voluntary program will have an annual out-of-pocket cost of $136 before they will get even limited reimbursement for medical bills.

Mr. Nixon first recognized the injustice of this burden in his 1971 Health Message when he proposed the elimination of Part B premiums. At that time he also proposed a decrease in Medicare benefits to make up the loss in premiums. He repeated his pledge to eliminate Part B premiums to a White House Conference that had made this an important plank in its recommendations for improved health security for the aged and again in his March 23, 1972 message on Aging. But by then he apparently intended that the loss be made up by raiding one of the Social Security trust funds of money needed to pay cash benefits or by increasing the Social Security tax on workers and employers. Needless to say, the nation's elderly would be worse off under these proposals, regardless of how attractive the President made them sound.

Again, Mr. Nixon in campaigning for reelection, and the Republican Party Platform made much of this proposal to eliminate the monthly premium required under Part B of Medicare—"the equivalent of more than a three percent social security increase."

In fact, the claims made for the President by the Committee to Re-elect the President in the pamphlet called *The President Cares* far outstepped this pledge, making it sound like an accomplished act. Lamenting the fact that the President had failed to stop the increase in medical fees, the pamphlet said:

"The $5.80 monthly premium for Medicare Part B (doctor) insurance is henceforth to be paid for by the government—worth another $1.5 billion to the nation's elderly."

The same pamphlet gave Mr. Nixon credit for increases in Social Security cash benefits, increases passed by the Congress over a threat of Presidential veto. But the falseness of the claims with respect to Part B premiums must have been evident to every older person who has to pay the premiums—and increasing premiums—every month. What he may not have known is that the President had never even proposed that this premium be paid for by the government.

And once reelected Mr. Nixon has withdrawn from his proposal for eliminating the premium. His proposal now is to continue this heavy burden on the older individual at the same time that Medicare benefits would be drastically slashed.

NIXON PROPOSALS FLAUNT WHITE HOUSE CONFERENCE RECOMMENDATIONS

Mr. Nixon, in his speech to the closing session of the White House Conference on Aging, promised that he would make sure that the recommendations of the December 1971 Conference would not gather dust in the National Archives. Right now the dust covering those recommendations must be inches thick. And his proposals for Medicare cut-backs not only ignore the recommendations for improvement but drastically reverse the course recommended by the Conferees.

One of the major recommendations of the Conference called for making comprehensive health care available to all Americans, including the elderly, without deductibles and without any other coinsurance or out-of-pocket payments, financed under Social Security. Pending National Health Insurance for the total population, the Conferees called for improvements in Medicare and Medicaid. Specifically, benefits should be increased immediately to include, at a minimum, out-of-hospital drugs; care of the eyes, ears, teeth and feet; improved services for long-term care and expanded and broadened services in the home and other alternatives to institutional care. There should be no deductibles, co-payments, or co-insurance under either program. Medicare should be financed through Social Security payroll taxes and a greatly expanded use of Federal revenues, not through ever-rising premiums paid by the elderly.

CONCLUSION

The President's proposal is clearly an attempt to strip the elderly of their hard-fought gains, to turn back the clock of health care progress!

Special note should be made of Nixon's tricky method of making the impact of his proposed cutbacks appear only half as bad as reality. The yearly added burden to the elderly sick is effectively twice what the budget suggests since the proposed changes would only be in effect during the last six months of fiscal year '74. The President wants, in effect, to cut back Part A and B coverage more than $1 billion a year! By including other cutbacks obscured in the budget message, the total added burden to the elderly is about $1.7 billion a year.

To add insult to injury, the President makes no proposal to pass this "saving" on to those who contribute to the health insurance trust funds. There is no attempt to use this budget "saving" to reduce the one percent hospital insurance payroll tax, raised in January from 0.65 percent, or reduce the announced increase in SMI premiums from $5.80 per month to $6.30, as of July, 1973. By maintaining the tax and premium, President Nixon is making available as a paper surplus in his unified budget another $1.7 billion in a year which is now going to support benefits that would be abolished.

We trust the Congress will never find acceptable this outrageous and unconscionable scheme to steal from the elderly sick and give to the rich, the Pentagon, and the special interests!

ITEM 2. COMMISSIONER BALL LETTER, WITH TAX STUDIES, INCLUDING BLUE CROSS-BLUE SHIELD STUDY

THE COMMISSIONER OF SOCIAL SECURITY,
Baltimore, Md., March 2, 1973.

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

DEAR MR. CHAIRMAN: This is in reply to your request of February 8 for background data and information concerning the effects of health insurance cost-sharing provisions on the utilization of health care services.

As you know, patterns of utilization of health services are subject to a variety of influences—including social and demographic as well as economic factors—so that the impact of one single element cannot be readily isolated from its interaction from the others. Nevertheless, there have been studies which attempt to measure the influence of cost sharing on the utilization of health care services. I am enclosing three relatively recent studies which we have found useful in our legislative planning activities. They include:

(1) The Effect of Deductibles, Coinsurance, and Copayment on Utilization of Health Care Services—Opinions and Impressions from Blue Cross and Blue Shield Plans, prepared by Blue Cross Association and National Association of Blue Shield Plans.

(2) Effects of Coinsurance on Medical Care Utilization, prepared by Mrs. Anne A. Scitovsky, Palo Alto Medical Research Foundation.

(3) Effect of Coinsurance: A Multivariate Analysis, prepared by The Rand Corporation, Santa Monica, California.

The latter two studies represent separate analyses of the same utilization and cost-sharing data and appear in the enclosed June 1972 issue of the "Social Security Bulletin."

The Blue Cross-Blue Shield study indicates in part that imposition of a 25-percent coinsurance on hospital stays by one plan which previously had no cost sharing was accompanied by a 10-percent decrease in hospital admissions and a slight increase in length of stays, suggesting that the admission reduction was in the shorter stays. When this coinsurance was removed subsequently, admissions and length of stays increased. In the other studies concerning utilization of physicians' services under a clinic plan which previously had no coinsurance feature, imposition of cost sharing on both inpatient and outpatient physicians' services led to substantial reduction in outpatient services and a smaller decrease in utilization of physicians' surgical and inpatient hospital services.

The possible impact of changes in cost sharing on patterns of utilization of the Medicare population will to some extent be influenced by their income situation and by current methods which these beneficiaries employ to meet existing cost-sharing requirements. At present, some 54 percent of Medicare beneficiaries have some form of complementary insurance to help meet the cost-sharing requirements of the hospital insurance program (part A). About 48 percent have some complementary insurance covering inhospital physicians' services but only about 15 percent have such coverage for outpatient services. Also as of July 1, 1973, about 3 million Medicare beneficiaries (aged and disabled) will be eligible for supplemental benefits under Medicaid.

I appreciate very much the generous comments you made about my government service in the *Congressional Record*. I hope that the enclosed studies will be helpful to your Committee.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

[Enclosure (3).]

BLUE CROSS AND BLUE SHIELD,
Chicago, Ill., September 28, 1971.

Subject: Survey on Deductibles, Coinsurance, and Copayments.

The Blue Cross Association and National Association of Blue Shield Plans recently surveyed all United States Plans on the effect of deductibles, coinsurance and copayments on utilization of health care services. The survey was conducted to determine whether the two organizations should continue their traditional emphasis on first dollar coverage or if there were indeed some beneficial aspects of deductibles, coinsurance and copayments.

Many proposals for National Health Insurance contain these types of provisions. For that reason, Blue Cross and Blue Shield feel the survey results are particularly significant.

The survey showed that Blue Cross and Blue Shield Plans believe deductibles, coinsurance and copayment do have a definite impact on utilization but the nature of that effect is hazy. It also showed that these three provisions could act as economic barriers to needed care, which would result in under-utilization of health care services.

A detailed report of the findings is attached.

Comments regarding this report should be directed to Margith Pachl, Research Analyst, BCA; or Joseph C. Krovisky, Director, Legislative Research and Reporting, NABSP.

ANTONE G. SINGSEN,
Senior Vice President, Research and Development,
Blue Cross Association.
LAWRENCE C. MORRIS, Jr.,
Vice President, Planning and Programming,
National Association of Blue Shield Plans.

THE EFFECT OF DEDUCTIBLES, COINSURANCE, AND COPAYMENT ON UTILIZATION OF HEALTH CARE SERVICES—OPINIONS AND IMPRESSIONS FROM BLUE CROSS AND BLUE SHIELD PLANS

Health insurance, and its influence on the way people use health care services, has been a controversial subject since maturing as a major social and economic factor in the mid-1930's. Numerous studies have reached general agreement that women use more services than men, urban populations use more than rural people, and usage increases with age among adults. With regard to health insurance, it's apparent the insured use more services than do the uninsured and, among the insured, utilization varies directly with the amount of coverage held.

Less clear, however, is the specific impact various forms of health insurance have on health services and their utilization. This is especially true of coinsurance, deductibles, and copayment. Several persons have investigated these areas and the results of their efforts have done little to clear the air of the confusion surrounding the use of these features. "Extremely difficult to quantify," "inconclusive," "further study needed," are comments that typify the conclusions of these investigators.

Michigan Blue Cross presented an example of the difficulties encountered when it compared utilization differences between its comprehensive and deductible contracts after noticing utilization under the deductible was 50 to 75 per cent of that under the comprehensive.[1] The study concluded that the central question—"whether the deductible, in itself is a real deterrent to utilization"—could not be answered from the available data.

These inconclusive and unsatisfying answers generated, in part, a study which surveyed all Blue Cross and Blue Shield Plans. The Plans were asked for information that would aid in determining what effect, if any, deductibles, coinsurance, and copayment have on utilization, cost, and selection of services. They also were asked for published articles or research data and, in the absence of such data, for their impressions based on experience. The responses were to be used as an instrument to re-evaluate Blue Cross and Blue Shield's position on whether the two organizations should continue their traditional emphasis on first-dollar coverage, or if there were indeed some beneficial aspects of coinsurance, deductibles, and/or copayment. Seventy-four Blue Cross Plans representing 73.8 million subscribers and 72 Blue Shield Plans representing 65 million subscribers were polled.

The survey results, not surprisingly, were mixed and emerged without a clear-cut picture or prevailing pattern of how coinsurance, deductibles and copayment affect utilization.

The responses were sprinkled liberally with these comments: "No specific evidence," "no valid statistics," or "some effect but unable to measure it." Therefore, it must be stressed that the tabulations accompanying this report represent, in large part, ideas and opinions on coinsurance, deductibles, and copayment and do not come from a solid data base. A coinsurance study by Indiana Blue Cross based on 1958 experience and a 1971 study by Pittsburgh Blue Cross on copayment are summarized in this paper.

[1] An unpublished study, "Deductible Contract Study," conducted by Henry F. Vaughn, Jr., of Michigan Hospital Service, Detroit, Mich., August 1965.

Several other Plans submitted comparisons of coinsurance, deductibles, or copayment with full coverage contracts, but warned that the comparability was limited by insufficient experience of the contracts containing coinsurance, deductibles, or copayment and other factors. For this reason, these comparisons were excluded.

However, the opinions expressed in this paper come from a variety of sources, spring from varying circumstances, and were formed after many years of Plan experience in working with, and keeping abreast of, contracts containing these provisions. If viewed in this context, they can be used to shed a little more light on an area that most health care professionals generally agree needs more study. The survey also brings together, perhaps for the first time, opinions concerning these three areas from Blue Cross and Blue Shield personnel from across the nation.

Historical Background

Before detailing the results of the study, however, it may be valuable to briefly summarize how deductibles, coinsurance and copayment came into being, the instances in which Blue Cross and Blue Shield subscribers are called on to pay part, or all of their health care expenses, and the theory supporting these types of payments along with the counter arguments.

In the early years of health insurance, Blue Cross and Blue Shield were the unchallenged leaders and their philosophy of service benefits (a contract benefit providing specific hospital or medical care rather than cash) and first-dollar coverage set the prevailing pattern. Major medical, which incorporated deductibles and coinsurance, did not appear until the 1950's. Gradually, the deductible and coinsurance features of major medical were extended to some forms of basic insurance coverage and other forms of health insurance. Coinsurance and deductibles have since been championed, in some quarters, as effective regulators of health care utilization although, as noted, there are little hard data to support such a conclusion.

The basic policy of Blue Cross and Blue Shield is to provide full coverage. However, subscribers may be called on to pay for part of their services under one or more of the following conditions:

(1) Indemnity—These contracts provide payment up to a set maximum per physician service or episode of illness, leaving the patient to pay for the remainder.

(2) Excluded benefits—These provisions exclude certain services, making the subscriber responsible for their payment.

(3) Copayment—These contracts require payment by the patient of a specified flat fee per day or service, either for full treatment or a limited number of days.

(4) Deductibles—These contracts have the patient pay for some initial part of the insured expenses of his health care bill, perhaps the first $25, $50, or $100.

(5) Coinsurance—These contracts call for a specified percentage of the insured expenses of the health care bill to be paid for by the insurer and the remainder by the subscriber. For example, 80 per cent by the insurer and 20 per cent by the subscriber.

(6) Maximum limits—These provisions make the subscriber liable for the payment of expenses above a specified dollar maximum, i.e., $10,000 or $20,000.

All of these provisions, of course, attempt to keep the liability of the carrier boundaries of premium income to cover the benefits of the contract.

Therefore, some Blue Cross and Blue Shield subscribers are faced with coinsurance and/or deductibles in their basic coverage while millions have these features in their supplemental coverage. The key question, however, is whether deductibles and coinsurance discourage the utilization of health care services and, if so, how much they discourage necessary service and how much they discourage unnecessary service.

Arguments for Coinsurance and Deductibles

Supporters of coinsurance and deductibles generally rest their argument on one or more of these points:

(1) They reduce the dollar liability of the insurer and the premium cost of the insured.

(2) Insurance should provide protection against big losses and, thus, small losses are more readily handled on a pay-as-you-go basis. This applies to deductibles only.

(3) They curb abuses by making the insured cost-conscious. Since the insured must bear a part of his health care bills, he is more likely to make a judicious selection of his health care service.

All of the arguments deal with the economic aspects of coinsurance, deductibles and copayment. However, the first two points rest on strictly theoretical arguments while the third point—which is the most important—must be proved with more than a theoretical argument—it calls for supporting data on the affect of coinsurance, copayment and deductibles on utilization.

The first two points, at first glance, lend credence to the idea that these provisions would not seem to be undesirable since all parties in an insurance contract would want to reduce their dollar liability, and probably subscribe to the idea that insurance should provide protection against big losses. But their main thrust is that people, in general, use an economic factor as their sole criterion in matters of health. This is hardly true. Psychological, personal and family considerations, among others, frequently outweigh economics in this area.

And these combined medical-social considerations lead to the heart of this report—do these features really make the insured cost-conscious and lead to better utilization of health care services? And this point—probably because less is known of its validity—is what stirs so much controversy about coinsurance, deductibles and copayment.

Charles P. Hall, Chairman, Department of Health Administration at Temple University, effectively summarized the conflicting view with these words:

> There is considerable evidence which supports the intuitive conclusion that these provisions (deductibles and coinsurance) do act as a brake on utilization, yet there are sufficient examples of no or negative correlation to cast a lingering doubt as to the exact role which they play . . . Because of the variety of deductible provisions in use and the seemingly infinite number of other variables which influence the utilization of health services—many of them uncontrollable—very little useful data are currently available.[2]

This point—the effect of deductibles and coinsurance on utilization—"still remains undecided," according to a study published as recently as October, 1970.[3] And, as revealed by the Blue Cross and Blue Shield survey, the controversy swirling around the issue of deductibles, coinsurance and copayment has not been resolved to the satisfaction of Plan personnel.

Survey Results

All Blue Cross and/or Blue Shield Plans were questioned, and 60 of the Plans responded. The majority of the answering Plans had offered or were currently offering contracts containing some form of coinsurance, deductibles or copayment. However, few had any hard data on hand that pinned down the effect of these provisions on utilization, or knew of the existence of such studies containing data that could be used in this report. Nearly all of the comments on deductibles, coinsurance and copayment were based on Plan experience with this type of coverage and reflect a distillation of that experience without supporting data.

The Plans' experience was exemplified in a statement made by R. M. Harrington, of the Watertown, N.Y., Blue Cross Plan, who wrote:

> We have offered a $50 deductible on our basic Blue Cross contracts for many years. The public seemed to demand one and the New York State Insurance Department practically insisted that we offer it. At first, a large number bought it and then we began getting requests to go full service. Now, very few people have the deductible and we have stopped selling it only because the demand is nil. I was never able to make any conclusion as to whether it was a deterrent to hospital admissions. Of course, it cut out all out-patient benefits, but I think only the people who believed they were good risks bought it. As soon as they had one bout with it, most of them did not want it any more. I think most people go to the hospital at the advice of their doctor and a small deductible has no bearing at all on whether or not they will go.

The deterrent affect of a high coinsurance and the public's desire for full coverage was further shown in a 1958 experiment Indiana Blue Cross conducted and furnished in response to the survey. The Plan's experience was with a 30 day non-group contract that covered roughly 30,000 people. The group was on a full service semi-private basis through 1957. Since the losses were great during 1957, the Plan converted all subscribers to a 75 per cent—25 per cent coinsurance basis, rather than keep them on a 100 per cent basis and install a large rate increase.

For 1958, the cost per day was almost exactly 25 percent below the expected trend position. The inpatient admission rate dropped about 10 percent for the

[2] Hall, Charles P., "Deductibles in Health Insurance: An Evaluation," *Journal of Risk and Insurance*, Vol. XXXIII, June 1966.

[3] Heaney, Charles T., and Riedel, Donald, "From Indemnity to Full Coverage: Changes in Hospital Use," *Blue Cross Reports Research Series 5;* October 1970.

same period, while average length of stay increased about 6 percent. Early in 1959, members in the group were offered the option to change to 100 percent benefits at a higher rate, and 93 percent changed to 100 percent coverage. Under the 100 percent benefit, the incidence cost per day, and average length of stay climbed steeply, in 1959, then made a more gradual rise in 1960.

Commenting on this experience, Harry Hineman, Plan Vice President, said, "It's my opinion that these results occurred because the coinsurance was quite large. I doubt that we would have had any savings from incidence if the coinsurance basis had been 90 percent–10 percent." This thought was echoed by W. G. Presson, Marketing Vice President of Arkansas Blue Cross and Blue Shield. The Plan's most widely held contract is a $25 deductible full comprehensive without any coinsurance, Presson said. "Our personal belief is that in the beginning the $25 deductible did affect incidence. However, we now feel that unless the deductible exceeds $50 it would have little effect," he said.

Robert E. Giles, Vice President, Development of North Carolina Blue Cross and Blue Shield, reported that the Plan's Board discussed these provisions generally and "the comments from various trustees indicated a pretty definite feeling that some patient copayment or financial responsibility for each day in the hospital does result in less utilization. What they meant was that the attending physician would be better prepared to resist the pressure of his patient to remain an additional day or more in the hospital when that was not medically required."

These comments, plus the experience of other plans, indicate that deductibles, coinsurance and copayment have a definite impact on utilization—if the subscriber pay-out is substantial—and they reduce plan pay-out by at least the amount of the deductible, coinsurance and copayment. The reduced Plan pay-outs, however, are off-set to some degree by the resultant increase in administrative costs. However, there is little real evidence to demonstrate the overall result of these features, i.e., whether they result in over-, under- or optimum utilization.

In a 1966 study, Robert J. Williams examined the relationship of full pay, deductible and copay coverage to utilization and costs of five Blue Cross Plans and concluded that a $20 to $25 deductible "had a minimal effect in reducing the utilization . . . Their chief effect seemed to be in reducing the admission rate but this may have been partially accomplished by the elimination of uncovered one-day stays. The absence of some one-day stays also contributed to the somewhat longer lengths of stay for deductible covered admissions."[4] This appears to lend support to the idea that the deductible must be large to affect utilization, a development that may lead to other problems.

Effect on Necessary Utilization

In the Blue Cross and Blue Shield poll, it was felt that, generally, large deductibles, coinsurance and copayment curb utilization but may constitute an economic barrier to needed care. James C. Brown, Senior Vice President of Blue Cross of Southern California, summed up this idea in this way:

> Even in the absence of actual experience, I would argue that it is self-evident that high deductibles, coinsurance or copayment features tend to promote under-utilization. My opinion is that this results only if these amounts are sufficiently high as to constitute an economic barrier to needed care. To put it another way, if it truly hurts to have to pay these amounts, then there would be a tendency to neglect needed care. If the amounts, on the other hand, are mainly token amounts and do not impose an economic barrier, then I would suggest that they have little or no effect on utilization. It is obvious on the surface that administrative costs have to be higher to some degree when these features are present. The mere fact of the additional calculation to determine the net liability is an added cost, although I would not argue that it is significant in comparison to overall administrative costs.

Statistics that validate to some degree the contention that deductibles might promote under-utilization are contained in a research bulletin printed by the Department of Health, Education and Welfare and cited by Pennsylvania Blue Shield.

The January 29, 1971 report, entitled *Current Medicare Survey Report*, investigates the distribution of Supplementary Medical Insurance (SMI) under Medicare for 1967 and 1968. The survey collected information on all medical services covered under SMI, except those provided to hospital inpatients by pathologists and radiologists.

[4] Williams, Robert, "A Comparison of Hospital Utilization and Costs by Types of Coverage," *Inquiry*, Vol. III, No. 3, September 1966.

The statistics presented in the bulletin seem to indicate that whites make greater use of the benefits of SMI than do nonwhites. In 1967, whites made up 92.9 per cent of total enrollees and had 96.9 per cent of potentially reimbursable charges, while nonwhites made up 7.1 per cent of total enrollees and had 3.1 per cent of these charges. In the same year, 58.6 per cent of the whites enrolled received no payments from SMI and 71.4 per cent of nonwhites received no payments from SMI.

If it is assumed that there are proportionally more lower income people among nonwhites than among whites and that the environment of lower income people often creates a need for medical attention, one can raise the valid question of whether the deductible and coinsurance might have discouraged lower income people from securing health care because they couldn't afford the $50 deductible nor the 20 per cent coinsurance. "In other words," says a memo highlighting the report sent by Arthur P. Keiser, Vice President-Sales of Pennsylvania Blue Shield, "deductibles and coinsurance may be in conflict with the objectives of the Medicare program." One of those objectives, it's noted, "is to relieve old people, especially the lower income class of the burden of excessive medical bills."

The memo concludes: "Assuming the above to be true and assuming that Pennsylvania Blue Shield strives to reduce the burden of health care bills by simply spreading the risk—then we would be doing the lower income people a disservice by utilizing deductibles and coinsurance in our insurance programs."

Copayment Demonstrates Little Effect on Utilization

In an effort to measure the effect of a copayment provision on hospital use as measured by five selected group indices, Blue Cross of Western Pennsylvania conducted a 1971 study on the effect of a copay agreement on hospital utilization. Two groups—one with the copay feature and the other will a full service benefit contract—were compared. In order to neutralize the effect of age and sex composition, the full service benefit sample group was drawn in the exact age-sex proportion as that of the copay group. The study compared the 1969 inpatient claims experience of the group having the full service benefit contract with another group with the same benefits but with a copayment of $5 per day for the first 15 days of inpatient hospitalization. Data were drawn from these sources: admissions per 1,000 subscribers, average length of stay, patient days per 1,000 subscribers, average benefit per day and benefits per admission.

As measured by the five indices, the study concluded that the $5 per day copayment had no significant effect on hospital use. Both average length of stay and benefits per admission were not significantly different (statistically) between the copay group and the control full-service benefit group.

"Of course," the report notes, "the results may have been different if the size of the copayment was substantially larger in comparison to the total cost of hospital care, either on a per day or per case basis."

The Swift Current Health Region Program of Saskatchewan adopted a copay in 1953 as a deterrent to what was believed to be excessive home and office visits.[5] The effect of this copay in the early years was a "dramatic reduction in home visits and a significant reduction in office visits." The reduction was partially offset by an increase in hospital visits and a "significant increase in minor surgery. But in later years (when lower utilization was not so obvious) there were grounds for suspecting that the listed copayment charges were more theoretical than real deterrents because the patients came to realize they were not always collectible."

Another problem area uncovered in the Blue Cross and Blue Shield poll was that those persons who believed they were good risks took a chance on purchasing a contract that contained a deductible, coinsurance or copayment while the poorer risks opted for full coverage—a point touched upon by Watertown, N.Y., Blue Cross.

Several plans commented on this aspect with Richard Rife, President of Capital Blue Cross of Harrisburg, Pa., providing this comment:

> Capital Blue Cross, I believe, was one of the first Plans in the country to offer a copayment certificate to its subscribers. This was in 1951 and the copayment requirement was $2 for each of the first 20 days of hospitalization. This certificate was offered as an option and at first, selected by about 7–8 percent of the Plan's subscribers. In successive annual offerings this percentage increased and for the first four or five years we believed that the copayment did have a favorable impact on hospital usage. Later, however, as the

[5] Straight, Byron W., "Reducing the Incidence of Office and Home Visits in a Medical Service Plan by Use of Co-Insurance Charges," *Proceedings of Conference of Actuaries in Public Practice;* 1961–62, Chicago.

number of subscribers with copayment coverage approached the number with full coverage we came to the conclusion that the difference in utilization really resulted from a better risk having selected the copayment coverage and not from the copayment itself. We have concluded that deductibles or copayment simply transfers cost from the prepayment mechanism to out-of-pocket expense at the time health service is required. Obviously, substantial deductibles or copayments would have an effect on utilization, however, they would be preventing necessary use as well as improper use.

Control for New Benefits

Another aspect of coinsurance, deductibles and copayments mentioned in an unpublished report by Donald Rucker is their possible use as a control for unknowns during the first years of a new benefit program when utilization and charges might be subject to wide swings.

Rucker, of the Office of Research and Statistics in the Social Security Administration, writes:

> One of the important factors here is the existence of prior insurance coverage. Not only does the actuary have a firmer base for his estimates if ongoing programs exist, but the adaption of beneficiaries to a new method of financing is likely to bring fewer unknowns than adjustment to an entirely new benefit.

Implicit in this argument, of course, is that the coinsurance, deductible and/or copayment would be lifted after a few years or when the program could be accurately predicted on a first-dollar contract basis.

Another point raised in the Blue Cross and Blue Shield poll was what was described as the introduction of an "administrative nightmare" by the use of coinsurance, deductibles or copayment. This is aptly illustrated by the present Medicare contract, which calls for a $50 deductible and 20 per cent coinsurance.

Including a deductible and/or coinsurance clause immediately introduces extra steps in the administration of the program—one of which is computation. With coinsurance, it can be a fairly simple step since often the carrier just looks at the bill, computes its share and pays it. But a deductible introduces more steps. The carrier must examine each bill and match it against its records. It must determine how much of the deductible the patient has already paid. If part of it has been paid, the carrier must note how much more the patient has to pay before it assumes payment. The carrier also must give this information to the patient. It must tell the patient how much more of the deductible he has to pay before the carrier's coverage will then take over.

About the time the patient begins to understand the deductible, he receives a statement from the carrier and finds he still owes money because of coinsurance. By this time, the patient is usually confused because the idea of deductibles and coinsurance is not easily understood, particularly in combination. Another problem that is raised is who is billed for these features when several physicians treat a patient.

For example, a hospitalized patient could receive the services of a surgeon, radiologist, anesthesiologist and cardiologist. Who, among these physicians, should be paid in full for his services and who should receive partial payment from the insurer and the remainder from the patient? For the hospitalization, an insurer need only pay one provider but it becomes a nettlesome problem when the insurer pays the physician. This is, of course, of primary importance to Blue Shield.

So when contracts call for deductibles or coinsurance, a carrier must, among among other things, keep track of which contracts have these provisions, how much they are and how much of the bill the patient pays and how much the carrier pays. And, it should be noted, the computation of the deductible and coinsurance must be done each contract year. At the beginning of the next year, the process begins once again.

These steps, of course, require more equipment and more personnel, both of which must be financed by the subscriber's premium.

Poll's Major Points

The above comments and opinions contained in the survey could, in general, be grouped under these five major points:

(1) High deductibles and coinsurance have a definite effect on utilization but the extent of the effect is hazy.

(2) A deductible or coinsurance feature could be large enough to prevent a person from seeking needed care. (It also was noted that these features could restrict

utilization on some elective cases. Postponement of treatment on these elective cases could, of course, lead to complications that could result in more expensive treatment plus more physical discomfort.)

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

(4) When offered the opportunity, the public will select more and more comprehensive coverage over those plans that include deductibles, coinsurance or copayments—even if the latter cost less. (A dramatic illustration of this is in the Federal Employees Health Benefits Program where 90 per cent of the Blue Shield and Blue Cross enrollees in the program chose the high option contract with broader benefits and lower deductibles and coinsurance rather than take the low option plan.)

(5) More Blue Cross than Blue Shield Plans offer contracts containing deductibles, coinsurance and copayment.

The table, which accompanies this report shows in statistical form how the answering Plans viewed deductibles, coinsurance and copayment.

Perhaps the following comment by Blue Cross of Northeastern Pennsylvania to the state insurance commissioner sums up the feelings of most of the respondents to the poll:

> We believe coinsurance and deductibles are without merit in affecting the use of medical care. We believe further that their popularity and the continued emphasis on their use proceed from the fact that they are "easy answers" . . . Blue Cross commercial insurance companies and government spokesmen espoused the concept of deductibles, hoping that they would rationalize and influence patterns of medical care, rather than contend with the much more difficult challenge of affecting medical care at the point from which it all proceeds: that is, the doctor and his style of medical practice. Even at this point in time, we would all rather believe that devices such as deductibles can accomplish the task of controlling hospital and medical care costs which we all face. I submit that the sooner we drop this notion, the quicker we can all address our energies to the difficult task we face.

IMPRESSIONS FROM BLUE CROSS AND BLUE SHIELD PLANS ON THE EFFECT OF DEDUCTIBLES, COINSURANCE, AND COPAYMENT

[Responses, 60 plans; definite opinions or impressions regarding the effects on utilization, 34 plans]

	Deductibles	Coinsurance	Copayment	1 or more provisions
Does curb utilization	13 plans [1]	11 plans [2]	9 plans [2]	20 plans. [3]
Does not curb utilization	12 plans	9 plans	6 plans	15 plans. [3]

[1] 6 of these plans specified that a large deductible would have an effect on utilization.
[2] 4 of these plans specified that a high coinsurance or copayment would have an effect on utilization.
[3] These 2 figures add to 35 plans because 1 plan felt a deductible does not curb utilization while coinsurance does and is therefore included in both columns.

EFFECTS OF COINSURANCE ON MEDICAL CARE UTILIZATION

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Summary

Objective: To study the effects of the introduction of a 25% coinsurance provision applying to physician services and outpatient ancillary services on the use of such services by a group of about 2,500 persons covered by a comprehensive prepayment plan of medical care.

Content: We compared utilization in 1966 before the introduction of coinsurance with utilization in 1968 after its introduction. We restricted our study population to those members covered the full 12 months in both years.

Principal Findings: The per capita number of *all* physician visits declined by 24% for the group as a whole; it declined, in varying degrees, for every subgroup: males and females; each of the three occupational groups into which we classified the members; and (with a few minor exceptions) for every age-sex cell in every occupational group. Similarly, the per capita number of physician visits by field of specialty declined for every specialty.

[From the Social Security Bulletin, June 1972]

EFFECT OF COINSURANCE: A MULTIVARIATE ANALYSIS

(By Charles E. Phelps and Joseph P. Newhouse[1])

Seldom is it possible to conduct effectively controlled experiments to assess the impact of economic variables on real world phenomena. The Palo Alto Group Health Plan (GHP) data of Anne Scitovsky and Nelda Snyder represent such an experiment, although the GHP was not explicitly designed for experimental purposes. (For a more complete description of the data base and a discussion of the nature of the GHP, see the analysis in the preceding article.) This article examines the GHP data, using a slightly different conceptual framework and a different statistical methodology. Essentially both articles have reached the same conclusions, although there are some differences.

Methodology

This study considers the impact of coinsurance upon four variables only—physician visits, physician expense, ancillary services, and ancillary services expense. For each person in the study, the following data were also available: age, relation to the subscriber, sex, distance from the Palo Alto Medical Clinic, occupation group (at Stanford University), and family size.

Multiple regression methods were used to analyze these data. This technique permits the estimation of equations such as:

$$\begin{aligned}\text{Physician visits} = {} & \alpha_1 \text{ age of individual in years} \\ & + \alpha_2 \text{ distance from GHP clinic in miles} \\ & + \alpha_3 \text{ family size}\end{aligned}$$

The α's in this equation are constants to be estimated from the data. They show the effect of changing one variable while holding the others constant. Thus, an individual who is 1 year older is hypothesized to make α_1 additional visits.

In this article the explanatory variables have not been entered in continuous form as in the above example. Rather, variables are broken into intervals or groups. Occupation is divided into faculty, other professional, and nonprofessional staff. Sex and subscriber variables are divided into five groups—male and female subscribers, male and female dependents, and children. Distance for dependents is divided into 5-mile segments, 0–5, 6–10, 11–15, 16–20, and greater than 20 miles; all subscribers are assumed to be in the 0–5 mile category. Age is divided into 0–4 years, 5–14, 15–18, 19–24, 25–44, 45–54, and 55 and over. When the individual being considered belonged to the category, the variable for that category took the value 1; otherwise it was zero. The advantage of this approach is that one does not have to assume, as in the above example, that each year or mile (or whatever) adds the same number of visits. The mean number of visits in each interval can be estimated by holding the other factors constant. (The family size variable is entered in continuous form.) For example, with other things equal, the mean number of visits among those aged 19–24 may be five, among those aged 25–44 it may be three, and among those aged 45–54 it may be four. No relationship among the age groups is assumed.

Initially, data for two years—1966 and 1968—were pooled, creating 5,134 effective observations. The explanatory variables listed above are virtually identical for each person in both years, except that age has increased by 2 years. These explanatory variables thus can only explain the level of visits by an individual, not any change between 1966 and 1968. In order to do that, a variable with the value 1 for all observations in the year 1968 and zero for all observations in 1966 was established. In 1968, of course, a coinsurance rate of 25 percent was in effect (that is, in 1968 patients paid 25 percent of the Clinic's normal fees but paid no money fees in 1966). The coefficient of this variable may be interpreted as the effect of a 25-percent coinsurance rate on the demand for medical care. Since virtually all other variables have been held constant, it is reasonable to expect that the only changes observed in demand were due to the introduction of coinsurance. By specifying the impact of coinsurance in such a way it is assumed that coinsurance led to an equal decline in visits or expense in each class. Evidence is presented below that this hypothesis cannot be rejected.

The technique of regression analysis leads to an estimate of the demand for physician visits and ancillary services and the changes in expenses for these

[1] The Rand Corporation, Santa Monica, Calif. The views expressed in this article are those of the authors and do not necessarily reflect the views of the Rand Corporation or the official opinion or policy of any of its government or private research sponsors.

services for a reference group. The reference group used for the following analyses was composed of persons in a family of four where the employed member was classified as nonprofessional staff and was a male subscriber aged 25–14. The estimated differences in levels of usage and expenses for groups of persons with different characteristics can also be calculated.

A word of caution is added here regarding these results. The decision to participate in the GHP could be made (or changed) by the family at any time. As a result, there may be some self-selection of persons in the plan in 1968 that would bias the results. About 300 of the original 2,870 members (10.6 percent) cancelled during the first year coinsurance was in effect; their overall use in 1966 was virtually identical to those who stayed in GHP. Therefore, it can be assumed that self-selection presents only a limited problem.

Demand for Physician Services

The basic finding of this article is the same as that of the Scitovsky-Snyder study: Coinsurance significantly reduces demand for medical care in this population, other things remaining the same. Table A in the Technical Note at the end of this article shows the coefficients of one regression on each of the four dependent variables (physician visits, physician expense, ancillary services, and ancillary services expense).

After the introduction of coinsurance all groups experienced declines of 1.37 in in the average number of visits and $18.66 in average expense. The probability is .00005 that decreases this large would have been observed if coinsurance in fact had no effect.

The results of the analysis for predicting usage among groups are shown in table 1 for physician visits and expense. Persons in the reference group averaged 4.27 visits in 1966. On the average, the number of visits in 1968 for each person in this group declined to 2.90 visits, or 32 percent; physician expense decreased from $66.81 in 1966 to $48.15 in 1968, or 28 percent.

TABLE 1.—PHYSICIAN VISITS AND EXPENSE AND CHANGE FROM REFERENCE GROUP, BY SELECTED CHARACTERISTICS, 1966

Characteristic	Physician visits			Physician expense		
		Change from reference group			Change from reference group	
	Number	Number	Percent	Amount	Amount	Percent
Nonprofessional male subscriber, age 25 to 44, family of 4 (reference group)	[1][2] 4.27			[1] $66.81		
Not male subscriber, but—						
Female subscriber	5.14	[2] 0.87	20.4	73.79	$6.98	10.4
Male dependent, adult	5.46	1.19	27.9	78.15	11.34	17.0
Female dependent, adult	6.80	[1] 2.53	59.3	108.83	[1] 41.02	61.4
Child	1.86	−2.41	−56.4	38.67	−28.14	−42.1
Not aged 25 to 44, but age—						
0 to 4	9.04	[1] 4.77	111.7	95.18	28.37	42.5
5 to 14	7.13	[3] 2.86	67.0	83.13	16.32	24.4
15 to 18	7.25	[2] 2.98	69.8	90.88	24.07	36.0
19 to24	5.66	1.39	32.6	68.17	1.36	2.0
45 to 54	5.07	[1] .80	18.7	80.58	[1] 13.77	20.6
55 and over	6.27	[1] 2.00	46.8	89.97	[1] 23.16	34.7
Not 0 to 5 males, but—						
8 to 10	3.91	−.36	−8.4	56.29	[2] −10.52	−15.7
11 to 15	4.26	.01	−0.2	66.04	−0.77	−1.2
16 to 20	3.48	−.79	−18.5	57.34	−9.47	−14.2
21 and over	2.76	[3] −1.51	−35.4	48.09	[3] −18.72	−28.0
Employee in family not professional, but—						
Faculty	4.63	.36	−8.4	69.79	2.98	−4.5
Other professional	4.43	.16	−3.7	68.75	1.94	−2.9

[1] Significantly different from zero at 1 percent.
[2] Significantly different from zero at 5 percent.
[3] Significantly different from zero at 10 percent.
[4] Dependents only.

Other demographic groups had somewhat different levels of usage. Table 1 also shows visits and expenses for groups of persons with different characteristics than the reference group. For example, if a person was a female dependent of a faculty member, aged 25–44, living 0–5 miles from the Clinic, and in a family of four, the mean difference from the reference group in the number of visits would be 2.53

(the difference for female dependents) plus 0.36 (the difference associated with faculty families), or a total difference of 2.89. The percentage change differs slightly across groups. The absolute decline is the same in each group, but each group had a different number of visits in 1966. The percentage reduction is slightly lower for faculty and other professional staff, higher for subscribers than for their dependents, and higher for dependents living further from the Clinic.

These results essentially corroborate the previous article's tables from the same data—that is, faculty members have higher utilization rates than other professional staff, who have higher rates than nonprofessional staff. Usage declines with distance from the source of care and follows a U-shaped pattern with respect to age. The U-shaped appearance is somewhat deceptive. Since all those under age 18 are considered children, the difference attributable to children should be added to those under age 18. Taking this into account produces a considerably less regular U-shape. Even when all of these systematic patters of demand for physician services are noted, the introduction of coinsurance is shown to have had a highly significant effect in reducing demand for physician services. Our analysis differs from that of the Scitovsky-Snyder study in that it holds all other variables constant while changing one variable—that is, it looks at the partial effect of each variable.

It has been suggested that the effects of coinsurance may be asymmetric. Behavior of persons when coinsurance goes from 0 to 0.25 may be different than behavior when coinsurance goes from 0.25 to 0. This result is not suggested by standard economic theory, but numerous institutional constraints may cause such a result. The question is clearly empirical and could be tested if a similar set of data could be found where a coinsurance provision had been removed, rather than instituted.

Expenditures for Physician Services

The physician expense column of table 1 shows that spending for these services also decreased with the introduction of coinsurance but to a lesser degree than the number of physician visits (28 percent, compared with 32 percent for the reference group). A "visit" can imply a simple examination by a general practitioner or a complex specialized workup by a board-certified specialist. Thus, a simple-visit variable may be a somewhat ambiguous measure of the quantity of physician services demanded. Since expenses were not reduced by as large a percentage as visits with the introduction of coinsurance, one might infer that relatively inexpensive procedures had been reduced proportionately more than expensive procedures. The differences between "use" and "expense" do not, however, appear to be statistically significant at normal levels of hypothesis testing.[1]

Time Costs in the Demand for Services

In the demand equations, it is striking how much the usage by female dependents differs from that by the reference group. Female subscribers (who are in the labor force) used slightly more services than male subscribers (0.87 more visits per year, significant at 0.03 probability), but female *dependents* (many of whom, presumably, are not in the labor force) used, on the average, 2.53 more visits per year than male subscribers and 1.66 more visits per year than female *subscribers* (1.66=2.53—0.87). The null hypothesis of no difference between the utilization rates of female dependents and female subscribers can be rejected at a 0.001 level of probability. On the assumption that time cost is higher on the average for female subscribers than for female dependents, these data give striking evidence on how much time costs influence the demand for medical services. It has been suggested that the differences between the utilization rates of men and women may have been pregnancy-related. That hypothesis was tested in another regression by including a dummy variable for female dependents aged 45 and over (who should be past childbearing age). If the female dependents' dummy showed pregnancy effects, then the subgroup aged 45 and over should show lower use. The actual coefficient was -0.38 visits ($t = .78$), an insignificant difference. Another inference from this result is that the major differences between the use of physician services by men and women are probably not due to biological differences—a common justification—but to differences in the cost of time.

[1] The mean decrease in visits was estimated to be 24.07 percent of the demand in 1966 (calculated as the decline in average visits for the entire population), with a standard error around that estimate of 2.98 percent. The mean decrease in expense was estimated to be 23.78 percent, with a standard error around that estimate of 4.25 percent. To rigorously test the hypothesis of no difference between these means would require knowing the covariance between them. Computing this figure does not seem worth the computational costs.

With this interpretation, a question can be raised concerning the relationship between sick-leave provisions and time costs for subscribers. Faculty and other professional subscribers hold jobs that require a certain amount of output rather than a certain amount of time, and, in fact, subscribers in these groups are generally not covered by sick-leave provisions. Thus, their visits would tend to come from time not devoted to market work, and time costs could be expected to be higher than they are for nonprofessional staff, where sick-leave provisions are more frequent. Moreover, sick-leave provisions only apply to employees paid hourly. Only 16 percent of the total number of employees work at an hourly rate (virtually all of whom are nonprofessional staff), and of these an undetermined number work less than half time and so would not be eligible for the health plan. Thus sick-leave provisions do not appear to be an important factor.

The average price per unit of service can be obtained by dividing annual expense by annual use. An overall average price per unit of $13.83 was obtained using the GHP data for both years ($69.14/5.00). With a 25-percent coinsurance rate, this means that in 1968 members paid an average of $3.46 more per visit than they did in 1966 when there was no coinsurance. From the GHP data an arc elasticity of demand for physician services—showing the percentage change in demand that results from a given change in monetary price—can be computed using the formula in the Technical Note. The arc elasticity of demand for a $3.46 increase in cost with a 25-percent coinsurance rate is —0.137,[2] a 10-percent increase in price would result in a 1.37-percent decline in visits.

This analysis is somewhat misleading regarding the sensitivity of medical care demand to total price, however. If a value of $10 were placed on time and transportation costs—so that the price of medical services jumped from $10 (with no monetary payment) to $13.46 (with the 25-percent coinsurance)—the arc elasticity would be: (—1.37/$3.46) × ($23.46/10.00) = —0.927. Thus, a 10-percent increase in total price would result in a 9.3-percent reduction in the quantity of medical care purchased.

The elasticity figure is obviously quite dependent upon the value of other costs, including time costs. If a value of $5.00 were used for time costs, a 10-percent increase in total price would result in a 5.3-percent reduction in the use of services. If a value of $15.00 were used for time costs, a 10-percent increase in total price would result in a 13.2-percent reduction in the use of services. This line of reasoning suggests that very time-intensive services, such as hospitalization, would show quite small elasticities with respect to money price but possibly large elasticities with respect to total price.

Even though the elasticity coefficient is quite dependent on the value of other costs used in the equation, it does reveal why normal estimates of demand for medical services show price elasticities that are relatively low compared with other commodities—the base prices used are not really the total prices consumers consider when deciding how much of the service to purchase. Which price to use depends upon what one is trying to predict. If one wants to estimate the effects of a change in the monetary price on demand for medical care, the monetary price is sufficient. If one wishes to estimate demand for the services of a different medical care delivery system that will alter time or travel expenses, it may be necessary to consider the value of the consumer's time, travel distances, and the time required to obtain the services.

Demand for Ancillary Services

The regressions on use and expense data for ancillary services (equations 3 and 4 of table A of the Technical Note) show similar but less strong effects of coinsurance on demand. The number of ancillary services used by the reference groups decreased 13 percent when coinsurance was introduced; expenditures on ancillary services decreased by an identical amount. These decreases are significantly different from zero at a 5-percent confidence limit (one-tailed test), but they are neither as large nor as statistically significant as the decreases in physician utilization and expense data. As the preceding article points out, these results suggest that patients may have less personal control over what is done by a physician than over the initial decision to visit a physician.

[2] The estimated own-price elasticity of demand for physician services of —0.14 is almost identical to an elasticity estimate of total medical expenditures from an entirely different data source. Using insurance premium data, that elasticity was computed to be —0.13 as the coinsurance rate changed from 20 percent to 25 percent. See Charles E. Phelps and Joseph P. Newhouse, *Coinsurance and the Demand for Medical Services*, Rand Report No. R-974.

Differential Impact of Coinsurance

The proposition that various groups are affected differentially by the change in insurance coverage was tested by ascertaining whether the change in quantities demanded between 1966 and 1968 was systematically related to any demographic variable. This procedure permitted testing the assumption that the absolute decline in visits was equal in all demographic groups. If the change was systematically related to a demographic variable, the 1.37 decline in visits and the $18.66 decline in physician expense for all groups should be corrected to show a different absolute decline for the particular demographic group in question. Results from this test are reported in table B in the Technical Note. The null hypothesis here is that the effect of coinsurance does not change with age, income, travel distance, or relationship to subscriber.

Because total price for medical services includes not only monetary price but a time cost, it can be assumed *a priori* that those persons with higher time costs (members living farther away from the Clinic, for example) would face a lower proportional increase in total price with the introduction of coinsurance. Hence, assuming that, on the average, all groups would respond similarly to price changes, their reduction in utilization should be less. Put another way, those with very high time costs should be relatively undeterred by changes in the monetary price. This hypothesis was borne out only partially by the data. In general, male plan members, who probably face time costs, were less affected by the coinsurance than female members.[3] Persons facing less travel time, however, were not more strongly influenced by the coinsurance, as would be predicted. (An F-statistic testing the joint hypothesis that all of the distance variables were zero was 0.34.) One explanation for this result is that when coinsurance was introduced those living further away had a greater tendency to switch to nonplan services than did those who were living close by.

Even more noteworthy is the fact that the change in demand did not differ significantly between different occupation (income) groups in this population, although it might be expected that the demand of those with lower time costs (the nonprofessional group) would be reduced significantly more than the highest income groups (professional staff). However, an F-statistic texting the hypothesis that there was no difference among the occupational groups in the amount of decline—that is, that the coefficients of the two occupational variables both were zero—equals 0.07, clearly insignificantly different from zero. (If there were in fact no difference among occupational groups, at least this much difference among the groups would be observed more than 90 percent of the time.) Whether this conclusion would be maintained over a wider income range cannot be answered from this study, but these results suggest that the response of outpatient medical care demand to price does not change with the income of the consumer unit—that is, there is not an interaction between income and price responsiveness.

The Scitovsky-Snyder study finds some evidence that the decline in visits after the introduction of coinsurance was greater among the nonprofessional group. That finding can be reconciled with the finding of this article in three ways:

(1) Nonprofessional staff had lower mean utilization rates, so that the same absolute change (described in this article) is a larger relative change (described in the preceding article).

(2) Their finding is based partly on other data, especially their finding regarding the change in the percentage of the various occupational groups having no physician visits during the year and the change in the volume of physical examinations.

(3) The analysis in the preceding article does not hold factors other than age and sex constant between the occupational groups. Given the results of table B—that the other factors were unrelated to the change in visits—this difference between the studies does not appear to be important.

Interaction between income and dependency status was also tested to see if subscribers of different income levels behaved differently than nonsubscribers. The results were generally negative, and they have not been included in this article.

F-statistics can be used to test the null hypothesis that none of the explanatory variables in the regression equation systematically affect the change in demand for medical services when a copayment of 25 percent is introduced (that is, that the entire coefficient vector is equal to zero). The following tabulation shows the F-statistics for four variables and the approximate probability of occurrence if in fact there were no difference among groups:

[3] An F-statistic testing the joint hypothesis that the coefficients for female dependents, female subscribers, and male subscribers equal zero is 2.56. A similar test on the dependency status jointly tested whether the coefficients on male and female dependents were zero; the F-statistic was 2.87. The critical level for rejection at the 5-percent level is 2.99.

Change in—	F-value	Percentage probability [1]
Physician visits	0.8219	65
Physician expense	.7686	74
Anciliary services	1.0552	40
Anciliary services expense	1.0563	40

[1] Calculated by interpolation from tabled values of F: the probability of F being greater than 0.76 is 75 percent; the probability of F being greater than 0.96 is 50 percent; and the probability of F being greater than 1.20 is 35 percent.

The F-statistics shown above are all sufficiently low so that the null hypothesis for these equations cannot be rejected at conventional levels of significance. The tabulation also shows the probability of occurrence if the null hypothesis were true: if there were, in fact, no differences between any of the groups in their response to insurance. For example, a 65-percent probability of occurrence means if there were no differences between the groups, an F-statistic this large or larger would be obtained 65 percent of the time. One cannot infer from this that there is a 35-percent (100—65) chance that there is a difference among the groups. If there were, in fact, an infinitesimal difference among groups in their response to coinsurance, an F-statistic this large would have been observed approximately 35 percent of the time. The larger any true difference, the smaller is the chance of observing an F-statistic as large as this. The assumption that monetary coinsurance reduces demand equally for all the persons in the sample is thus supported.

The F-statistics test the null hypothesis that the effect of coinsurance is the same for all groups. The hypothesis that the effect of coinsurance is different for any individual demographic group (considered singly) can be tested by investigation of individual t-statistics in table B. (The t-statistics are calculated on the assumption that the other estimated coefficients equal their true values.) These t-statistics show that only one demographic variable—female dependents—is significant at conventional levels of probability,[4] and this variable is significant for all four measures of utilization under investigation. The introduction of coinsurance reduced demand by female dependents significantly more than for other members of this population. Again, on the assumption that female dependents face on the average lower time costs, this result is in accord with previous hypotheses that those facing the lowest total price in 1966 (time and travel costs) would be most significantly affected by coinsurance. This result further strengthens the belief that the major reason for the higher demand by female dependents in 1966 (and in 1968) was the implicitly lower time costs for that group than for any of the other members of the study population.[5]

Moreover, this result implies that the introduction of better insurance will raise the share of visits made by female dependents. If the total number of visits does not expand, this increase will be at the expense of other groups. At the moment there is little evidence on what might be expected to happen to total visits.

Another piece of evidence that strongly supports the hypothesis that the introduction of coinsurance results in a large change in utilization among groups with low time costs is the Scitovsky-Snyder finding that all visits decreased by 24.1 percent but home visits decreased by 51.6 percent. Since there is essentially no travel time or waiting time for home visits, the time price for home visits is negligible.[6]

Possible Shortcomings of Study

Several factors could possibly limit the application of these findings. First, if some exogenous factor such as a local epidemic artificially increased demand in 1966, or some factor (such as a miracle) systematically reduced demand for the entire community in 1968, then the observed differences in these data could be attributed to factors other than or as well as the introduction of coinsurance. The GHP plan data in the Scitovsky-Snyder study, however, show essentially no change in visits to the Palo Alto Medical Clinic between the two years. Further-

[4] One must be careful in attaching much confidence to this result, since the chance of finding one variable significant at the 1-percent level among 17 variables is not 1 percent but nearly 17 percent.

[5] For technical reasons, it was necessary to include some variables in the regressions in table B that contained similar information, such as "dependent child" and "age under 5." The appropriate statistical tests of significance are on the sum of those two variables. For the change in physician visits, the difference for dependent children under age 5 is 1.41 (t=1.90); the sum of the coefficients is not statistically significant for dependent children aged 5–14 and for children aged 15–18.

[6] Assuming a zero time cost for home visits, the implied value of time for an office visit is approximately $2.50. This is computed as the value of time that would make the arc elasticity for office visits equal 0.347, the elasticity for home visits as computed from table 10 of the Scitovsky-Snyder study.

more, the Kaiser Foundation Health Plan-Northern California reports a similar number of outpatient visits in the two years (see their table 12).

In addition, it would be preferable, as mentioned earlier, to conduct an investigation of those who remained in the GHP in 1968 and those who chose some other source of insurance/medical care.[7] Unfortunately, no data are available on the demand of those persons in 1968 who left GHP, since they could presumably obtain their medical care from any provider in the community, rather than being restricted to the Palo Alto Clinic.

A final potential problem with this study is that, with the introduction of coinsurance in 1968, some persons enrolled in GHP may have continued their enrollment but purchased some of their medical care from other providers, presumably at full market prices. Doing this would be rational behavior if the total cost of some private services (including travel time) were lower than the costs of GHP. If such behavior occurred, then some of the observed reduction in care may actually be only a shift to other suppliers, rather than an actual decrease in the market quantities demanded. Such behavior would be more likely among those who lived far from the Clinic. As noted above, this could account for the greater reduction in demand for GHP services among those who live further away. To the extent that this is true, the decrease in demand for an entire community would be less than estimated here for this particular prepayment group. As the preceding article pointed out, however, an individual who intended to make much use of outside providers would probably have opted for alternative insurance coverage; thus, this factor does not appear to be significant.

Summary

Multiple regression analysis of the GHP data shows that the introduction of 25-percent coinsurance in a prepayment setting reduced physician visits among the subscribers and their dependents by 1.37 visits on the average. Furthermore, the only group that was likely to have been more sensitive to the change in price was female dependents of subscribers. For other groups in the GHP population responses to the change in price were not significantly different from each other. The data also show that the use of ancillary services did not decrease as much as the use of physician services.

Technical Note

Regression Results

In this article the dependent variables are in absolute form rather than in relative form as they are in the Scitovsky and Snyder study. This causes some minor differences in results as noted.[8] Except for family size, all of the explanatory variables have been entered in dummy variable form, since all the information is categorical. In these regressions, the constant term refers to the usage by male-subscriber, nonprofessional staff with travel distance less than 5 miles, whose age in 1966 was 25–44. The coefficients of the other variables, such as aged 45–54, refer to the decrease (or increase) in use associated with that category in relation to the constant term. The distance variables apply only to dependents; subscribers are assumed to travel from work to the Clinic and so fall in the 0–5 mile category.[9]

[7] The decision of GHP members to participate in the plan and to use its services should be analyzed in the context of a simultaneous equation model. On the basis of their use of services in 1966, persons dropping GHP appeared to be little different from those keeping plan membership, so the simultaneous equation bias is probably small.

[8] Since some individuals had zero use in the base year, relative changes could not be used as a dependent variable. Dividing the coefficient estimates by the appropriate average value of variables in 1966 (as in table 1) will provide estimates of relative changes comparable to those found by using group averages.

[9] Less than 5 percent of subscribers' visits took place at night (after 8 p.m.) or on weekends (other than Saturday from 9 a.m. to 1 p.m.).

TABLE A.—REGRESSION ESTIMATES OF THE DEMAND FOR MEDICAL CARE UNDER THE PALO ALTO GROUP HEALTH PLAN, 1966–68 [1]

Explanatory variables	Dependent variables			
	Physician visits	Physician expense (dollars)	Ancillary services	Ancillary services expense (dollars)
	Equation 1	Equation 2	Equation 3	Equation 4
Coinsurance (1958)	−1.3677	−18.660	−.6774	−3.5395
	(−8.0848)	(−5.5932)	(−2.3413)	(−1.7398)
Faculty	.3568	2.9767	1.4216	6.4606
	(1.3917)	(.5888)	(3.2422)	(2.0956)
Other professional	.1630	1.9435	.2045	1.2528
	(.6422)	(.3882)	(.4710)	(.4103)
Female subscriber	.8682	6.9835	.6518	−.2339
	(2.1650)	(.8831)	(.9504)	(−.0485)
Male dependent	1.1888	11.335	1.4821	7.8766
	(1.3354)	(.6467)	(.9750)	(.7369)
Female dependent	2.5348	41.018	2.6798	14.436
	(10.099)	(8.2867)	(6.2425)	(4.7826)
Child	−2.4100	−28.136	−.7243	−12.858
	(−1.4389)	(−.8518)	(−.2528)	(−.6384)
Distance (miles): [2]				
6 to 10	−.3588	−10.520	−.3811	−2.3941
	(−1.1082)	(−1.6478)	(−.6882)	(−.6149)
11 to 15	.0125	−.7698	−.7187	−4.1933
	(.0374)	(−.1171)	(−1.2604)	(−1.0459)
16 to 20	−.7862	−9.4664)	−1.8077	−11.941
	(−.8962)	(−.5472)	(−1.2048)	(−1.1318)
21 and over	−1.5119	−18.720	−1.3906	−5.0130
	(−2.7317)	(−1.7151)	(−1.4690)	(.7532)
Age:				
0 to 4	4.7737	28.371	−1.0708	−.7660
	(2.7870)	(.8399)	(−.3655)	(−.0372)
5 to 14	2.8626	16.324	−.8756	1.1288
	(1.7063)	(.4934)	(−.3051)	(.0560)
15 to 18	2.9828	24.070	.4638	8.2698
	(1.7608)	(.7205)	(.1601)	(.4060)
19 to 24	1.3914	1.3603	−.9314	2.4193
	(.8497)	(.0421)	(−.3325)	(.1228)
45 to 54	.7991	13.774	2.5395	19.535
	(3.0643)	(2.6784)	(5.6938)	(6.2293)
55 and over	2.0017	23.158	2.8350	22.734
	(6.2908)	(3.6906)	(5.2093)	(5.9413)
Family size	−.0934	−.8365	.0984	−.2621
	(−1.2583)	(−.5716)	(.0663)	(−.2937)
Constant term	4.6339	70.158	4.5411	24.096
	(11.535)	(8.8556)	(6.6090)	(4.9875)
R^2	.0619	.0493	.0559	.0520
"F"	18.751	14.744	16.819	15.582

[1] Figures in parentheses are t-statistics. In a sample of this size, t=1.65 has 0.10 probability, t=1.26 has 0.05 probability, and t=2.58 has 0.01 probability.
[2] The distance variable is set at 0 to 5 miles for subscribers.

In table B, the dependent variable is the change in demand, so that a negative coefficient implies that the coinsurance had a stronger effect in reducing demand for the group represented by that particular independent variable. For example, since the coefficient of female dependent in the table B equations is negative, the coinsurance reduced demand more for female dependents than for male subscribers (whose change in usage is measured by the constant term).

From the data in this article one may compute an arc elasticity of demand showing the percentage change in demand for a given percentage change in monetary price over the range of zero coinsurance to 25-percent coinsurance. The formula for arc elasticity ($\bar{\eta}$) is:

$$\bar{\eta}=\frac{\Delta y}{\Delta x}\cdot\frac{(\bar{x})}{(\bar{y})}=\frac{(y_2-y_1)}{(x_2-x_1)}\cdot\frac{(x_1+x_2)/2}{(y_1+y_2)/2}=\frac{(y_2-y_1)}{(x_2-x_1)}\cdot\frac{(x_1+x_2)}{(y_1+y_2)}$$

where x is the monetary price (x_1=\$0 and x_2=\$3.46) and y is the number of visits (y_1=5.683 and y_2=4.314).

TABLE B.—REGRESSION ESTIMATES OF THE CHANGE IN DEMAND FOR MEDICAL CARE UNDER THE PALO ALTO GROUP HEALTH PLAN, 1966–68 [1]

	Dependent variables			
Explanatory variables	Physician visits Equation 1	Physician expense (dollars) Equation 2	Ancillary services Equation 3	Ancillary services expense (dollars) Equation 4
Faculty	0.0329	−12.137	−0.2686	−4.5152
	(.0751)	(−1.2724)	(−.3400)	(−.7880)
Other professional	.0524	−4.4812	.2434	−.7855
	(.1209)	(−.4745)	(.3112)	(−.1384)
Female subscriber	−.7449	−12.308	−.2343	.5785
	(−1.0874)	(−.8249)	(−.1896)	(.0645)
Male dependent	1.1850	30.582	−2.4355	−15.661
	(.7805)	(.9248)	(−.8893)	(−.7878)
Female dependent	−.9335	−22.254	−1.5295	−12.784
	(−2.1773)	(−2.3724)	(−1.9777)	(−2.2773)
Child	2.7558	15.136	2.5909	17.050
	(.9632)	(.2429)	(.5020)	(.4551)
Distance (miles): [2]				
6 to 10	−.5532	3.6752	.3165	1.0470
	(−1.0003)	(.3051)	(.3173)	(.1446)
11 to 15	−.2862	−1.5885	.4768	5.2941
	(−.5024)	(−.1281)	(.4641)	(.7100)
15 to 20	−.7446	3.1003	.3557	9.2158
	(−.4969)	(.0949)	(.1316)	(.4697)
21 and over	.0953	−21.960	1.2279	6.0446
	(.1008)	(−1.0665)	(.7200)	(.4883)
Age:				
0 to 4	−4.1802	−21.243	−4.0155	−23.209
	(−1.4287)	(−.3333)	(−.7608)	(−.6058)
5 to 14	−3.1280	−19.200	−3.2612	−20.847
	(−1.0915)	(−.3076)	(−.6309)	(−.5556)
15 to 18	−2.9714	−17.180	−3.4513	−22.363
	(−1.0269)	(−.2726)	(−.6612)	(−.5902)
19 to 24	−3.6643	−28.463	−5.2748	−29.498
	(−1.3099)	(−.4671)	(−1.0453)	(−.8053)
25 to 54	−.3539	−.3252	−2.0463	−14.792
	(−.7945)	(−.0335)	(−2.5467)	(−2.5362)
55 and over	−.2018	4.5403	−1.5717	−7.2991
	(−.3713)	(.3835)	(−1.6031)	(−1.0257)
Family size	.0323	.6772	−.3634	−1.2829
	(.2550)	(.2453)	(−1.5892)	(−.7730)
Constant term	−.6235	−7.0471	2.1127	12.055
	(−.9294)	(−.4823)	(1.7459)	(1.3725)
R^2	.0055	.0051	.0070	.0070
"F"	.8219	.7686	1.0552	1.0563

[1] Figures in parentheses are t-statistics. In a sample of this size t=1.65 has 0.10 probability, t=1.96 has 0.05 probability, and t=2.58 has 0.01 probability; an F value of 2.20 for the entire equation has 0.25 probability on the null hypothesis, an F value of 0.96 has 0.50 probability, and an F value of 0.76 has 0.75 probability.

[2] The distance variable is set at 0 to 5 miles for subscribers.

POSSIBLE BIASES

Is it possible that the standard errors of the coefficients on the 1968 coinsurance dummy variables in the regressions of table A are biased, because of (presumed) positive correlation of the error terms between the i^{th} person's physician visits in 1966 and 1968. Suppose the error term is of the form $\epsilon_{it}=\mu_i+\nu_{it}$, where μ_i is a random variable specific to each individual and time invariant, and ν_{it} varies with each individual in each time period. Then, if μ_i and ν_{it} are independent, the covariance of ϵ_{i1966} and ϵ_{i1968} equals the variance of μ_i. This correlation is not a standard first-order autocorrelation, and any established direction of bias that such a correlation might produce is unknown. To guard against the possibility of such biases, y_i was defined to be the difference between the i^{th} person's use in 1966 and in 1968, and regressions of the form $y_i=b_o+u_i$ where b_o is simply a constant term and u is a random error term were run. The error term in these regressions equals $\Delta\nu_{it}$ and by assumption has a variance-covariance matrix proportional to the identity matrix. The constant term that results from this equation is identical to the coefficient on the 1968 coinsurance dummy in the regressions reported in table A.

The standard errors of the coefficients in these sample regressions should be higher than the corresponding coefficients in table A if the autocorrelation in the data biases the standard errors of table A coefficients downward, and the reverse should be true if the autocorrelation biases the standard errors in table A upward. The results uniformly suggest that the *t*-statistics on the 1968 coinsurance variables in table A are biased downward (that is, that standard errors are biased upward) compared with the simple regression suggested here. (The actual coefficients were identical—to the five decimal places reported—in all pairs of regressions.) The *t*-statistics for these regressions are given in table C. The means and their standard deviations for the explanatory and dependent variables are shown in table D.

TABLE C.—COMPARISON OF *t*-STATISTICS OF COINSURANCE COEFFICIENT FOUND IN TABLE A WITH *t*-STATISTICS FOR 2-YEAR DIFFERENCE REGRESSIONS

Dependent variable	1968 coinsurance coefficient, *t*-statistics	2-year difference coefficient (bs) *t*-statistics
Physician use	8.08	9.47
Physician expense	5.59	5.93
Ancillary services	2.34	2.60
Ancillary services expenses	1.74	1.57

TABLE D.—SUMMARY STATISTICS ON POPULATION CHARACTERISTICS, UTILIZATION, AND EXPENSE FOR MEMBERS OF THE PALO ALTO GROUP HEALTH PLAN, 1966 AND 1968

Variable	Mean	Standard deviation
	Explanatory variables	
Faculty	0.404	0.491
Other professional	.385	.487
Female subscriber	.069	.253
Male dependent	.010	.098
Female dependent	.234	.423
Child	.421	.494
Distance (miles):		
6 to 10	.082	.275
11 to 15	.076	.265
16 to 20	.010	.098
21 and over	.020	.159
Age:		
0 to 4	.049	.217
5 to 14	.237	.425
15 to 18	.088	.283
19 to 24	.049	.216
45 to 54	.182	.386
55 and over	.127	.333
Family size	4.020	1.500
	Dependent variables	
Physician visits:		
1966	5.68	6.58
1968	4.31	5.81
Average	5.00	6.25
Physician expense:		
1966	$78.47	$129.17
1968	$59.81	$114.40
Average	$69.14	$122.37
Ancillary services:		
1966	6.03	12.95
1968	5.35	7.72
Average	5.69	10.65
Ancillary services expense:		
1966	$30.91	96.16
1968	$27.37	$43.76
Average	$29.14	$74.73

ITEM 3. DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES COMMISSION ON AGING

Baltimore, Md., February 27, 1973.

DEAR SENATOR MUSKIE: I am pleased to send you a statement concerning the Administration's proposed Medicare cutbacks. Since it is not possible to secure concurrence in the views I state with members of the National Association of State Units on Aging, my comments are brief but will, I believe, reflect the views of State agencies on aging.

We are most concerned about the proposal to increase the co-insurance and deductibles under Medicare.

Over-utilization of hospital services, to the extent that it exists, can and should be held in check by available means that will not tend to deter elderly people from obtaining needed hospital care. The co-insurance and deductibles affect most seriously the lowest income elderly who cannot afford to take advantage of private insurance plans that cover these costs of hospitalization not paid by Medicare.

For all but a small percentage of persons covered by Medicare, the costs of this insurance program are financed by social security contributions and not from general revenues. The purposes of this contributory program should not be defeated by unnecessary increases in the charges that must be borne by the patient.

The proposed hearings on the costs of co-insurance and deductibles for Medicare participants is a move that we welcome. I would hope that not only would the testimony relate to the proposed increase in the cost for Medicare participants, but address itself to the matter of whether co-insurance and deductibles may not be eliminated as part of the program.

In answer to your second question concerning subjects that your Subcommittee might explore in future hearings, I will discuss this with the Board of our organization and answer your question in detail at a later date.

Very truly yours,

HARRY F. WALKER.

ITEM 4. AMERICAN ASSOCIATION OF RETIRED PERSONS/NATIONAL RETIRED TEACHERS ASSOCIATION

Washington, D.C., February 27, 1973.

DEAR SENATOR MUSKIE: Our associations, the American Association of Retired Persons and the National Retired Teachers Association, with a combined membership of over five million persons, appreciate this opportunity to express our concern about the Administration's proposals to increase coinsurance and deductibles under Medicare.

We are particularly concerned that the cost-sharing proposals recommended by the President would strike hardest at older Americans relying on limited retirement income from public and private sources. These Americans are those whose income, while small and fixed, is nonetheless too high to meet Medicaid requirements. For these individuals who are deemed ineligible for Medicaid assistance because they had the foresight and the opportunity to invest for their retirement, the burden of medical expenditures not covered by Medicare must be shouldered by themselves. It is for this reason that our Associations' basic position is that any health proposal must take into account the substantial out-of-pocket outlay that older people now must make at a time when their income is apt to be fixed or diminished and their health care requirement increased.

In light of the fact that Medicare in fiscal year 1971 covered only 42 percent of the total health payment of the elderly, that per capita expenditures in fiscal year 1971 were $861 for persons 65 and older compared to $228 for those under 65, that in fiscal year 1971 out-of-pocket payments for people 65 and older were about the same as the total medical care expenditure of the average person under 65 and were more than double the younger person's out-of-pocket payment, it is alarming that the President would recommend increased personal expenditures by older Americans to meet their health needs.

The President's proposed Medicare changes which would force Medicare patients to pay for actual hospital room and board charges for the first day plus 10 per cent of all subsequent hospital room and board cost is a cruel punishment to older persons. We wonder how the President expects the average Social Security

recipient receiving an average cash benefit of $164 a month to pay the average daily charge for a hospital bed of $105.30 and still provide for his other needs during the month.

Our Associations fear that increased out-of-pocket costs to the patients are more likely to result in the postponement of needed care—especially preventive care—which might forestall longer and more costly treatment at a later date.

Spokesmen for the President have stated that the proposed increase in out-of-pocket cost is needed to prevent over-utilization of hospital facilities and doctors' services. The justification points out that both doctors and patients will become more cost conscious and reduce over-utilization if the patient's out-of-pocket share of the cost is increased. There is no evidence to support this claim. In fact, a survey by Blue Cross Association and the National Association of Blue Shield Plans indicates that unless deductibles and coinsurance payments are large enough to constitute a serious economic hardship they have no significant effect on utilization. Furthermore, if out-of-pocket costs truely act as a deterrent to over-utilization, then patients who pay nothing for hospital care would spend more time in hospitals than patients who must make substantial out-of-pocket payments for hospital stays. Department of Health, Education and Welfare figures demonstrate, however, that patients belonging to health maintenance organizations, where hospitalization is provided free, actually spend less time in hospitals than do other patients.

We are pleased that a number of the members of your committee, yourself included, share our conviction that the President's proposal is ill-timed, based in myth and harsh to older Americans.

We appreciate this opportunity to bring our views before this committee, and to express our concern. We would hope that our protest and those of groups sharing our interest in legislation affecting older Americans will illuminate the false logic upon which the suggested cutbacks are based. Furthermore, we hope that these preliminary hearings will demonstrate the strong sentiment against these cost-sharing proposals so that the President would not have to suffer the embarrassment of defending an untenable position before a hostile Congress. In short, we are hopeful that you will communicate to the President our views that the suggested increase in coinsurance and deductibles under Medicare is unacceptable to the older public and should be withdrawn.

The recommendations of the President only make it more obvious that our Nation must now find a comprehensive solution to the problems of delivering and financing health care and must reform substantively the present health care system. Attention must be paid to the inadequacies of the present health care system; inadequate funding, maldistribution of services, insufficient personnel, inappropriate delivery systems, inattention to preventive care are the real difficulties in providing older Americans with quality care.

Our Associations are in agreement with the fundamental proposition reflected in virtually all major health care proposals before Congress: the medical care system requires substantial and comprehensive improvement of the benefits of medical care, the manner of delivery of medical services, the quality of medical services and care and the means of financing the system. It is shortsighted to tax the older recipient of health services for the failure of the Congress and the President to recognize and act on the health crisis in our Nation. Unfortunately, it is sad commentary that our Nation, the richest and most powerful in the world, must resort to burdening those most in need to pay for their health services.

We would hope that during the coming months, your committee can explore steps to make immediate improvements in Medicare. New directions must be initiated to improve the administration of the Medicare program, to expand its coverage, and to insure that older Americans are receiving quality care under these services. A renewed effort must be made toward merging parts A and B of Medicare so that the health needs of older persons are better met. Emphasis should be placed on expanding geriatrics and the study of gerontology to further the research in health care for older persons. An investigation should be initiated into the quality of services available under Medicaid, and facts should be gathered on the effect of the Title XIX Amendments authorized under P.L. 92–603.

These areas are but a few of the major health issues in which we share your interest. As you know, our Legislative Council which formulates our legislative policies will be meeting in the near future, March 19–March 22, here in Washington. Following this meeting, I shall be in further communication with you as to our goals for 1973, and ways in which we hope we can be of assistance to the Congress in achieving these goals.

Again, Senator Muskie, I want to thank you for your invitation to comment on the upcoming hearings of the Subcommittee on Health of the Elderly. Needless to say, I look forward to our continued close liaison and working friendship.

Sincerely,

CYRIL F. BRICKFIELD,
Legislative Counsel.

ITEM 5. NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

Washington, D.C., March 1, 1973.

DEAR SENATOR MUSKIE: I was pleased to receive your letter of February 22nd, and learn that the Subcommittee on Health of the Elderly will hold hearings on "Barriers to Health Care for Older Americans", on March 5th, 6th and 7th. I believe the matter of adequate health care is one of the most important and frustrating problems facing today's senior citizens, and I am glad that your Subcommittee is taking an early initiative in studying this problem.

The National Association of Retired Federal Employees strongly opposes any cutback in present Medicare benefits and coverage. I simply do not think that in this day of skyrocketing hospital and medical costs, there is any justification to impose further financial burden on our older Americans by increasing deductibles and coinsurance under Medicare.

While we are grateful for the extended Medicare coverage provided in H.R.1 of the last Congress, our Association would hope that instead of reducing current benefits, the 93rd Congress would consider and act to further increase these benefits especially in the area of out-of-hospital prescription drug costs, and preventive eye and dental care.

As the majority of Retired Federal Employees are not eligible for full Medicare coverage, unless they can afford to pay the full cost of this coverage, we should like to see Medicare Part A coverage made available to this group of retirees, so that they might benefit from the same health coverage as other older Americans.

Again, thank you for your interest in this important area of health care, and we emphasize NARFE's opposition to any reduction in present Medicare benefits. If this Association can be of any assistance to you or the Subcommittee staff, do not hesitate to contact us.

Sincerely,

ARTHUR L. SPARKS, *President.*

ITEM 6. AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Washington, D.C., March 5, 1973.

DEAR SENATOR MUSKIE: I am replying to your letter of 21 February 1973, concerning the hearings of the Subcommittee on Health of the Elderly on "Barriers to Health Care for Older Americans," and asking the views of the AFL–CIO on the Administration's proposed Medicare cutbacks and on subjects which the Subcommittee might explore at future hearings.

The AFL–CIO feels that of all the ways in which the Administration could have selected to cut the budget none is more inappropriate than the proposed cutbacks in Medicare. The costly deductible and coinsurance features of the law already deter the elderly from obtaining needed medical care and should be reduced or eliminated, not increased. Such provisions may reduce costs, but they are obstacles if the purpose is to provide good health care. Health services should be available as a matter of human right and should be based on health needs alone and not on a test of ability to pay. Otherwise, the burden of sacrifice falls largely on the elderly poor.

Over-ultilization should be handled by administrative and professional controls and should be approached from the providers side. The patient can't control the medical care he needs for only a doctor can determine the health services a patient requires. Doctors dominate the marketplace for medical care and are generally free of the normal constraints imposed by consumer demand. Their individual decisions determine both the allocation and utilization of services. If there is over-utilization in the Medicare program, the blame for rising costs lies with doctors who are not meeting their responsibility to control the utilization of medical care. What is required is appropriate controls on the providers of services, particularly physicians.

We also feel it is unjust to reduce benefits and to maintain the Medicare payroll tax at its present level for the purpose of building up surpluses in the Social Security Trust Funds in order to show a misleading deficit reduction for the consolidated Federal budget.

In regard to the second question raised in your letter, there are a number of health problems which the Subcommittee could examine which are of vital importance to older people. For example, we suggest the following possibilities:

(1) The impact on the elderly resulting from Medicaid cutbacks contained in H.R. 1.

(2) The possibility of cutbacks in the scope of Medicaid services required because of increased costs to the States resulting from increased Medicaid eligibility of Supplemental Security Income recipients.

(3) In view of the Federalization of the Adult Categories under the new Supplemental Security Income program, and examination of the possibility of a Federally-administered Medicaid program covering all the aged, blind and disabled.

(4) An examination of the major National Health program proposals in terms of how they relate to the needs of the elderly with particular emphasis on the lack in most of them of any real national program of long-term care (or alternatives) for the elderly.

(5) An inquiry into physician reimbursement in the Medicare program and into the possibility of requiring doctors, who accept reimbursement from Medicare, to accept the assignment method of payment and thereby agree to the "reasonable and customary fee" as determined by the program.

(6) A general examination of the Medicare program in terms of needed improvements.

I hope these observations and suggestions will be of help to you. For your information, I am also enclosing a copy of a statement on slashes in health programs adopted by the AFL–CIO Executive Council at its February meeting. Please know that we appreciate the excellent work that the Subcommittee has been doing to draw attention to the health needs of older people.

Sincerely yours,

BERT SEIDMAN.
Director, Social Security Department.

[Enclosure]

STATEMENT BY THE AFL-CIO EXECUTIVE COUNCIL ON SLASHES IN HEALTH PROGRAMS

BAL HARBOUR, FLA., *February 23, 1973.*

The Administration's health budget would cripple a host of programs which are vital to meeting the health needs of the American people.

The President's 1972 health message stated:

"An all directions reform of our health care system—so that every citizen will be able to get quality health care at reasonable cost regardless of income and regardless of area of residence—remains an item of highest priority on my unfinished agenda for America in the 1970's."

How has the Administration implemented this "highest priority?"

The President vetoed the hospital construction bill.

He pocket vetoed the bill to provide more family doctors.

Only Congress stymied his efforts to close down the Public Health Service hospitals.

The President has impounded millions of dollars appropriated by Congress for health programs.

He has twice vetoed the appropriations bill for the Department of Health, Education, and Welfare.

In announcing next year's health budget, the Administration has topped last year's dismal record. Despite increased costs the budget for the fiscal year ending June 30, 1974, is $500 million less than for the previous year. It would cut or eliminate many current health programs.

The Administration would wipe out the Regional Medical program to coordinate efforts to treat heart, cancer, stroke and other killer diseases.

It would also phase out the Hill-Burton hospital and health facilities construction program and assistance for development of community mental health centers.

The budget for Medicaid would eliminate Federal matching for dental care.

Proposed changes in Medicare would require the elderly to pay part of the cost of their hospital bills from the 2nd to the 61st day now provided without charge. The initial deductible under Part B of Medicare covering physician serv-

ces would be increased from $60 to $85 and co-payment by the patients above the deductible amount would be increased from 20 percent of the bill to 25 percent.

The proposed changes in Medicare will force the elderly and disabled to pay out of their own pockets for doctor and hospital bills more than an additional half-billion dollars in the first six months of 1974 and upwards of a billion dollars during the following 12 months. What is worse, many will be cut off from needed care because with their limited incomes they won't be able to make the payments at all.

The Administration defends the elimination of the Hill-Burton hospital and health facilities construction program on the grounds that more hospital beds are not needed. This may be true for many but by no means all areas. A surplus of beds in one community won't provide hospital facilities in a city a thousand miles away where there are still not enough beds to meet the community's needs.

Moreover, Hill-Burton grants have been used in recent years mainly to modernize obsolete hospitals rather than to construct new ones. There is a tremendous backlog of need for modernization grants. Hill-Burton also provides grants for out-patient facilities, public health centers and nursing homes for which there are substantial shortages.

The budget provides no funds for new community mental health centers and support for existing centers would be phased out. This would eventually wipe out a valuable new program which for the first time has made it possible for low and middle income families to obtain quality mental health care.

Funding to increase the supply of health manpower would be substantially reduced. Student aid for other than physicians and dentists would be restricted to loans and health research scholarships and fellowships abolished. Funds for schools of public health and for training of the allied health professions would be significantly cut.

The AFL–CIO urges Congress to reject the sharp cuts for health programs in the Administration's budget and substantially increase funding of needed health services. We will also vigorously oppose any attempt to load additional costs on the elderly and disabled who depend on Medicare.

Appendix 2

A CHART BOOK PROVIDED BY NEW YORK CITY OFFICE FOR THE AGING*

NEW YORK CITY'S ELDERLY— A PROFILE

—947,878 over 65; 12% of city's population

—Increase in elderly population 1960-1970; 16.5%

—Growth greatest among oldest & frailest:
1 out of 3 over 75

—Women outnumber men 6 to 4

—30% live alone

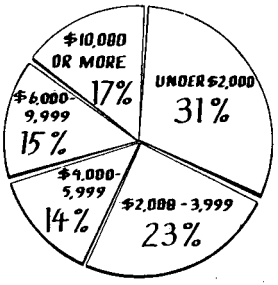
—9 out of 10 are white but
nonwhite increased 78% from 1960 to 1970

—Only 3% institutionalized

SOURCE: U.S. BUREAU OF CENSUS

*See statement of Majorie H. Cantor, pp. 11–18, for discussion related to chart book.

OVER HALF NEW YORK'S ELDERLY HOUSEHOLDS LIVE ON INCOMES OF LESS THAN $4,000 A YEAR

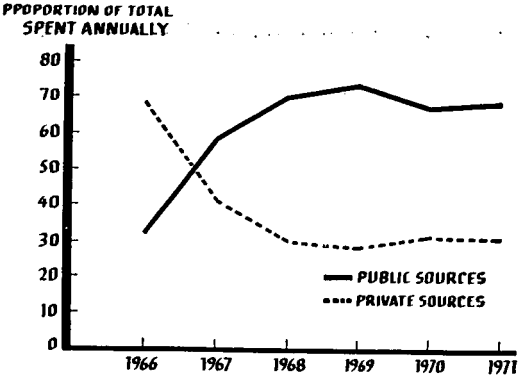


Median income: $3,520

SOURCE: 1970 NEW YORK CITY HOUSING AND VACANCY SURVEY

2

WITH MEDICARE, A DRAMATIC SHIFT FROM PRIVATE TO PUBLIC PAYMENT FOR PERSONAL HEALTH CARE OF ELDERLY



SOURCE: H E W, SOCIAL SECURITY ADMINISTRATION

3

PUBLIC AND PRIVATE SHARE OF HEALTH CARE EXPENDITURES FOR ELDERLY PERSONS, 1971

EXPENDITURE ITEM	PROPORTION PAID PUBLICLY	PRIVATELY
Hospital Care	86.1 %	13.9 %
Physicians' Services	71.5	28.5
Nursing Home Care	60.3	39.7
Other Professional Services	33.3	66.7
Drug & Drug Sundries	16.1	83.9
Dentist's Services	10.5	89.5
Eyeglasses & Appliances	*	99.9
Total	67.5	32.5

*Less than .05%

SOURCE: HEW, SOCIAL SECURITY ADMINISTRATION

4

THE COST OF MEDICAL CARE ROSE RAPIDLY FROM 1966 TO 1970 — IN NEW YORK IT ROSE EVEN FASTER THAN IN U.S.

ITEM	1966-1970 U.S.	1969-1970 U.S.	1969-1970 N.Y.C.
HOSPITAL ROOM AND BOARD SERVICES	66.1%	13.5%	17.0%
PHYSICIAN'S FEES	30.1%	8.1%	12.5%
DRUGS AND PRESCRIPTIONS	3.8%	2.5%	5.3%
DENTAL FEES	25.3%	5.5%	2.8%
TOTAL MEDICAL CARE	28.7%	7.3%	10.1%

SOURCE: BUREAU OF LABOR STATISTICS

5

AFTER RENT AND MEDICAL COSTS ARE PAID, ELDERLY NEW YORK CITY COUPLES HAVE LITTLE LEFT FOR FOOD AND OTHER NECESSITIES

MARCH, 1973

Median Income (including 20% Social Security increase 10/72)	$4,000
Out of pocket medical costs	600
Rent	1,284
REMAINDER LEFT FOR FOOD, CLOTHING AND ALL OTHER EXPENSES	$2,116 or $176.33 per month

SOURCE: N.Y.C. HOUSING & VACANCY SURVEY; BLS; N.Y.C. OFFICE FOR THE AGING

MEDICARE: COSTS INCREASE BENEFITS DECREASE

	1966	1973	% INCREASE	PRESIDENT'S PROPOSAL
HOSPITAL INSURANCE				
DEDUCTIBLE	$40	$72	80%	$110*
CO-INSURANCE				
HOSPITAL				
1st - 60th DAY	NONE	NONE	—	10% DAILY ROOM & BOARD CHARGES
61st - 90th DAY	$10 DAILY	$18 DAILY	80%	
NURSING HOME/EXTENDED CARE				
1st - 20th DAY	NONE	NONE	—	UNCHANGED
21st - 100th DAY	$5 DAILY	$9 DAILY	80%	
MEDICAL INSURANCE				
PREMIUM	$3.00	$5.80	93%	$6.30**
DEDUCTIBLE	$50.00	$60.00	20%	$85.00
CO-INSURANCE	20%	20%	—	25%

*Aug. full-cost 1st day hospitalization in New York City

**Increase scheduled for July 1973

SOURCE: HEW, SOCIAL SECURITY ADMINISTRATION

THE IMPACT OF THE PRESIDENT'S PROPOSED CHANGES IN MEDICARE
ON OUT-OF-POCKET EXPENSES FOR DOCTOR'S FEES
IN CASE OF CHRONIC ILLNESS

DOCTORS' SERVICES FOR A CHRONIC HEART FAILURE PATIENT
INCLUDING ONE 21 DAY HOSPITALIZATION

	Yearly Cost (e)
Regular Doctors' Visits (14)	
Once every 3 weeks	$140 ($10 per visit)
Specialists for Related Conditions	
2 Visits	$100 ($50 per visit)
Laboratory Tests (Cardiograph, Blood Tests, X-Ray)	
6 times per year	$330 ($20 - cardiograph; $20 - X-ray; $15 - Blood Tests)
Doctors' Visits During Hospitalization	
Once per day for 21 days	$315 ($15 per visit)
Total Costs	$885

OUT-OF-POCKET COSTS

Present Provisions	Proposed Changes
$60 Deductible + 20% of remaining bills	$85 Deductible + 25% of remaining bills
$60 + $165 = $225	$85 + $200 = $285

INCREASE IN OUT-OF-POCKET COSTS
FOR DOCTORS' FEES
27%

Source: New York City Office for the Aging

THE IMPACT OF THE PRESIDENT'S PROPOSED CHANGES IN MEDICARE
ON OUT-OF-POCKET EXPENSES
FOR A TYPICAL HOSPITAL STAY
NEW YORK CITY

(Based on an average stay of 21 days in a voluntary hospital at $110 daily for room and board.)

Days	Present Provisions	Proposed Changes
1st	$72.00	$110.00
2nd to 21st	-	220.00 (10% of daily rate)
Total Out-of-Pocket	$72.00	$330.00

INCREASE
IN OUT-OF-POCKET COSTS
358%

Source: New York City Office for the Aging

9

THE HEALTH CRISIS OF OLDER NEW YORKERS

SUMMARY AND RECOMMENDATIONS

Health care becomes increasingly important, indeed crucial, as people grow older. Although most older people are not necessarily housebound, their health needs increase, requiring on-going medical attention and usually a considerable amount of drugs. There is greater incidence of hospitalization and long-term care. Often there is interaction between illness and the isolation of old age.

In New York City at present there are 947,878 persons 65 and over, 12% of the city's population. One out of three of these older New Yorkers are 75 years of age or older. And the number of older people in the city continues to increase.

Although only 3% of the elderly are institutionalized and another 8% incapacitated enough to be homebound, with increasing age comes increased incidence of chronic illness. Three-fourths of the older New Yorkers suffer from at least one such illness.

The higher incidence of illness in old age requires greater use of health services. The National Center for Health Statistics found that people over 65 make an average 7.2 visits per year to doctors, compared with 5 for those 45–64 years of age. In 1970, older patients in New York's municipal hospitals stayed an average 38.6 days compared with 13.6 days for all patients, and in voluntary hospitals, older patients stayed an estimated 20–21 days compared to 11–12 days for those under 65.

These older New Yorkers live on Social Security and meager retirement incomes. Over half have incomes of $3,000 or less; over a third, incomes of $2,000 or less.

Studies have clearly documented that as income declines, the incidence of chronic illness increases. Old people with their low incomes and poorer diets contribute significantly to the reservoir of unmet health needs of New York's poor.

Although New York City is probably the greatest medical center in the world with the most up-to-date technology in its hospitals and a broad spectrum of health care agencies and institutions throughout the city, access to health care for older people remains hedged by what sometimes appear impenetrable barriers.

Older people have severely limited incomes, yet the price of health care has rocketed to the point where many older people have literally been priced out of the market. Older people have limited mobility, yet health care is fragmented and difficult to find and easy transportation to care almost unavailable. Older people need a wide range of supportive health services in their homes and their neighborhoods, yet such care is almost non-existent or too expensive. Older people need preventive medical care, yet their health insurance fails to cover this need. Older people are major consumers of health care, yet the medical profession has not given cognizance to their special needs and, indeed, has usually treated them with little interest and even impatience.

Although this monograph has concerned itself primarily with the structure and delivery of medical care in times of illness, we are not unmindful that the health needs of older people must be seen in the broadest perspective. The kind of environment in which a person lives out his retirement years, the level of income and the opportunities for constructive use of leisure time are as essential to positive physical and mental health as are the number and quality of doctors, hospitals, nurses, etc. Older people, given a decent income and a range of supportive services in the community, have shown that they can live with chronic illness and still function positively as members of society.

In caring for older people, we must continue to stress the positive aspects of health including the importance of rehabilitative medicine and an environment which encourages older people to leave their isolated apartments and interact with their peers and the community at large. Dignity and equality of medical opportunities, and avoidance of charity must be the foundations on which any health care delivery system for older people is built.

The time has come to recognize and act upon the health needs of older people. The following recommendations are divided into those which are amenable to immediate implementation and those which may require more extensive long-range planning.

A. RECOMMENDATIONS FOR IMMEDIATE ACTION

(1) Revision of the Medicare Program is imperative. Medicare, at the time of its enactment in 1965, was hailed as the beginning of a new era for older people in which the crushing burden of medical costs would be removed and equal access to quality medical care made available to all regardless of ability to pay. Not only would the cost of most health services be covered but medical purchasing power would be more equalized, enabling all older people to freely select the doctor or hospitals of their choice. Second-class medicine for the elderly poor would become a thing of the past and equality and dignity would characterize health care for older Americans.

As is documented in the following pages, the dream of Medicare has too often proven to be an empty illusion. Medical costs have become so inflated that older persons are presently paying out of their own pockets for health care (i.e. premiums, coinsurance, deductibles) as much or sometimes more than was the case prior to the advent of Medicare. And most importantly, access to the highest quality medical care is too often only available to older people with means. Many private doctors in New York City do not accept Medicare assignment but prefer to bill older persons directly, forcing the patient to collect from Medicare on his own. Current levels of doctors' fees in New York City far exceed Medicare reimbursement allowances and older persons must either be able to pay the differential themselves or depend on the overcrowded, under-staffed out-patient

clinics of hospitals, making illness even more difficult for older people. Thus, under Medicare as presently constituted only the affluent elderly have free choice of medical care.

No matter what happens in the future in regard to National Health Insurance, some restructuring of Medicare is necessary now if the goals of the program as outlined at its inception are ever to be fulfilled. At the least, the following are required:

(*a*) Parts A and B of Medicare must be combined into a single system which automatically covers all older persons on their 65th birthday. Such a system should include hospitals, doctors, nursing homes and a host of auxiliary medical, rehabilitation and social services necessary to maintain older people independently in the community. A combination of A and B would also eliminate the premium for Part B.

(*b*) All deductibles and coinsurance must be eliminated. Older people with limited incomes cannot continue to absorb the rising cost of medical care. If the monies in the Social Security fund are not sufficient to cover costs of the Medicare program, additional funds must be provided for out of general revenue rather than from the pockets of older persons themselves.

(*c*) The present option that enables doctors to require older people to pay doctors' bills out-of-pocket and claim reimbursement from Medicare should be eliminated. Doctors should be reimbursed directly by the Social Security Administration according to the scheduled fees for service. Such a payment method would in the first instance, strengthen the ability of the government to hold down spiraling doctors' costs and insure that all older persons have equal purchasing power and free choice of health personnel.

In addition, the present method in which the patient must file for reimbursement works a hardship against less educated, less sophisticated older persons who may have difficulty completing the forms necessary for reimbursement.

(*d*) Medicare benefits must be expanded to include prescription drugs, dental services, eyeglasses, prostheses and expanded home health services. On the federal level, the definition of reimbursable home health care should be liberalized to include homemaking services in situations where skilled nursing care may not be necessary.

State regulations should be amended to permit supervision of home health care programs by professionals other than public health nurses. Such liberalization would enable hospitals to greatly expand home health services.

2. Revisions in Medicaid:

(*a*) If the above revisions in Medicare become a reality, the need for Medicaid for older people could be virtually eliminated. But as long as Medicaid is still important to any older person, the most recent Medicaid cuts, which reduced income eligibility and eliminated vital services and supplies, such as out of hospital dental, podiatric, chiropractic and optometric care, eyeglasses, hearing aids, dentures and prosthetic devices, should be rescinded by the New York State Legislature.

(*b*) Although some improvement has taken place in the administration of New York City's Medicaid program, some serious difficulties still exist.

Several immediate steps are indicated: *First*, there is a need for a more rapid method of emergency action both at the point of certification of new patients and at recertification. Either staff of hospitals must have power to issue an immediate temporary letter of eligibility for the elderly or personnel in Medicaid Satellite offices should be assigned specifically to this purpose. Another possibility is to place authorized Medicaid staff right into the hospitals, with authority to facilitate action. Secondly, to reduce the large number of applications rejected for inaccuracy or incompleteness, a training program should be undertaken by Medicaid, reaching hospital and social agency personnel who assist older people, regarding the proper way to fill out Medicaid registration forms. *Thirdly*, a procedure must be devised to return incorrectly filled out forms promptly, with the problem areas indicated, rather than rejecting applications out of hand. *Fourth*, the possibility of waiving recertification of the elderly should again be raised with appropriate federal and state authorities by the city of New York. Undoubtedly, more money is spent in recertifying older people than would possibly be saved if even a few ineligible older persons were to continue to receive Medicaid. *Finally*, the system of vendor payments should be reorganized to enable reimbursement to occur within a reasonable time interval. Present procedures cause delays in payments of upwards of a year to medical providers. As a result, many doctors and druggists refuse to accept Medicaid patients.

3. New York City's Hospitals and Health Facilities must take Health Care Into the Community not as an experiment but as an integral part of their service through such means as:

(a) Expansion of ambulatory neighborhood-based geriatric clinics, especially in areas with a scarcity of private doctors, as a firstline of comprehensive health care for older people. Screening, diagnosis and some treatment could occur in these clinics. Present District Health Offices offer a possible site for such clinics as do housing projects with high density of older persons. The backup for such clinics must, of course, come from the hospitals. Close planning and coordination between all providers of health services in a given area is essential (i.e., the clinics, hospitals, private doctors, Visiting Nurse Service). Where possible, a municipal hospital or district health office might serve as a coordinator.

(b) Attachment of screening and selected services to existing non-medical community programs for the elderly. The projected expansion of nutrition programs offers an unusual opportunity to link social services and medical care. Through cooperative efforts of community programs and the medical and dental professions, it should be possible to make available dental care, eye examinations, podiatry and mental health services available to many thousands of older New Yorkers.

(c) In order to expand the potential of health care for older people, there should be an exploration of the greater use of paramedical personnel such as nurse-clinicians. Such specially trained nurses are particularly well suited for health maintenance care and for outreach health services.

4. Transportation must be seen as an integral part of the health care delivery system.

(a) Hospital and clinic hours for older out-patients should be adjusted to permit usage of the Half-Fare card for travel to and from medical facilities.

(b) Demand—activated group riding programs, such as New York's Dial-A-Ride, must be expanded so that older people do not refrain from using medical facilities for lack of ability to get to them.

5. Background Information of the Social, Economic and Psychological Needs of Older People should be immediately included in training curricula for all health personnel, from doctors to nurses to paraprofessionals.

Federal funds should be allocated for training programs in geriatrics for young physicians.

6. Nursing Homes Require Continued Close Supervision by the Health Department and more beds must be established in such facilities as nursing homes, intermediate care facilities and health-related facilities to meet waiting lists.

If nursing homes are to care for increasing numbers of disoriented older persons, arrangements should be made by the Department of Mental Health and Retradation with municipal, voluntary hospitals and mental health agencies in the various catchment areas to provide the necessary psychiatric care including scheduled examinations of patients and consultations with staff in nursing homes.

7. A Central, Coordinated Registry for Home Health Care should be established in New York City from which older people can request service and personnel. At the present time many private and public agencies have registries of home health personnel, but older people in need of home health services must be both sophisticated enough to know where to ferret out such service and may have to call numerous agencies before they connect with service. If there were one widely publicized place to which older people could turn for these services, it would be very helpful.

8. Federal, State and city governments must take responsibility for providing *alternate types of housing for older people* who can no longer maintain their own households (i.e., housing with central dining facilities, apartments shared by groups of older people.) The No. 202 Program (direct loan) for many communities and non-profit sponsors offers a more appropriate means of financing such housing than the No. 236 Program.

9. Some Immediate Provision Must be Made for Taking Care of Disoriented Older Persons who cannot stay in their homes but are ineligible for State hospital admission. Unused beds in municipal hospitals or vacant buildings on the grounds of State mental institutions should be converted into special facilities for their use. The State Department of Mental Hygiene must accept some responsibility for such patients and provide necessary backup services where needed. Old Age Assistance levels need to be raised to provide the necessary funds for the care of such patients in Municipal Hospitals and/or special facilities. Currently OAA levels are too low to cover such costs and Medicare and Medicaid do not presently provide reimbursement when nursing care is not required.

10. Older people, as major consumers of health care, deserve a Voice In Planning the Delivery and Operation of Health Care. Immediate vehicles for this are the Community Health Boards. Other ways of guaranteeing this participation should be explored at once.

11. Medical research funds should be channeled both toward the conquering of the diseases of old age and the newer efforts to slow down the aging process. Toward these ends, the establishment of a National Institute of Gerontology as proposed in the Brademas Bill now before Congress is of primary importance.

B. RECOMMENDATIONS FOR LONG RANGE ACTION

The above recommendations can make an immediate difference in the lives of older people but in and of themselves will not guarantee adequate health care for older New Yorkers. Much more is needed and what is most needed is a broad commitment on the part of the government to underwrite comprehensive health care for all.

(1) At the very least, a comprehensive national health insurance plan is necessary so that all people—rich and poor alike—are insured cradle-to-grave coverage, including preventive care. The Kennedy-Griffith plan seems to be the only one of the several plans presently under discussion that meets this goal. We urge Congress to act immediately to make national health insurance a reality.

(2) To make national health insurance meaningful, the present health delivery system must be rationalized and there must be an immediate expansion in medical facilities and personnel. Unless such an expansion occurs, health insurance will not be able to offer everyone the services promised and will, in fact, merely usher in a wild competitive scramble for the use of too few services, resulting in a further spiraling of medical costs. Unless the government takes an active role to assure quality health care and control of health costs, a national health insurance plan is no more than a hollow mockery.

(3) However, national health insurance is only a financing mechanism. It must be accompanied by a full commitment on the part of the government to establish a national health system which makes available to all citizens the benefits of our most advanced medical technology. Many European countries have chosen to provide such a system under government sponsorship. Whatever the form it takes in this country, such a commitment to comprehensive health care must incorporate the following features of importance to older persons:

As a first step, for each area of the city, a determination must be made of the number of older persons, their health status, the health facilities currently available, and a comprehensive plan for their health care developed. Older people, as health consumers, must be involved in this planning process (this process may be beginning under the auspices of New York City's Comprehensive Health Planning Agency.)

A network of neighborhood-based geriatric clinics affiliated with hospitals, staffed by doctors, nurses and social workers specially trained in geriatric health screening, preventive medicine, nutrition and health education as well as capable of providing maintenance care for chronic illnesses.

A wide range of alternative services to help older people remain in their own homes as long as possible. Such services would range from doctors and nurses visiting in the home to the provision of home health aides, homemakers, housekeepers and companions and could be coordinated by neighborhood clinics. Just as the young are experimenting with alternate forms of living aimed at reducing isolation and alienation, so older people should be encouraged to learn to live together in various types of congregate residential arrangments. For some it may be merely the opportunity to share meals, while for others it may be a total communal living experience.

A wide range of living arrangements with supportive services for older people who cannot remain in their own homes. The present pattern of older persons living alone in their isolated box-like apartments leads to both physical and mental deterioration.

An adequate number of nursing homes, extended care facilities, hospitals and institutions for mental health care. In this long-range context nursing homes should be an integral part of the entire continuum of homes and infirmary facilities. Thought should be given as to whether these facilities, like hospitals, more properly belong under voluntary or government sponsorship.

A restructuring of our thinking to give recognition to diseases of old age. Geriatric medicine should have the status of pediatric medicine—these are, after all, the two groups in the population who need most medical care.

Finally, there should be experimentation in the innovative use of medical personnel and a rationalization of the use of paraprofessionals at different levels of health care.

Many of these recommendations may seem visionary or far in the future. But ill health at any age is a frightening experience. In old age haunting fears of being unable to obtain or afford health care make illness a virtual nightmare. A nation that can afford to send spaceships to the moon and wage a long-term unnecessary war certainly can find the men and resources to provide the best medical care for its elderly, rich and poor alike.

MARJORIE CANTOR,
Director of Research.
MARY MAYER,
Research Associate.

Appendix 3

LETTER FROM MAE LAUFER, SENIOR CITIZEN HEALTH CONSUMER, BRONX, N.Y., TO PRESIDENT RICHARD M. NIXON, JANUARY 1973

The President of the United States:
Mr. RICHARD NIXON
Washington, D.C.

My dear Mr. President, I would like to thank you for the picture you sent me from the White House, do also appreciate the kind words that was inscribed, picture was taken at Washington Hilton Hotel, the morning you give your speech. We did hope some of the services would become a reality, that you mentioned but so far we see no progress in the field of Aging.

It is 1:07 a.m. in the morning when you left the last visit to the east ball, I have watched the ceremony, the parade, and your visits to the six balls in your honor. As I sat all alone at home, I thought of the next four years, would we make it, will the goodies you promised the Elderly who in their twilight years won't have too much time left to enjoy.

Senior Citizens are not statistics they have basic needs so far we hear rhetoric and read the literature we get from Washington, but no results.

Have been born in New York City, May 27, 1903, we of that era had a trying time, lived through five wars, and no one could complain as we were not educated to know. I am the mother of two sons who live out of town, with their families. I become very lonesome in the evening, this is worse than a chronic disease. My both boys served in the war, one in the Navy the other in the Air Force, and was shot down in Barth, Germany, a prisoner of war for many months in Stalag Luft one.

At the age of sixty-two was forced to retire as the doctor required me to take care of my disability. I started to work with Senior Citizens at Bronx River Housing, got in touch with officials and received many refusals, I then knew we are the forgotten generation. Senator Robert Kennedy heard our plight and helped our program by contacting Dept. of Social Service we then became a Senior Center with staff, lunchroom, five days a week program enclosed in envelope. H.E.W. is a fine government organization but most of the funds are going to the children and adults. I like children and approve, but we should be taken care of also. Our problems are not in the library and can't be read in books we are human, contributed a lot to this country not with machines but with muscles. If more our Elderly become concerned we could have comfort, socialize and help the less unfortunate ones. I know I have found out helping those who are unable to help themselves has been a labor of love for me.

In three months I will be three score and ten my next birthday, if I can have a conference with you and your committee will be the greatest honor for me to discuss the needs for all Elderly people in this country. This would be the best birthday gift I could ever receive, the Bible says, three score and ten is a full life please Mr. President don't make me wait too long.

Have many citations, plaques from officials in office, state, city and local government. Have been in touch with members of your special committee on Aging, Senator Frank Church who serves as chairman.

As President of Bronx River Senior Center, and a concerned citizen I am appealing to you Honorable President help us to have nutrition at all Centers, quality medical service. Medicare should have a better program, right now it is not good, no medication, no glasses, many other problems should be studied in the field of Medicine.

Have written to you before, but the answer came from Mr. Mann with no feeling, I believe Mr. President you never got to read my letter. Hoping you will read this letter some time in the future, and thanks for Peace again.

I have the honor to remain,

Respectfully yours,

MAE LAUFER.

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