SOCIAL SECURITY AMENDMENTS OF 1970

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

H.R. 17550

AN ACT TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE INCREASES IN BENEFITS, TO IMPROVE COMPUTATION METHODS, AND TO RAISE THE EARNINGS BASE UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO MAKE IMPROVEMENTS IN THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS WITH EMPHASIS UPON IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF SUCH PROGRAMS, AND FOR OTHER PURPOSES

PART 3 OF 3 PARTS

SEPTEMBER 22 AND 23, 1970

PUBLIC WITNESSES

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

47-530 WASHINGTON : 1970

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 – Price $2.25

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

CLINTON P. ANDERSON, New Mexico
ALBERT GORE, Tennessee
HERMAN E. TALMADGE, Georgia
EUGENE J. McCARTHY, Minnesota
VANCE HARTKE, Indiana
J. W. FULBRIGHT, Arkansas
ABRAHAM RIBICOFF, Connecticut
FRED R. HARRIS, Oklahoma
HARRY F. BYRD, JR., Virginia

JOHN J. WILLIAMS, Delaware
WALLACE F. BENNETT, Utah
CARL T. CURTIS, Nebraska
JACK MILLER, Iowa
LEN B. JORDAN, Idaho
PAUL J. FANNIN, Arizona
CLIFFORD P. HANSEN, Wyoming

TOM VAIL, *Chief Counsel*
EVELYN R. THOMPSON, *Assistant Chief Clerk*

CONTENTS

(Parts 1, 2, and 3)

Administration Witnesses

Public Witnesses

Additional Information

Communications

(Part 1)

Appendix A

Appendix B

(Part 3)

Appendix A

Appendix B

SOCIAL SECURITY AMENDMENTS OF 1970

TUESDAY, SEPTEMBER 22, 1970

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Harris, Byrd, Jr., of Virginia, Williams of Delaware, Curtis, and Jordan of Idaho.

The CHAIRMAN. This hearing will come to order.

This morning we will hear from a number of outstanding and well-known witnesses, the first of which will be the Honorable Winston L. Prouty, Senator from the State of Vermont.

Senator Prouty, we are pleased to have you here.

STATEMENT OF HON. WINSTON L. PROUTY, A U.S. SENATOR FROM THE STATE OF VERMONT

Senator PROUTY. Thank you very much, Mr. Chairman, for this opportunity to discuss with this committee several basic changes that I believe could be made to H.R. 17550, the House-passed social security bill. I have provided the committee with a detailed statement concerning the changes I am proposing. Therefore, I will take only a few minutes of your time to summarize my recommendations.

First, let me say that H.R. 17550 does represent a step forward toward solving some of the problems facing older Americans. However, when viewed in either the context of the needs of older Americans or the ability of our country to meet those needs, H.R. 17550 simply does not go far enough.

Now, naturally, over 20 million older Americans will be grateful if we quickly pass this bill, even though it does not go far enough. Over the years, older Americans have grown accustomed to being thankful for small favors. I can understand why so little pleases so many so much.

Consider, if you will, those 3.5 million social security recipients getting a minimum social security benefit of $64 a month. Under the House-passed bill, they will receive 10 cents a day more. Under their accounting system, that is a lot. It is almost 10 slices of bread or half a slice of baloney.

Under our accounting system, involving billions of surplus in the social security trust funds, a trillion dollar gross national product, or a $200 billion Federal budget, we should be ashamed.

However, I am not here to rehash the past. I am here to ask this committee to make modest changes in H.R. 17550, so that older Americans will be able to exist with a little more dignity.

My recommendations for improving H.R. 17550 generally fall into three categories: The need for greater cash benefits, the need for reopening eligibility under the so-called Prouty amendment, and the need to carefully scrutinize some of the proposed changes in medicare and medicaid.

Very briefly, my first three amendments relate to increasing cash income to older Americans. When we realize that three out of every 10 older Americans live in abject poverty, we know that much more needs to be done. Specifically, my amendment No. 696 increases the present $64 minimum social security payment to $100 a month. In addition, it provides a scaled 10-percent benefit increase for those who receive more than $100 rather than a flat 5-percent increase provided in H.R. 17550.

My amendment No. 697 simply passed the 10-percent increase on to the special monthly payments provided under the so-called Prouty amendment.

As you will recall, during the last session the Senate passed an amendment calling for a $100 minimum monthly payment. The best the Senate could agree upon with the House conferees was $64. I am hopeful that this committee will incorporate both of my amendments into any version of H.R. 17550 in their report to the Senate floor.

Such a move would certainly strengthen the hand of the Senate when this bill goes to conference with the House.

My amendment No. 698 simply increases the retirement earnings limitation to $2,400 per year. As you know, ever since 1963 I have been attempting to have the retirement earnings limitation completely removed from the social security act. It perhaps made sense to have such a limitation in the depression year 1935. It makes absolutely no sense in 1970. Older Americans who are physically able to work should be encouraged to do so because of the great contribution they can make.

Now, I realize that at this time I cannot realistically hope for a complete abolishment of the retirement earnings limitation. Therefore, my proposal simply liberalizes it by permitting a retired individual to earn up to $2,400 per year without any benefit loss. I chose $2,400 a year because it is a figure that has twice before passed the Senate.

My amendment No. 785 is designed to reopen eligibility under the so-called Prouty amendment. An individual had to become age 72 on or before December 31, 1967, in order to be eligible for benefits under the Prouty amendment. Nearly 2 million at one time or another have received that benefit. At present over 650,000 of those individuals are still living and continue to receive $46 a month.

The Prouty amendment did succeed in getting cash to many older Americans who had missed coverage under the Social Security System during their working years. However, because of the cutoff date, December 31, 1967, a number of uninsured individuals continue to be without cash benefits simply because they were not old enough to be eligible.

It is estimated by the Social Security Administration that around 700,000 individuals will be affected by amendment No. 785.

The cost of increasing special benefits to $50.60 and extending them to persons aged 70 before 1972 is quite modest; $125 million is the first-year cost, of which approximately $110 million will be paid from general revenues.

I urge the committee to adopt this amendment so that these truly forgotten Americans will not be forced to face retirement without any cash income from nonwelfare sources.

Finally, Mr. Chairman, I have a few remarks concerning medicare and medicaid.

First, I hope that the committee will give serious consideration to S. 2184, a bill I introduced which is now before this committee, and would permit the coverage of prescription drugs under part B of medicare. Older Americans actually go without medicine simply because they cannot afford to buy it.

We have no way of knowing, but I suspect many of them end up in the hospitals simply because of lack of adequate medication which caused excessive physical deterioration. If that is the case, the inclusion of prescription drugs under medicare would represent a long-range cost saving for the program.

I am also concerned about section 225 of the House-passed bill, which arbitrarily reduces Federal matching funds under medicaid by one-third for any patient after 90 days of care in a skilled nursing home. The premise behind section 225 seems to be that patients in nursing homes do not require inpatient care after 90 days but may be cared for at home.

Now, to my mind, that is a medical judgment, not a political one. Therefore, I urge the committee to find other ways of cutting the cost of medicare.

In this connection, I might add that I am also concerned about the new HEW regulations which have had a serious effect on home health agencies. Visiting nurse associations and other home health agencies provide services which, in the long run, save considerable sums of money for the entire medicare system. Their use should be encouraged and not discouraged by denials of reimbursement and bureaucratic judgment.

I know the committee is grappling with this problem, and I have confidence that the product of its work will so clarify the situation that the needs for medicare patients will be met.

Mr. Chairman, I wish to thank the committee for receiving my views. I hope that the members will accept my proposals to improve upon H.R. 17550 in order that we may truly acclaim the Social Security Amendments of 1970 a landmark in progressive legislation for our 20 million older Americans.

Thank you very much, Mr. Chairman.

(Senator Prouty's prepared statement follows. Hearing continues on page 932.)

STATEMENT OF HON. WINSTON PROUTY, A U.S. SENATOR FROM THE STATE OF VERMONT

Mr. Chairman, I am pleased that the Committee has afforded me this opportunity to present my views on H.R. 17550, for I regard this measure as the most significant reform of the Social Security System since at least as early as 1950.

Although I do not agree with some of the half-way measures taken in this bill, I regard it is an important starting point from which I hope this Committee will shape a truly meaningful and historic law.

I am convinced that this particular week of September 20th is especially significant for older Americans. This week older Americans are meeting in over 3,000 communities across the country to formulate plans for the 1971 White House Conference on Aging.

For the first time thousands of older Americans themselves will have direct in-put in formulating plans for a White House Conference. I know many problems will be presented including the adequacy of services, housing, and opportunities available to older Americans. I am also convinced that the number one concern which will be expressed is the economic hardships which continue to plague older Americans.

During the next few weeks we in Congress can promptly pass meaningful Social Security legislation. In other words we can move long before the 1971 White House Conference on Aging to alleviate the number one problem facing older Americans—the inadequate cash income.

Most of my comments will center around my four amendments to H.R. 17550 (amendments 696, 697, 698 and 785) which were referred to this Committee. I shall also comment briefly on some of the Medicare and Medicaid provisions with which I differ.

My amendments provide substitutes to Sections 101, 102 and 107 of HR 17550. Section 101 is designed to increase social security old age survivors' benefits. As passed by the House, Section 101 provides a 5% across-the-board increase in these benefits, raising the minimum benefit of $64 a months to $67.20 a month and to $100.80 for family benefits. Section 102 increases special age-72 benefits under the Prouty Amendment of 1966. Section 107 liberalizes the retirement earnings test.

On May 21 the House of Representatives passed a landmark bill, HR 17550, which contains many significant and needed changes in Social Security, Medicare and Medicaid. I can support most of those changes wholeheartedly. I, too, have long advocated an increase in widow's benefits from 82½ to 100% of the spouse's benefits, a liberalization of the retirement test and many other reforms contained in HR 17550.

I am particularly pleased that the House has increased the so-called Prouty payment special benefits for certain uninsured persons over age 72.

For the past three sessions of Congress I have sought to raise minimum social security benefits to a more realistic level—a level which can truly fulfill the purpose of the Social Security System to provide a basic floor of protection for our retired workers. Last year I supported an increase in the minimum to $100 which passed the Senate. However, the best we could obtain in conference with the House was $64 a month. Just try to imagine an elderly person actually living on $64 a month. It can't be done. That is one reason why over one million social security beneficiaries are currently on welfare. That is one reason why 60% of all old age assistance goes to social security beneficiaries.

Therefore, I cannot accept the meager 5% increases in benefits which raises the minimum level from $64 to $67.20. Such an increase is meaningless in light of the needs of our older people to support themselves in this period of rising prices. Indeed, $67.20 a month is only two-fifths of the minimum poverty level income. In effect, we are being asked to sanction a Federal Government program which does not even provide beneficiaries half of the minimum income needed to sustain life.

I would like to emphasize strongly to the Committee that Congress has fallen behind in caring for the aged, because the number of our elderly poor as a percentage of all poor people has actually risen, from 15% in 1959 to 18% in 1968. A retired person could barely buy a month's supply of food on $67.20, let alone pay for the necessary utilities, rent and clothing. I have received a number of letters from elderly citizens describing the extreme difficulty of living on even as much as $100 a month.

As the ranking Republican member of the Senate Special Committee on Aging, I have studied voluminous first hand accounts of the income plight of the elderly. Our Committee for the past two years has conducted an in-depth survey of the economics of aging, and we have concluded that income is by far the number one need of the elderly. Fully one-third of all persons 65 and over live below or near the poverty line.

Therefore, I want to present this Committee with the following recommendations for amending HR 17550:

Recommendation No. 1: A $100 minimum benefit.—I ask this Committee to adopt my amendment No. 696, which would amend Section 215 of the Social Security Act so as to provide, beginning January 1, 1971, a minimum benefit of $100 a month, and a correspondingly scaled increase up the line, beginning with a 10% increase at the lower levels and a 1% increase at the upper levels, averaging about a 5% increase in benefits above $100. My proposal is being cosponsored by the distinguished minority leader, Mr. Scott, and by Senators Fong and Cotton.

Even $100 a month is insufficient to provide an adequate income for retired persons. But we must strike a balance somewhere between a fully adequate minimum and the financial soundness of the System as an income replacement device. The System has always been regarded as a basic floor of retirement income, which the retired beneficiary may then supplement from other sources. I estimate that $150 a month is the truly realistic estimate of an elderly person's minimum monthly income needs. My proposal is to close the gap between social security benefits and minimum income needs to a realistic degree. A minimum social security benefit of $67.20 requires a beneficiary to find additional income sources to the tune of over $80 a month if he is to live above poverty means. Such a burden cannot easily be met, even if the beneficiary is fortunate enough to have savings or a private pension—and most beneficiaries have no private pension income and only modest savings. I propose to reduce that burden to an acceptable level. Thus, my amendment is wholly consistent with the fundamental rationale of the Social Security System, while at the same time, it faces up to the realistic income needs of retired persons.

I want to make it clear that I do not advocate turning the Social Security System, which is an earnings-related pension into a straight welfare program. However, I realize that raising minimum benefits under the Social Security System in order to meet minimum needs places an unwarranted burden on wage earners subject to the regressive social security payroll tax.

Therefore, both in the last Congress and again this Congress I introduced a bill entitled the Older Americans Income Assurance Act, S. 3554, which would assure all older persons a minimum income of $150 a month which would be financed out of general revenues. I am hopeful your Committee will take action on S. 3554 in order to alleviate some of the problems facing between 5½ and 6 million older Americans.

I approve the imaginative leadership of President Nixon in advocating automatic cost-of-living increases in social security benefits, which the House has adopted. Congress should, however, at the same time provide an adequate benefit level upon which to build as the cost of living increases. Under the House version, the first benefit increase under the cost-of-living factor would not take effect, if at all, for two years, until January of 1972. In the meantime, we cannot complacently compliment ourselves on providing adequate retirement benefits if we are content to accept only a $67.20 minimum. Such action would constitute a callous disregard of the present needs of our older citizens.

Recommendation No. 2: Restructuring the System's Finances.—The cost of increasing minimum benefits to $100 and of providing a scaled increase up the line, as I propose in my amendment, is estimated at $2 billion in the first 12 months above the cost of HR 17550, as passed by the House. Based upon the financing data compiled by the House, Ways and Means has reported that, on a conservative basis, the Old Age and Survivors Insurance Trust Fund will increase by over $16 billion from 1970 to 1975, i.e. from $32.09 billion to $48.66 billion. The long-range estimate through 1985 shows a similar trend. Such estimates, moreover, are based upon the House provision which delays a previously passed increase in the combined employee-employer tax rate from 1971 to 1975. The law now calls for a combined rate of 9.2% in 1971 and 10% in 1973. The House has voted to keep the rate at 8.4% until 1975.

I have been convinced for several years that massive accumulations in the Trust Fund are wholly unnecessary and economically unsound. The Social Security System, unlike a private insurance program is founded upon the taxing power and backed by the credit of the United States Government. It is a compulsory system; all covered jobs must contribute. Year after year, inevitably, funds pour into the System. This income, together with interest credited, substantially exceeds annual benefit payments and administrative expenses and will continue to do so under the present system for many years. I believe that it is now time for us to ask ourselves: Why?

Why is it necessary to accumulate billions of dollars as a reserve while each year's income exceeds payments by an ever-increasing margin?

Why must a System backed by the best credit in the world—the Federal tax power—operate as if it didn't know where its next dollar is coming from?

Proposals for altering the Trust Fund concept are not new; they have been debated for many years and they take various forms. They generally advocate adoption of partial general revenue financing. (E.g., *Social Security: Perspective for Reform*, by Peckman, Aaron and Taussig, Brookings, 1968).

I myself am persuaded that the time for reform in financing the System has arrived. We cannot perpetually fund increased benefits on the basis of increases in a regressive payroll tax. The wage earner cannot be asked to sacrifice an ever-increasing portion of his salary to pay for current benefit increases. It is a misconception to view the System as an insurance-saving concept whereby one reaps in benefits what he has personally contributed. In the past retirees have received more by virtue of benefit increases than they have contributed. Strong evidence suggests that this will not continue. Today's worker may well contribute up to $10,000 in payroll taxes over his working life, assuming a 5% rate and an automatically increasing wage base, yet he stands to reap in benefits far less. Therefore, let us now recognize that the Social Security System is truly based upon a current income-outgo basis whereby today's workers pay for today's benefits.

On this basis, I propose that my amended benefit level be financed out of the Trust Fund initially for a period of five years, and that thereafter all benefit increases be financed from the general revenues.

It may sound like heresy to suggest that the Trust Fund operate at a deficit for a few years, but this poses no risk to the System at all, as long as we eventually move to a financing program whereby income exceeds expenses, and at the same time it avoids levying further and unnecessary taxes on the hard-pressed wage earner.

However, let me emphasize that I regard an adequate minimum benefit of $100 as more important than the method chosen to finance it. I would, therefore, reluctantly but necessarily propose that if the present financing philosophy is retained, the increased benefits be financed by one of two alternative methods:

1. By retaining the present law's tax rate schedule whereby the combined rate increases to 9.2% in 1971 and 10% in 1973 (with a corresponding increase in self-employment taxes from 6.3% to 6.9%). This would yield an estimated $3.3 billion to cover the first year cost of $2 billion for a $100 minimum.

2. Preferably, by increasing the contribution base in 1971 to $12,000. This would also finance a $100 minimum and would more fairly apportion the tax burden.

Whatever financing policy this Committee decides upon, I submit that the imperative priority is to establish a decent $100 minimum.

Recommendation No. 3: A 10% increase in special benefits for the uninsured.—My second amendment, No. 697, very simply substitutes a 10% increase for the House-passed 5% increase in special age-72 benefits, so that the new monthly benefit will be $50.60. As the original author of Section 228 of the Social Security Act, providing benefits to uninsured persons who reached age 72 by 1967, I can testify to the incalculable benefits this modest measure has produced in terms of easing the economic hardship of our elderly citizens who were unable to obtain coverage under the Social Security System. My amendment simply conforms the special benefit to the 10% increase which I propose for covered beneficiaries. Thereafter, special benefits will increase automatically pursuant to Section 104 of HR 17550.

Recommendation No. 4: Expansion of special benefits under Section 228 to persons reaching age 70 by 1972.—On July 16 I introduced amendment No. 785 to HR 17550, in order to expand coverage of special benefits under Section 228 to all persons reaching age 70 by 1972.

As the law now stands, persons otherwise ineligible for social security benefits because they lacked quarters of coverage who reached age 72 before 1968 are entitled to the special payment. The monthly amount is currently $46; I seek, as I indicated previously, a 10% increase in that amount.

I am proud to have been the author of the special payment law enacted in 1966 to blanket in elderly persons who, although they worked all their lives, happened through no fault of their own to have worked at jobs not covered by social security. Thousands of Americans labored throughout the 'forties and 'fifties in non-industrial jobs—agricultural workers, migrant laborers, retail employees, domestic and part-time workers—only to retire into poverty without

even minimum social security coverage. For most of them, poverty was a new experience.

My initial proposal in 1966 would have blanketed in at $44 per month all non-covered persons age 70 and over. Although the Senate adopted my measure, it was limited in conference to a $35 payment for persons reaching age 72 before 1968. This modest benefit has now helped over 1 million retired persons to enjoy at least some semblance of a decent living; they can at least buy food for their tables.

Yet there still remains in this abundant nation a large segment of retired persons who did not—and for the most part could not—qualify with quarters of coverage under social security. Approximately 700,000 retired persons who were age 65 and older in 1966, when my amendment became law, continued to suffer their retirement without any social security benefits. These people had worked in many fields of labor to contribute to this nation's prosperity.

My modest proposal is simply to correct this gap by expanding special benefits to cover all persons reaching age 70 by 1972, thereby including those persons who reached age 65 in 1966, when my initial amendment was enacted.

Until 1950 social security benefits were payable only to persons who worked in industry and commerce. Beginning in that year, coverage has been extended to most farm and domestic workers and non-farm self-employed persons, so that today very few workers—indeed, about 2%—are not now eligible for social security, and most of those people are eligible for state or Federal civil service pensions. Yet a small pocket of retired persons does remain ineligible. I believe that 1970 should be the year when Congress accepts its responsibility to those unfortunate few.

The cost of increasing special benefits to $50.60 and extending them to persons age 70 before 1972 is quite modest; $125 million is the first year cost, of which approximately $110 million would be paid by the general revenues.

Recommendation No. 5: A $2400 exemption under the retirement test.—Finally, I am also sponsoring an amendment to Section 107 of the House measure. As passed by the House, Section 107 would increase from $140 to $166.66 the amount of monthly earned income permitted to a social security beneficiary prior to reduction of benefits. The House bill then very wisely creates an automatic scaled-up exempt amount every 2 years in proportion to the increase in average taxable wages. I am also very pleased to note that the House has adopted a $1 for $2 benefit reduction for all earnings above the exempt amount so that benefits would never be cut off entirely. I propose to exempt $200 per month from benefit reduction. Whereas the House measure would allow $2000 a year of earned income, I propose $2400. Otherwise the law would remain unchanged, so that the exempt amount will rise as average taxable wages increase.

I believe that it is economically and socially unfair to discourage able-bodied retired persons from supplementing their pension income with part-time work. In my home State of Vermont, I am aware of numerous situations where healthy 70 year old retired persons, such as carpenters and painters, would contribute their useful skills part-time if they would not thereby lose their social security checks. This kind of work can be meaningful not only economically but psychologically to a man who was accustomed to hard work all his life. At the same time, he can contribute needed skills to his community and in many communities today the skills of retired persons are sorely needed. I believe that a $2400 allowance base for earned income would realistically meet the desired goals of useful work and economic security. Indeed, I am hopeful that Congress can virtually eliminate the work discentives of the program.

MEDICARE-MEDICAID

There are many aspects of the medical provisions of HR 17550 on which I could comment, but suffice to say generally that I especially favor the health maintenance option and coverage for the uninsured. I believe that some of the cost-cutting measures in the bill are wise and necessary.

I would like to see this Committee add a provision to cover the cost of out-of-hospital prescription drugs, dental care and the cost of glasses. I have myself sponsored bills to include such services.

But there is one objectionable provision in the bill which I strongly suggest be eliminated, and I shall limit my remarks to that item at this time.

Section 225 of the House-passed bill provides that Federal matching funds under Medicaid shall be reduced by one-third for any individual patient after 90 days of care in a skilled nursing home. Present law contains no such cutoff. The purported justification for this cut-off provision is to provide incentives for

outpatient care. Thus, Section 225 increases by 25% the Federal share of Medicaid outpatient care and home care services, and decreases the Federal share by one-third for hospital care after 60 days. These amendments are obviously designed to reduce the growing costs of Medicaid, however I fear that they do so at the expense of the patient and to the detriment of decent health care.

The house-passed cut-off provision is based on an erroneous premise that patients in nursing homes do not require in-patient care after 90 days but may be cared for at home. Such a sweeping and general judgment cannot be made by lawmakers; it can only be made on a case-by-case basis by the physician. Indeed, over two-thirds of all nursing home patients are found to require more than 90 days of care. I believe that H.R. 17550 already contains adequate strengthened safeguards against providing unnecessary health care by placing limits on reasonable costs, by cutting off funds if the program is abused, and by setting up utilization review committees to evaluate the need for care. If such a review determines that care is necessary after 90 days, it is grossly unfair to reduce the funds needed to provide such services.

The magnitude of Section 225's evil is enormous. Medicaid patients account for 60% of all nursing home admissions. If one-third of the Federal funds are cut off, the states will be required either to scrape up the money themselves or to turn patients out of bed prematurely.

I believe strongly that the Federal government should not build up expectations only to shatter them. After Medicare and Medicaid were enacted in 1965 and 1966, hundreds of skilled nursing homes geared up to provide for increased admissions. They have operated for four years in reliance on an assumed Federal payment. Now, they face a mid-stream cut-off. I hope that this Committee will recognize the unfairness in Section 225 and eliminate it from the bill.

I cannot, in good conscience, conclude this statement without expressing my deep concern about confusion as to what services will or will not be reimbursed under Medicare.

Denials of reimbursement, sometimes retroactively, have apparently been made in a manner which implies disregard of professional judgments by physicians and other health professionals responsible for medical care. This has created hardships for many patients and health care institutions. In some instances, as with home health agencies, the very existence of the agency providing essential services to the patient may be jeopardized.

Experience of home health agencies in my own State, Vermont, suggests that if such conditions are allowed to prevail, it may become impossible for some Medicare patients to receive care for which they are eligible under the law.

I believe it is imperative that home health agencies, such as Visiting Nurse Associations, be strengthened, not weakened. Humanitarian considerations demand it; sound economics recommend it. With regard to the latter, a study by the Vermont Assembly of Home Health Agencies shows that one dollar spent on home health agency services saves anywhere from $6 to $15 in hospitalization costs.

I am sensitive to the fact that the Committee is aware of this problem and is grappling with it. I commend the Committee for this concern and have confidence that the product of its work will so clarify the situation that the needs of Medicare patients will be met.

I want to thank the Committee for receiving my views. I hope that the members of the Committee will accept my proposals to improve upon HR 17550 in order that we may truly acclaim the Social Security Amendments of 1970 a landmark in progressive legislation for our 20 million older Americans.

The CHAIRMAN. Thank you very much, Senator Prouty.

Any questions, gentlemen?

Thanks very much, Senator.

Next we will hear from the junior Senator from Oklahoma, the Honorable Henry Bellmon.

We are pleased to have you with us today.

STATEMENT OF HON. HENRY BELLMON, A U.S. SENATOR FROM THE STATE OF OKLAHOMA

Senator BELLMON. Thank you, Mr. Chairman.

Mr. Chairman, I have a statement which I will file for the record,

but I would just like to summarize it for the committee in view of the short time that we have.

I would just like to say that I appear before you to urge the committee to report out the social security and welfare bills pending before you in order that the Senate will have an opportunity to vote on this important legislation this session.

I strongly support the concept of this legislation, and while I recognize there are needs for amendments and hopefully some improvement, I feel that we do need to get these bills out.

As a former Governor who virtually lived with the administration of a well-run welfare program during my 4-year term, I am deeply concerned about many of the problems involved in the welfare program. The number of individuals receiving welfare and the cost of welfare have been increasing and will continue to increase under the present program. The States are finding it more difficult to finance their part of the cost. The striking inequalities and inequities among the States create powerful incentives for welfare recipients to move from low-income States to the crowded slums and inner cities. The provision of Federal aid to families, only when the father is absent from the home or unemployed, tends to encourage the breakup of families.

The welfare bill, now pending before your committee, is an important improvement in the existing program. It is not perfect and needs to be amended and I hope your committee will look for proposed further amendments that will make it more workable and eliminate inequities.

Mr. Chairman, during the time I served as Governor, I became convinced that a large number of people on welfare can and will take jobs and that they can hold jobs and can compete in the job market.

Under the terms of title V of the Economic Opportunity Act, the State of Oklahoma operated a program from June 15, 1965, to June 30, 1969, that was intended to give these individuals incentives to work and to give them the training necessary to help them hold jobs. During this period of time, 5,201 persons were referred to the program. Of this number, 2,669 either were not accepted or dropped out. The remainder, 2,482, completed their training, and of that number 2,119 were employed, about 70 percent.

The average monthly beginning salary for these people, 2,119 who were employed, was almost $300. This amounted to $616,629 per month, or $7,399,548 per year in new income.

Because of these earnings, the Oklahoma Department of Public Welfare was able to close out 1,274 AFDC cases, in this way saving the Government $206,388 per month, or $2.5 million a year. This was the record of getting individuals who would otherwise have been on welfare probably for the rest of their lives and probably would have raised families, many of whom would have been on welfare.

So this proved to me, at least, that many of these individuals do have the ability and the interest in becoming wage earners, and that by breaking the welfare cycle in this way many of their children will also continue in the work force.

At the same time, the Opportunities Industrialization Center of Oklahoma has had a similar record of success.

Between the period of December 1966 and December 1969, this program, the one we called OIC, has trained 3,448 trainees. Of that num-

ber, 1,278 have been trained to the point where they can be placed on jobs. The average monthly income of those trainees, prior to entering OIC, had been $116.89, and most of this was from welfare.

After they had been trained, their monthly starting salary averaged out to $265.

Now, during this period of time, OIC succeeded in placing 146 persons who had been on welfare in gainful employment, and this succeeded in saving the Federal Government about $300,000 a year in direct welfare payments.

So it is obvious to me that these people that many of us look upon as hopeless welfare cases are not in that category at all and can, under the terms of legislation such as you are considering, be made productive members of our society, and, certainly, this kind of a change is long overdue.

Mr. Chairman, I would like to suggest that the present system, where the income supplement is in one agency and the job training responsibility and job placement is in another agency, is not working satisfactorily. In order to help remedy this situation, I propose an amendment to H.R. 16311, and I have a copy for the committee, but primarily what this does is to make certain that whenever a State agency refers an individual to the Secretary of Labor for employment in a special work project or in any of the work training programs, the Secretary of Labor shall give priority for such training or such employment to the individual who has been recommended by the State agency.

At the present time, it appears that in many cases the Department of Labor is not giving proper attention to the referrals that come in from the State welfare department and my amendment is intended to help correct that situation.

I would like to leave it for the committee's consideration.

There is another aspect of the law that I feel needs to be made more flexible in order to accomplish the objectives of the committee.

I believe that the law should provide for federally matched payments to an individual who is a resident of an intermediate care facility in a public institution.

I further recommend that the law be changed to include an intermediate care facility program for those persons eligible for medical care under title XIX in addition to those who are receiving money payments or who would be eligible for money payments if they were not in the intermediate care facility.

I have an amendment to accomplish that objective.

Now, on another piece of legislation that is before the committee, H.R. 17550, I would also propose an amendment to help remove an objectionable feature, at least something I feel is objectionable. This amendment has to do with the nursing home program, and unless this amendment is adopted, it is going to cause some extremely serious problems in many States that have done a remarkable job, I feel, in helping to improve the treatment and care of our mentally retarded.

Unless an amendment along the lines that I am proposing is adopted, our own State of Oklahoma is going to suffer a total loss of about a half-million dollars in Federal medicaid matching funds for hospital care in the States for mentally retarded this coming year.

I strongly feel that the committee needs to carefully examine this provision of the law, and I propose an amendment to strike out para-

graphs (b) and (c) on pages 104 and 105 of the House-passed social security bill, to help the States provide the necessary care for mentally ill and mentally retarded, to enable the States to continue care of individuals who are in nursing home services.

Mr. Chairman, I urge your committee to report out a welfare revision bill at this session. I hope that any amendments which the committee adopts which provide for experimental projects will be based on including in the bill specific dates for implementing the coverage of the program.

I believe that all Senators should be given an opportunity to vote on this measure during this session along with amendments such as those I have proposed.

I would like to express my support for the concept embodied in H.R. 16311, the Family Assistance Act of 1970. I am convinced that the present jumble of programs is doomed to fail, that its cost will become politically unbearable, that the socially destructive effects of the disincentives which the present law contains will continue to produce chaos in our cities, that the different levels of welfare support between States will continue to produce serious population distortions, and that the welfare cycle that has accelerated during the 1960's will, unless checked, become jet-propelled in the next decade.

Mr. Chairman, the present welfare program, well intended as it is, has had the effect of holding people down. The Family Assistance Act with amendments can become the "Up With People" Act of 1970.

(Senator Bellmon's statement follows. Hearing continues on p. 938.)

STATEMENT OF HON. HENRY BELLMON, A U.S. SENATOR FROM THE STATE OF OKLAHOMA

Mr. Chairman, Members of the Committee, in view of the extensive hearings this committee has conducted on the Family Assistance Program and the Social Security Amendments and the large number of witnesses who have been scheduled, I greatly appreciate the opportunity to appear here today. May I offer my congratulations to my colleagues on the committee for your earnest and diligent efforts in considering this comprehensive and important legislation.

Mr. Chairman, I appear before you today to urge your Committee to report out the Social Security and Welfare bills pending before you in order that the Senate will have an opportunity to vote on this important legislation this session.

As a former Governor who virtually lived with the administration of a well-run welfare program during a four-year term, I am deeply concerned about many of the problems involved in the welfare program. The number of individuals receiving welfare and the cost of welfare has been increasing and will continue to increase under the present program. The States are finding it more difficult to finance their part of the cost. The striking inequalities and inequities among the states create powerful incentives for welfare recipients to move from low income states to the crowded slums and inner cities. The provision of Federal aid to families, only when the father is absent from the home or unemployed, tends to encourage the breakup of families.

The welfare bill now pending before your Committee is an important improvement in the existing program. It is not perfect and I hope your Committee will propose further improvements which will make it more workable and eliminate inequities.

I know that the welfare revisions will temporarily cost more in Federal funds and will temporarily increase the number of individuals receiving welfare payments, However, by stressing incentive payments to individuals who work it will give support and encouragement to those who work and want to improve their situation. It will help to keep families together instead of encouraging them to split up. The principles underlying this measure are sound and compassionate. In the long run I believe these revisions will reduce both the cost of welfare and the number of welfare recipients.

My experience with the welfare program during the time I served as Governor of Oklahoma convinces me that a large number of recipients, particularly in the AFDC and aid to totally and permanently disabled category want to work and earn, have the ability and energy to hold jobs, that they can compete and succeed in making their own way. I am further convinced that the atmosphere in a home where there is a wage earner is far more desirable than the atmosphere in the homes where the total income is from a government handout.

My purpose in appearing before the Committee today is twofold. First, I would like to offer some general views about the so-called welfare system and the need for some new approaches to the problem of making producing wage earners out of employable welfare recipients. Secondly, I want to make some specific comments on and offer amendments to certain features of the pending legislation which I feel are objectionable and need to be reconsidered.

For several years I have been concerned that our welfare program, while well intended, has discouraged rather than encouraged those who needed help to become self-supporting. An examination of the record will show that even during recent periods of high employment the welfare care load and costs have risen sharply, from $4,039,433,000 in 1960 to $11,886,083,000 in 1969. This rise is most pronounced in the AFDC category where federal costs alone have increased from $1,021,097,000 in 1960 to $3,189,053,000 in 1969. At these rates of increase it is easy to see that unless a new approach is taken the costs of welfare may double again in this decade.

Serious as is the problem of paying the costs of welfare has become, the human and social problems are probably even more serious. Many of the difficulties in our Nation today relating to crime, drug abuse, and congestion are related to aspects of the present welfare program which has tended to draw people into the cities, to break up families, and to force many able and willing workers into a condition of perpetual idleness.

In my opinion, desired social progress and stability cannot be achieved under existing departmental structures and under present welfare concepts. There is a need to combine within one agency the responsibilities of the Federal Government for income maintenance, manpower training, child care, and job placement. In effect, such an agency would combine and coordinate the functions of existing federal agencies administering employment security and welfare programs, and assume many of the manpower training responsibilities presently assigned to the Department of Labor.

At the present time, these efforts are separated, and as a result, no one agency has the full responsibility for preventing unemployment and for providing maximum incentive to train and beneficially utilize our nation's human resources.

Oklahoma's experience in programs for work training for welfare recipients substantiates the need for integrated effort.

From June 15, 1965 to June 30, 1969, the Oklahoma Department of Public Welfare operated a work incentive program under Title V of the Economic Opportunity Act. During this period, 5,201 persons were referred to the program. Of this number, 2,669 were not accepted or dropped.

A total of 2,482 completed their training, and of that number, 2,119 were employed. The average monthly beginning salary for those employed was $291. This amounted to $616,629 per month, or $7,399,548 per year, in new income earned from the private sector. Because of these earnings, the department was able to close 1,274 AFDC cases for a savings to the government of $206,388 per month, or $2,476,656 per year, in money payments alone, not considering Medicare or other benefits. The social benefits which will accrue as a result in this break in the welfare cycle are impossible to over emphasize.

In addition, the Opportunities Industrialization Center of Oklahoma City has experienced a great degree of success. Between the period of December, 1966, and December, 1969, there have been 3,448 trainees enrolled by the OIC in Oklahoma City, and 1,278 of these had been trained to the point that they could be placed on jobs. The average monthly income of a trainee, prior to entering OIC, has been $116.89 (mostly from welfare). The monthly starting salary of OIC graduates, after training, averages $265.73. During this period of operation, OIC succeeded in placing 146 persons who had been on welfare rolls in gainful employment, thus saving State and Federal Governments $295,934 per year in direct welfare payments. Those same 146 persons, whose total income had been from welfare, are now earning $465,561.88 per year, or more than 100% of their previous income.

Dr. Leon Sullivan, in a statement before the House Education and Labor Committee, on February 26, 1970, said, "The Philadelphia OIC prototype, since its beginning in 1964 through 1969, has trained and placed on jobs 100,000 men and women with new useful skills, one-third of whom had been on relief rolls and 95 percent of whom were classified in poverty categories. In Philadelphia alone, there are some 5,000 additional persons at this time on a waiting list.

Under Title V, an average of 614 persons were trained per year. In contrast, under the WIN program operated by the Department of Labor, which succeeded Title V, only 330 individuals were enrolled for training as of July 31, 1970. It is reported that county welfare offices are having difficulty in geting referrals accepted into the WIN program.

Mr. Chairman, in order to help remedy this situation, I would like to offer the following amendment to HR 16311:

Section 431 (d) of HR 16311 is amended by adding Subsection (5) as follows:

"(5) Whenever a state agency in any state refers any individual in such state who is an applicant for or recipient of assistance to the Secretary of Labor for employment in a special work project, or in any other work or training program, the Secretary shall give priority to such training or employment of such individual in any such project or program, which meets the requirements of this title. The Secretary is authorized and directed to consult with appropriate state authorities in each of the states in the establishment of special work projects which expand the opportunities for constructive work experience, the conservation of works skills, the development of new skills, and needed training. Expenditures for any month for any assistance shall not be excluded because such expenditures are made in the form of payments for work performed in such month for any state agency or any other public agency under a special work project approved by the Secretary."

I respectfully urge that this change be incorporated into the legislation currently pending before this committee.

One other aspect of the law needs to be made more flexible in order to accomplish the objectives of the Committee. I believe the law should provide for Federally matched payments to an individual who is a resident of an intermediate care facility in a public institution. I further recommend that the law be changed to include an intermediate care facility programs for those persons eligible for medical care under Title XIX in addition to those who are receiving money payments or who would be eligible for money payments if they were not in the intermediate care facility.

To accomplish these objectives, I propose the following amendment to HR 16311:

On Page 100 of the Committee print of the Bill, lines 7 and 8 (title XVI, section 1610(1)) strike out "an inmate of a public institution (except as a patient in a medical institution); or" and insert in lieu thereof the following:

"an inmate of a public institution (except as a patient in a medical institution or a resident in an intermediate care facility); or".

On Page 136 of the Committee print of the bill (Section 402(10)(B)) strike out lines 24 through 26.

Section 1121 of the Social Security Act is amended by (a) inserting in subsection (a) after "intermediate care facilities" the first time it appears the following words "(public or private)," (b) striking out the period and inserting in subsection (a) after the term "money payments"; the following, "or medical assistance;", (d) inserting in subsection (e) after the term "intermediate care facility" when it first occurs the following, "as determined in accordance with and subject to limitations in regulations of the Secretary.".

As to HR 17550, the Social Security Amendments of 1970, this bill contains some objectionable features which I hope will be removed.

Oklahoma, in good faith has followed the directions of HEW Federal Letter 571, dated June 15, 1962, which stated that Federal sharing was available with respect to persons on convalescent leave from mental health and retarded institutions, who enter medical institutions, including nursing homes.

During the time I served as Governor of Oklahoma, this program made it possible for dramatic improvements to be made in the care and treatment of the mentally disturbed or retarded patients who were no longer responding to treatment or training. It was found that they could receive satisfactory and often improved care by transfer from the state institutions to privately operated nursing homes. Similar improvements undoubtedly were made in other states during this period.

According to information supplied by the Oklahoma Department of Public Welfare, provisions contained in section 225 of HR 17550 would destroy this highly successful program in Oklahoma and deal our state a severe financial blow.

If adopted by Congress, these provisions would reduce federal Medicaid matching funds by one-third after the first sixty days of care in a general hospital and by one-third after the first ninety days of care in a skilled nursing home. It is estimated that under the proposed reduction, Oklahoma would suffer a total loss of at least $6 million on Federal Medicaid matching funds for skilled nursing homes in one year. The number of Medicaid patients in skilled nursing homes whose stay exceeded ninety days in the past year was 17,895, or 78.93 percent of those admitted.

Those individuals in skilled nursing homes whose condition remains unchanged will continue to have the need for such care even though the ninety days have elapsed. Persons who need skilled nursing home care may not in Oklahoma be transferred to intermediate care facilities since under the Oklahoma health facilities licensing law such facilities are only for persons who "do not routinely require skilled nursing care but do require care of a lesser degree than that provided by a skilled nursing home."

Under the proposed reduction, Oklahoma would suffer a total loss of at least $418,000 in Federal Medicaid matching funds for hospital care in state schools for the mentally retarded in one year. The average number of medicaid patients in such hospitals whose stay exceeded 60 days in the past year was 499. If Federal Medcaid matching funds were reduced as proposed by one-third after 90 days of care in a skilled nursing home, resultant financial stringency could lead in Oklahoma to a serious situation for the mental retardation program under which it might be necessary to take steps to return to state schools for the mentally retarded some 1,200 adult retardates eligible for and needing skilled nursing home care and receiving such care in certified skilled nursing homes throughout the state. To accommodate such retardates a new school for the mentally retarded would have to be built at a cost of roughly $18 million. To return an additional 500 adult retardates now in skilled nursing homes to their families would pose many problems for such families including that of meeting multiple medical requirements.

Oklahoma entered into original agreements to provide these medical services in good faith and made financial plans on the basis of the current federal matching ratio. The reduction proposal would be highly disruptive and would place an unfair financial burden upon the State of Oklahoma.

Therefore, I hope you will accept an amendment which would strike out paragraphs (B) and (C) on pages 104 and 105 of the House-passed Social Security Bill (section 1903(e)(2) (B) and (C) of the Social Security Act.) This amendment will help the states to provide necessary care to the mentally ill and mentally retarded and to enable the states to assure continued care of individuals needing skilled nursing home services.

Mr. Chairman, I urge your Committee to report out a welfare revision bill at this sesssion. I hope that any amendments which the Committee adopts which provide for experimental projects will be based on including the bill specific dates for implementing the coverage of the program. I hope all Senators will be given an opportunity to vote on this measure this session along with amendments such as I have proposed in my statement.

In conclusion, I would like again to express my support for the concept embodied in H.R. 16311, the Family Assstance Act of 1970. I am convinced that the present jumble of Federal programs is doomed to fail, that its cost will become politically unbearable, that the socially destructive effects of the disincentives which the present law contains will continue to produce chaos in our cities, that the different levels of welfare support between states will continue to produce serious population distortions, and that the welfare cycle that has accelerated during the 1960's will, unless checked, become jet propelled in the next decade.

Mr. Chairman, the present welfare programs, well intended as it is, has had the effect of holding people down. The family assistance act with amendments can become the "Up With People" Act of 1970.

The CHAIRMAN. Thank you for the statement, Senator.

I am glad you said something about the mentally ill. We will certainly consider what you said. Personally, I am not too much concerned

about what we spend on this program, provided we spend it wisely and it proves to be a good productive investment of Government money.

I am very concerned about spending money, Federal money, in a way that proves to be ineffectual, wasteful, or self-defeating.

In the mental health area, we probably have a better opportunity to get a yield from our investment than anywhere else because there, particularly if we are willing to help the States provide treatment and cure for these mentally ill people, at an early date they can become productive citizens in many respects.

You were Governor of Oklahoma and you are aware of the potential in that area, are you not, Senator Bellmon?

Senator BELLMON. Mr. Chairman, what you say is exactly right.

Our State, like many States, had fallen into the trap of operating primarily custodial institutions and a lot of individuals who came into those hospitals and schools who were trainable or curable were simply kept there and never treated so that they could return to normal life.

Under the terms of a new program that was instituted, we took from those hospitals and schools the individuals who were custodial patients, and lessened the burden on the staff of those institutions so that they could give treatment and training to people who were curable or trainable.

As a result, we have had a rather remarkable reduction in the caseload and a remarkable record of success in returning people permanently to private life. I feel strongly that a great deal more can be accomplished in this same way in many other States.

I might say that unless an amendment such as the one I have recommended is approved that we are going to force a lot of these people who are now being housed in private nursing homes back into these State hospitals and State schools and we will have the same crowded conditions that we have had previously.

The CHAIRMAN. I hope we can make some progress toward reversing some of the upside-down thinking that we have been confronted with in years gone by.

As you know, when some of us tried to help the mentally ill under our Federal programs in the early days, we had to settle for a situation where we could help them in a general hospital but could not provide any help if they were in a mental hospital. That is about as silly as anything that I know of, but we could not get any better so we had to settle for it. I hope that we can make more progress in this bill, and I look forward to having your help in that, Senator.

Senator BELLMON. The committee has done a remarkable job in giving the States the tools they needed to work with, and I think it is going to be a great mistake if we now take some of these tools, which have proved effective, away from the States.

I know as a new Member of Congress how tight money is here, but I also know, as a former member of State government, how tight money is at the State level and States just do not have the money to back up now and return to the old system which was not working.

The CHAIRMAN. Right.

Senator HARRIS. I would like to say to Senator Bellmon that you made a very helpful and thoughtful statement and I think you are exactly right in what you recommend in regard to striking this pro-

vision limiting the number of nursing home days. I do not think the States can afford this change, and I think that it ought to be stricken out of this bill.

I think your proposal in regard to a more centralized administration of referral to jobs is one that has merit and ought to receive serious consideration.

I think there is just too much confusion and duplication and overlapping in these training and job programs, and I think what you have said in regard to that certainly has merit.

Senator BELLMON. Mr. Chairman, if I might, I would like to comment on this statement by Senator Harris.

I appreciate his feeling and am glad we agree on this point. But let me just say, if you watch these programs operate you will find when you have a divided responsibility, as we have now, between the Department of Labor and the Department of HEW, you will find that many times the Department of Labor will accept only those referrals that seem to have the greatest chance of success, and a referral that seems to be maybe a little doubtful or a little questionable will be turned down and kept forever on welfare rolls when this might not be necessary.

If we give one agency the responsibility of both income maintenance and job training and job placement, then I believe we will come much closer to developing the full potential that many of these individuals have.

Senator HARRIS. That is all I have, Mr. Chairman.

The CHAIRMAN. Any further questions, gentlemen?

Senator CURTIS. Just one, Mr. Chairman.

I want to commend the distinguished Senator for his appearance here. It is very helpful.

In reference to section 225 of the House bill, do you believe that this will not only cause a financial hardship on the States but it is also bad practice from the standpoint of the individuals involved? That is the section that changes the Federal matching funds in reference to mental hospitals as well as the stay in nursing homes.

Senator BELLMON. Senator, any change in the law that forces a large number, even any number, of mentally ill or mentally retarded persons back into these State institutions is going to be very bad for the individuals and for the States.

At the present time, at least in our State, those individuals who are housed in privately operated nursing homes are generally getting better care than they were able to get in those large State institutions. They get a more personalized care, and by reducing the population of those large State schools and hospitals, the patients who are trainable and curable are getting the benefits of intensive care and are being returned to normal life.

So any change that is going to cause those populations to be increased is going to be a great detriment to everyone.

Senator CURTIS. Do you regard it as important that Governors and State legislatures have an assurance that once a Federal program is embarked upon that they can depend upon it in making up their programs and raising their money and budgeting for it?

Senator BELLMON. Yes, sir; I certainly do.

Senator CURTIS. I think that is all, Mr. Chairman.

Senator BELLMON. This is a vitally important feature of the Federal law. Once we begin a program, we simply cannot back out.

Senator CURTIS. Yes. I feel that it is almost an axiom of political comment that you can refrain from granting a subsidy or a payment or a benefit and it will be a disappointment but show things go on. But when you remove one that States, municipalities, and individuals are dependent upon, you get a whole new series of problems involved because they have made their adjustment to it, they budgeted that way, and it usually ends up, in the attempt to remove a program, that it fails.

Senator BELLMON. It is like trying to unscramble an egg.

Senator CURTIS. It cannot be done.

Senator JORDAN. Mr. Chairman, I would like to commend the distinguished Senator from Oklahoma for his very fine statement. I think that your success in getting people off of welfare rolls and getting them to be productive taxpaying citizens is unexcelled in any State that I know of in the whole Union during your term as Governor, and I think we can take a page out of your book of experience and apply it nationwide and do very well by that experience.

Thank you very much, Senator.

Senator BELLMON. Thank you, Senator.

I might say that some of these things happened after I went out of office. We started the programs in 1965 and I left the office in 1967. Some of the figures I gave you came following that time, but it did convince me that it was possible to put a lot of these people to work, and many of them want to go to work if they just have the opportunity.

I believe this legislation will give these people that chance.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

The next witness will be John F. Nagle, chief of the Washington office of the National Federation of the Blind.

STATEMENT OF JOHN F. NAGLE, CHIEF, WASHINGTON OFFICE, NATIONAL FEDERATION OF THE BLIND

Mr. NAGLE. Mr. Chairman and members of the committee, my name is John F. Nagle. I am chief of the Washington office of the National Federation of the Blind. My address is 1346 Connecticut Avenue NW., Washington, D.C.

Mr. Chairman, I am appearing here today to urge committee approval of S. 2518, a bill to amend title II of the Social Security Act so as to liberalize the conditions governing eligibility of blind persons to receive disability insurance benefits thereunder.

S. 2518 was introduced in the U.S. Senate by Senator Vance Hartke, able and distinguished member of this committee, joined by 68 cosponsoring colleagues, including nine members of this committee.

H.R. 3782, a measure identical to S. 2518, was introduced in the House of Representatives by Congressman James A. Burke, along with 158 similar bills.

S. 2518 is also identical to measures adopted by the Senate in three previous Congresses—1964, 1965, and 1967.

I cite these statistics and point out this legislative history, Mr. Chairman, not to impress you, but so that you will understand that

the Hartke disability insurance for the blind bill is not merely the proposal of an organization, with only organization membership support.

It is our earnest hope that with this record of Senate approval of our disability insurance for the blind bill, and with the number of cosponsoring Senators and Congressmen of this proposal in the present Congress as a conclusive indication of continuing overwhelming congressional support for this measure, that this committee will again accept and approve S. 2518 and incorporate it into the provisions of H.R. 17550.

S. 2518 would make two changes in the Federal disability insurance law with particular reference to blind persons.

It would permit a person whose visual impairment is such as to constitute blindness in accordance with the definition made a part of the disability insurance law in 1967, and who has worked in social security covered work for six quarters, to qualify for disability insurance payments and to continue qualified so long as he remains blind and regardless of his earnings.

Mr. Chairman, the purpose of S. 2518 is to make of the Federal disability insurance program a true insurance program for the blind—for those who are now blind, for those who will become blind in the future.

S. 2518 would condition the right to receive disability insurance payments, and the right to continue to receive them, upon the existence and the continuing existence of the loss of sight.

S. 2518 recognizes that the severest of all the consequences resulting from the occurrence of blindness in the life of a workman is not the physical loss, the physical deprivation of sight but, rather, the severest loss sustained is the economic disaster which engulfs the newly blind worker, the economic handicaps which are incidental to blindness.

It is these economic consequences:

The abrupt termination of weekly wages;

Diminished earning power;

Drastically curtailed employment opportunities; and

Greatly reduced possibilities for advancement and increased earnings when employment has been secured.

These, and not the physical loss of sight, convert the physical disability of blindness into the economic handicap of blindness, and this is so, whether a person is recently blind or has lived a lifetime without sight.

S. 2518 would provide a partial solution to the financial catastrophe which results from blindness.

It would provide a floor of minimum financial security for those who must learn to live again, who must learn to function again, but without sight, in a world of sighted men.

S. 2518 as Federal law would reduce the competitive disadvantages of sightlessness. It would provide a continuing source of funds to meet the extra cost, the equalizing expenses of functioning, blind, in a sight-oriented society and working in a sight-geared economy.

S. 2518 would be of immeasurable help to the worker suddenly confronted with the devastating effects of blindness—the discouragement of protracted unemployment, the despair of an expected lifetime of unemployment and inactivity, the shocking loss of independence, the shame and humiliation of dependency.

S. 2518 would also provide a special and necessary kind of independence security for blind persons, for whether such a person is a lawyer, a piano tuner, a teacher, a salesman, a vending stand operator, or a housewife, they must have sight available to them.

Disability insurance payments would provide them with the needed dollars to buy sight, for we, blind people, have all learned that only sight that is hired is readily and regularly at our command and at our time of need.

Mr. Chairman, the usual blind person, with average abilities, with no particular talent or training, such a person works when he can get work, but frequently he is the victim of the inexorable laws so well-known to all disabled people: last hired and first fired, and, when physically fit men are available for jobs, physically impaired men need not apply, for they will not be hired.

Gainfully employed, when he is employed at all, the blind man is usually hired for jobs which are the shortest in duration, jobs offering the poorest pay, and even these jobs, these employment opportunities, are now rapidly being automated out of the economy.

For this person, the usual blind person, the 20 of the last 40 quarters eligibility requirement in the disability insurance law makes the protection and equalizing potential of disability insurance unavailable to him, and the proposed six quarters requirement in S. 2518 would be much more reasonable, much more realistic because of the special circumstances confronting such a blind person.

Mr. Chairman, we of the National Federation of the Blind believe that the social security programs which are intended to reduce the adverse economic and social consequences of advancing years and disabling impairments must never be considered unchangeable in policy or provision, for such rigidity may nullify the purposes to be served by these programs, while flexibility of approach and adjustment of legal provision to meet special circumstances may assure realization of such purposes: the diminution of the hazards and the heartaches of old age, the lessening of the discouragements and the disadvantages of physical disability.

We ask this committee and the Congress to recognize the special difficulties and handicapping circumstances confronting blind people, and we ask you to liberalize the disability insurance law for the benefit and assistance of blind people.

Under existing law, a person must work in social-security-covered work for 5 of the last 10 years to establish eligibility for disability insurance payments.

We ask you to approve S. 2518 to reduce this requirement to 1½ years, in order that the benefits under the disability insurance program may be more readily available to more persons when blindness occurs, in order that blind persons, unable to meet the present requirements of employment for 20 quarters in covered work, may be able to qualify for disability insurance payments under the Federal disability insurance program.

Under existing law and practice, persons who are disabled and earn as little as $70 a month and, sometimes, who earn anything at all, may be disqualified as insufficiently disabled to draw disability insurance payments.

Under existing law and practice, it is not enough that a person is severely disabled, that he is unable to get a job because he is disabled, to qualify for disability insurance payments.

He must establish his physical inability to do a job to be eligible for such payments.

We of the National Federation of the Blind ask you to change this, to allow persons who are disabled by blindness to draw disability insurance payments upon proof of blindness and to continue qualified to receive payments even though they are employed, even though they are earning and irrespective of the amount of their earnings, in order that disability insurance payments may be available to them to offset the extra, the "equalizing" expenses that must be incurred by them as they try to live and compete without sight in a sighted environment.

In conclusion, Mr. Chairman, and members of the committee, S. 2518, the Hartke Disability Insurance for the Blind bill, has an ancient and honorable congressional history.

A predecessor to S. 2518 was offered in the 88th Congress Senate by Senator Hubert Humphrey as a floor amendment to the pending social security bill, and it was adopted by voice vote without a dissenting vote.

Another predecessor to S. 2518 was offered in the 89th Congress Senate by Senator Vance Hartke as a floor amendment to the pending Social Security bill, and it was adopted by roll call vote of 78 to 11.

Still another predecessor to S. 2518 was offered in the 90th Congress Finance Committee, again by Senator Hartke, and it was given unanimous committee approval as an amendment to the House-passed social security bill.

Earlier in this 91st Congress, I visited all of the Senate offices seeking cosponsorship support when Senator Hartke introduced the Disability Insurance for the Blind bill in the U.S. Senate, and as I stated previously to you, 68 Senators joined on the bill, including all five of the Senate majority and minority leaders—Senator Dirksen had become a cosponsor before his death.

Believing that the same kind of massive support existed in the House of Representatives as had been repeatedly manifested in the Senate for the Disability Insurance for the Blind bill, I visited all House offices, explaining the provisions of H.R. 3782 and asking for the introduction of companion bills as evidence of member support of this legislation.

The 159 introduced bills identical to S. 2518 was the result.

The number of Senators and Congressmen in the 91st Congress who have indicated their endorsement and support of our Disability Insurance for the Blind bill S. 2518 certainly justifies my original belief, that this measure has the support of a substantial percentage of the membership of this Congress.

As I went through the Senate and House and discussed the merits of our disability insurance proposal, I encountered two objections to this measure:

Why liberalize disability insurance for blind persons and not for other severely disabled persons?

Why should a blind person with meager or substantial earnings draw disability insurance payments when other type disabled persons

are cut off from such payments if their earnings exceed $140 a month?

The answer to these questions, we believe, are simple, obvious, and conclusive.

Blindness is not a worse disability than any other, but it is different from any other—and because of this difference, S. 2518 is socially and economically necessary legislation, it is uniquely needed and not precedent-setting legislation.

A person may have just about any other kind of physical impairment, get repaired, obtain prosthetic devices or appliances, and be restored to substantial self-sufficiency.

A man may lose both legs, secure artificial limbs and, after learning their use, function as he functioned before.

The blind man, however, who must learn to live in a world structured for and by sighted people, can never reach a point where he is freed from a dependence upon sight—and this is so, whatever abilities the blind man may possess, whatever his accomplishments may be.

And the blind person is just exactly like the sighted person—whatever his earnings, he lives above and beyond them—and is no better able to remove a portion of his income from family expenses to use for the purchase of sight than would his sighted fellows engaged in the same employment and with similar earnings.

The fact is that whatever level of earnings a blind person may achieve, whatever position a blind person may attain, a blind person functions at an economic disadvantage for he must function without sight in competition with sighted men, he must compete without sight in an economy based on sight.

S. 2518 as Federal law would reduce this economic disadvantage.

Gentlemen, S. 2518 is not humbly-held-hat-in-hand begging legislation. It is not a plea to alleviate the unhappy lot of helpless and shelter-seeking blind people.

S. 2518 is a renunciation of tradition-established lives of demeaning dependency of the blind men and women of this Nation.

S. 2518 expresses the courageous determination of blind Americans to escape from the centuries-long captivity of ignorance, prejudice, and discrimination and to live normal, self-supporting, self-dependent lives.

I would remind this committee as I have reminded you on other occasions:

No blind person in this country needs to work, to strive to provide for himself and his family, or assume the responsibilities and burdens of full and active community membership. And no word of criticism or condemnation would be heard of the blind person who accepts defeat and dependency as his unalterable condition of life, and exists throughout his entire life upon the productivity of others.

But the blind of this Nation reject as false and totally unacceptable the notion that blindness must mean utter helplessness and they are trying, in spite of all difficulties, in spite of all disadvantages of sightlessness surrounded by sight, to obtain training and education, to obtain employment commensurate with their talents and occupational preparation, and to achieve full and valued lives, lives of value to themselves, to their families, and to the Nation.

And I will assure you of this, Mr. Chairman, whether this committee and this Congress approves S. 2518, the blind of this Nation

will persist and persist and persist in the course they have chosen, whatever the difficulties, whatever the disadvantages.

But with S. 2518 as Federal law, with disability insurance payments as a regular and continuing source of funds to hire sight, these difficulties would be lessened, these disadvantages would be fewer.

I thank you, Mr. Chairman, for this opportunity to appear here.

Senator ANDERSON (presiding). Are there questions?

Senator CURTIS. Yes, I would like to commend our distinguished witness for his reading ability. We followed with great interest as your hand ran along the page.

I have one or two questions.

Will you elaborate just a little bit on what you mean by hiring sight?

Mr. NAGLE. Going back to my office, Senator, I have a stack of mail waiting for me. In order for me to be sure that I can function in my job, that I can read my mail, that I can check the Congressional Record every day, I am totally blind, I have to have sight available to me.

Now I, of course, have the choice of asking people out of kindness to come in and do my reading for me, volunteers, generous people. But I need someone throughout the day, not just for a few minutes, occasionally. I need someone I can depend upon, that I know will be there when I need the sight that I must have.

So, for me to function at all in my job, in any kind of activity I pursue, I have to have sight available to me when I need it. It has got to be reliably available to me and the only way we blind peope find to do this is to hire it.

Senator CURTIS. I found, much to my surprise and disappointment, that the Federal Government does not provide readers for sightless Government employees. I find that if a blind person is employed in any branch of the Government, there is no provision made to provide an employee either on part-time or otherwise, as a reader.

Were you aware of that?

Mr. NAGLE. I am aware of it, Senator. It has only been in the past few years that it was possible for a blind person employed by the Federal Government to arrange to have a member of his family or in a job where he is not entitled to secretarial assistance, it has only been a few years that he has been allowed to arrange to have a volunteer come in or to hire someone to come in to read to him. This was not legally possible until the Reader Assistance Act was passed a few years ago.

Senator CURTIS. Are you making the point in general that a blind person who has equal capabilities, equal training, and equal skill of a sighted person, still has an economic disadvantage working at the same job with the sighted person?

Mr. NAGLE. He has it because, of course, the job is geared to sight.

Now, it is conceivable there might be a job or there may be many jobs in the Federal service where a person who is able to read material or have a blind person have a reader available to him for an hour a week, could get caught up to date on changes and regulations, and this reading material or reading opportunity for 1 hour a week might be enough to keep him fully employed for the entire week.

But, if he does not have this 1 hour of a reader available, then he just cannot do the job. If he has the hour he can do the job. It is this basic! It is this important! The world is a sighted world, and we have long

ago given up trying to change the world to suit our convenience. It is up to us to adapt, and the way for us to adapt is to have sight available to us when we have need for it, and when we do this we can function.

I think many blind people have demonstrated they can function with much success.

Senator CURTIS. I was visiting with a young sightless individual who was a friend of mine, and I asked him how he got through college, because there are no recordings or braille publications of the many, many textbooks used in the college. It just happened that some of our prisoners in the penitentiary at Lincoln, Nebr., volunteered as readers, and they would take a book in physics or chemistry or philosophy or what have you, and they would read it and put it on tape.

He was very grateful for that, but it was not an ideal arrangement because the man doing the reading and placing it on tape was not trained in the material he was reading, and, consequently, it was not the best job so far as his instruction was concerned. They had trouble not only pronouncing the words, but they could not read understandably when the reader himself does not understand what he is reading.

I thank you here for your appearance.

Senator ANDERSON. Thank you very much, Mr. Nagle. I appreciate your appearance.

The next witness is Mr. McDaniel, Durward McDaniel, national representative of the American Council of the Blind.

STATEMENT OF DURWARD K. McDANIEL, NATIONAL REPRESENTATIVE, THE AMERICAN COUNCIL OF THE BLIND

Mr. MCDANIEL. Mr. Chairman and gentlemen of the committee, I am Durward K. McDaniel, national representative of the American Council of the Blind, and my address is 20 E Street NW., Washington, D.C.

I appear here today on behalf of the American Council to speak on H.R. 17550, and I want to give emphasis to a few of those points made in the statement which we filed here and which we would like to have made a part of the record.

The American Council of the Blind joins with the National Federation of the Blind and other major organizations of and for the blind in support of S. 2518, which Mr. Nagle has spoken about here today.

We recognize that the amendments contained in H.R. 17550 relating to fully insured status would be a halfway measure, an improvement nonetheless, but would not really meet the security needs of the blind population of this country. Therefore, we also advocate the adoption of S. 2518, and we assume from the fact that a majority of the Senate has joined as cosponsors that it will be passed, and we urge on this occasion that the Senate not recede on this amendment if it should be adopted. This would be the fourth time that it had been passed by the Senate, and certainly the economics of it all are such that the trust funds can afford this change in the law, and it is socially desirable.

One other provision of H.R. 17550 which I would like to comment on is that improvement in the childhood disability benefits, raising to age 22 the age of eligibility of a child who becomes disabled before that age. The amendment falls short in one respect, however, and that is it still depends upon the death, disability or retirement of the insured worker in order for the disabled child to receive benefits.

The American Council of the Blind would advocate that when the disabled child reaches an age of majority that he be entitled to social security benefits if either of his parents is fully insured, without respect to death, disability, or retirement. The reason for this is that the program ought to protect disabled persons under those conditions who have reached the age of majority. They should not be legally dependent upon their parents thereafter, and this is a proper responsibility of the Social Security Act. We would urge an amendment to this effect upon the committee.

With further reference to the amendments before the committee, I think that all of the studies that have been made show the great need for medical and hospital care for persons under the age of 65, and we would seriously advocate at this time that medicare provisions now available to people over 65 be extended to disability beneficiaries under the Social Security Act.

We advocate further that those persons under 65 who are medically indigent be included in section 1843, the buy-in provision of the present law, which applies only to medically indigent people over the age of 65 who are not covered by medicare. We say that it is discriminatory not to make it applicable to people under age 65 who are medically indigent.

Of course, under the whole medicaid-medicare program, with respect to people under age 65, these people are hopelessly dependent upon an inadequate system, the American Council of the Blind is convinced that the patchwork program of the Federal-State approach to the health needs of this country has not worked and will not work. Indeed, H.R. 17550, in section 228, would repeal the existing requirement that by 1977 the States provide a comprehensive health program for medically indigent people; this, of course, would be a very backward step. I know that the reasons advanced for the repeal were that the Government cannot afford it. Well, gentlemen of the committee, if the Government cannot afford it, certainly these medically indigent people cannot afford it either. To repeal this, to let the States recede from any kind of comprehensive program by any date, would be to place an extreme hardship upon these people.

Moreover, the provisions that Senator Prouty and Senator Bellmon talked about in section 225 relating to long-term institutional care, the reduction of Federal matching is—or would be—an arbitrary decision made by act of Congress, if it passed, that people do not need long-term institutional care.

How can we or anyone sitting here in Washington decide in individual cases whether they need long-range institutional care or not? Of course, the States could pick up the difference in cost but, as we all know, the States are hard-pressed financially, and if they do not pick up the difference, these people are going to be forced into State institutions, or to be outpatients, and who knows how they will be cared for under those conditions?

This is an attempt to save money, and I suppose that it is virtuous to save money, but we ought to be more concerned about what happens to people than what happens to the expenditures.

With respect to medicaid, in particular, the American Council of the Blind is convinced that the system of unequal programs in the several States will never work and will never provide for citizens of the

United States the kind of medical care and hospital care that they need, and for that reason we advocate that the Congress act now to create a Federal program of medicaid for medically indigent people, at least for the smallest of the categories, the blind.

It is not fair for anyone to say that in one State you can have one or two of the programs and in another State you may have several, when all the while the Federal Government is doing most of the financing.

But, be that as it may, the hospital and medical needs of the people in this country are not being met, and if the Government surrenders to the unreasonable costs which have risen radically in recent years, the chief victims will be these people who cannot afford it even under these circumstances. What will happen is that they will do without the service, and that is going to fill up the public institutions with people who cannot care for themselves medically, and in the long run it is not going to save the Government money.

I think that the biggest single thing that could affect the disabled population of this country in terms of medical and hospital needs at this time would be, first, the extension of medicare to social security disability beneficiaries, and to recipients of aid to the blind and disabled; and secondly, the federalization of the medicaid program so that we will have for the first time single and uniform standards of health care for these people. It still may not be adequate, but it will be uniform in all the States, and that is the only way the needed improvements are going to come about.

Gentlemen of the committee, I appreciate the opportunity to speak here today. The American Council of the Blind hopes that the patchwork approach for solving these problems will give way to some concrete and sweeping reforms which will federalize the programs and which will, for the first time, treat the real needs of this population.

In that respect, we are concerned about the proposals to delay the financing arrangements of social security because, if those in taxes are delayed, as proposed, then we will in this year write the negative answers for the next few years to demands or requests for further reform to meet the needs of the people. We think that the responsible thing to do now is to keep the timetable on the financing arrangements for social security.

I know that the comparison has been made between the rising cost of social security in terms of taxes, and the withholding of income taxes. I say to the committee that at least in the case of social security taxes the taxpayer knows something about what he is going to get back, and that is not quite true of income tax. Social security withholding is a tax which people pay for an insurance program, and we believe that it should be kept progressive and that trust funds should be protected so that future improvements can be made in the program.

Thank you very much.

(The prepared statement follows. Hearing continues on page 953.)

STATEMENT BEFORE THE COMMITTEE ON FINANCE BY THE AMERICAN COUNCIL OF THE BLIND

SUMMARY

The American Council of the Blind—

1. Favors enactment of S. 2518, which provides for disability insurance benefits for blind persons with at least six quarters of coverage.

2. Favors enactment of S. 1132, which provides that the definition of disability in the Social Security Act shall be the same as that in effect prior to the passage of the Social Security Amendments of 1967.

3. Favors enactment of E. 1781 to eliminate the reduction in disability insurance benefits which is presently required in the case of an individual receiving workmen's compensation benefits.

4. Endorses the methods now provided in H.R. 17550 for automatic adjustments in benefits, the earnings limitation, the earnings counted for benefit and tax purposes, and the contribution and benefit base.

5. Endorses Section 109 of H.R. 17550, providing for childhood disability benefits for persons becoming disabled before age 22 instead of age 18.

6. Favors the participation of social security beneficiaries in the periodic evaluation of the program, and advocates the provision of additional procedures for the representation of the interests and views of beneficiaries.

7. Shares Congressman Vanik's concern about actuarial imbalance in the trust funds, which will result if timely adjustments in the tax rate are not made.

8. Favors medicare coverage of disability insurance beneficiaries as proposed by S. 1477 and, in addition, the extension of coverage under Section 1843 of the Social Security Act to disabled and blind public assistance recipients under age 65.

9. Opposes Section 228 of H.R. 17550, which would repeal the requirement that the States have comprehensive medicaid programs by 1977.

10. Advocates federalization of medicaid for medically indigent blind persons.

11. Opposes the provisions of Section 225 of H.R. 17550, establishing incentives for States to emphasize outpatient care under medicaid programs by reducing Federal matching funds.

12. Favors enactment of S. 1251, which would prevent the imposition of relative responsibility requirements in connection with certain cases of medical assistance under Title XIX of the Social Security Act for blind and disabled individuals.

INTRODUCTION

H.R. 17550, as amended on the House floor, contains significant improvements which the American Council of the Blind has supported for several years. Some of the improvements, however, are only half measures, and the effective dates of others have been postponed unnecessarily. Several badly needed improvements in the program are not even dealt with, and some of the medicaid provisions are regressive and defeatist. Our views on certain provisions of this bill and on other constructive measures before the Committee on Finance are set out in the following statement.

1. DISABILITY COVERAGE

The American Council of the Blind supports S. 2518, which would provide benefits to blind persons having six quarters of coverage, with the same earned income allowance as that for beneficiaries who have attained the age of 72. This would afford blind beneficiaries a genuine opportunity for security and a decent standard of living.

The Council has always opposed the eligibility requirement that a disabled worker must have 20 quarters of coverage of the last 40. H.R. 17550 abolishes this rule for blind persons and substitutes the requirement of fully insured status. While this change represents a material improvement in the law, it makes no change in the earnings limitation provisions. The logical and equitable solution to the security needs of blind persons is contained in S. 2518. The Senate has passed similar measures on three occasions, but none of them survived the Joint Conference. We urge that the Committee on Finance include S. 2518 in H.R. 17550.

2. DEFINITION OF DISABILITY

Adoption of the definition of disability included in Section 223(d)(2)(A) of the Social Security Act in this amendments of 1967 was a reactionary step. Under this definition an individual's disability claim can be denied if a job which he theoretically can perform allegedly exists somewhere in the national economy, even though he would not be hired if he applied for such job. The law should provide that a claimant otherwise eligible cannot be disqualified for disability benefits if he is willing to accept a job which is suitable, taking into considera-

tion his education and work experience. Or, if the alleged existence of a job somewhere in the national economy is to be an eligibility factor, then the appropriate public agency should be required to place the claimant in that job. The American Council endorses S. 1132 by Senator Metcalf and many other Senators, including several members of this Committee; this bill would repeal Section 223 (d) (2) (A) of the present law.

3. WORKMEN'S COMPENSATION

Section 114 of H.R. 17550 is another measure which is good as far as it goes. Whereas under present law social security disability benefits must be reduced when workmen's compensation also is payable so that the combined benefits will not exceed 80 per cent of the average current earnings before disablement, Section 114 would increase the ceiling to 100 per cent. On the face of it this provision seems equitable. What generally is not realized, however, is that the periods during which workmen's compensation benefits are received often are relatively short and that thereafter the disability benefits received fall far short of 100 per cent of previous earnings. The excess over 100 per cent during the period of concurrent receipt of disability benefits and workmen's compensation could serve as a partial offset to the decline in income after the termination of workmen's compensation. The American Council endorses S. 1781 by Senator Randolph and others, which would completely eliminate the reduction in disability insurance benefits presently required in such cases.

4. AUTOMATIC ADJUSTMENTS

The House took a progressive step when it overrode the objections of the Chairman of the Committee on Ways and Means by adopting machinery for automatic adjustment of benefits, the earnings limitation, the earnings counted for benefit and tax purposes, and the contribution and benefit base. We are happy to note that one of the principal proponents of this legislation in the House stated that this amendment would not foreclose Congress from acting in the future to increase benefit levels in accordance with changes in living standards but would provide for automatic increases if Congress did not act. We see no valid reason for delaying the effective dates of these amendments, however. No adjustment in benefit amount would take effect before January 1, 1972, and adjustments in the earnings limitation would be delayed until January 1973. Even if Congress this year increases benefits above the niggardly amount contained in the House bill, the ever-rising cost of living could wipe out any increase in real income long before the automatic adjustment provisions go into effect. The American Council urges that the benefit amount be adjusted no later than July 1, 1971. The adjustment in the earnings limitation should be effective at least one year earlier than proposed in the House bill.

5. CHILDHOOD DISABILITY INSURANCE

Section 109 of H.R. 17550 extends from 18 to 22 the age of eligibility for childhood disability benefits. The Council endorses this progressive change which will afford protection to young persons who become disabled before they have had the opportunity to qualify for benefits by reason of their own covered employment. Section 109 should be further amended to provide that such a disabled child who has reached the age of majority shall be entitled to benefits if either of his parents is fully insured. In other words, a disabled child who has reached the age of majority should not have to wait until his parent has died, retired, or become disabled to receive benefits.

6. REPRESENTATION OF BENEFICIARIES

Administrative remedies available to the individual under existing law provide no methods by which beneficiaries can effectively advocate any improvements and reforms in the administration of the program. The creation of procedures for the representation of the interests and views of social security beneficiaries is desirable and necessary for the effective planning, delivering, and reviewing of these important government services. Complaints and proposals for improvements could be dealt with properly and expeditiously on a regular formal basis through consultation and evaluation of these services by government officials and representatives of such beneficiaries. Section 1602(a) (16) of Title II of H.R. 14173 provided for the participation of recipients of

aid to the aged, blind, and disabled in the periodic evaluation of State welfare programs. While that provision was not adopted by the House, we urge that those procedures and principles be made applicable to social security beneficiaries by appropriate amendment of H.R. 17550. This would be a step in the right direction, but there should be a system by which beneficiaries would select their own representatives. An appropriate model for such procedures and consultation has been established by Executive Order No. 10988, which provides a system for choosing representatives of Federal employees.

7. ACTUARIAL IMBALANCE

The Council shares the distress expressed by Congressman Charles A. Vanik in House Report 91-1096. It is all too clear that the tax stretch-out provided in H.R. 17550 seriously threatens the actuarial soundness of the trust funds. Moreover, if the proposed delays in tax changes are adopted, the trust fund reserves will be so decreased that the social security program will be unable to keep pace with the changing needs of our population. We urge that the proposed delays in tax rate changes be deleted from H.R. 17550.

8. MEDICARE

The inclusion of disability beneficiaries in the medicare program is long overdue. All wage earners pay an additional tax to finance medicare, but if they become disabled, they are deprived of medicare benefits unless and until they reach age 65. The American Council of the Blind endorses S. 1477, which would extend this coverage to all disabled persons receiving benefits under the Social Security Act.

9. STATES' COMPREHENSIVE MEDICAID PROGRAMS

Section 228 of H.R. 17550 repeals the requirement that the States have comprehensive medicaid programs by 1977. We are all painfully aware of the unreasonable increases in the cost of medical and hospital care, but repealing this requirement would represent surrender to those responsible for the unreasonable costs and would leave the medically indigent subject, to an even greater degree, to the uncertain half measures in most of the States.

10. FEDERALIZATION OF MEDICAID

The present federal-state medicaid program cannot be a satisfactory solution to the health needs of medically indigent persons as long as the great variations in coverage prevail in the several States. The Council advocates that medicaid for medically indigent blind persons become an entirely Federal program providing uniform standards of eligibility and service throughout the country. We believe that a pilot program of the smallest of the categories will demonstrate the feasibility and desirability of a single national program.

11. LONG-TERM INSTITUTIONAL CARE

Section 225 of H.R. 17550 would reduce federal matching for long-term institutional care by one-third and would drastically reduce the duration of federal matching. This is an attempt to save money without regard to the actual needs of the people involved. This section would require the States to make up the difference in the cost of long-term institutional care, but if a State chose not to pay the difference, then each individual would be financially compelled to become an outpatient, regardless of his condition. This kind of economy would translate into greater hardship for substantial numbers of people. The Council advocates that the provision for the reduction of federal matching for long-term institutional care be deleted from Section 225.

12. RELATIVE RESPONSIBILITY

Title XIX of the Social Security Act allows the States to consider the financial responsibility of another individual for an applicant or recipient if he is a blind or disabled child of the individual, regardless of the age of such child. This permits the imposition of financial responsibility requirements on parents of adult blind and disabled persons. The Council advocates the amendment of Title XIX by the inclusion of S. 1251 in H.R. 17550. If these changes are not made, large numbers of blind and disabled adults will continue to be disqualified for medical assistance.

Senator ANDERSON. Any questions?
Senator JORDAN. No questions.
Senator ANDERSON. Thank you very much.
Mr. Irvin P. Schloss.

STATEMENT OF IRVIN P. SCHLOSS, LEGISLATIVE ANALYST, AMERICAN FOUNDATION FOR THE BLIND

Mr. SCHLOSS. Mr. Chairman, I have submitted a written statement which I would appreciate having included in the record of the hearings.

Senator ANDERSON. It will be printed in full.

Mr. SCHLOSS. With your permission I will proceed to summarize it.

Today I am representing the American Foundation for the Blind, the national voluntary research and consultant agency in the field of services to blind persons of all ages, and the American Association of Workers for the Blind, the national professional membership association in the field.

Both of these organizations endorse the provisions of H.R. 17550 increasing cash benefits for OASDI recipients, and also endorse the increase in the taxable wage base with both the benefit structure and the wage base structure tied to automatic increases based on increases in the cost of living.

We believe that inevitably there is a lag before the Congress can act, especially during periods of high inflation, such as we have recently experienced, and we believe that an automatic increase mechanism is highly desirable without precluding periodic review by the Congress.

With regard to survivor benefits, we endorse the provisions of the House-passed bill which would make widows eligible at age 65 for cash benefits at the rate of 100 percent of what their husbands would have received had they lived and retired with actuarial reductions to the present 82.5 percent at age 62. We also endorse the eligibility for cash benefits of a disabled child based on the disability having been incurred before age 22.

We have some recommendations to make, however, for improvements in several of the other survivor programs: namely those involving the cash benefit provisions for disabled widows, widowers, and surviving divorced wives. These individuals are particularly hard-pressed, and the provisions of the act concerning them are unduly harsh.

We would recommend, first, that the age 50 requirement for eligibility for cash payments be eliminated altogether; that the payment be based on 100 percent of the primary insurance amount of the individual on whose wage record the benefit is based. We would also recommend liberalizing the definition of disability so it is the same as the one for disability insurance programs.

As you know, for disabled widows, widowers, and surviving divorced wives, the disability must be so severe that it precludes any gainful activity. This would mean that an individual under these circumstances could not even earn $50 a month to supplement the social security benefit.

We would also endorse inclusion of the provisions of S. 4038, which would liberalize the age at which widows and widowers would become

eligible for social security cash benefits. We would particularly commend to you for your serious consideration the provisions of that bill, which would make it possible for disabled wives and husbands to become eligible for cash benefits at age 50.

With the regard to the disability insurance provisions for the blind, Mr. Nagle of the National Federation of the Blind has very capably outlined the provisions and the rationale for inclusion of the provisions of S. 2518 in H.R. 17550. Both the organizations I am representing concur wholeheartedly with the statement he presented.

We believe that enactment of the provisions of S. 2518 would spur the rehabilitation of blind persons; whereas, under the existing provisions, as the law is administered, it very definitely acts as a deterrent to rehabilitation since an individual who may have earnings as low as $900 a year under present law could lose disability insurance cash benefits that might be three or four times higher, considering family benefits as well.

With regard to the health care provisions, we firmly believe that the cost of prescription drugs should be included in title XVIII, the medicare part of the act. These costs for an elderly person who has a chronic ailment which requires the regular use of medication are burdensome, and drastically reduce cash benefits. As you know, many of these people depend almost exclusively on their social security cash benefits for food, clothing, and shelter.

We would also recommend extension of medicare provisions to disability insurance beneficiaries. As you know, the Advisory Council on Social Security has recommended this, and we believe that these individuals may be in serious straits without this benefit.

We would also recommend including under the medicare benefits of title XVIII those individuals who are entitled to cash benefits as disabled children, widows, widowers, and surviving divorced wives.

We have one other recommendation with regard to the health care provisions. Present law does not cover an individual who is blind or otherwise seriously disabled for the cost of special rehabilitation center training which would equip him for adequate self-care so that he could stay at home instead of having to be in an extended care facility for a long period of time.

Although these costs of special rehabilitation center training are not covered under the present act, we would strongly recommend that they be covered. They are, in effect, a paramedical service, a very legitimate health service, which enables a blind person to learn how to operate at his maximum potential without using sight, in his own home, and in other circumstances which would make it possible for his family to keep him at home with them.

One of the provisions of the Social Security Act, one of the titles with which we are particularly concerned, is title V providing maternal and child health and crippled children services. The National Federation of the Blind joins with the American Foundation for the Blind and the American Association of Workers for the Blind in endorsing our recommendation.

We believe that this program has an excellent potential for preventing and ameliorating disability in children, thereby making it unnecessary for these individuals to receive more expensive special education or rehabilitation services later. It is certainly better to prevent or correct the disability when the child is very young rather

than have him go through life as a severely disabled person having, perhaps ultimately, to go on the welfare rolls.

Our recommendations for improvements are as follows:

First, we would like to change the term "crippled children" in the title of title V and in the text to "handicapped children" to more nearly reflect the actual scope of the program. We believe that this simple change of terminology, which will not cost anything, would give the program much more visibility not only for the parents of children who should be helped by it but also the State legislatures who have to provide matching funds.

Second, we would recommend that the financing mechanism be made the same as it is for the public assistance program so that each State will receive as much in Federal funds as it is capable of matching.

I might say that the present formula in maternal and child health and crippled children's program is at a great disadvantage compared to most other Federal grant-in-aid programs. The matching formula is something like 50–50. In most Federal-State grant-in-aid programs the formula runs from approximately a 75-percent Federal share to 90-percent Federal share.

We believe that this improvement would more than pay for itself in preventing the need for costlier special education and rehabilitation procedures later on.

Third, we would recommend strengthening the State planning provisions in various ways to make these services more comprehensive throughout each State. This will be especially important when the special project programs under sections 508, 509, and 510 of the Social Security Act expire June 30, 1972, and it is particularly important that the basic Federal-State program have the financing and the State planning provisions to assure comprehensive detection, prevention, and treatment services.

In conclusion, Mr. Chairman, I appreciate this opportunity to make our views known to you. We sincerely hope that our recommendations will receive your favorable consideration.

(Mr. Schloss' prepared statement follows. Hearing continues on page 959.)

STATEMENT OF IRVIN P. SCHLOSS, LEGISLATIVE ANALYST, AMERICAN FOUNDATION FOR THE BLIND

SUMMARY

The American Foundation for the Blind, the national voluntary research and consultant agency in the field of services to the blind, and the American Association of Workers for the Blind, the national professional membership association in the field, wholeheartedly endorse the increase in cash benefits effective January 1, 1971, for all beneficiaries under Title II of the Social Security Act. We also endorse the provisions for automatic increases in the taxable wage base and cash benefits based on increases in the Consumer Price Index in order to avoid severe financial hardship for beneficiaries during periods of rapid increases in the cost of living similar to those experienced in recent years. However, an automatic benefit increase mechanism should not preclude periodic Congressional review to determine the need for further additional benefit increases to make OASDI cash payments more adequate and to take into account generally improved living standards.

Both organizations welcome and endorse the provision in H.R. 17550 increasing the widow's benefit at age 65 to 100% of her deceased husband's primary insurance amount with actuarial reductions to the present 82½% if she accepts benefits at age 62. We also welcome the provision extending eligibility for disabled child's benefits to individuals whose disability occurred before age 22.

We would strongly recommend liberalization of benefits for disabled wives, widowers, and surviving divorced wives, so that these particularly hard-pressed individuals will receive more adequate cash benefits. We recommend the following improvements: (1) elimination of the age 50 requirement as the minimum age qualification; (2) cash benefits based on 100% of the primary insurance amount of the deceased individual on whose wage record the benefit is based; and (3) making the qualifying definition of disability the same as that used for disability insurance. Similarly, we would recommend inclusion of the provisions of S. 4038, liberalizing the age at which widows and widowers qualify for cash benefits and covering disabled wives and husbands for cash benefits at age 50.

We wholeheartedly endorse inclusion in H.R. 17550 of the provisions of S. 2518 which would make it possible for blind persons to qualify for cash disability insurance benefits with at least six quarters of covered employment without regard to their ability to engage in substantial gainful activity. Since "substantial gainful activity" is interpreted by the Social Security Administration to mean annual earnings varying from half the amount specified in the retirement test ($840 to $1,680 under present law), such annual earnings could hardly be characterized as "substantial." Yet earnings of $900 a year could deprive a disabled beneficiary of substantially higher cash benefits and work a severe hardship on the individual and his family. S. 2518 would provide a secure financial floor from which a blind person would be able to rehabilitate himself without fear of losing his benefit should he find it possible to obtain only low-paying employment after completing training.

With regard to health care benefits under Title XVIII, we believe that the program should be improved to cover the cost of prescription drugs, a burdensome cost which consumes a substantial part of an elderly individual's monthly cash benefit. We would strongly urge the Committee to cover disability insurance beneficiaries for health care benefits under Title XVIII in accordance with the recommendations of the Advisory Council on Social Security in recent years. The special needs of these individuals for adequate health care may be even more acute than the needs of most elderly persons already covered, while their financial resources may be more limited. Finally, we would recommend improving Title XVIII to cover special rehabilitation center services designed to train blind and otherwise disabled persons for more adequate self-care. This would be particularly important to older beneficiaries who cannot expect similar services under the Federal-State vocational rehabilitation program.

The National Federation of the Blind, whose representative is appearing before this Committee on other aspects of the Social Security Act, joins with the American Foundation for the Blind and the American Association of Workers for the Blind in advocating improvements in Title V, covering maternal and child health and crippled children's services. This program has an excellent potential for preventing and ameliorating disability. We believe that this potential could be attained if the following improvements were made: (1) change the term "crippled children" in the title and text to "handicapped children" to more accurately reflect the scope of the program; (2) provide for financing similar to that used in the public assistance program, so that each State will receive as much of a Federal contribution as it is capable of matching; and (3) strengthen State plan provisions in various ways, including assurance of comprehensive services after the special project programs expire.

INCREASE IN OASDI CASH BENEFITS

The American Foundation for the Blind and the American Association of Workers for the Blind wholeheartedly endorse the increase in cash benefits effective January 1, 1971, for all beneficiaries under Title II of the Social Security Act. Rapid increases in living costs in recent years have made it extremely difficult for OASDI beneficiaries, especially those who must rely exclusively on that income, to live at a level adequate for minimum human needs. Therefore, we also endorse the provision for automatic increases based on increases in the Consumer Price Index. This will avoid severe financial hardship for beneficiaries during periods of rapid rises in the cost of living similar to those experienced in recent years before Congress has time to act. However, an automatic benefit increase mechanism should not preclude periodic Congressional review to determine the need for further benefit increases to make OASDI cash payments more adequate and to take into account generally improved living standards.

Similarly, we advocate an increase in the taxable wage base to at least $9,000 with provision for automatic increases as wage levels increase, in order to as-

sure adequate benefits to current and future beneficiaries more closely related to their total earnings during their working years. Over the years wage levels have increased, but the taxable wage base has not been raised in the same proportion. As a result, retired persons have found that the so-called "golden years" of retirement to which they had looked forward were, in effect, years of financial deprivation with the need for drastically reduced living standards. Again, automatic wage base adjustments should not preclude Congressional review to assure actuarial soundness of financing and to make necessary adjustments.

IMPROVED SURVIVOR BENEFITS

Both organizations welcome and endorse the provision in H.R. 17550 increasing the widow's benefit at age 65 to 100% of her deceased husband's primary insurance amount with actuarial reductions to the present 82½% if she accepts benefits at age 62. We also welcome the provision in H.R. 17550 extending eligibility for disabled child's benefits to individuals whose disability occurred before age 22.

We would strongly recommend liberalization of benefits for disabled widows, widowers, and surviving divorced wives, so that these particularly hard-pressed individuals will receive more adequate cash benefits. Existing eligibility requirements on cash benefits for these individuals are unduly harsh. We recommend the following improvements: (1) elimination of the age 50 requirement as the minimum age qualification; (2) cash benefits based on 100% of the primary insurance amount of the deceased individual on whose wage record the benefit is based; and (3) making the qualifying definition of disability the same as that used for disability insurance.

We also recommend inclusion of the provisions of S. 4038, which would make it possible for widows to begin receiving cash benefits at age 50 and widowers at age 60. We particularly commend to the Committee inclusion of the provisions of this bill which would make it possible for disabled wives and husbands to begin receiving cash benefits at age 50. The serious financial burden on the family wage earner of severe disability covered under this provision would be partly alleviated by this bill. Invariably, in addition to high medical care costs, the wage earner would also have to arrange for costly full-time homemaker service to assure adequate care of the disabled spouse.

DISABILITY INSURANCE FOR THE BLIND

We appreciate the provision of H.R. 17550 eliminating the requirement of 20 out of 40 quarters of coverage preceding the onset of disability as a qualification for cash disability insurance benefits for blind persons. However, we would recommend substitution of the provisions of S. 2518. This bill would make it possible for blind persons to qualify for cash disability insurance benefits with at least six quarters of covered employment without regard to their ability to engage in substantial gainful activity. Of course, the actual amount of disability insurance cash benefits will vary with the number of quarters in covered employment and the wage credits of the individual. This bill would base the award of cash benefits on a medical determination that blindness exists, that this condition severely curtails opportunities for employment, and that it is a serious handicap in other than economic ways.

We are firmly convinced that enactment of the provisions of S. 2518 into law will definitely serve to spur the rehabilitation of blind persons. By providing blind persons with an economic floor from which to operate while rehabilitating themselves, the Congress will give them an opportunity to explore various occupations without the risk of losing their benefits should they fail in one endeavor and find it necessary to try something else.

On the other hand, the existing law serves as a deterrent to rehabilitation; for there is no incentive to experiment when a blind person has to risk losing the security of his cash benefits when he accepts employment which may provide an income substantially smaller. As you know, the term "ability to engage in substantial gainful activity" in the present definition of disability is variously interpreted across the country by the different state agencies making disability determinations. Thus, an individual who earns anywhere from $840 to $1,680 a year after rehabilitation will no longer be entitled to receive *any* disability insurance cash benefits, depending on the state in which he resides. Since the cash benefits could easily have been double the individual's earned income, the present defini-

tion of disability works a hardship on the disabled individual and his family in the name of rehabilitation.

We know from the experience of World War II and Korean Conflict blinded veterans that the floor of financial security provided by their disability compensation has been an incentive rather than a deterrent to rehabilitation. We can confidently predict that the same will be true of blind disability insurance beneficiaries under Social Security.

HEALTH CARE BENEFITS

With regard to health care benefits under Title XVIII, we believe that the program should be improved to cover the cost of prescription drugs, a burdensome cost which consumes a substantial part of an elderly individual's monthly cash benefit. Adequate medical care of many chronic ailments of the elderly requires the use of expensive medication. We believe that the cost of covering prescription drugs would be offset by avoiding or delaying the need for costlier inpatient care in a hospital or extended care facility.

We would strongly urge the Committee to cover disability insurance beneficiaries for health care benefits under Title XVIII in accordance with the recommendations of the Advisory Council on Social Security in recent years. Also, we would recommend that those entitled to receive cash benefits as disabled children, widows, widowers, and surviving divorced wives be covered by Title XVIII benefits. The special needs of these individuals for adequate health care may be even more acute than the needs of most elderly people already covered, while their financial resources may be more limited. Finally, we would recommend improving Title XVIII to cover special rehabilitation center services designed to train blind and otherwise disabled persons for more adequate self-care. This would be particularly important to older beneficiaries who cannot expect similar services under the Federal-State vocational rehabilitation program.

MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

The National Federation of the Blind, whose representative is appearing before this Committee on other aspects of the Social Security Act, joins with the American Foundation for the Blind and the American Association of Workers for the Blind in advocating improvements in Title V, covering maternal and child health and crippled children's services. This program has an excellent potential for preventing and ameliorating disability. We believe that this potential could be attained if the following improvements were made: (1) change the term "crippled children" in the title and text to "handicapped children" to more accurately reflect the scope of the program; (2) provide for financing similar to that used in the public assistance program, so that each state will receive as much of a Federal contribution as it is capable of matching; and (3) strengthen state plan provisions in various ways, including assurance of comprehensive services after the special project programs expire.

As you know, the original emphasis in this program was treatment of children with orthopedic disabilities. Hence, the name "services for crippled children" was an appropriate one. Over the years, however, other types of handicapping conditions were included within the scope of the program. These conditions include epilepsy, congential malformations, impaired vision, impaired hearing, cerebral palsy, and mental retardation.

To both professional and lay persons, the term "crippled" still refers to an orthopedic disability. We firmly believe that changing the name of the program and appropriate text in accordance with our recommendation will give the program substantially better visibility to the parents of children who should be served by it and result in increased state financial support as well.

Two examples of correctable eye diseases in children will illustrate the value of this program in preventing blindness. Strabismus (cross eye) is a condition which is readily correctable through the use of prescription eye glasses or surgery. If not corrected, vision in the crossed eye is suppressed until severe sight loss results. Similarly, amblyopia ex anopsia (lazy eye) is a condition which results in severe sight loss in the suppressed eye. Both of these conditions should be detected and treated as early as possible in the preschool years in order to prevent the serious sight loss which may then necessitate costly special education and vocational rehabilitation procedures.

The Social Security Amendments of 1967 added a definition of crippling conditions to the Federal law which should result in comprehensive services to

children with a wide variety of handicapping conditions as the impact of this amendment is increasingly felt. We would strongly urge the Committee to improve financing of the basic Federal-State program by making it similar to the financing method used in Title XVI to assure the needed increase in services on a comprehensive basis in every State. Improved financing will be particularly important when the special project programs under Sections 508, 509, and 510 expire on June 30, 1972.

Similarly, State plan provisions for the basic program should be strengthened to assure comprehensive detection and treatment procedures when the provisions of these same special project programs are no longer applicable. We would further recommend that the State agencies administering State plans for vocational rehabilitation services for the blind be authorized to provide services for children with vision problems in the Title V program.

With more adequate Federal financial support, with authorization for a specialized State agency to serve the group it knows best, and with a proper system of priorities based on the handicapping effects of a condition, no child need be deprived of services which would assist him to lead a more normal life as a result of prevention or correction of a handicapping condition.

CONCLUSION

In closing, Mr. Chairman, I should like to express the appreciation of The American Foundation for the Blind and the American Association of Workers for the Blind for the consideration of this Committee is giving our recommendations. We believe that these recommendations will strengthen our social insurance programs in urgently needed ways and improve Title V programs. We sincerely hope that the Committee will take favorable action on these recommendations.

Senator ANDERSON. Thank you very much.

Senator CURTIS. Mr. Chairman, I have one question.

You suggested a change in the law from the term "crippled children" to "handicapped children."

Mr. SCHLOSS. Yes, sir.

Senator CURTIS. Would that mean any change in the number of children to be benefited?

Mr. SCHLOSS. No; it would not.

Originally the program was called Crippled Children's Services because the emphasis was on children with orthopedic disability. Over the years children with epilepsy, visual problems, hearing problems, mental retardation, and congenital malformation have been included in the program; but the term "crippled children" is still used, and we believe changing that term to "handicapped children" would be actually more expressive of what the scope of the program really is.

Senator CURTIS. And you suggest it because it would be more descriptive and better understood?

Mr. SCHLOSS. Better understood by both the public and the State legislatures, professionals who are involved in the program or who would be referring people to the program.

Senator CURTIS. That is all, Mr. Chairman.

Senator ANDERSON. Thank you.

There will be one change in the program.

Mr. McManus, director of the Nebraska Department of Public Welfare.

Senator CURTIS. Mr. Chairman, I would like to have the record show that I welcome Mr. McManus here today. He is an official witness for the State of Nebraska.

Nebraska, like all other States, is vitally interested in social security and welfare programs. It is an important item in the budget of the State and they are interested in the work that is being done in these various programs.

I am glad you can be here, Mr. McManus.

Senator ANDERSON. We are glad to have you here.

STATEMENT OF ROBERT D. McMANUS, DIRECTOR, NEBRASKA STATE DEPARTMENT OF PUBLIC WELFARE

Mr. MCMANUS. Mr. Chairman and members of the Committee on Finance of the U.S. Senate, I appear before you today as the director of the department of public welfare for the State of Nebraska.

I am also the director of administrative services for the State of Nebraska.

The bill which is before you, H.R. 17550, contains certain monetary incentives and certain other monetary disadvantages to the State of Nebraska. We feel that there is an extreme imbalance of disincentives contained in this bill.

The effect of these provisions would be the transfer of financial responsibility from the Federal Treasury to that of the State. There would not be the resulting savings envisioned by the bill.

There is also in this bill some disincentives to upgrading of nursing home care.

Now the State of Nebraska supports the intent of many of the provisions. Our State, as all other States, also is interested in reducing costs for long-term care, and for using short-term out-patient hospital services, clinics, and home health services wherever possible.

The State has been rushing and continues to make every effort to encourage just what this bill encourages.

However, the movement toward this goal cannot be forced upon the State by the use of financial disincentives. This requires considerable long-term planning and a development of alternates to long-term care.

We respectfully submit that the following sections of the bill be reconsidered in light of the transfer of fiscal responsibility from the Federal Government to the State with, in fact, no saving of tax dollars.

Section 225(a)(1) contains major provisions, the purpose of which is to increase by 25 percent the matching rate up to 85 percent for out-patient hospital services, clinic services, and home health services.

In our State, the fiscal impact of this provision would be small. It would result in an, if the load were doubled it would result in only an increase in Federal funds of $169,000, less than one and a half percent of Nebraska's total medical assistance expenditures.

There is no indication that we would realize any savings in long-term care expenditures from this increased effort. We do support the expansion of these services, and the incentives for their provision are also supported.

Section 326(a)(2) contains disincentives which have the effect of transferring fiscal responsibility from the Federal Treasury to the State treasury.

It deals with, (a)(2) deals with in-patient hospital care which proposes reducing Federal matching over the first 60 days by 33⅓ percent.

In our State there are relatively few people who require more than 60 days of hospital care. In 1969, there were 90 people.

The impact in 1970, is estimated at $24,800 of additional State funds for these people who do in fact require hospital care for more than 60 days.

There is no indication that the reduced Federal matching for in-patient hospital care will in any way affect the number of people requiring hospital care for more than 60 days.

For example, the 90 persons in Nebraska who received in excess of 60 hospital days in 1969, required a total of 6,324 days at a total cost of $130,000 which would, under the new formula, reduce the Federal share from $74,000 to about $48,000 or a transfer of about $25,000 to the State cost.

Section 225(a)(2)(b), the skilled nursing home care limitation of 90 days during any fiscal year, there will be affected a total of over 3,000 persons in Nebraska requiring skilled nursing facilities, and in fiscal year 1971, there will be an estimated 642,000 days of skilled nursing care provided over the 90 days resulting in the transfer of almost $1.6 million to the State general fund or other tax sources for skilled nursing care for a 12-month period.

Aside from the fiscal impact of the reduced funding is the possible incentive for long-term care facilities to downgrade their staff and other services because of the limitation on the payment.

The State is interested in assuring that care required is received and that payment is only for care received. There is no indication that the reduction in Federal participation after 90 days will result in any patient now receiving care in a skilled nursing facility not requiring skilled nursing care after the first 90 days of in-patient status in the home. If they need the care, they will still need it whether the Federal Government pays or not.

A reduction in Federal matching will not contribute to effective control of inappropriate costs.

The State is also concerned with such inappropriate costs.

We believe that the incentive provisions and other constructive provisions to encourage more efficient use of health services are desirable. Disincentives for long-term institutional care may not be a practical solution, and care will not be reduced in the short term regardless of the incentives built into the Federal matching funds.

The State of Nebraska general fund will not be able to pick up the added costs from the State general fund.

Section 225(a)(2)(c) adds to the limitations to in-patient hospital and skilled nursing, is an additional backing away from Federal support for patients in mental hospitals, the proposed limitations of Federal participation to 90 days and then reducing the matching by 33⅓ percent.

Even more restrictive is the complete backing away after 365 days of care in a mental hospital for the lifetime of a mentally ill person. We estimate that this provision will transfer to the State general fund approximately $400,000 to $500,000 during the next fiscal year. It will affect a minimum of 75 persons requiring more than 90 days of hospitalization for treatment of mental disorders.

This represents a complete backing away by the Federal Government from care in public institutions for our less fortunate citizens requiring less than skilled nursing care, but do require institutional care and intermediate care facilities, whether public or private.

This restriction will result in a transfer of costs from the Federal Government to the State of approximately $500,000 in a 12-month period.

I think it should be pointed out that many of the proposed changes in the medicaid program affect poor people who have no means except some source of the tax dollar to pay for their medical care where it is required. A reduction in Federal funding is only a savings to one tax base and creates an equal additional tax burden on the State or local tax dollars. This is not a saving but a movement by the Federal Government away from a previous obligation which the State of Nebraska entered into with the Federal Government assuming a full commitment by the Federal Government on a continuing sustained basis.

I am sure that cutbacks in Federal matching will affect future Federal, State, and local governments' participation in any new programs considering the steps proposed in this bill. These proposals will create a lack of confidence by the States.

Now, Nebraska does support many of the provisions that are in the bill. We do not regard all of the provisions as being regressive in nature.

We support, for example, sections 229, 232, 235, and 236.

We are opposed to section 251, which makes mandatory a 3-month retroactive eligibility date where now this is a permissive section of title XIX. This section should be deleted, and States should continue to be allowed to determine their own retroactive eligibility periods.

The bill removes—this section of the bill removes from the State one present cost control element which, as I said, this section would eliminate.

In summary, gentlemen, the primary section of this bill concerning the State of Nebraska is section 225, wherein reduced Federal matching is proposed for long-term care. This section of the bill merely transfers fiscal responsibility and the State does not have the funds to assume this additional obligation.

I thank you for your attention, and I will be glad to answer any questions.

(Mr. McManus' prepared statement follows:)

TESTIMONY OF ROBERT D. MCMANUS, DIRECTOR, NEBRASKA STATE DEPARTMENT OF PUBLIC WELFARE

SUMMARY

The State of Nebraska is in agreement and supports the constructive provisions contained in H.R. 17550.

These provisions for out-patient hospital care, clinic service, and home health are supported but the fiscal impact on the State general fund is small.

Nebraska favors the provision allowing the States to determine the method used to establish reasonable cost for in-patient hospital care and that provision providing for the development of compatible processing systems and for cooperation between Title XVIII and Title XIX in utilization review.

The State of Nebraska does not support the part of the Bill dealing with financial disincentives resulting in the transfer of financial responsibility from the Federal Government to the State or County.

The cost of backing away from funding for in-patient hospital care, skilled nursing homes, mental hospitals and public intermediate care facilities will result in the transfer of approximately two and one-half million dollars to the State or County. This backing away by the Federal Government in Grant-in-Aid Programs will certainly create a confidence gap. States would be very hesitant in the future

to enter into a partnership with a partner who fulfills only a part of the agreement. The States are just as concerned with rising medical costs as the Federal Government. Disincentives will not result in tax savings but will merely transfer the tax burden to other taxing sources.

OUTLINE FOR TESTIMONY ON H.R. 17550

I. Disincentives outweigh incentives
II. Intent of the bill is supported by Nebraska
III. Nebraska encourages alternates
IV. Reconsider the following sections
    Section 225(a)(1) support incentives for alternate care
    Section 225(a)(2) disincentive for inpatient hospital care
    Section 225(a)(2) disincentive for skilled nursing home
V. Possible downgrading of facilities
VI. Disincentives not a solution
    Federal backing away from support on mental hospitals
    Federal backing away from support of public intermediate care
    A shift of tax support and a decrease in confidence in Federal programs
VII. Nebraska supports
    State Freedom to establish reasonable rate for in-hospital care
    Processing systems compatible between title XVIII and XIX
    Cooperation in utilization review between medicare and medicaid
    Freedom for States to establish cost sharing levels
VIII. Oppose mandated retroactive period
IX. Primary concern is the reduction in long-term care participation

TESTIMONY

Mr. Chairman and Members of the Committee on Finance of the United States Senate, I appear before you today as the Director of the Department of Public Welfare of the State of Nebraska. I am also the Director of Administrative Services for the State of Nebraska.

DISINCENTIVES OUTWEIGH INCENTIVES

There is before you a Bill (H.R. 17550) that contains certain monetary incentives and certain other monetary disincentives to the State of Nebraska. There is an imbalance of disincentive contained in this Bill. The effect of these provisions would be the transfer of financial responsibility from the Federal Treasury to the State. There would not be the resulting savings envisioned by the Bill. There is also in this Bill some disincentives to the upgrading of nursing home care.

THE INTENT OF THE BILL IS SUPPORTED BY NEBRASKA

The intent of many of the provisions appears to be in complete accord with the efforts of the State of Nebraska. The State also is interested in reducing outlays for long-term care and, if feasible, using short-term out-patient hospital, clinic services, and home health services wherever possible.

NEBRASKA ENCOURAGES ALTERNATES

The State has been making, and continues to make, every effort to encourage just what this Bill envisions. However, the movement toward this goal cannot be forced upon the State by the use of such financial disincentive. This requires considerable long-term planning and the development of alternates to long-term care. This is particularly true in our rural areas.

SUPPORT INCENTIVES FOR ALTERNATE CARE

Section 225(a)(1) contains major provisions which propose to increase by 25 percent the matching rate (up to a maximum of 95 percent) for out-patient hospital services, clinic services, and home health services (other than physical therapy services). The fiscal impact of this provision would be indeed small. Our estimates indicate that if the out-patient services, clinic services and home health services efforts could be doubled, the fiscal impact in one year of additional Federal funds would be only $160,100. This amount is less than 1.5 percent of Nebraska's total Medical Assistance expenditure. There is no indication

that we would realize any savings in long-term care expenditures. The expansion of these services is supported by Nebraska and the incentives for their provision is also supported.

RECONSIDER THE FOLLOWING SECTIONS

We respectfully submit that the following sections of the Bill be reconsidered in light of the transfer of fiscal responsibility from the Federal Government to the State with, in fact, no saving of tax dollars.

DISINCENTIVES FOR IN-PATIENT HOSPITAL CARE

Section 225(a)(2) contains disincentives which have the effect of transferring fiscal responsibility from the Federal Treasury to the State. The first disincentive deals with in-patient hospital care which proposes reducing Federal matching after the first sixty days by 33⅓ percent. There is a relatively small number of persons who require more than 60 days of hospital care (90 persons in 1969 received 60 or more in-patient hospital days care in Nebraska). The impact in 1970 is estimated at $24,804 additional State funds for care for people who do require hospital care for more than 60 days. There is no indication that the Reduced Federal matching for in-patient hospital care will in any way affect the number of people requiring hospital care for more than 60 days. (In Nebraska 90 persons received in excess of 60 days care, a total of 6,324 days of care, a total cost of $130,000, reduced Federal share from $74,425 to $49,621, an additional $24,804 State funds.)

DISINCENTIVES FOR SKILLED NURSING HOME CARE

The second disincentive is the skilled nursing home care limitation of 90 days during any fiscal year. There will be affected a projected total of over 3,000 persons requiring skilled nursing facilities. In fiscal year 1971 there will be an estimated 642,000 days of skilled nursing care provided and required over the 90 days. This will result in the transfer of an estimated *$1,592,000 to the State General Fund* or other tax sources for skilled nursing care for twelve months (Federal percentage decrease from 57.25 to 38.17. $8,346,000 total cost of care over 90 days, 57.25 Federal share $4,778,085; reduced Federal share 38.17%, $3,185,668.20).

POSSIBLE DOWNGRADING OF FACILITIES

Aside from the fiscal impact of the reduced funds, there is the possible incentive for long-term care facilities to downgrade staff and other services realizing that payment to skilled nursing facilities and skilled care is limited to 90 days. The State is very interested in assuring that only care which is required is being received and that payment is for the care received. The limitation will result in the probable downgrading of nursing facilities. The incentive is the reduction in payment after 90 days. There is no indication that we are aware of, indicating that the reduction in Federal participation after 90 days will result in any present patient in a skilled nursing facility not requiring skilled care *after* the first 90 days of in-patient status in the facility. The reduction in Federal matching will not contribute to effective control of inappropriate costs. The State is also concerned with such inappropriae costs. There are only very limited alternatives to long-term in-patient hospital and skilled nursing homes care.

DISINCENTIVES ARE NOT A SOLUTION

We feel that the incentive provisions and other constructive provisions to encourage more efficient use of health services, are very desirable. The disincentives for long-term institutional care are not a practical solution and will not be substantially reduced in the short term regardless of the incentives built into the Federal matching formulas. The State of Nebraska will not be able to pick up the added costs from the State General Fund.

FEDERAL BACKING AWAY FROM SUPPORT ON MENTAL HOSPITALS

In addition to in-patient hospital and skilled nursing facility limitations, there is the additional backing away from Federal support for people in mental hospitals. This provision proposes limiting Federal participation to 90 days after which the Federal matching is reduced by 33⅓ percent. Even more restrictive is the complete backing away after 365 days of care in a mental hospital for

the lifetime of a person who is mentally ill. It is estimated that this provision will transfer to the State General Fund approximately $399,828 during the next fiscal year. The provision will affect approximately 75 persons who require more than 90 days hospitalization for treatment of mental disorders.

A SHIFT OF TAX SUPPORT AND DECREASE IN CONFIDENCE IN FEDERAL PROGRAMS

It must be remembered that many of these proposed changes in the Medicaid program affect poor people who have no other means than some source of the tax dollar to support them in situations where medical care is required. This limitation in funding may require the State to limit funding, in which case, the cost of care of these persons not able to pay their own medical bills will in Nebraska revert to the county over-burdened property tax. The result of this reduction in Federal outlays is a savings only to one tax base and does in fact create additional tax burdens on the State or local tax dollars. The savings is not a savings but a movement by one segment away from a previous obligation, which the State of Nebraska entered into assuming that the commitment of the Federal Government would be sustained. These cutbacks in Federal matching, I am sure, will affect future Federal, State and Local Governments entering into any new programs considering the steps proposed in this Bill. These proposals for a reduction in funding from the Federal Government will, I am sure, create a lack of confidence in the Federal Government.

NEBRASKA SUPPORTS

State freedom to establish reasonable rate for in-hospital

The provisions of this Bill are not all of a nature indicated as being regressive. We are in favor of the provisions of Section 229 that allow the States to determine the method to be used to establish reasonable cost for in-patient hospital care.

Processing systems compatible between title XVIII and XIX

Section 232 deals with the development of processing systems making these systems Title XVIII and XIX compatible. The State of Nebraska also supports the developing of information systems relating to providing recipients with information and the increased funding to encourage such operations.

Cooperation in utilization review between medicare and medicaid

In a similar line, Section 235 provides for Title XVIII and Title XIX cooperation in the utilization review function and relieves the State of the responsibility for establishing separate utilization review capabilities.

Freedom for States to establish cost-sharing levels

Section 236 allows the States to establish their own cost-sharing and deductible levels for non-cash recipients and will allow the States more flexibility in the control of expenditures in the Medicaid Program.

OPPOSE MANDATED RETROACTIVE PERIOD

Section 251 makes mandatory a 3-month retroactive eligibility date wherein now this is a permissive section of Title XIX. We feel that this section should be deleted and the States should continue to be allowed to determine their own retroactive eligibility periods as this section of the Bill removes from the State one possible cost control element which this section would eliminate.

PRIMARY CONCERN IS THE REDUCTION IN LONG TERM CARE PARTICIPANTS

In summary, the primary section of this Bill which the State is concerned with is Section 225 wherein reduced Federal matching is proposed for long-term care. This section of the Bill merely transfers fiscal responsibility and the State does not have the funds to assume this obligation.

I will be happy to answer any questions at this time.

Senator ANDERSON. Are there questions?

Senator CURTIS. According to your reading of this bill, if the House provisions are not changed, when would this shift of funding take place?

Mr. McMANUS. It would take place as soon as the bill became effective, Senator. If the bill were to be signed into law prior to July 1, 1971, it would immediately transfer responsibility for additional funding to the State during the current biennium.

As the Senator knows, the State of Nebraska operates on a biennium funding basis. We appropriate on a 2-year basis. Our next—the end of the current biennium occurs June 30, 1971.

Senator CURTIS. Would you agree with the distinguished Senator from Oklahoma that it is very important that a State be permitted to rely upon existing programs and the commitment that goes along with them when they are tendered to the States?

Mr. McMANUS. Absolutely, Senator.

There is no way in which the State can develop its budget and provide for services to the people if they cannot rely on a continuing basis upon the commitments that have been enacted into law, and that have—and upon which they have developed their programs.

Senator CURTIS. Are there problems present for both administrative people as well as the legislators who must raise the funds when such shifts are made?

Mr. McMANUS. Yes, Senator.

As you know, the costs of the medical program and all of the associated welfare programs have been increasing tremendously for a variety of reasons.

The administration of the program at the present time is extremely difficult. The States, and our State in particular, have been making great strides in developing controls and systems to insure the proper cost expenditures and the proper control of the expenditures to the vendors of health services.

The transfer of this change would create tremendous administrative problems as well as the problems created for the legislature in finding the funds to support the change.

Senator CURTIS. Is it not true that members of the legislature, relying upon the existence of a given program, make commitments or plans for other programs, maybe entirely removed from that, that are disrupted when the Federal Government decides to discontinue something that has already been tendered to the State and been in force for several years?

Mr. McMANUS. Absolutely.

As you know, as the director of administrative services, Senator, I have responsibility for the development of the executive budget, among other things, and I do have some firsthand knowledge of the problems of budgeting.

With the limited amount of money that is available from the taxes, the Governor and the legislature endeavor to make the most efficient use of those funds and allocate them to the programs that they feel are most needed within the State.

Now, all of these funds are planned for and accounted for and earmarked for expenditure. Therefore, when a change of this nature takes place, it immediately has the effect of depriving other programs which have already been planned for and are underway, and to be disrupted or curtailed.

Senator CURTIS. The staff calls my attention to the fact that the House bill, by its terms, in this particular respect, at least would be-

come effective January 1, 1971. So, even if a State was financially able to bear the added load, you could not be ready for it by January 1, could you?

Mr. McMANUS. We would not have the money. There is no money available for this purpose.

Senator CURTIS. Would it be your opinion that the problems faced by Nebraska would be likewise faced by many other States?

Mr. McMANUS. I would assume that this would be true, Senator. Many of the States end their fiscal year on June 30, 1971, as we do, and this would not be a problem that would be peculiar to Nebraska alone.

Senator CURTIS. That is all, Mr. Chairman.

Senator ANDERSON. Any other questions?

Thank you very much for your practical experience.

Mr. McMANUS. Thank you very much, Mr. Chairman.

Senator ANDERSON. Dr. Martin D. Steinberg.

STATEMENT OF DR. MARTIN R. STEINBERG, MEMBER OF THE BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY JOHN M. STAGL, DIRECTOR OF THE PASSAVANT MEMORIAL HOSPITAL; AND KENNETH WILLIAMSON, DEPUTY DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

Dr. STEINBERG. Mr. Chairman and members of the committee, I am Dr. Martin R. Steinberg, professor of administrative medicine at the Mount Sinai School of Medicine in New York City, and a member of the board of trustees of the American Hospital Association.

With me is John M. Stagl, director of the Passavant Memorial Hospital, Chicago, Ill.

Also with me is Kenneth Williamson, deputy director of the American Hospital Association, and director of its Washington Service Bureau.

I would like to assure you gentlemen, I am not going to take more than 20 or so minutes, despite the apparent length of the testimony. It is my purpose to excerpt this in the interests of saving time.

Senator ANDERSON. Thank you very much.

Dr. STEINBERG. Thank you.

Now, if you will, turn to the top of page 3. These excerpts, sir, will be identified and located in the text, although from time to time we will simply summarize them instead of reading them.

At the top of page 3, we note that section 221 provides for the establishment of a new type of planning agency. We see no need for establishing "super planning agencies," and we recommend against it.

If you will turn, please, to page 4, at the top of the page. We recommend that the last sentence of paragraph (c) of section 221 be deleted, and that there be added the following:

> A determination by the Secretary under this section shall be subject to an administrative hearing to the same extent as is provided for in section 205(b) of the Social Security Act and if the capital expenditure in question exceeds $100,000, it shall be subject to judicial review to the same extent as is provided for in section 205(g) of such act.

We have for some time been concerned with the inability of hospitals under the law to appeal from determinations made by the

Social Security Administration or the intermediary on reimbursement matters. We, therefore, also recommend a similar appeal provision be included for such determinations.

Turning now, please, to the second paragraph on page 5.

We note that section 221, as currently written, imposes limitations which would apply to all replacements of capital equipment within a hospital, even routine replacements. We recommend, as stated at the top of page 6, that expenditures for the routine replacement of nonclinical items shall not be deemed to be capital expenditures for the purpose of this section. Further, we recommend that this section shall not apply to any expenditures for which approval has been given under a State certification of need law.

Section 222, continuing on page 6, deals with experiments and demonstration projects in prospective reimbursement, and provides that these experiments cannot be initiated until they are reported in full to the House Ways and Means Committee and the Senate Finance Committee.

We are concerned that the Secretary will await approval by the committees or at least indications that there is no disapproval, and we recommend, as stated on the top of page 8, that:

> The Secretary shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate, quarterly reports containing full and complete descriptions of each and every such experimental project which has been recommended to the Secretary for approval, has been approved, or has been placed in operation.

This, we feel, will eliminate the necessity for prior approval and the danger of overlong postponement.

Section 223 deals with limitations on coverage of costs under the medicare program. It appears to give the Secretary of the Department of Health, Education, and Welfare, authority to disallow costs which he deems in some manner result from inefficiency or which he deems arise from the provision of unnecessary services.

We believe this whole section constitutes a most dangerous and unwarranted invasion of the administrative authority and prerogatives of hospitals.

On the next two pages, that is pages 9 and 10, we have set forth and recommend for your adoption three requirements. These are numbered, which we believe will avoid the dangers alluded to.

Turn, please, to page 12 at the top of the page. Section 226 deals with payment for services of teaching physicians under the medicare program.

On pages 13 and 14, we have set forth five guiding principles which, we believe, will make for equity and which, therefore, we recommend for your adoption.

Turn, please, to page 14. On page 14 we note that section 227 provides for the authority of the Secretary to terminate payments to suppliers of services. Our comments on the provisions are set forth on this and the next page. The key comment is in the second paragraph on page 15, which I should like to read:

> We believe the provision which permits the Secretary to declare that care was excessive, harmful, or of grossly inferior quality is very dangerous and highly questionable as to its application and will set the stage for a multiplicity of malpractice suits.

Further, on page 15, we note that section 228 eliminates the requirement that States must move toward providing comprehensive medicaid programs. Such action, we believe, would be a very backward step, and we recommend that this entire section be eliminated.

We turn now to our comments on section 229, at the bottom of page 16.

This section, section 229, provides that the States would no longer be required to reimburse hospitals under title XIX on the same basis as under title XVIII. We believe that the administration of the medicare and medicaid programs would become increasingly costly and wasteful if this section is enacted, and what is most important, its enactment would vitiate the basic purpose of the Federal Government in establishing the medicaid program which was to provide needed care for the poor.

We recommend, at the bottom of page 17, No. 1, that section 229 be deleted from the bill.

No. 2, that the bill be amended to provide that the term "reasonable cost" as used in the Social Security Act shall mean the total monetary resources that a health care institution or service needs or will need to fulfill its role in meeting community health service objectives; and to provide that the Federal Government's share of these financial requirements for its beneficiaries under all titles of the Social Security Act shall not be more than, nor less than, the share borne by all other paying patients.

Please turn now to page 23 for comments on section 237.

Senator BYRD. Mr. Chairman, may I ask a question at that point?

Senator ANDERSON. Senator Byrd.

Senator BYRD. You recommended both sections 228 and 229 be eliminated?

Dr. STEINBERG. Yes; we do, sir.

Senator BYRD. Both sections?

Dr. STEINBERG. Yes, sir.

Senator BYRD. Thank you.

Thank you, Mr. Chairman.

Senator ANDERSON. You might amplify on some of these at a little later time. You have done very fine so far.

Dr. STEINBERG. Yes; we will, sir.

On page 23, section 237 deals with notification of unnecessary admission to a hospital or extended care facility under the medicare program.

We recommend, as stated in the second paragraph of page 24, that the committee include in its report on the bill a statement clearly indicating their intent that all payment cutoffs will be prospective only and made effective only after 3 days' notice.

Please turn now to our comments on section 239, on the next page, page 25.

Section 239 deals with payments to health maintenance organizations.

We recommend, as stated on the next page, page 26, that the concept of the HMO, the health maintenance organization, and the encouragement of experiments and demonstrations in the development of the concept as proposed in this section be promptly and fully implemented.

While we fully support the concept of the health maintenance or-

ganizations, we think Congress should be fully aware of the considerable problems that will be encountered in the development of health maintenance organizations. The enactment of section 239 will not, in our opinion, result in any sudden development of health maintenance organizations across the country. The costs of setting up such programs will be very large.

Also, there are very few incentives in the proposal which would encourage consumers to join the new organizations, and very few incentives to the providers of health care to create such an approach to the provision of health care.

On pages 27, 28 and 29, we set forth six suggestions regarding the HMO proposal which we feel merit your consideration.

Please turn now to the second paragraph on page 29. We suggest to the committee that the objectives sought under section 239 of the bill; namely, the provision of comprehensive health care to the aged, might more effectively be achieved by combining parts A and B of the medicare program.

Our specific recommendation, at the bottom of page 30, is that parts A and B of title XVIII of the Social Security Act be combined in a single program to provide institutional health care services and physicians' services; and that the social security tax structure be amended so that future beneficiaries will be able to prepay the cost of physicians' services in exactly the same manner as they presently prepay the cost of institutional health care services.

Turn, please, to the next page, page 31. Section 253, Exemption of Christian Science sanitoriums from certain nursing home requirements under the medicaid program. We can see no reason why any institution should be exempted from compliance with established standards.

Turn to page 32, please. Section 254 deals with physical therapy services under the medicare program. This provision would only increase the fragmentation of services and would not be in the best interests of the patients. We recommend, therefore, as stated in the second paragraph on the next page, page 33, that subsections (a) (1), (2), (3), and (4) of section 254 which provide for physical therapy services by physical therapists in independent practice, be deleted from the bill.

If you would turn now, please, to the next page, page 34, that contains our comments on section 263 which calls for a study of chiropractic coverage.

As stated at the top of page 35, we note that the Department of Health, Education, and Welfare has previously conducted an extensive study of chiropractic which resulted in the Department's enunciation of the position that chiropractic does not come within the healing arts. In view of the determination, we see no necessity for any additional studies, and we recommend that section 263 be deleted from the bill.

When we appeared before your subcommittee on May 26, we recommended a number of other changes in the law which we felt would simplify the administration of, and otherwise improve, the medicare and medicaid programs. We shall restate but not elaborate on these recommendations, and have set them forth on this page and on page 36, and the top of page 37.

Please turn now to page 37. Here we discuss the establishment of professional standards review organizations as proposed in an amendment by Senator Bennett.

The amendment introduced by Senator Bennett is, as he stated, based upon a proposal urged on him by the American Medical Association. The proposal would establish professional standards review organizations in each county of the country to conduct ongoing reviews of the maintenance and regular examination of the patents, practitioners, and provider profiles of care and services. While we feel the overall purpose is laudable and is intended to accomplish what we believe is desirable in terms of effecting improved utilization controls, the proposal has very serious implications as far as the operations of hospitals and their medical staffs are concerned, and we would strongly oppose the amendment in its present form for a number of reasons, as set forth on pages 39, 40, 41, 42, and 43.

Please turn now to page 42. We say there that if the Bennett amendment is to be activated, serious consideration should be given, first, to developing some demonstrations of the idea which would reveal its possible accomplishments, the costs involved, the administrative problems and its effect on the delivery of quality medical care.

Please turn now to the heading at the bottom of page 43, "Comments on Recent Changes in Regulations Dealing With Reimbursement."

On pages 43, 44, and 45, we call to the committee's attention two recent actions by the administration concerning medicare and medicaid reimbursements. These actions illustrate the reasons for our members' concern about the fairness of the reimbursement principles that have been established for the program.

Finally, Mr. Chairman and gentlemen, we appreciate the opportunity to appear and present the views of the hospital field on the proposed changes affecting the medicare and medicaid programs. We regret deeply the necessity to excerpt our full statement because of time limitations. We know it has been difficult for you to follow our departures from the full text and we do hope you can take the time to read it in its entirety. We wish to cooperate fully with the committee to make necessary improvements in the legislation.

(The complete statement of the American Hospital Association follows. Hearing continues on page 984.)

TESTIMONY OF THE AMERICAN HOSPITAL ASSOCIATION, PRESENTED BY MARTIN R. STEINBERG, M.D.

Mr. Chairman, I am Martin R. Steinberg, M.D., Professor of Administrative Medicine at the Mount Sinai School of Medicine in New York City and a member of the Board of Trustees of the American Hospital Association. With me is John M. Stagl, Director of the Passavant Memorial Hospital, Chicago, Illinois. Also with me is Kenneth Williamson, Deputy Director of the American Hospital Association and Director of its Washington Service Bureau.

On May 26, 1970, we appeared before your Subcommittee on Medicare and Medicaid. At that time we reviewed the over-all operation of the medicare program in some depth and expressed our concerns in respect to the program as well as our specific comments on the various recommendations embodied in the staff report. We will not at this time repeat our general comments but rather direct our testimony to the specific provisions incorporated in H.R. 17550 as passed by the House of Representatives.

We think there is no doubt that the medicare program has been an outstanding success in terms of providing needed health services to the aged people of the country. Experience gained to date points the way to changes that need to be made in the program to insure its improvement and continued success. Our testimony is directed to that purpose.

Limitation of Federal Participation for Capital Expenditures

This Section authorizes the Secretary to enter into agreements with the states under which designated planning agencies would evaluate and find for the Secretary whether any proposed capital expenditure is inconsistent with state or local health facilities plans. The language seems to permit the use of existing P.L. 89-749 planning agencies or the establishment of a new "super agency." The role of this body is to evaluate the plans proposed as a basis for controlling capital expenditures.

Though we fully support the establishment and use of health planning agencies, we would caution that such agencies do not yet exist in all parts of the country. A major reason for this is the lack of essential financing as well as acute shortages of qualified planning personnel. Though the Congress has provided in other legislation for the use of planning agencies, it has yet to assure the financing essential for their operation.

Recommendation.—We see no need to establish a new agency superimposed on planning agencies within the states and we have been assured that it was not intended that such an agency be established. Therefore, the language of this section should be amended to make absolutely clear that no new "super agency" is to be established to evaluate planning and the existing planning mechanisms are to be utilized. Further, the language should specify that this section shall not apply to any expenditures for which approval has been given under a state certification of need law.

Subsection (f) of the Section 221 states that determinations by the Secretary that a capital expenditure is not reimbursable under the medicare, medicaid, and maternal and child health programs, shall not be subject to administrative and judicial review. In reality, this means there is *no* appeal from such decisions. Such denial of administrative or judicial review is doubly onerous inasmuch as the capital expenditures involved are part of the cost of providing services under a contract. This is quite different from any government grant program. We believe there should be provision for administrative and judicial review of decisions of the Secretary disallowing capital expenditures as an element of reimbursement to hospitals under these three programs.

Recommendation.—We recommend that the last sentence of paragraph (e) of this Section be deleted and that there be added the following: "A determination by the Secretary under this Section shall be subject to an administrative hearing to the same extent as is provided for in Section 205(b) of the Social Security Act and if the capital expenditure in question exceeds $100,000, it shall be subject to judicial review to the same extent as is provided in Section 205(g) of such Act."

We have for some time been concerned at the inability of hospitals under the law to appeal from determinations made by the Social Security Administration or the intermediary on reimbursement matters. We, therefore, also recommend a similar appeal provision be included for such detemination.

Recommendation.—Amend Section 1815 of the Act to include the following provision:

"Determinations by the Secretary under this Section shall be subject to administrative hearings to the same extent as is provided for in Section 205(b) of the Social Security Act and in the case of a determination involving payment to a provider of $1,000 or more or in the case of an expenditure, regardless of the amount which by agreement between the provider or his representative and the representatives of the Secretary constitutes a principal reimbursement common to all providers to judicial review of the Secretary's final decision after such hearings as provided for in Section 205(g) of such Act."

Under Section 221 reimbursement would not be made with respect to capital expenditures which (1) exceed $100,000, (2) change the bed capacity of the facility, or (3) substantially change the facility's services, if such capital expenditures are determined to be inconsistent with state or local health facilities plans. As currently written, these limitations would apply to *all* replacements of capital equipment within a hospital, even routine replacements. This would constitute a serious interference with the operation of existing hospitals.

Recommendation.—Add at the end of Section 1122(g) as added by this Section the following:

"However, in the absence of a determination by the appropriate planning agency that the hospital or the particular service involved has been designated for phasing-out expenditures for the routine replacement of non-clinical items

shall not be deemed to be capital expenditures for the purpose of this Section. This Section shall not apply to any expenditures for which approval has been given under a state certification of need law."

* * * * * * *

SECTION 222

Experiments and Demonstration Projects in Prospective Reimbursement and To Develop Incentives for Economy in the Provision of Health Services

This Section authorizes the Secretary to contract with or provide grants to organizations to experiment in reimbursement methods involving negotiated rates, group practice, comprehensive care, payment for teaching activities and patient care, and areawide utilization and medical review mechanisms. It calls for the Secretary to develop and carry out demonstration projects designed to determine the relative advantages and disadvantages of various alternative methods of reimbursing hospitals on a prospective basis. We believe that methods of payment based on prospectively determined rates have very real opportunities for meeting the objectives of public accountability, predictability, and preservation of institutional autonomy. Last May the American Hospital Association urged its member institutions to make immediate efforts to develop workable methods of prospective payment and the full text of the Association's policy on this was made a part of our May 26 presentation.

The Section further provides that such experiments and demonstration projects may be initiated only after the Secretary obtains the advice of specialists and after a written report containing a full and complete description of each project has been submitted to the House Ways and Means Committee and the Senate Finance Committee. We are concerned that this provision will cause the Secretary to await approval by the committees, or at least indications that the committees do not disapprove a proposed project of this kind, before initiating it. The result can be an undesirable delay in undertaking promising demonstrations and experiments.

Because of the very nature of experiments and demonstrations and the fact that they are of limited duration and involve limited financial outlays, we believe they should not be impeded by burdensome and restrictive requirements. We recognize the desire of the Committee to encourage the development of promising projects and to insure that they are undertaken as expeditiously as possible and without undue administrative delay.

Recommendation.—Delete the last part of the last sentence of paragraph (3) after "completed or in process" and add the following new sentence:

"The Secretary shall submit to the Congress on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate, quarterly reports containing full and complete descriptions of each and every such experimental project which has been recommended to the Secretary for approval, has been approved, or has been placed in operation."

* * * * * * *

SECTION 223

Limitations on Coverage of Costs Under Medicare Program

This Section states that costs for purposes of provider reimbursement under the medicare program will be limited to "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." This Section proposes in numerous ways to apply the "prudent buyer" concept to hospitals and other providers of services for purposes of reimbursement under Part A of the medicare program. The Section appears to give the Secretary of the Department of Health, Education and Welfare authority to disallow costs *which he deems* in some manner result from inefficiency or *which he deems* arise from the provision of unnecessary services.

We believe this whole Section constitutes a most dangerous and unwarranted invasion of the administrative authority and prerogatives of hospitals. Even before the inception of the medicare program, the American Hospital Association supported the principle that the reimbursement of hospital costs should be limited to only those costs which are reasonable. In our *Statement on the Principles of Payment for Hospital Care*, August 1963, we stated: "If a hospital's costs depart substantially from other hospitals of a similar size, scope of services and

utilization, maximum reimbursement may be established through agreement reached between third-party purchasers and hospitals."

The 1969 revision of the Association's financing policy, *The Statement on the Financial Requirements of Health Care Institutions and Services*, re-endorsed the principle of the "reasonable cost" limitation. In that document the Association outlined three mutually dependent requirements for constructing a "reasonable cost" limitation:

1. Objective criteria should be established prior to the rendering of any decisions about the reasonableness of cost. The penalty should be understood by the health care institution prior to its imposition to provide the opportunity for the health care institution to take corrective action.

2. Health care institutions subject to such judgments must be provided an opportunity to have their situation reviewed and evaluated through an established equitable appeal mechanism. The unilateral imposition of penalties totally violates the health care institution's right to due process of law.

3. The basis for evaluating reasonableness of cost should be the total cost of providing institutional health care. Because there are many factors, such as local wage rates, availability of capital, the mix of labor manpower available, etc., which will alter the way an individual health care institution produces its total health care service, it is only the total cost which provides an objective basis for comparison and evaluation.

Recommendations.—Any cost limitation provision incorporated into the law should be in keeping with the above stated principles.

* * * * * * *

SECTION 225

Establishment of Incentives for States to Emphasize Outpatient Care Under Medicaid Programs

This Section relates only to the *medicaid* program and would provide an increase of twenty-five percent in the federal matching percentage for outpatient hospital services, clinic services and home health services for medicaid beneficiaries. It would provide for a one-third reduction in the federal matching percentage after sixty days in a general or TB hospital, after the first ninety days in a year in a skilled nursing home, and after ninety days in a mental hospital, with a total cut-off of federal matching after an additional 275 days of care in a mental hospital during an individual's lifetime. The Administration estimates this Section would bring savings of $235 million annually in the medicaid program.

We have been advised by a number of state hospital associations that this provision will result in very substantial decreases in the funds available for care to medicaid beneficiaries. The impact of this provision will be borne primarily by long term care facilities. We notice that a number of senators have spoken in the Senate in respect to this provision and its impact upon the needy in their states. The decrease of federal funds which will result from this provision will not be made up by the states and, therefore, the end result without any doubt will be an appreciable cut-back in the care rendered to medicaid beneficiaries. The entire history of programs to provide health services to the poor demonstrates that the states will move to meet the need only when there are very substantial federal funds to induce their participation. It is without doubt true that the Federal Government can save $235 million. However, this saving will be at the price of rendering $235 million less care.

* * * * * * *

SECTION 226

Payment for Services of Teaching Physicians Under Medicare Program

This Section would revise the current method for payment for services of teaching physicians. Payment to individual physicians of customary charges would be made only in those instances where non-medicare service patients having ability to pay are charged. In the instances where physicians are salaried by the hospital or paid from university complexes, the hospital will be reimbursed on the basis of its cost. This will include reimbursement to the hospital for any amounts which they, by agreement, pay to medical schools for the services of teaching physicians.

"Classes of persons" as used in the bill refers to service type patients and others, including private patients. The Secretary would establish by regulation, criteria defining the method of determining a patient's ability to pay. The committee report indicates that this contemplates the use of income levels and would use as a base the maximum family income limits set for federal matching under medicaid, (one and one-third times the level of aid to families with dependent children.)

As a matter of principle, we believe that the law should provide for the payment of all physician's services rendered to beneficiaries under government health programs.

It is recognized that the administration of this provision under the many varied teaching settings which exist in hospitals is extremely difficult. We urge that the following principles be followed in the development of regulations to implement this Section of the law.

1. In order to provide equity to everyone involved in the various teaching settings, there should be a pluralistic approach to the payment for physicians' services in a teaching setting.
2. The methods followed should assure that there will be no double payment for services provided.
3. The methods should assure that the medical services for which payment is being made were actually rendered.
4. The methods should assure quality of care and that there will not be any double standard of care as between Federal Government beneficiaries and other patients.
5. The methods should assure maximum accessibility of physicians' services to patients.

* * * * * * *

SECTION 227

Authority of Secretary to Terminate Payments to Suppliers of Services

This Section authorizes the Secretary to terminate payments to suppliers of services under Part A or Part B of the medicare program for making false statements, submitting bills in excess of customary charges or actual costs, or furnishing services the Secretary deems are in excess of medical need, or are harmful, or are of grossly inferior quality. The same authority would also be given the Secretary with regard to the medicaid and maternal and child health programs.

We view this Section with considerable alarm. We believe there is a serious question as to what would be covered by the term "grossly inferior quality" and as to how these determinations would be made. This appears to go into the whole area of medical devices. The government itself is already struggling to determine what is a medical device and has reached no conclusion. In various legislative proposals regarding medical devices it has been recognized that specific exemptions should be provided for experimental and developmental use of devices.

The imposing of any sort of established standards to define "inferior quality" would be very difficult. This difficulty seemed to be fully recognized by Commissioner Ball in his testimony before this Committee.

We believe the provision which permits the Secretary to declare that care was "excessive, harmful, or of grossly inferior quality" is very dangerous and highly questionable as to its application and will set the stage for a multiplicity of malpractice suits.

Our nation's hospitals have voluntarily sought to further improve standards of care through participation in a major revision of the standards established by the Joint Commission on Accreditation of Hospitals. It would be a great mistake for the government to interfere with the authority and responsibility of the medical staffs of hospitals to maintain the quality of patient care.

* * * * * * *

SECTION 228

Elimination of Requirement that States Move Toward Comprehensive Medicaid Programs

This Section eliminates the requirement that the states must move toward providing comprehensive medicaid programs. Such action would be a very backward step and really would remove from the Federal Government any

leverage it has to require the states to expand their programs of medical care to the indigent and the medically indigent. Without some kind of federal leverage it is most unlikely that many of the states will develop needed health programs for this group. There is a long history of such inactivity on the part of the states. When the Federal Government through medicare assumed the burden of health care costs for most of the aged, it relieved the states of their responsibility to this group. It was a legitimate expectation that the states would then establish programs to provide medical care for the indigent and medically indigent not covered by medicare.

Recommendation.—That Section 228 be deleted from the bill.

* * * * * * *

SECTION 229

Determination of Reasonable Cost of Inpatient Hospital Services Under Medicaid and Maternal and Child Health Programs

This Section would authorize each state to determine reasonable costs under the medicaid and maternal and child health programs. It means the states would no longer be required to reimburse hospitals under Title XIX on the same basis as under Title XVIII. The amendment would likely eliminate efforts to coordinate the over-all administration of Titles XVIII and XIX, which we believe is essential. In all probability it would require hospitals to keep two sets of books. The possibility of hospitals developing desirable incentive programs would be greatly minimized. Frequently, a single hospital has patients from more than one state and this would present increased administrative difficulties if the states have different reimbursement formulas. We believe the administration of the programs would become increasingly wasteful and costly if this Section is enacted.

It must be recognized that the Section is prompted by the desire of state governments to pay hospitals less than they now pay for care rendered to medicaid patients. The basic purpose of the Federal Government is establishing the medicaid program was to provide needed care for the poor. It was further intended to urge the health field to move to one level of health care in the country, rather than two. It was hoped that this would bring marked improvement in the provision of health services to the poor. All such desirable goals could be killed by this Section.

Recommendation.—

1. That Section 229 be deleted from the bill.
2. That the bill be amended to provide that the term "reaosnable cost" as used in the Social Security Act shall mean that the total monetary resources that a health care institution or service needs or will need to fulfill its role in meeting community health service objectives; and to provide that the Federal Government's share of these financial requirements for its beneficiaries under all titles of the Social Security Act shall not be more than or less than the share borne by all other paying patients.

We recognize that the total monetary resources necessary to provide institutional care must be fairly evaluated to protect the interest of purchasers. We also recognize the shortcomings of a retrospectively determined payment mechanism in which providers of care receive an implicit guarantee of recovery of cost. We have sought to develop programs of prospectively determined rates of payment which would permit effective internal planning and provide proper incentives for the economical delivery of health care by incorporating public review in the approval process. The primary objective of these programs has been the protection of the quality of care delivered in an economical manner through the development of state-local-community controls and full recognition of the hospital's legitimate financial requirements as defined in the *Statement on the Financial Requirements of Health Care Institutions and Services.*

* * * * * * *

SECTION 230

Amount of Payments Where Customary Charges for Services Furnished Are Less Than Reasonable Cost

This Section provides that payments under the medicare, medicaid and maternal and child health programs may not be higher than charges regularly made for these services. Such payments would be the lesser of "reasonable cost" or "cus-

tomary charges" or "fair compensation" for services furnished free or at only nominal charge by a public provider. To make this provision equitable and administratively feasible the legislation should clearly state that the provision applies only to the total annual payment to a given institution and that new institutions will be given some safeguards during their start-up years.

* * * * * * *

SECTION 231

Institutional Planning Under Medicare Program

This Section would require institutions to have a written plan and budget reflecting a detailed annual operating budget and a three-year capital expenditures budget. It would require that the plan and budget be prepared by a committee consisting of representatives of the institution's governing body, its administrative staff and its medical staff, if any.

The Association's *Statement on Financial Requirements* recognizes that health care institutions have the responsibility of providing a plan delineating their future programs of health service to the people of the community and that the plan should be reviewed regularly with the designated areawide health planning agency to assure consonance of institutional and community health objectives.

Recommendations.—That the Committee include in its report on this Section of the bill a statement asuring that the language is not intended to provide the government a role in the budgeting and planning process of health care institutions or to give the government authority to exercise any supervision or control over the practice of medicine or over operation and administration of medical facilities.

* * * * * * *

SECTION 233

Advance Approval of Extended Care and Home Health Coverage Under Medicare Program

This Section provides for determining in advance a minimum period of coverage by illness categories in an extended care facility or under a home health plan for medicare beneficiaries.

It is not clear exactly what the "plan" referred to in the Section, which the physician must file prior to the patient's admission to the ECF, is intended to encompass. This, no doubt, would be spelled out in administrative regulations. The responsibilities under this Section would fall mainly upon physicians and would necessitate their outlining in advance why a patient needs the services to be provided and exactly what the plan of treatment is. Physicians will, no doubt, find this Section burdensome. Also, because of the problems the Section poses for physicians, there would certainly be increased administrative problems for hospitals if the Section is enacted.

We recognize, however, the legtimate concern the government has for some better controls over the admission of patients to extended care facilities and over coverage for home health services.

* * * * * * *

SECTION 235

Utilization Review Requirements for Hospitals and Skilled Nursing Homes Under Medicaid and Maternal and Child Health Programs

This Section extends the utilization review process now required under medicare to the medicaid and maternal and child health programs.

In our opinion if utilization review in hospitals is to work, it has to apply to all patients and so far as we know, hospitals generally do not limit their utilization review programs just to medicare patients. The accomplishments of this control mechanism resulting from the efforts of hospitals and their medical staffs are beginning to emerge strongly; thus, the length of hospital stay for the elderly has been decreasing since the beginning of 1969 and the volume of care offered to nearly 20 million citizens 65 and over has virtually stabilized.

In previous testimony before House and Senate Committees we have expressed our concern about the problem facing physicians who serve on utilization review committees, namely the potential of personal legal liability resulting from actions of the committee. We have urged that the Federal Government study this problem

and initiate any necessary changes to protect physicians serving on utilization review committees.

We have reviewed the amendment proposed by Senator Bennett which would affect this and other sections of the bill, and we propose to comment fully upon this later in the testimony.

* * * * * * *

SECTION 236

Elimination of Requirement That Cost-Sharing Charges Imposed on Individuals Other Than Cash Recipients Under Medicaid be Related to Their Income

This Section provides that states would be permitted to impose a flat deductible or cost-sharing requirement with respect to persons eligible for health care benefits under the medicaid program, but not eligible for cash public assistance payments. The provision is intended to allow the states to explore methods of cost-sharing by the medically indigent which it is hoped would reduce the overall utilization of services.

The provision might well reduce the cost of the program to the states, but we believe it will increase the cost to hospitals because of the bad debt problem certain to arise in collecting the cost-sharing charges imposed on such patients.

* * * * * * *

SECTION 237

Notification of Unnecessary Admission to a Hospital or Extended Care Facility Under Medicare Program

This Section would authorize the termination of reimbursement for care of patients where utilization review mechanisms find hospitalization or extended care services for the patient are no longer necessary, or never were necessary. The termination would be effective only after three days notice to the patient, the physician and the institution.

We have been concerned about reports to us that the Social Security Administration has been refusing to reimburse institutions for any part of the cost of care of a patient in an extended care facility, when an utilization review committee finds that the patient should not have been admitted to the ECF. This has been especially disturbing because of the discriminatory application, i.e., physicians are paid for their services while hospitals suffer the retroactive loss of payments.

Recommendation.—That the Committee include in its report on the bill a statement clearly indicating their intent that all payment cut-offs will be prospective only and made effective only after three days notice.

* * * * * * *

SECTION 238

Use of State Health Agency to Perform Certain Functions Under Medicaid and Maternal and Child Health Programs

This Section would require state health agencies to perform certain functions under the medicaid and maternal and child health programs related to the quality of health care furnished to beneficiaries.

While we are concerned at the potential increased involvement of state health agencies in the day to day operation of hospitals which might result from the amendment, it appears to us that this amendment moves in the direction which the American Hospital Association has always encouraged, namely placing responsibility for health programs in health departments rather than in welfare departments.

* * * * * * *

SECTION 239

Payments to Health Maintenance Organizations

This Section would amend the existing law to afford individuals eligible for both Part A and Part B medicare coverage the option of electing to receive their health care through a health maintenance organization. This would include comprehensive health care programs organized and operated by hospitals. This provision favors the use of group practice plans providing comprehensive health

care services on a capitation payment basis. The amendment provides that the health maintenance organization may charge individuals electing such health maintenance coverage an additional amount for the comprehensive benefits which are in excess of those services provided under Parts A and B.

The American Hospital Association has long favored the health field moving toward the provision of more comprehensive health care as rapidly as possible. For example, we have recommended that the medicare program be amended to provide annual physical examinations as a preventive measure, multiphasic screening and an expansion of other ambulatory benefits. We strongly support any action which has as its goal the movement of health care institutions in the direction of providing more comprehensive care.

Recommendation.—That the concept of the HMO and the encouragement of experiments and demonstrations in the development of the concept as proposed in this Section be promptly and fully implemented.

While we fully support the concept of the HMO's, we think Congress should be fully aware of the considerable problems that will be encountered in the development of Health Maintenance Organizations. The enactment of Section 239 will not in our opinion result in any sudden development of HMO's across the country. The costs of setting up such programs will be very large. Also, there are very few incentives in the proposal which would encourage consumers to join a new organization and very few incentives to the providers of health care to create such an approach to the provision of health care.

As we have studied this proposal for the development of HMO's and have discussed it with representatives of the Federal Government and other health agencies, we find concern expressed on several points which we feel merit comment.

1. The bill would authorize payment to HMO's of "up to 95%" of the cost of providing services under Parts A and B of the law. There has been some suggestion that this should be amended so as to authorize payment of a flat 95%. Since the basis of the law at present is to pay the "reasonable costs of services," we believe the present language proposed, "up to 95%," is in keeping with the law and that if such services can be rendered for less than 95%, such lesser amount is all that should be paid. Certainly, if there are economic advantages to be gained, such advantages should be passed on to the aged recipients.

2. The bill provides that 50% of the enrollees in an HMO must be under 65 years of age. We feel this requirement may impose undesirable restrictions on the development of HMO's in certain areas. We believe the Secretary should be allowed to waive the 50% requirement under particular circumstances in accordance with carefully drawn administrative regulations.

3. There appears to be uncertainty as to whether an enrolle in an HMO program is required to purchase additional services beyond those provided under Parts A and B. If there is any uncertainty on this point created by the present language, there should be an appropriate clarification insuring that no such requirement is placed upon the enrollees.

4. Under the present language of the bill, there is no requirement that the HMO establish a special contractual obligation with the Federal Government. There is a good deal of thought that the relationship between the Federal Government and the HMO should be by contract and not simply through an agreement under the existing act. At present a provider is not required to provide services to medicare beneficiaries, but only to accept payment in a prescribed manner if they do render services. The HMO contemplates a different relationship, that of providing specified services at specified amounts for every enrollee. It appears to us that such a relationship would only be likely of achievement by specific negotiation and the development of a contract with each individual HMO.

5. There is concern that the HMO proposal in the bill may not permit a provider to continue to provide services on a fee for services basis to non-HMO subscribers, after agreeing to also provide services on a capitation basis to HMO subscribers. We feel that the language should be clarified so as to assure that an HMO may provide care on a fee for service basis to non-HMO subscribers.

6. There is a suggestion that the requirement that physicians must be affiliated with an organized group to participate in an HMO should be eliminated. We believe that dropping such requirement would be contrary to the whole concept of the HMO.

We suggest to the Committee that the objectives sought under Section 239 of the bill, namely the provision of comprehensive health care to the aged, might more effectively be achieved through a single broad program combining institu-

tional health care and physicians' services, as well as preventive care, multiphasic screening and an expansion of other ambulatory health services. This could be accomplished by combining Parts A and B of the existing program.

The combining of Parts A and B of the medicare program would insure for all medicare beneficiaries coverage of both institutional and physicians' services. Further, it would eliminate the waste and duplication of administrative costs that are inherent in the present separation of Parts A and B. It also would provide the base from which additional health care services such as multiphasic screening, immunizations, etc., could be added when and if enacted by the Congress.

The American Hospital Association recommended such action in testimony before the House Ways and Means Committee last October and before the Senate Finance Committee on May 26 of this year.

The placing of physicians' services on the same basis as institutional services would allow the population to prepay physicians' services just as they now prepay institutional health care services through the Social Security tax. It would remove the existing requirement that aged persons upon retirement pay an ever-increasing amount from their limited incomes for physicians' services. Inasmuch as admission to a hospital is dependent upon the availability of physicians' services, the present requirements are most unfair to aged persons.

Recommendation.—That Parts A and B of Title XVIII of the Social Security Act be combined in a single program to provide institutional health care services and physicians' services; and that the Social Security tax structure be amended so that future beneficiaries will be able to prepay the cost of physicians' services in exactly the same manner as they presently prepay the cost of institutional health care services.

* * * * * * *

SECTION 253

Exemption of Christian Science Sanatoriums from Certain Nursing Home Requirements Under Medicaid Program

This Section permits Christian Science sanatoriums to continue to be eligible to receive reimbursement under the medicaid program without complying with requirements imposed on all other nursing homes receiving reimbursement under the program.

We support the provisions which require nursing homes to meet basic standards and service requirements in order to qualify for participation in the medicaid program. We see no reason why any institution that does not comply with such standards and does not provide such minimum services should be permitted to participate.

Similarly, we see no justification for the exemption of Christian Science sanatoriums from the provisions of Section 221 of the bill.

Recommendation.—1. That paragraph (h) of Section 1122 be added by Section 221 to the bill be deleted.

2. That Section 253 of the bill be deleted.

* * * * * * *

SECTION 254

Physical Therapy Service Under Medicare Program

The existing law provides that physical therapy services are covered under medicare only when furnished under prescribed conditions by a participating hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency.

This Section would include as covered services under the supplementary medical insurance program the services of a physical therapist in independent practice when furnished in his office or in the patient's home. The effect of such an amendment if enacted would be to splinter this service from the facility-based health team. Further, it could be anticipated that similar arrangements would be sought for other members of the health team such as psychologists, social workers, speech therapists, etc. These actions would only increase the fragmentation of services and would not be in the best interest of the patient.

The House Ways and Means Committee has expressed concern about possible abuse of this benefit and has provided as a safeguard a limitation of $100 as the total of payments during the course of a calendar year which may be made to an

individual beneficiary for physical therapy services furnished to him in a practitioner's office or in the patient's home by an individually practicing physical therapist. The exercise of such a control would require an enormous amount of complicated and expensive administrative procedures and would increase significally the administrative costs of the program.

Recommendation.—That subsections (a)(1), (2), (3) and (4) of Section 254 which provide for physical therapy services by physical therapists in independent practice, be deleted from the bill.

* * * * * * *

SECTION 262

Payment for Certain Inpatient Hospital Services Furnished Outside the United States

Under present law, services furnished medicare beneficiaries in hospitals located outside the United States are not covered except for emergency services in a nearby foreign hospital if the beneficiary is in the United States when the emergency arises and the foreign hospital is closer to the place where the emergency arises or is more accessible than the nearest U.S. hospital adequately equipped and available for his treatment.

This Section would amend the law to permit payment for care rendered medicare beneficiaries in hospitals located outside the U.S. if the beneficiary is a resident of the U.S. and the foreign hospital is closer to or substantially more accessible from his residence than the nearest hospital in the U.S. that is suitable and available for his treatment, without regard to whether an emergency existed or where the illness or accident occurred. The hospital furnishing the services would have to be accredited by the Joint Commission on Accreditation of Hospitals or by a hospital approval program having essentially comparable standards.

We believe it is desirable to provide the additional protection this Section would give medicare beneficiaries living near the borders of the U.S. who find the nearest hospital suited to their inpatient needs is located outside the U.S. and we support this section.

* * * * * * *

SECTION 263

Study of Chiropractic coverage

This Section directs the Secretary of Health, Education and Welfare to study the coverage of services of chiropractors under medicaid to determine whether and to what extent such services should be covered under Part B of the medicare program. A report of the study would be made to the Congress within two years.

We note that the Department of Health, Education and Welfare has previously conducted an extensive study of chiropractic which resulted in the Department's enunciation of the position that chiropractic does not come within the healing arts. In view of the determination, we see no necessity for any additional studies; and, in fact we believe there is no basis for chiropractic services being included under the medicaid program.

Recommendation.—That Section 263 be deleted from the bill.

When we appeared before your subcommittee on May 26, we recommended a number of other changes in the law which we felt would simplify the administration of and otherwise improve the medicare and medicaid program. Without going into detail, we wish to reiterate the following recommendations that were made in our earlier testimony.

Spell of illness

That Section 1861(a) of the law be amended as to eliminate the spell of illness concept and to provide instead authorization for a specified number of days of inpatient care per calendar year to be used at that institutional level required by the medical needs of the patient.

Three-Day Inpatient Requirement

That as an alternative to the three-day inpatient requirement the law be amended to authorize admission to an extended care facility if the patient has had a medical workup in the outpatient department of a hospital and following such workup his admission is recommended by the utilization committee of the hospital.

Coverage for All Over 65

That the medicare program be broadened to cover all persons over 65 years of age.

Deductibles and Coinsurance

In our May 26 testimony we pointed to the serious problems facing hospitals in connection with the handling of deductibles. We specifically recommended that deductibles be eliminated and that in their place the principle of co-insurance be applied to become effective at a specified point in an inpatient stay. We recommended also that the same principle be applied to outpatient services.

Because of the extreme administrative burden with regard to deductibles in the outpatient area, we would like at this time to recommend that all outpatient services be placed under Part A of the program. We suggest that the outpatient deductible be eliminated and in lieu thereof each beneficiary be required to pay to the provider 20% of the cost of outpatient services furnished him. The coinsurance factor is intended to serve as a deterrent to unnecessary or excessive utilization of such services. In order to protect beneficiaries from burdensome payments for outpatient care, we recommend the inclusion of a reclaim provision authorizing beneficiaries to recover 80% of any outpatient care expenditures in excess of $100 in any calendar year.

* * * * * * *

THE ESTABLISHMENT OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS AS PROPOSED BY SENATOR BENNETT

The amendment introduced by Senator Bennett is as he stated based upon a proposal urged on him by the American Medical Association. The proposal would establish Professional Standards Review Organizations in each county of the country to conduct on-going reviews of the maintenance and regular examination of patients, practitioners, and provider profiles of care and services. While we feel the over-all purpose is laudable and is intended to accomplish what we believe is desirable in terms of effecting improved utilization controls, the proposal has very serious implications as far as the operation of hospitals and their medical staffs are concerned and we would strongly oppose the amendment in its present form.

We seriously question placing responsibility for the control of admissions to all health facilities in the hands of local medical societies. In essence, the county medical society is the local chapter of the American Medical Association. Physicians join many organizations. They join the American Medical Associations as their professional association, as a tradesman would join his union and only about 50 percent of the physicians in the country belong to the American Medical Association. Many of the organizations which they join are more closely oriented to the actual practice of their professions, such as the American College of Physicians and the American College of Surgeons, etc. The organization with which physicians most closely identify is their hospital medical staff organization.

The only organization of practicing physicians which has had the experience, ability and willingness to conduct quality and utilization peer review is the organized medical staffs of hospitals. The priority given to county medical societies precludes the medical staffs of hospitals from organizing themselves to perform as a PSRO. County medical societies have little history or experience in the delivery of health care. They are not looked to by physicians who are actively practicing on hospital medical staffs as a point of authority in respect to the delivery of health care.

The care and treatment of patients cannot be separated from their admission and discharge; both aspects must, therefore, be a responsibility of the institution's medical staff. It would be a serious backward step to weaken the whole structure of medical staff organization by going outside the hospital complex for the provision of control over the practice of institutional medicine.

The practice within physicians' offices is completely free of any control or supervision in contrast to the protection afforded the public by the organized staff within hospitals. We understand the American Medical Association has proposed that organized medicine develop programs for peer review of physicians' practices within their private offices. This would seem to us to be a de-

The boards of trustees of hospitals have final responsibility and are legally accountable for the quality of care rendered within the institution. The organized

medical staffs are their means of fulfilling this responsibility. The Bennett amendment raises very serious questions as to the authority of the boards of trustees and we believe, in fact, that they cannot legally divest themselves of these responsibilities.

The proposal envisions the establishment and maintenance of complete patient profiles within the review organization. This would necessitate a duplication of the records presently maintained in hospitals and which are essential to the care of the patients and to meet the various legal responsibilities of the institutions. We have grave doubts of the propriety of allowing the medical information for which the institutions are responsible being either duplicated or transferred to an outside organization. Such action would present serious legal questions. Furthermore, the cost of establishing and maintaining the mechanisms prescribed appears to us to be completely prohibitive and might well overshadow any possible savings which would otherwise be accomplished through lower utilization of facilities and services.

The whole direction in which health care is moving is towards more comprehensive care and towards treatment of the individual in toto rather than simply treating episodic illnesses. This proposal we believe reverses this whole direction. The over-emphasis on cost cannot help but result in treating illnesses on an episodic basis rather than on a complete diagnostic and health care basis.

The proposal as it would develop appears to not only affect controls over the admissions of patients, but it will become the means for controlling the quality of patient care. Furthermore, by authorizing the PSRO to become the payment agency, it would gradually take over all the responsibilities of the present intermediary organizations and, thus, would control the economics of the delivery of health care.

The proposal places great stress upon utilization and the desirability of decreasing utilization of health care facilities and services. Quality control in many instances will result in *increased* utilization rather than decreased utilization. Rather than either over-utilization or under-utilization, we would stress the necessity of *adequate* utilization, and we believe the language should be brought into conformity with this purpose.

The utilization procedures in hospitals are, we believe, really beginning to have effect and the over-all figures of use of facilities by the aged would indicate that there is great promise in respect to strengthening existing utilization procedures. The hospital field is greatly interested in improving utilization review because of the over-all effect of utilization on the cost of maintaining and operating health care facilities. However, we believe that proper utilization review can be obtained only when representatives of the administration of the institution and members of the boards of trustees participate in the utilization review process.

We believe it would be foolhardy to initiate a program of such magnitude on a nation-wide basis without some demonstrations which are very carefully organized, analyzed and reported upon. If the Bennett amendment is to be activated, serious consideration should be given first to developing some demonstrations of the idea which would reveal its possible accomplishments, the costs involved, the administrative problems and its effect on the delivery of quality medical care.

If any pilot projects or demonstrations are to be initiated, we would urge the following changes:

1. Remove the special priority afforded local medical societies in establishing the PSRO's in order to afford equal opportunity for the medical staffs of the hospitals in the area to develop a PSRO for their area.

2. The proposal provides that members of the active staff of hospitals be members of the PSRO's. This should be amended to provide that the medical staffs of hospitals be responsible for naming the individual members of the medical staff to serve on such committees.

3. Though the proposal seems clearly to intend that the control of admissions be related to elective cases only, the language in Section 1155(b)(2) leaves some doubt of this intent.

4. Delete Section 1164 which would appear to give the national PSRO control over all existing health programs or any which might be developed in the future. Further, the control is not limited to patient care programs, but includes all other types of federal programs providing funds such as the Hill-Burton and Federal Housing construction programs.

5. It is our conviction that any external organization responsible for quality of care and utilization should not control or be responsible for the expenditures

of health care. Thus, we would recommend that the dual responsibility of the PSRO's as provided in Section 1170 be eliminated.

* * * * * * *

COMMENTS ON RECENT CHANGES IN REGULATIONS DEALING WITH REIMBURSEMENT

We would also like to call to the Committee's attention two recent actions by the Administration concerning medicare-medicaid reimbursement. These actions illustrate the reasons for our members' concerns about the fairness of the reimbursement principles that have been established for the program.

One of these regulations revised the handling of accelerated depreciation. While this regulation nominally recognizes the need to employ depreciation payments in meeting the health care institution's debt amortization payments, the test for permitting accelerated depreciaion controverts the principle by relating debt amortization payments to depreciation on *total* assets. Since the need to repay debt relates to the purchase of specific assets or groups of assets, the Association believes that the test for employing accelerated depreciation should be based on the relationship between the depreciation payments of these specific assets and the related debt amortization payments. Depreciation payments on an institution's other assets will be required to maintain these other capital facilities.

The other regulation recognizes the additional nursing care for elderly patients and, hence, the greater allocation of nursing cost to the medicare program. This adjustment is predicated on the assumption that the pediatric and maternity patients, as well as the elderly, require more than average nursing time. However, the Administration has refused to recognize the higher nursing care cost for *medicaid* patients who are 65 and over or are maternity and pediatric patients. The logical inconsistency and the resulting inequity of one government program recognizing the higher nursing cost of maternity and pediatric patients, when it is to the government's advantage, and another government program simultaneously refusing to do so, when such refusal is to the government's advantage, is difficult to comprehend.

We appreciate the opportunity to appear and present the views of the hospital field on the proposed changes affecting the medicare and medicaid programs. We stand ready to cooperate with the Committee in their efforts to improve these programs.

The CHAIRMAN. You gentlemen made a fine statement, and we will see to it that all of your recommendations are considered in the course of our executive sessions.

Senator ANDERSON. It was a very good presentation.

Senator JORDAN. Senator Bennett could not be here this morning, Mr. Chairman, and he asked me to say that he has made a comprehensive rebuttal of your arguments against his amendment, and that rebuttal appears in yesterday's Congressional Record beginning on page S16033 through S16035.

I do not suppose you have had an opportunity to read Senator Bennett's statement but I believe, Mr. Chairman, it would be worthwhile to have Senator Bennett's statement appear at this point in the record, adjacent to the testimony of these distinguished witnesses.

The CHAIRMAN. Fine, we will do just that, then. If you would like it, Senator, we will be glad to do it. We will also include a letter I have received from the Catholic Hospital Association directed at this subject.

(The material referred to follows. Hearing continues on page 991.)

CATHOLIC HOSPITAL ASSOCIATION,
St. Louis, Mo., September 21, 1970.

Hon. Senator RUSSELL LONG,
Chairman, Senate Finance Committee,
Senate Building,
Washington, D.C.

DEAR SENATOR LONG: I have been directed by the Executive Committee of The Catholic Hospital Association, in behalf of its nine hundred health care member

institutions, among which its acute care facilities accounts for approximately one-third of the admissions for all voluntary short term general hospitals in the United States, to convey to you the attached position.

We deeply appreciate your willingness to conduct a thorough and fair review of the Medicare Program.

We believe that a complete and very professional study of such a profoundly important Federal Program is required by the nature of the complexity of issues inherent therein, and this is precisely why we feel that the Bennett Amendment deserves this review.

I trust that you and your committee will give our position your utmost consideration and take this occasion to thank you for the opportunity to communicate with you.

Sincerely yours,

Sister MARY MAURITA, RSM,
Executive Director.

CATHOLIC HOSPITAL ASSOCIATION,
St. Louis, Mo., September 21, 1970.

To: Constituent, associate, and personal members of the Catholic Hospital Association.

Subject: Amendment 851 to the Social Security Amendments of 1970—H.R. 17550 (Bennett amendment).

DEAR MEMBER: The attached reflects the position and the reasons for the position of The Catholic Hospital Association concerning the above proposed legislation. This position statement was approved by the Executive Committee of the CHA Board of Trustees at its September 15, 1970 meeting in Houston, Texas. The Executive Committee directed that the Association's position be presented to the Senate Finance Committee which is presently holding hearings on the Social Security Amendments of 1970. The position statement has been transmitted to Mr. Russell B. Long, Chairman of the Senate Finance Committee.

We encourage you to read the complete text of the attached CHA Position Statement carefully. In essence, the Association's position is that the Senate Finance Committee *not approve the Amendment as it is now written.* The reasons for this position are outlined in the attached statement with identification of positive and advantageous segments of the Amendment as well as those segments giving us concern.

A copy of this letter and the attached statement has been communicated, in addition to the CHA membership, to allied hospital associations and organizations.

We will continue to keep abreast of developments concerning this proposed piece of legislation as well as other legislative activities that affect the health field and thus our member institutions. You will be kept informed on a continuing basis of your Association's activities in this and other areas.

Sincerely yours,

Sister MARY MAURITA, RSM, *Executive Director.*

Enclosure.

POSITION STATEMENT OF THE EXECUTIVE COMMITTEE OF THE CHA BOARD OF TRUSTEES ON THE BENNETT AMENDMENT, AMENDMEND 851 TO THE SOCIAL SECURITY AMENDMENT OF 1970, H.R. 17550

INTRODUCTION

Public hearings are presently under way on the above noted Amendment since the introduction to Congress of this proposed Amendment on August 20, 1970, the CHA staff and Executive Committee of the Board of Trustees have been alert to the potential implications of this Amendment. At their September 15 meeting, the Executive Committee reviewed the current developments pertaining to this proposed legislation. This statement reflects the position and action taken by the CHA Executive Committee and the highlights of the Bennett Amendment.

EXECUTIVE COMMITTEE ACTION

In appraising the Bennett Amendment, the Executive Committee has taken the following course of action.

It has directed that the Senate Finance Committee, at the public hearings presently being held in Washington, D.C., be advised of the position and con-

cerns of The Catholic Hospital Association with respect to the Bennett Amendment. In view of the very short lead time available for the preparation of constructive suggestions and submission of same, and because of the concerns listed below, the Executive Committee is recommending *that this proposed Amendment not be approved at this time.* Pending its reactivation at the next Congress, The Catholic Hospital Association will be prepared to submit constructive suggestions to the appropriate body for modification of the Amendment and development of regulations.

It is to be noted that the Executive Committee's recommendation is not an action to defeat this Amendment but simply a postponement to permit clarification of a number of its major aspects.

The Executive Committee also went on record as considering it necessary to advise its membership as to the need for and the inevitability of increased regulatory measures in the hospital industry. It is for this reason a few of the highlights of the proposed Bennett Amendment are being communicated to you.

THESIS OF THE BENNETT AMENDMENT

The essence of the Bennett Amendment is that there must be improved controls over the many billions of dollars the federal government is paying out for Medicare and Medicaid. It proposes controls whereby groups of practicing physcians would be established outside of the hospital—Professional Standards Review Organizations (PSROs)—for the purpose of reviewing, analyzing, and evaluating health care rendered by their peers and to see that the care paid for by the federal government is: (a) medically necessary, (b) conforms to generally accepted professional standards, and (c) that the appropriate facility or service is used.

While acknowledging that the major share of the health dollar does not go to the medical profession, the sponsors point up that it is the medical profession that exerts the greatest influence on the spending of the health dollar. While offering the medical profession the opportunity to accept responsibility for the influence it exerts, the proposed Amendment also provides for alternate approaches in the event the medical profession is reluctant to accept this responsibility or if it fails to discharge the responsibility once it accepts it.

THE RELEVANCE OF THE BENNETT AMENDMENT

In studying the Bennett Amendment and its implications for CHA membership, it is recognized—

(a) that there is a need for improved mechanisms to ensure adequate review and controls with respect to quality, quantity, and cost of health care;

(b) that while some hospitals have had effective utilization review and medical audit programs, for the most part there has not been adequate review of clinical performance;

(c) that the traditional hospital-centered controls, even if they were effective, do not meet the need for controls outside the hospital;

(d) that within the context of a total health systems concept many aspects of this proposed Amendment have merit;

(e) that the proposal for a national advisory group of physicians to assist in the development and application of inter-hospital comparisons and norms of care and treatment is a worthwhile step towards the establishment of much needed national standards.

The Executive Committee is of the opinion that Senator Bennett should be commended for his interest in improving the health delivery system and for introducing measures designed to implement more effective measures some of which are referred to above.

CONCERNS REGARDING BENNETT AMENDMENT

At the same time, it is felt that there are certain aspects of the proposed Amendment in need of clarification. The Executive Committee has some concern that adoption of the Amendment as it presently stands, could create a good deal of confusion and thereby defeat the intended purpose of the proposed legislation. Included among the points of concern are the following:

(a) What is the intended relationship of the local Professional Standards Review Organization to a hospital's board of trustees? Statutory and court decisions leave no doubt about a hospital's board's legal responsibility. Is it intended to shift this relationship?

As the Amendment presently reads, it can be contended that the presently recognized and needed authority of a hospital's board of trustees may be significantly diminished. By the same token, it may be contended that inherent in the Amendment is the potential to facilitate a hospital board of trustees to more effectively discharge its responsibilities. While the Executive Committee hopes it is intended as a means of strengthening existing controls rather than the establishment of an entirely new set of controls, it feels strongly that the intent must be clearly stated.

(b) Is it the intent of the Amendment that the functions of professional peer review and management control decisions be synonymous? If the review organization is to exercise the control function, does this mean that hospitals become subject to the direction of the local Professional Standards Review Organization?

(c) Are the services of the Professional Standards Review Organizations available for the review of medical care paid for by agencies other than Medicare or Medicaid? In other words, can a board of trustees, in its desire to obtain maximum assurance that the care rendered in its institution is commensurate with generally accepted professional standards, purchase from the local Professional Standards Review Organization a review service for other than Medicare and Medicaid patients?

(d) Within the context of a total health systems concept, many aspects of the proposed Amendment have merit. However, it is essential to clarify the relationships of Professional Standards Review Organizations to existing health planning mechanisms and comprehensive health programs. In other words—inasmuch as the Professional Standards Review Organizations are to be directly involved with facilities and services, how will they relate to health planning agencies already set up with the intended purpose, and commensurate authority, for determining the establishment of facilities and services, including non-hospital health facilities.

[From the Congressional Record, Sept. 21, 1970]

Professional Standards Review Organizations

Statement by Senator Bennett

Mr. Bennett. Mr. President, on August 20, I submitted an amendment to H.R. 17550, designed to establish professional mechanisms for the review of hospital, medical and other types of health care covered under the Medicare and Medicaid programs.

The amendment would establish Professional Standards Review Organizations of proper size (probably a minimum of 300 physicians) and competence to assure that Medicare and Medicaid pay only for medically-necessary services provided in accordance with professional standards and that physicians are encouraged to use, where appropriate, less costly alternative sites and modes of treatment.

I describe the amendment in detail in my remarks on August 20 when it was submitted, and included in the Record the text of the amendment, as well as a section-by-section summary of its provisions. I urge Senators to review the Record for that day and see the amendment from my perspective. It is an important amendment. It offers a means of controlling Medicare and Medicaid costs by placing physicians in command of substantially all utilization review functions.

This seems entirely appropriate to me, inasmuch as it is the physician who orders or provides virtually all health care services rendered to the ill and infirm. He is the one best able to review the health services ordered by other physicians, and he is the one most qualified to determine when services, such as hospital stays, are no longer needed, or which services can be provided equally as well on an out-patient basis at lower cost.

Utilization review today—as carried on largely by hospitals—is a dismal failure. Hearings before the Committee on Finance and its Subcommittee on Medicare and Medicaid attest to its failure. The report of the staff of the Committee on Finance on the Medicare and Medicaid program chronicles the failings of utilization review as it has developed in the hospitals. Let me quote from the staff report:

"The detailed information which the staff has collected and developed indicates clearly that the utilization review requirements have, generally speaking, been

of a token nature and ineffective as a curb to unnecessary use of institutional care and services. Utilization review in medicare can be characterized as more form than substance. The present situation has been aptly described by a State medical society in these words: 'Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token.'"

At another point, the staff report notes a Health, Education and Welfare survey which shows that in 1968, ten percent of hospitals surveyed were not conducting a review of extended stay cases and that 47 percent were not reviewing any admissions. I ask unanimous consent that the full excerpt to which I refer be printed at this point in the record.

There being no objection, the excerpt was ordered to be printed in the Record, as follows:

UTILIZATION REVIEW PLANS LARGELY IGNORED BY INSTITUTIONS

The requirement for a utilization review mechanism is one of several which a hospital or extended care facility must meet in order to be eligible to participate in the medicare program. Each institution must have a written utilization review plan and copies of that plan are required to be maintained by the State health agencies (which perform certification functions for the program) and by the intermediaries. But whether the terms of the plan are actually being carried out is quite another matter and that is the test the law requires to be met. In actual fact, many State health agencies (and intermediaries) know that utilization review plans are not being followed, but they take no action to remove certification or to require that the plan be properly implemented. Based on a sample of hospitals taken in the middle of 1968, the Social Security Administration found:

1. 10 percent of the hospitals not conducting a review of extended stay cases.
2. 47 percent of hospitals were not reviewing any admissions (a basic statutory requirement).
3. 42 percent of hospitals did not even maintain an abstract of the medical record or other summary form which could provide a basis for evaluating utilization by diagnosis or other common factor.

In one State, the health agency conducted a detailed program review in November 1968. Their findings were that half of the hospitals and all of the extended care facilities failed to perform any sample reviews of cases which were not in the long-stay category (a statutory requirement).

Only recently did the Social Security Administration conduct a nationwide sample study of utilization review plans in extended care facilities. The results are not yet complete, but indications are that failure to comply with the statutory utilization review requirements will be found on an even greater scale in ECF's than the demonstrated poor compliance in hospitals.

The long delay by the Social Security Administration in seeking to determine the extent of compliance and application of these vital provisions of the law may very well be a prime factor in the much-higher-than anticipated utilization of ever-more-costly institutional care and services.

The staff recommends that the Social Security Administration and State health agencies increase their educational and enforcement efforts to assure that hospitals and extended care facilities have operating and effective utilization review plans. Combined with a tightening of the regulations related to utilization review plans such activity should help reduce the case-load and lower the costs of the program, consistent with congressional objectives established in the original law.

Mr. BENNETT. Mr. President, utilization review is a statutory requirement for institutions participating in the medicare program, and the widespread laxity among institutions in setting up effective utilization review procedures has contributed mightily to the financial crisis facing Medicare today. The Committee on Finance was advised by the Department of Health, Education and Welfare that Medicare is confronted with a $216 billion actuarial deficit. Much of this deficit could have been avoided if utilization review had been vigorously pursued from the beginning. Unfortunately, it was not.

It is my belief that organized medicine can give Medicare more effective review than it has received up to now, enabling this major health program to more efficiently meet its commitment to the aged citizens of America. I think we owe our taxpayers—who, after all, must bear the bulk of Medicare costs—the responsibility of seeing that the program delivers the highest quality care we can

provide, but that it does so in an atmosphere where excessive services—such as overlong hospital stays—and unneeded services are weeded out and not paid for by the program.

Against this background, I believe it is most unfortunate that the American Hospital Association has directed a letter-writing campaign to defeat my amendment. In a letter addressed to the chiefs of staff of member hospitals, the Association presents a distorted appraisal of my amendment.

But this is not the first time it has misinformed its members—although I am certain no misrepresentation was intended—about amendments in the Senate Finance Committee. I recall very well, and I am sure other Senators will also, the charge they led in 1967 to upset a health facility planning amendment in the Social Security bill of that year which the Committee had just agreed to. They misread the amendment, and therefore failed to note that we had so modified it that they no longer had real cause for alarm.

We retained that amendment in the Senate, despite their opposition, but we lost it in the conference because of their opposition. I recall this bit of history simply to note that the Social Security bill passed by the House this year contains the same sort of planning amendment the Senate passed in 1967—with one big difference: This year the Hospital Association indicated general support of the provision. I feel confident that the hospitals would have supported the Senate version in 1967 if they had been fully—and fairly—informed about it.

Similarly, I believe if they were fully and fairly informed about my Professional Standards Review Organization amendment, they would find little cause for alarm. Patients who need hospitalization will get it under my amendment just as surely as they get it today. But hospitals no longer would be permitted to bill Medicare for patients who do not need hospitalization, or for patients who safely may be discharged from the hospital sooner than they leave today. That, along with assuring proper care, is the purpose of utilization review. Yet, today it functions only spasmodically and sporadically; and in some instances, appears to place the financial interests of medical care institutions above the interests of the taxpayers who support the program and the aged patients hospitalized under it by keeping their otherwise empty beds filled—at Medicare expense.

The American Hospital Association appears bent on defeating my amendment. In the following paragraphs, I shall explore the arguments they make against my amendment and show how they have misunderstood its provisions. But first, I want to comment on the last paragraph of their letter directed to their member hospitals. It reads:

"We hope we can defeat this legislation if you express your views to the Senate Finance Committee. But if we do, we must take this opportunity to make sure our own voluntary utilization review mechanisms work! Let's be sure we are giving our patients optimal quality care, neither over-utilizing nor under-utilizing our facilities, voluntarily keeping our pricing mechanisms under control, using less expensive out-patient, ambulatory, or home care programs whenever possible. In this way, we will be sure that we give our patients more for their health dollar!"

I applaud this expression of concern over the very problem with which my amendment is concerned. But it is four years too late, and the shortcomings of utilization review as we have it today, generally speaking, are too ingrained in the system to expect significant improvements without basic and comprehensive changes in the review structure. It reminds me of the title of that famous Broadway play: "Promises, Promises."

Now I turn to my analysis of the Hospital Association criticisms.

Argument: They agree with the concept of peer review and concede that only physicians can review medical services. However, they say that such review must take place in the hospital by the medical staff.

Answer: Review solely within the hospital is generally inadequate. This sort of review has largely been a failure in the past, as hospital utilization review committees appear reluctant either to antagonize fellow staff members (who often refer and consult with each other) or to reduce the hospital's bed census. Secondly, institutional utilization review committees are usually too small to make efficient use of computer profiles, and other aids to the review process. Thirdly, and perhaps most important, only one aspect of medical care is reviewed. Hospital utilization review committees, which may meet as infrequently as once a month, do not provide a logical nor comprehensive focus for the continuing review of total patient care—physicians' office services, skilled nursing home care, drugs, physical therapy, and so forth. The top operating official of the American Hospital Association, Dr. Edward L. Crosby, also recognized these problems. In

the October, 1969, issue of *Hospital Progress* he states: "Personally, I don't think utilization review has ever worked."

The amendment provides for comprehensive locally-based review of all medical services provided under the Medicare and Medicaid programs, as opposed to current review activities which are fragmented and uncoordinated. The amendment would free reviewers from the institutional pressures which currently restrict their activities.

Argument: The amendment removes quality control and utilization review functions from the hospital staff.

Answer: The amendment most emphatically does not do this. Hospitals would continue to be able to establish quality or utilization control mechanisms which they believe lead to improved patient care (both Medicare and non-Medicare) within their institutions.

The amendment calls for the establishment of a comprehensive review system to review all of the health care services—not just hospital care—provided in a geographic area to assure that Medicare and Medicaid funds are properly expended.

The amendment simply and logically provides that in an area where a PSRO is functioning effectively, the Secretary may waive any present requirements in law or regulations imposed upon hospitals for utilization review as it relates to Medicare and Medicaid patients. It frees the hospitals to carry out their quality and other utilization review activities in whatever fashion is best suited to particular institutions without Medicare pushing and pressuring.

Argument: The amendment sets up a "control mechanism" which excludes the practicing physician and other providers from the control process.

Answer: This statement is difficult to understand, as the entire thrust of the amendment is to place review responsibilities in the hands of practicing physicians at the local level rather than leaving those responsibilities with intermediaries, carriers, and the government.

Argument: The amendment requires the maintenance of patient care profiles and ongoing review of physicians and institutions, and this would require a duplication of all physicians' and hospitals' medical records.

Answer: The profiles called for in the amendment can easily be constructed and have already been constructed in many areas of the country, using the claims data which the carriers and intermediaries must maintain and utilize in the present claims payment process.

Part B Intermediary letter number 70-5 issued by the Social Security Administration in February 1970 directed all carriers to establish charge and service profiles for each physician. No additional duplication of hospitals' or physicians' records would be necessary under the amendment.

Argument: The amendment requires approval, in advance, from the Professional Standards Review Organization before a doctor "can admit any patient to the hospital, except in an emergency."

Answer: The physician's privilege of admitting patients to a hospital is absolutely not affected by the amendment. His admission privileges will continue to be governed solely by the limitation presently imposed upon him by the organized medical staff of his hospital. The amendment simply provides that a proposed hospital admission, if disapproved by the Professional Standards Review Organization in advance will not be *payable* under Medicare or Medicaid. Thus, the doctor can still admit his patient—but he, the patient and the hospital would have to look beyond Medicaid for payment. This is similar to the present practice of Blue Cross-Blue Shield and private health insurance with one important improvement. Instead of care being provided and then having payment denied, under the Bennett Amendment, everyone will know where they stand in advance, rather than after the fact. If a Professional Standards Review Oragnization does not disapprove otherwise covered hospital care in advance, that care would be paid for until such time as the Professional Standards Review Organization acted.

Argument: The amendment gives physicians, through the Professional Standards Review Organizations authority to inspect hospital records and facilities.

Answer: Government already has and exercises the authority to inspect hospital records and facilities through conditions of participation and through State and local health departments.

Argument: The amendment is in effect government control of medical practice with the county medical society and other physician organizations acting as the government's agent.

Answer: The entire point of the amendment seems, again, to have been missed. The amendment was developed on the premise that the government cannot and should not control medical practice where there are effective local professional alternatives. The amendment clearly places responsibility for the review of medical practice in the hands of local practicing physicians wherever possible. The arguments of the Hospital Association sems to be against the ability and capacity of the local physicians to review medical practice. The amendment is an expression of faith that properly qualified and motivated physicians can and will do what is so desperately required in the Medicare and Medicaid programs. Where that is not the case, the amendment provides for alternative review mechanisms to be established.

Argument: The amendment will cost more than any potential savings.

Answer: This argument bears little relationship to reality. Authoritative estimates of overutilization of hospital care alone in this country range from 15 percent to 35 percent. That is to say that 15 percent to 35 percent of hospital days represent hospital care which is avoidable or not medically necessary.

These estimates have been given in testimony by medical organizations such as the Sacramento and San Joaquin Medical Foundations, and by individual physicians such as Dr. Amos Johnson, past President of the American Academy of General Practice. Dr. Angelo Angelides of the Association for Hospital Medical Education stated that "30 percent to 35 percent of the patients in acute short-term general hospitals do not need to be in this type of costly facility."

Mr. Walter McNerney, President of the Blue Cross Association, and a member of the Medicare Advisory Council, agreed at a meeting of that Council that where bed space is available patients are admitted to hospitals for rest rather than medical care.

With payments for hospital care amounting to about one-half of the government's $15 billion Medicare and Medicaid costs, potential savings from proper professional control of hospital overutilization are readily apparent.

Argument: The amendment ". . . affronts the integrity of the practicing physician" by creating a review process.

Answer: On the contrary the amendment is based upon a firm respect for the integrity of the practicing physicians. The thrust of the amendment is that physicians as members of a profession can and should be responsible for the care they order and render. The amendment represents a forthright move away from using outside agencies such as insurance companies to review physicians' practice in favor of using practicing physicians who have hospital staff privileges to review care in other hospitals.

Argument: The amendment is "regressive" as it assumes perpetuation of "episodic" treatment rather than encouraging "preventive" treatment.

Answer: The amendment most assuredly does not emphasize episodic treatment over preventive care.

The amendment calls for physicians to review care on the basis of whether the care is "medically necessary" and whether the quality of the care meets professionally recognized standards.

Appropriate preventive care and treatment is not only medically necessary, but such care is an integral part of high quality care. Under the amendment it would be provided without question just as it is today.

"Medically unnecessary" care refers *not* to preventive care, but to unnecessary care such as unneeded surgery and needless extensions of hospital stays—the payment for which should not be a charge to Medicare—or for hospital care where services could and should have been provided on an outpatient basis. Under the amendment this outpatient care, much of which is presently covered by Medicare, would be provided and its cost would remain reimbursable.

In an upcoming article on the Bennett Amendment in the October issue of *Hospital Practice*, this conclusion is reached: "The Bennett proposal represents a gamble, or a series of political, economic, and professional gambles. The Senator says he is open to suggestions for improving his proposal. His invitation to scoffers in the midst of the Medicare-Medicaid costs crisis is direct: Put up or shut up."

The CHAIRMAN. Thank you very much, gentlemen.

Dr. STEINBERG. Thank you.

The CHAIRMAN. I appreciate very much the way you have summarized your statement. We have to proceed with these hearings and conclude our testimony if we are going to act on this bill.

Dr. STEINBERG. Thank you, sir, for the opportunity.

The CHAIRMAN. Now, our next witness will be Mr. Sherwin L. Memel, vice president, Federation of American Hospitals, accompanied by Mr. Sam A. Weems, and Michael D. Bromberg.

STATEMENT OF MICHAEL D. BROMBERG, DIRECTOR, WASHINGTON BUREAU, FEDERATION OF AMERICAN HOSPITALS; ACCOMPANIED BY SAM A. WEEMS, DIRECTOR, LEGISLATIVE BUREAU

Mr. BROMBERG. Thank you, Mr. Chairman.

I am Michael Bromberg, director of the Washington Bureau of the Federation of American Hospitals, and with me is Mr. Sam Weems, director of the legislative bureau of the federation.

Mr. Memel could not be with us today, and with the permission of the chairman, I would ask that his full statement be printed in the hearings.

The CHAIRMAN. That will be done.

(Mr. Memel's prepared statement follows. Hearing continues on page 1001.)

PREPARED STATEMENT OF SHERWIN L. MEMEL, ON BEHALF OF FEDERATION OF AMERICAN HOSPITALS

Mr. Chairman and members of the committee, I am Sherwin L. Memel, a Vice-President of the Federation of American Hospitals and a member of the Health Insurance Benefits Advisory Council (HIBAC), the statutory advisory committee for the Medicare program. With me is Mr. Sam A. Weems, Director of the Federation's Legislative Bureau, and Mr. Michael D. Bromberg, Director of the Federation's Washington Bureau.

The Federation of American Hospitals is the national association of investor-owned (proprietary) hospitals and speaks for approximately 500 hospital facilities through its members and affiliated State organizations. Our member institutions range from small rural facilities to the largest investor-owned comprehensive medical care complex in the nation.

On May 26, 1970 Federation representatives were privileged to appear before this committee's Medicare-Medicaid Subcommittee in order to outline the position of investor-owned hospitals on the title XVIII and XIX programs and to discuss this Committee's staff report on those programs. At that time we discussed broad areas of agreement with the Committee staff and emphasized the immediate need to reorganize our he[illegible]h system. The investor-owned hospitals of America are ready to participate in this reorganizaiton. As health professionals as well as businessmen, dedicated to the delivery of quality health care at reasonable costs, we are conscious of the urgent need for a more efficiently administered health care delivery system which can more effectively combat escalating health care costs without sacrificing quality.

We submit this statement today on H.R. 17550, the House passed Social Security Act Amendments of 1970 with that goal in mind. We believe such a goal is attainable through changes in federal health policies designed to stimulate appropriate competition among providers and provide alternatives to the consumers of health care. There are a number of provisions in H.R. 17550 which recognize the desirability of this approach but there are also, in our opinion, other provisions which place obstacles in the way of this alternative by stifling competition and narrowing the available alternatives for delivering health care.

Another general concern of the investor-owned hospitals is the degree to which the Title XVIII and XIX laws and the proposed amendments contained in H.R. 17550 delegate to administrative agencies the authority to formulate policy through the issuance of regulations. Our hospitals have already experienced the economic damage and confusion which result from retroactive policies imposed through the unpredictable and vague regulations of agencies pressured to cut costs or by the uncertain and inconsistent decisions of intermediaries.

With these concerns in mind, we turn now to the provisions of H.R. 17550 and offer the following comments and recommendations:

CAPITAL EXPENDITURES

The Federation of American Hospitals has always supported the principle that hospital expansion or modernization programs should be consistent with sound planning. Proper steps to achieve comprehensive health care planning on State and areawide levels have been endorsed by Federation through both resolutions and the active participation of our membership in these efforts. The official Federation position on planning is quoted in our testimony before the Subcommittee on Medicare-Medicaid, May 26, 1970.

Section 221 of H.R. 17550 would direct the Secretary of H.E.W. to withhold reimbursement for capital expenditures which are determined to be inconsistent with State or local health facility plans. The Secretary is required to deny reimbursement where a State's designated planning agency advises the facility that its proposed capital expenditure is not in conformity with the plans of that agency "or any other agency" established under the Comprehensive Health Planning or Hill Burton Acts.

The section also provides for an exception to this directive where the Secretary determines, after submitting the matters involved to a national advisory council, that an exclusion of expenses related to a capital expenditure would not be "consistent with the effective organization and delivery of health services or the effective administration of Title V, XVIII, or XIX * * *" In such cases, the Secretary "shall not exclude such expenses * * *"

Federation supports the intent of section 221—to incorporate appropriate health planning procedures for capital expenditures by hospitals participating in federal health programs. At the same time we are concerned that the rights of providers be protected and that providers have a right to be heard. We therefore make the following recommendations for modifications to section 221:

1. Provide authority for withholding reimbursement under section 221 on a discretionary rather than a mandatory basis.
2. Require the Secretary to submit any proposed exclusion of expenses to the National Advisory Council.
3. Provide the institutional provider with an opportunity to appear before and present evidence to the Secretary, or the National Advisory Council, in order to contest any proposed exclusion of expenses.
4. Authorize the provider to appeal decisions of the Secretary excluding expenses to the U.S. District Courts.
5. Change the definition of "capital expenditure" to an expense which "exceeds $100,000", or "*substantially* changes the bed capacity or services of the facility", in order to eliminate low cost expenditures which result in minor changes in bed capacity.
6. Require the Secretary to establish a new national advisory council to assist him in implementing this section and mandate the composition of such national advisory committee to assure the appointment of "appropriate and technically qualified" persons to the council (See, Senate Finance Committee Staff Report, p. 6). We also urge that appointments to the council be representative of health facilities of all types of ownership.
7. Provide that where P.L. 89-749 planning agencies are in existence, these should be utilized as the designated agencies to avoid duplication and overlapping jurisdiction.
8. Limit the scope of section 221 to capital expenditures for equipment related to "new services", thereby excluding from coverage routine replacement of equipment.
9. Provide that where capital expenditures have been approved under this section, the provider shall be entitled to 150 percent declining balance depreciation payments.

PROSPECTIVE REIMBURSEMENT (SECTION 222)

Federation supports expanded experimentation with incentive reimbursement demonstration programs in order to develop an equitable system of prospective payment for health care services. Section 222 provides a vehicle for such increased experimentation by directing the Secretary to develop demonstration projects designed to determine the relative merits of various alternative methods of making payment on a prospective basis to providers. The Secretary is also directed to submit to the Congress by July 1, 1972 a report of the results of the various projects and detailed recommendations on specific methods for converting medicare reimbursement from retroactive cost reimbursement to a prospective payment system.

We favor this approach and urge this Committee to approve broad experimentation with provider participation on a voluntary basis. There are literally hundreds of variations on prospective payment systems, including those based on formulas and negotiated rates, and consequently, it would be, in our opinion, an unwise delegation of authority, to allow the Secretary of H.E.W. to force providers to participate in any particular pilot project as originally proposed by the Administration. The brief period of experimentation will enable Congress to select a new method of payment for health services based on an evaluation of a number of pilot programs.

In moving toward a prospective payment approach, we would emphasize the utilization of the profit motive as a constructive and positive vehicle for bringing about increased efficiency in hospital management, improved planning efforts both internally and on a State or area-wide basis, introduction of appropriate cost saving controls and procedures, and an atmosphere of competition in the health industry. We are confident that these goals can be achieved without sacrificing or compromising the quality of health care providing there is real competition and a meaningful profit potential.

For these reasons Federation, through its Bureau of Health Insurance Committee—a Committee of 20 men including physicians, attorneys, CPA's and hospital administrators—has developed a prospective payment proposal designed to maximize the opportunity for real competition to achieve cost savings to the federal government without sacrificing quality of care or curtailing services while holding out a meaningful profit incentive to providers. The proposal was also designed to avoid the administrative problems, cost to the program and potential inequities inherent in a system or prospective payment based on the findings of or so-called negotiations by rate-setting bodies or budget review commissions.

In addition we reject the idea of individually determined prospective rates because there can be no real competition under a system which bases the ultimate payment for service on the internal operating budgets of each participant. Under such a procedure, each hospital simply competes against itself with any profit resulting in a reduced rate for the following fiscal period and the elimination of all incentive to reduce costs.

The Federation of American Hospitals is presently engaged in discussions with the Social Security Administration for the purpose of developing a pilot program along these lines?

Payment on a prospective basis determined by averaging the defined costs of all providers in the same class (by size and scope of service) in the same geographical area by service and adding to that average certain specified costs not susceptible of averaging and a profit or surplus factor based on a fixed percentage of gross revenues or the difference between average defined community charges and average defined community costs in the preceding year. The resulting rate would be tied to agreed upon indices. The total rate would be fixed with the provider required to absorb all costs in excess of that rate, giving actuarial predictability to the program.

LIMITATIONS ON COVERAGE OF COSTS (SECTION 223)

Section 223 of H.R. 17550 is a clear and we believe an unwise step back from the federal commitment to meet the direct and indirect costs of providers of services to medicare beneficiaries. It is a retreat from the established policy of reimbursing institutional providers for reasonable costs actually incurred and it substitutes as a stopgap measure a vague procedure under which providers may, in certain limited situations, charge medicare beneficiaries for those costs not reimbursed by the program.

Federation of American Hospitals opposes the concept of section 223 as well as the broad delegation of authority to the Secretary of H.E.W. in connection with the proposed implementation of this section.

The starting point in establishing limitations on reasonable costs is the premise that there are providers which actually incur costs, a part of which are "unnecessary in the efficient delivery of needed health services." The legislation does not further define or state guidelines to be used in determining which services are "unnecessary" or "necessary" nor does the legislation state who is to make these determinations. Presumably the Secretary of H.E.W. through regulations and internal guidelines will be solely responsible for implementing this rather vague and broad authority to limit reimbursement for reasonable costs.

The budgetary pressures which now exist and which may exist in future years are more likely to influence the manner in which this limitation is implemented

than either the intent of Congress, the financial requirements of institutional providers, or the needs of program beneficiaries. In effect section 223 delegates to the Secretary the ultimate power to squeeze providers to whatever extent budgetary conditions at any given time dictate. The uncertainties of retroactive cost reimbursement seem more equitable when contrasted with this attempt at prospective setting by ceilings or limitations on reasonable costs by regulation with no basic safeguards such as the right to a hearing or appeal.

In light of the clear intent expressed in section 222 of the bill to move toward a system of prospective payment of institutional providers—a desire which we share—we question the need for authority to place arbitrary limits on the reasonable cost approach, while it remains in effect. If on the other hand, such an approach is adopted, we feel that Congress should spell out in the legislation guidelines for administrative implementation in order to prevent the friction which has developed in the past over administrative decisions which have penalized providers and program beneficiaries or have resulted in a lack of uniformity among intermediaries in applying administrative standards.

Section 223(e) authorizes providers to charge medicare beneficiaries for the cost of items or services in excess of or more expensive than items or services reimbursable under the above system. This authority applies where such charges are customarily imposed by the provider, do not exceed the excess cost of such items in the provider's previous fiscal period, are identified to the patient as cost in excess of those determined to be necessary and where the Secretary provides public notice that such charges may be imposed.

There is one exception to this provision and that is covered in section 223(g) which prohibits a provider from imposing an additional charge where "the admitting physician has a direct or indirect financial interest in such provider". The Federation of American Hospitals is strongly opposed to this prohibition and questions the basis, wisdom and constitutionality of the subsection.

First, with respect to the basis for the prohibition, we wish to question the concern that there is an inherent conflict of interest whenever a physician admits a patient to an institution in which he owns an interest. Federation disputes this while recognizing that there is a potential for conflict—a potential for which there exist proper and adequate safeguards.

The American Medical Association recently expressed itself on the ethics of physician ownership of hospitals and their position is restated in the following resolution unanimously adopted by the Board of Directors of Federation on June 27, 1970:

"It is the opinion of the Judiciary Council that:

(1) Under no circumstances may the physician place his own financial interest above the welfare of his patients. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration.

(2) When in the course of the physician-patient relationship a conflict develops between the physician's financial investments and the physician's allegiance to his patient, the conflict must be resolved to the patient's benefit.

(3) It is not in itself unethical for a physician to own a for-profit hospital or interest therein. The use the physician makes of this ownership or interest may, however, be definitely unethical. For example, for a physician to send a patient to such a hospital or to prolong a patient's stay in the hospital for his financial benefit rather than solely for the patient's needs and benefit would be unethical.

(4) When a physician has an interest in or owns a for-profit hospital to which he sends his patients, he has an affirmative ethical obligation to disclose this fact to his patient."

The integrity of the medical profession, enforcement of the AMA position by local medical societies, strengthened utilization review procedures and peer review are a few of the safeguards against overutilization by physicians who own an interest in institutional providers.

The soundness of the approach incorporated in section 223(g) is certainly questionable as a proper check on overutilization for several reasons. First it discriminates against one small class of physicians owning a relatively small interest in the nation's private hospitals. Secondly, it discriminates against that segment of the hospital industry—the investor-owned hospitals—which has a lower average length of stay and lower cost per hospitalization than all other sectors of the industry.

If the real intent of section 223 is to encourage efficiency and weed out those who deliver "unnecessary" services, then it is both ironic and unfair that sub-

section (g) should penalize that part of the hospital field which has been in the forefront of improved management systems and creative cost saving techniques.

Finally, Federation questions the constitutionality of subsection (g) of section 223 as a violation of the Fifth Amendment's Equal Protection and Due Process clauses. Economic discrimination against a closed class or distinctions in the treatment of business entities engaged in the same business activity have been held to be unconstitutional and we are leaving with the Committee staff a memorandum on this subject prepared by counsel to the Federation. Our position on this point is simply that the subsections relating to the imposition of additional charges on medicare patients should apply to all providers or to none.

For these reasons, we urge the Committee to consider the following alternative actions with respect to section 223:

1. Delete the entire section.
2. Delete section 223(g) and apply the authorization to impose additional charges on an all or none basis.
3. Include guidelines on the professional standards and procedures to be used in determining "unnecessary" services or costs.
4. Include a right to a hearing and a right to administrative and judicial review of decisions that services or costs are "unnecessary in the efficient delivery of needed health services".
5. Add a subsection clarifying the intent of Congress (as expressed in House Report 91-1096, p. 33) that this section will be used in connection with a relatively small number of so-called "luxury" institutions, as defined in the legislation by regulation.
6. Provide for administrative and judicial review of provider classifications wherever used for cost comparisons.

HEALTH MAINTENANCE ORGANIZATION OPTION (SECTION 239)

The Board of Directors of Federation of American Hospitals has endorsed in principle the development of health maintenance organizations. We have advocated this approach to improving our nation's health care delivery system in the belief that the private sector of the health industry can play a significant role in improving our delivery system through stimulating competition among providers.

The traditional lack of competition in the hospital field has prevented the health industry from keeping pace with the advances in medical knowledge and from controlling spiraling costs of medical equipment and services. The H.M.O. option may well provide a means for stimulating the kind of competition which will reward efficient and effective private management of all the components involved in delivering quality care.

The H.M.O.'s, acting in essence as partial underwriters of the Medicare program in a geographic area, can test the creativity and efficiency of the private sector. There will also be an opportunity for the federal government to streamline and thereby strengthen its own role in the administration of the program for a large group of beneficiaries. Paperwork can be reduced and auditing time substantially cut by building up a system of H.M.O.'s able to deliver all covered services from a single control point.

The key to the success of this project in our opinion lies in the development of a variety of H.M.O.'s. As H.E.W. Secretary Elliot L. Richardson stated in his testimony before this Committee on July 14, 1970: "I would like to emphasize, however, that we do not think any particular structure or sponsorship is a prerequisite for a health maintenance organization. Indeed, we think the country will benefit, by diversity and competition among different kinds of H.M.O.'s and between H.M.O.'s and other providers of health care."

We therefore endorse the approach set forth in section 239 with the following recommendations:

1. Authorize rates of payment during the first three years after the effective date of this section at levels of not less than 95 and up to 100 percent of the estimated payment for services furnished by others in the area. This will encourage development of H.M.O.'s by recognizing additional start up costs for establishing these new delivery systems.
2. Authorize experimentation on a contract basis with the inclusion of preventive medicine in the covered services provided by H.M.O.'s.
3. Suspend for three years after the effective date of this section the requirement that at least one half of the enrolled members of the H.M.O. be under age 65.

4. Provide that quality standards for services provided by H.M.O.'s shall be satisfied by meeting those standards established by existing professional organizations and accepted by the program as quality controls for existing health care providers.

5. Authorize the Secretary of H.E.W. to provide, by regulation, for a system of patient referrals to components of other H.M.O.'s and to other providers located in geographic areas outside the area served by the H.M.O. in which the beneficiary is enrolled.

6. Authorize the Secretary to exclude from covered services those services defined by regulation to be extraordinary such as heart transplants and kidney dialysis or in the alternative to establish by agreement with H.M.O.'s, other providers and insurance companies a system of insurance to cover the cost of extraordinary services.

TERMINATION OF PROVIDER PARTICIPATION (SECTION 227)

Section 227 of H.R. 17550 authorizes the Secretary of H.E.W. to terminate or suspend payment under Medicare to any supplier of health services found to be guilty of program abuses. Abuses set forth in this section include overcharging; furnishing excessive, inferior, or harmful services; and making a false statement to obtain payment.

Program Review Teams would be appointed in each State with physicians, other professional health care personnel, and consumers represented on the teams. While only professional members would review cases of alleged excessive, inferior, or harmful services, the full review teams would submit reports to the Secretary on all other cases.

Federation supports the principle that those who abuse the program should be excluded from future participation but we oppose the proposed procedure under which the accused are presumed guilty before trial. The section in its present form permits termination of future payments with no prior hearing or appeal. The right to an administrative hearing and judicial appeal is granted only after the effective termination of provider participation.

Federation recommends a modification of section 227 to provide for a hearing and judicial review prior to the effective termination of services. This would still enable the Secretary to withhold payment to providers for past or current claims on an individual basis, thereby protecting the program from such abuses.

In addition, since few suspensions or terminations are anticipated (see House Report 91–1096, p. 44) we recommend that Program Review Teams be composed entirely of professional health care personnel including representatives of hospitals of all types of sponsorship. All cases of alleged abuse will undoubtedly involve issues requiring consideration by professionals. While there have been headlines about the cases of abuse, studies have also revealed that less than one percent of the nation's physicians and hospitals have acted unethically or illegally. Those cases which are reviewed should be handled by professionally qualified personnel to insure equitable treatment.

INSTITUTIONAL BUDGETS (SECTION 231)

Section 231 of H.R. 17550 requires institutional providers to have a written plan and budget to include an annual operating budget and a capital expenditures plan covering a three year period prepared under the direction of the facility's governing body.

Federation of American Hospitals endorses the idea that hospitals should be encouraged to participate in the health planning process on an individual institution as well as an area-wide basis. At the same time we question the usefulness of requiring such individual budget planning as a precondition to participation in the Medicare program. We are also concerned about the extent to which the budget information may be used as a vehicle to coerce providers into accepting changes in their plans or operational procedures.

The House Ways and Means Committee, in House Report 91–1096 on H.R. 17550, states that: "The plan would not be reviewed for substance by the Government or any of its agents. The purpose of the provision is to assure that such institutions carry on budgeting and planning on their own. It is not intended that the Government will play any role in that process."

We suggest that this statement of legislative intent be incorporated into the language of H.R. 17550. Without such a clarification, the section might be construed or implemented in a manner inconsistent with and in direct violation of

Section 1801 of Title XVIII which states that the government will "not exercise any supervision or control over the practice of medicine or over operation of administration of medical facilities".

In addition to this modification we recommend that language be added to prohibit the disclosure of such plans or budgets and protect providers against the disclosure of parts of such plans out of context.

Finally we would recommend an exemption for those hospitals in which Medicare and Medicaid patients represent a relatively small portion of the total hospital patient load. The extra work and expense involved in requiring such facilities to prepare fiscal plans would not be justified or contribute toward a more efficiently managed program.

UTILIZATION REVIEW (SECTION 235)

Federation of American Hospitals recognizes that the utilization review mechanism has the potential for curbing overutilization of high cost medical facilities without infringing upon the practice of medicine. We support all efforts to strengthen utilization review within that framework while being cautious against the control of this mechanism by those not involved in the daily procedures of hospital work.

We therefore support section 235 which extends the requirement for utilization review to the Medicaid and Maternal and Child Health Programs. We also support experimentation on a voluntary basis with utilization review procedures, as authorized by Section 222(b)(1).

With respect to proposed experiments we would support programs designed to test the effectiveness of rotating utilization review committees among hospitals in a community provided at least one member of the committee remains at his facility. We would also recommend experimentation with "peer review", in cooperation with local medical societies.

While we would not oppose experimentation with computers to develop community-wide utilization review guidelines and statistics on average lengths of stay and services, we do caution against over-reliance on such statistics or their use by non-professionals. Computerization should be used to separate cases requiring more personal and professional review, just as is done under Internal Revenue Service procedures.

We note that the House of Representatives rejected the Administration's request to apply utilization review findings to hospital admissions on a retroactive basis. Such an amendment was contained in the Health Cost Effectiveness Amendments originally proposed by the Administration but not introduced in legislative form. We oppose any such retroactive use of the utilization review mechanism because it would penalize the hospital for an alleged medical judgment by the admitting physician.

In lieu of this proposal, the House approved Section 237 of H.R. 17550 which extends the authority of utilization review committees to findings made during reviews of sample admissions. Where findings of unnecessary admissions are made, payment would be cut off three days after notification to the physician, the patient and the provider. This section operates prospectively and is consistent with existing procedures.

Finally, we recommend that an amendment be adopted exempting physicians from liability for decisions made during the performance of duties as members of a utilization review committee. Such an amendment would remove the threat of lawsuits arising from conflicting opinions in this area.

PEER REVIEW

We have noted with interest the proposals made by Senator Bennett for the establishment of Professional Standards Review Organizations (PSRO's) to be responsible for review of quality of care. There is a real need for the development of a true professional peer review system in order to strengthen and make more equitable the provisions under federal law for checks against overutilization as well as to assure the delivery of quality care.

The Federation of American Hospitals would support such a system provided the professional members of such review organizations included those with knowledge and experience in the administration of hospitals of all types of sponsorship. This would be necessary in order to make the composition of the review teams equitable and appropriate for the responsibilities charged to the review team.

Such a system of PEER REVIEW might also be used as a screening process in a system of administrative appeals from the decisions of federal officials or intermediaries concerning disputes arising out of the administration of Medicare and other health programs. Such an appeals mechanism would relieve the federal government of the responsibility for review and would afford professional review to the physicians and other providers who are involved in disputes under these programs.

We believe that the concept of peer review should be tested in demonstration programs to determine the cost and feasibility of adopting this kind of program on a national basis.

We recommend the following modifications to the amendment sponsored by Senator Bennett:

1. Authorize experimentation only on a two year demonstration program basis in several localities to determine the cost and test the feasibility of implementing the Professional Standards Review Organizations approach on a national scale.
2. Provide for direct representation of all types of institutional providers on P.S.R.O.'s as well as on State and national councils.
3. Separate the utilization and quality review functions by establishing separate Professional Review Organizations or subcommittees to assume responsibility for each of these areas.

DETERMINATION OF MEDICAID REASONABLE COSTS (SECTION 229)

Section 220 authorizes the States to develop their own standards and guidelines for determining the reasonable cost of inpatient hospital services under Medicaid and Maternal and Child Health Programs. This provision would change the position of Administration Legal Counsel and the Courts that the "reasonable costs" provisions of the Title XVIII and XIX programs should be interpreted in the same manner.

While Section 229 restates the Congressional intent of preventing hospitals or their private patients from subsidizing inpatient costs of Medicaid patients and vice versa, the delegation of the authority to interpret the reasonable cost to the States can only bring about confusion and a lack of revenue predictability which in turn is likely to produce higher charges for non-covered patients.

In addition to these pressures on facilities, there will be budgeting pressures on the States which will tempt the States, as they have been tempted before, to adopt arbitrary and unreasonable cost control regulations in order to reduce the heavy fiscal burden of the Title XIX program. These pressures have already induced several States to attempt to impose some type of freeze on Medicaid charges which Court decisions have held in violation of federal law.

We recommend limitations on the power of the States to establish reasonable costs under Medicaid, including an appeal procedure for providers under which reasonable cost determinations by States could be challenged before the Department of Health, Education and Welfare and subsequently in the Courts. There should also be specificity with respect to the services expected to be provided by an institution with assurance that the actual costs of those services will be met. Otherwise we might return to the situation which existed prior to the adoption of existing regulations where reasonable costs were interpreted in some cases to be lower than actual costs.

PHYSICAL THERAPY SERVICES (SECTION 254)

Section 254 provides that reimbursement for physical therapy services provided under an independent arrangement between the therapist and the facility and under the supervision of the facility, may not exceed an amount equal to the salary which would have been payable to a qualified physical therapist under an employment relationship. This ceiling on the reasonable costs of physical therapy services will undoubtedly cause uncertainty and disputes over the reasonableness of costs of services performed under contract arrangements.

The retroactive application of an administrative determination as to the reasonable costs of such services, had they been performed pursuant to an employment relationship could cause substantial economic harm to a facility acting in good faith. In addition provision should be made to exempt facilities which have entered into contracts with physical therapists or made binding commitments prior to passage of this legislation.

For these reasons, we recommend an amendment to section 254 requiring the amount of salary considered reasonable for the employment of physical therapists to be determined and applied prospectively.

RETROACTIVELY APPLIED RULINGS

The complaint most often voiced by institutional providers about the administration of the Medicare program is that retroactively applied interpretations by fiscal intermediaries too often result in unforeseen financial harm to hospitals and other providers. The Federation seeks to avoid or substantially reduce the opportunity for unpredictable policy interpretations of this nature by limiting the area of interpretation which is delegated to the Social Security Administration and to fiscal intermediaries under the Title XVIII program.

Some examples of the hardships caused by retroactively applied policy determinations, as brought to our attention by Federation members, are set forth below for the information of the Committee:

1. Prior to July 20, 1970, hospital providers had been advised to exclude state and federal income tax from their equity capital computations. As a result of Blue Cross Medicare Providers Bulletin No. 48, hospital providers were instructed to include such taxes in computing their equity capital. The result of such inclusion is to reduce net asset value and thereby reduce return on investment.

2. In a prior fiscal intermediary directive, Medicare reserves were excluded from equity capital computations. But intermediaries recently reversed this position and have now advised hospital providers that Medicare reserves now must be included as a liability, with a resultant reduction in net asset value and a concomitant reduction in return on investment.

3. Prior to Intermediary Letter 398, the fiscal intermediaries had been advising hospital providers that no cost or depreciation elections would be binding until the audit of cost reports. But as a result of Intermediary Letter 398, this position was reversed in mid-stream and fiscal intermediaries are now advising hospital providers that all cost and depreciation elections made prior to cost report audits will be binding at the time of such audits. For example, if a facility elects straight-line depreciation prior to the audit, it may not at the time of audit switch to accelerated depreciation. This, as you can well imagine, can have horrendous results.

4. Blue Cross has been engaging in the practice of redetermining Part B payments following the rendition of services and billing. Thus, if a portion of such billing was originally directed to Part A, some of the Part A billing is now being thrown into Part B billing and being reduced thereby since there is patient liability under Part B for 20% of the total Part B billing. This, as a consequence, results in the reduction in the liability of the governmental program and places an increased financial burden on the facility to, in effect, finance the program. In addition, if the billing statute of limitations has run prior to the fiscal intermediary's redetermination, it is possible that the portion thrown into Part B could not be billed because time for such billing has passed. Again, the detrimental effect of such a policy is quite apparent.

5. At one point, fiscal intermediaries were advising hospital providers that purchase goodwill could be included when computing returns on equity. But now fiscal intermediaries are taking the position that purchase goodwill may not be included in making such computations, with a resultant decline in return on equity.

These policy determinations and abrupt reversals in policy lead to an escalation of the already high costs of auditing by requiring large scale reworkings of Medicare cost reports. The difficulties are further compounded when adjustments have to be made to cost data which is three or four years old. Since some hospitals have not yet had their initial cost reports accepted, this is a very real problem.

We support a revision and simplification of cost-finding procedures to bring short-term relief to providers—particularly small facilities. A long-term solution will only be possible when the cost reimbursement approach of the current program is replaced by a prospective payment system.

APPEALS PROCEDURE

Throughout this statement we have urged the adoption of administrative or judicial review mechanisms, or both, in order to meet basic standards of due process in resolving disputes under certain sections of H.R. 17550. The Federation of American Hospitals also recommends a more general appeals mechanism for providers under the Medicare and Medicaid programs.

In our appearance before the Senate Finance Subcommittee on Medicare and Medicaid (May 26, 1970) we emphasized that the Medicare program is a rather unique exception to the principle that a party with a grievance shall have recourse to some impartial source. It is clear that those intermediary hearing procedures which do exist are by their very nature limited and partial.

The conflicting interpretations of the Title XVIII program by intermediaries has created an atmosphere of uncertainty—an atmosphere which is certainly not conducive to efficient management or fiscal predictability. The ever present danger that a new interpretation of a regulation, set forth in an intermediary letter from S.S.A., will be applied retroactively can wipe out all efforts to achieve efficient and effective management forecasts of operations.

We strongly recommend the establishment of procedures under which providers may seek administrative relief as well as the right to judicial review under the Title XVIII program.

CONCLUSION

We believe that private initiative is the most effective instrument we have to achieve our common goal of high quality health care for all at a reasonable cost. We must improve management and control health care costs but we must achieve that goal without compromising on quality care.

The investor-owned hospitals of America appreciate this opportunity to be heard and we pledge our cooperation in efforts to meet the challenges of the future in the health field.

Mr. BROMBERG. The Federation of American Hospitals is the national association of invester-owned hospitals and speaks for approximately 500 hospital facilities through its members and affiliated State organizations.

Earlier this year we were privileged to appear before this committee's Medicare-Medicaid Subcommittee, and we offered a statement agreeing in great part with many of the recommendations made by the staff of the Senate Finance Committee. A number of these recommendations already are included in H.R. 17550.

At this time we would briefly like to tell the committee some of our recommendations for improvements of certain sections of the bill.

First, with respect to section 221, the federation has supported the principle that hospital expansion or modernization programs should be consistent with sound and appropriate planning. Therefore, we support the concept of this section which would allow the Secretary of HEW to withhold reimbursement for expenditures which are determined to be inconsistent with State or local health planning agencies.

In order to make the section more equitable, however, we strongly recommend that the committee include an appeal procedure so that providers may seek both administrative and judicial review of these determinations.

In connection with that, we recommend that the National Advisory Council, which is established in this section, would be a proper body to hold hearings and allow providers to present oral testimony.

We have also made a number of other recommendations for minor changes in the section which appear on pages 5 and 6 of our testimony.

With respect to prospective reimbursement, we have set out on pages 6 through 9 our position on this matter. Briefly we would like to say that we believe the fairest and best way of implementing this eventually will be a system which allows competition among providers. By this we mean a formula which would apply to all providers rather than an individual budget review system under which each hospital submits a budget and thereby competes against itself. Any gain which the hospital made, in other words, would result in the hospital being penalized for the following year by a lower budget.

On page 9 we start our testimony on limitations on coverage of costs. This is the one section in the legislation, Mr. Chairman, which the federation opposes in toto, and we urge complete deletion. We believe it is a clear retreat from the Federal commitment to meet the direct and indirect costs of providers of health care.

At this point I would ask permission to leave for the committee counsel, Mr. Chairman, a memorandum prepared by legal counsel to the federation on the constitutionality of certain aspects of this section, particularly subsection (g) which provides that whereas in the previous sections of the bill hospitals may, under certain circumstances, charge patients over and above medicare reimbursement, that that provision shall not apply to hospitals where the admitting physician owned an interest in the facility.

We believe that either no hospital should be able to charge a patient over and above medicare reimbursement or all hospitals should. There should be no distinction based on ownership or sponsorship. This is particularly true in light of a recent regulation which prohibits any physician with a financial interest from serving on utilization review committees.

We believe this would make the section unnecessary in any event, but we seriously question the constitutionality of subsection (g).

On page 15 of our testimony we discuss health maintenance organization options, and I would like to say at this point that the federation believes this is one of the two areas which offers the best hope in controlling costs under the medicare program, the first being prospective reimbursement, and the second being the development of health maintenance organizations.

We believe the key to this section is as quoted from the testimony of HEW Secretary Richardson, who appeared before this committee on July 14, at which time he said:

> I would like to emphasize, however, that we do not think any particular structure or sponsorship is a prerequisite for a health maintenance organization. Indeed, we think the country will benefit by diversity and competition among different kinds of HMO's and between HMO's and other providers of health care.

We have listed a number of recommendations on HMO's on pages 17 and 18. I would like to just briefly discuss two or three of them.

The first is that we would suggest that instead of a maximum of 95 percent, that the committee also institute a floor or a minimum in the legislation as an incentive. We have recommended a minimum of 95 and a maximum of 100 percent, at least during the first 3 years, after enactment of the bill, to encourage development of HMO's and to recognize that there will be startup costs.

Second, suspend for the first 3 years of the HMO experiment the requirement that at least one-half of the enrolled members of the HMO be under the age of 65.

We would also urge the committee to make provision for adequate referrals of patients and to exempt HMO's for liability for extraordinary health care, such as heart transplants or kidney dialysis. Under the bill, as it now exists and HMO would be responsible for all health care regardless of the nature of that care, and we think there should be certain limited exemptions.

We support the section on termination of provider participation. We simply urge that the judicial review provision of the act apply prior to, rather than after, the termination.

On page 20 we discuss institutional budgets which are required by section 231 of H.R. 17550.

The major recommendation we have in this area is that language which has been incorporated in the House report, which appears on page 21 of our testimony, be incorporated in the legislation itself. That language reads:

> The plan would not be reviewed for substance by the Government or any of its agents. The purpose of the provision is to assure that such institutions carry on budgeting and planning on their own. It is not intended that the Government will play any role in that process.

We believe the bill, itself, is very unclear on this point and should be clarified.

On pages 22 through 25 we discuss both utilization review and peer review. Let me say briefly that we support the extension of utilization review to medicaid. We believe that this will be helpful.

We also support broad experimentation with peer review.

With respect to Senator Bennett's amendment, however, we have listed several reservations. One of the reservations which I would like to mention is cost. We have not seen anywhere a cost estimate on this program, but we have heard that some foundations in the country, which are now running similar programs, may have costs as high as $10 per case.

We would note that there were 30 million hospital admissions last year, and even if that cost were shaved in half or lowered to a few dollars per case, we are talking about several hundreds of millions of dollars.

Therefore, we recommend, first, that Senator Bennett's amendment be experimented with on a 2-year demonstration program basis in several localities of the country.

We also urge that institutional providers be directly represented on the local peer review organizations.

Mr. Chairman, I would briefly like to mention an amendment which is not included in our testimony because it is incorporated in an amendment introduced last week by Senator John Tower, of Texas. This is Senate amendment 920, and this amendment would recognize and bring some relief to hospitals with under 50 beds. Many of our facilities which have been limited-access facilities are having difficulty meeting the medicare requirement that they have 24-hour-a-day, 7-day-a-week, registered nurses on duty and, as a result, many hospitals are being closed down, particularly 20- and 30-bed facilities.

Senator Towers' amendment would provide that licensed practical nurses could make up for the deficiencies in registered nurses. As you know, there is a great shortage in this area, and there is a great shortage in rural areas to meet it.

In conclusion, Mr. Chairman, I would like to read the last paragraph on page 31 of our testimony. Throughout this statement we have urged the adoption of administrative or judicial review mechanisms or both, in order to meet basic standards of due process in resolving disputes under certain sections of H.R. 17550.

The federation also recommends a more general appeals mechanism for providers.

The conflicting interpretations of the title XVIII program by intermediaries has created some atmosphere of uncertainty, which is certainly not conducive to efficient management of the medicare program. The ever present danger that a new interpretation of a regulation set forth in an intermediary letter will be applied retroactively can wipe out all efforts to achieve efficient and effective management forecasts of operations.

We have listed on pages 28 to 30 several examples of this, and we strongly recommend that this committee put a provision in this bill giving providers the right to administrative and judicial relief.

There are very, very few, if any, other major Federal programs in which there is no appeal procedure. Thank you, Mr. Chairman.

(The summary and memorandum follow:)

SYNOPSIS OF MEMORANDUM

Subject: Constitutionality of proposed amendment to section 1866(a)(2) of the Social Security Act.

From: Weissburg, Jacobs and Gerst, Bureau of health law, Federation of American Hospitals.

I. The proposed amendment to section 1866(a)(2) of the Social Security Act, contained in H.R. 17550, provides that hospitals and extended care facilities can charge beneficiaries for items and services not covered under medicare, except in the case of an admission by a physician who owns an interest in the facility.

II. Is the proposed amendment to section 1866(a)(2) constitutional under the fifth amendment to the United States Constitution? No.

III. The proposed amendment to section 1866(a)(2) is unconstitutional for the following reasons:

(A) It violates the fifth amendment right to equal protection under the laws by discriminating against facilities in which admitting physicians have financial interests.

(1) The proposed amendment does not serve the legislative purpose of preventing excessive and unnecessary charges.

(B) It violates the fifth amendment by taking property without due process of law.

(C) It violates the fifth amendment by taking property for public use without just compensation.

MEMORANDUM

Subject: Constitutionality of proposed amendment to section 1866(a)(2) of the Social Security Act.

From: Weissburg, Jacobs and Gerst, Bureau of Health Law, Federation of American Hospitals.

H.R. 17550, introduced on May 11, 1970 and thereafter referred to the Committee on Ways and Means, contains a proposed amendment to Section 1866(a)(2) of the Social Security Act to provide that hospitals and extended care facilities can charge beneficiaries under the Medicare program for items and services not covered under Medicare except in the case of admissions by physicians who have a direct or indirect financial interest in the provider of services.

This proposed amendment creates two separate classifications of providers for purposes of the Medicare program: (a) hospitals and extended care facilities in which admitting physicians have no financial interest, and (b) hospitals and extended care facilities in which admitting physicians have a direct or indirect financial interest. Thus, on its face, the proposed amendment is discriminatory of providers in which an admitting physician has a financial interest.

The right of equals to equal justice under the law is so basic to our jurisprudence and traditions that it is fundamental and must be protected against discrimination.

The crucial questions arising from this discriminatory classification within the proposed amendment is whether such discrimination is violative of the provisions of the Fifth Amendment to the Constitution of the United States. Reliance

must be placed on the provisions of the Fifth Amendment to the Constitution, an specifically, the due process clause contained therein, since the Fourteenth Amendment is inapplicable to Federal Legislation.

In the case of *Korematsu* v. *United States*, 323 U.S. 214, the United States Supreme Court held that the due process clause of the Fifth Amendment contains a limitation upon congressional classifications. In other words, the court found inherent in the due process clause of the Fifth Amendment the concept of equal protection under the laws. This finding was made even more explicit in the case of *Bolling* v. *Sharpe*, 347 U.S. 497, wherein the United States Supreme Court stated that "discrimination may be so unjustifiable as to be violative of due process." See also, *Hirabayashi* v. *United States*, 320 U.S. 81; *Ivanhoe Irrigation District* v. *McCracken*, 357 U.S. 275. Based upon these cases, it is safe to conclude that the due process clause of the Fifth Amendment is the proper constitutional means to hold the legislative and executive branches of the Federal government to the demands of equal protection.

The proposed amendment has the effect of imposing economic discrimination on a closed class—namely, providers in which admitting physicians hold financial interests. The leading and most recent United States Supreme Court case overturning legislation because of economic discrimination is *Morey* v. *Doud*, 354 U.S. 457. In the *Morey* case, the court considered a state statute which imposed licensing and other requirements upon currency exchanges that issued money orders with the express exclusion of those who issued United States Post Office, American Express Company, Postal Telegraph Company, or Western Union Telegraph Company money orders. A contention was made in this case that by expressly excluding those who issued money orders of the American Express Company, there had been an unreasonable statutory discrimination made which violated the equal protection clause of the Fourteenth Amendment. This case is important not so much for its holding as for the principles which it sets forth in determining a violation of the constitutional right of equal protection of the laws. The court stated that "Distinctions in the treatment of business entities engaged in the same business activity may be justified by genuinely different characteristics of the business involved. This is so even where the discrimination is by name. But distinctions can not be justified if the discrimination has no reasonable relation to those differences."

The fundamental concept which lies at the heart of the equal protection argument is that a statutory discrimination must be based on differences that are reasonably related to the purpose of the statute in which it appears. The equal protection clause aims at invidious discrimination of the sort where there is an absence of reasonable basis for such discrimination.

The proposed amendment sets forth the statutory discrimination between business entities engaged in the same business activity which do not have genuinely different characteristics. Hospitals and extended care facilities, whether or not of the sort in which admitting physicians hold financial interests, are not only physically similar among themselves, but also provide the same or similar services and are subject to the same regulatory and licensing laws of the respective states. In addition, they are accredited by the same accrediting bodies. This is not to say that variations among hospitals or extended care facilities will not be found, such as the availability of certain services, but in their essential forms, such institutions are basically without genuine differences. Furthermore, admitting physicians, whether or not they have financial interests in the facility in which they are admitting patients, are bound by fixed legal and ethical standards in the conduct of their practice. Therefore, under state law, all admitting physicians are treated equally.

The purpose for which the proposed amendment has been offered is no secret. There has been considerable activity in the Federal government centered on financial interests of admitting physicians in the facilities in which they admit patients. The fear of the proponents of the proposed legislation can be summed up in the phrase "conflict of interests." These legislators apparently feel that there is a greater danger that excessive charges and unnecessary services will result in situations in which the admitting physician has a financial interest in the health care facility.

Of considerable import is the position of the Judicial Council of the American Medical Association on this question. It has declared that it is not in itself unethical for a physician to own a for-profit hospital or interest therein.

Factually, there is no support for the very obvious fear of the proponents of the proposed legislation. Furthermore, if these legislators were truly concerned with the problem of excessive costs, they would prohibit billing bene-

ficiaries for all non-covered items and services irrespective of the type of ownership of the provider. There is no reason to believe that institutions not subject to the limitations of the proposed amendment engage in billing and utilization practices which differ from those which are restricted by the legislation.

If the purpose of the legislation is to eliminate unnecessary, excessive charges, then the legislation does not accomplish these ends since it is aimed solely at a closed class which does not account for the majority of hospital beds in the United States. There is therefore a violation of the due process clause of the Fifth Amendment since the statutory discrimination does not serve the purposes of, and has no reasonable relation to the purposes of, the proposed amendment. As noted in the *Morey* case, where there is a remote relationship of the statutory classification to the legislation's purpose, and where there is created a closed class with accompanying economic disadvantages, there is a denial of equal protection of the laws. Based upon the principles set forth in the *Morey* case, it is submitted that the proposed amendment is violative of the due process clause of the Fifth Amendment.

Furthermore, the proposed amendment is confiscatory in nature and thus violates the concepts of substantive due process and the taking of private property for public use without just compensation under the Fifth Amendment of the United States Constitution. By restricting the right of certain health care facilities to bill for uncovered charges, the proposed amendment is depriving such facilities of their property without due process of law and constitutes such an interference with property as to amount to a taking for which compensation must be paid under the Fifth Amendment. If a public purpose is to be served by legislation, then generally the Supreme Court has found that such a taking has not occurred. It is submitted that the proposed amendment does not serve a public purpose, but rather avoids the problem of excessive charges entirely by its piecemeal approach.

Summary of Statement by Federation of American Hospitals

The following is a summary of recommendations submitted by the Federation of American Hospitals, the national association of investor-owned (proprietary) hospitals, in connection with this Committee's consideration of H.R. 17550, the House passed Social Security Act Amendments of 1970:

CAPITAL EXPENDITURES—SECTION 221

Federation supports the incorporation of appropriate health planning procedures in provisions relating to the reimbursement of institutional providers under federal health programs. We recommend the following modifications to section 221:

(1) The Secretary's authority to withhold reimbursement for non-approved capital expenditures should be on a discretionary rather than a mandatory basis.

(2) The Secretary should be required to submit any proposed exclusion of expenditures to the National Advisory Council.

(3) Providers should have the right to appear before the National Advisory Council to contest proposed exclusions of expenditures.

(4) Providers should be given the right to appeal adverse decisions under section 221 to the U.S. District Courts.

(5) Members of the National Advisory Council should be "appropriate and technically qualified persons" and should be representative of health care facilities of all types of sponsorship.

(6) The scope of section 221 should be limited to capital expenditures for "new services" excluding routine replacement of equipment.

(7) Where expenditures have been approved, providers should be authorized to elect reimbursement based in 150% declining balance depreciation.

PROSPECTIVE REIMBURSEMENT—SECTION 222

Federaton advocates experimentation on a voluntary basis with incentive reimbursement programs. We support a prospective reimbursement system based on a comparison of costs of providers grouped by size and scope of service within the same geographical area thereby stimulating competition among all providers. We do not favor individually determined prospective rates because this would discourage competition. We oppose the establishment of rate-setting bodies or

budget review commissions for the same reason but also because of the administrative chaos and potential inequities of such a system.

LIMITATIONS ON COVERAGE OF COSTS—SECTION 223

This section is a retreat from the established policy of reimbursing providers for reasonable costs actually incurred and it gives the Secretary broad power to limit reasonable costs without adequate guidelines. Subsection (g) is discriminatory in its treatment of admitting physicians who have a financial interest in the institution and we question the constitutionality of this provision. We urge the Committee to:

(1) Delete the entire section 223.

(2) Delete subsection (g) and apply the authority to charge patients for additional services to all hospitals or to none.

(3) Include legislative guidelines for standards to be used in determining "unnecessary" services or costs.

(4) Include administrative and judicial appeal rights for providers to contest the classification of providers and the determination that services are unnecessary.

HEALTH MAINTENANCE ORGANIZATION OPTION—SECTION 239

The Federation has endorsed in principle the development of health maintenance organizations and recommends the following:

(1) Authorize rates of payment to H.M.O.'s during the first three years after the effective date of this section at levels of not less than 95% and up to 100% of the estimated payment for services furnished by others in the area.

(2) Authorize experimentation on a contract basis with the inclusion of preventive medicine in the covered services provided by H.M.O.'s.

(3) Suspend for three years after the effective date of this section the requirement that at least one-half of the enrolled members of the H.M.O. be under age 65.

(4) Authorize the Secretary of H.E.W. to provide by regulation for a system of patient referrals to components of other H.M.O.'s and to other providers located in other geographic areas.

(5) Authorize the Secretary to exclude from covered services those services defined by regulation to be extraordinary such as heart transplants and kidney dialysis or in the alternative to establish by agreement with H.M.O.'s, other providers and insurance companies a system of insurance to cover the cost of extraordinary services.

TERMINATION OF PROVIDER PARTICIPATION—SECTION 227

Federation supports the principle that those who abuse the Medicare program should be excluded from future participation, but recommends that section 227 provides for a hearing and judicial review prior to the termination of services.

INSTITUTIONAL BUDGETS—SECTION 231

We recommend the following modifications:

(1) Include language to clarify that budgets will not be reviewed by the Federal Government for substance.

(2) Prohibit the disclosure of such plans or budgets, and protect providers against the disclosure of parts of such plans out of context.

(3) Exempt those hospitals in which Medicare and Medicaid patients represent a relatively small portion of the total hospital patient load.

UTILIZATION REVIEW—SECTION 235

We support the extension of utilization review to Medicaid and Maternal and Child Health Programs and favor experimentation on a voluntary basis with utilization review procedures, as authorized by Section 222(b) (1).

We also recommend that an amendment be adopted exempting physicians from liability for decisions made during the performance of duties as members of a utilization review committee.

PROFESSIONAL PEER REVIEW ORGANIZATIONS

We urge the following modifications to the Peer Review amendment sponsored by Senator Bennett.

(1) Authorize experimentation only on a two year demonstration program basis in several localities to determine the cost and test the feasibility of implementing the Peer Review approach on a national scale.

(2) Provide for direct representation of all types of institutional providers on P.S.R.O.'s as well as on State and National councils.

(3) Separate the utilization and quality review functions by establishing separate review organizations or subcommittees to assume responsibility for each of these areas.

DETERMINATION OF MEDICAID REASONABLE COSTS—SECTION 220

We recommend limitations on the power of the States to establish reasonable costs under Medicaid, including an appeal procedure for providers under which reasonable cost determinations by States could be challenged before the Department of H.E.W. and subsequently in the Courts.

PHYSICAL THERAPY SERVICES—SECTION 254

We recommend an amendment to section 254 requiring the amount of salary considered reasonable for the employment of physical therapists to be determined and applied prospectively.

APPEALS PROCEDURE

We recommend the establishment of procedures under which providers may seek administrative relief as well as the right to judicial review under the Title XVIII program.

The CHAIRMAN. Thank you very much.

The next witness is Mr. Richard C. Herrmann, president, administrator, Bossier City General Hospital, in behalf of Louisiana Hospital Association; accompanied by Mrs. Phyllis Eagan, administrator of Sara Mayo Hospital, New Orleans; and Raymond C. Wilson, executive director, Southern Baptist Hospital, New Orleans.

STATEMENT OF RICHARD C. HERRMANN, PRESIDENT, LOUISIANA HOSPITAL ASSOCIATION; ACCOMPANIED BY PHYLLIS D. EAGAN, PRESIDENT-ELECT, NEW ORLEANS DISTRICT, LOUISIANA HOSPITAL ASSOCIATION; AND RAYMOND C. WILSON, PAST PRESIDENT, LOUISIANA HOSPITAL ASSOCIATION

Mr. HERRMANN. Mr. Chairman, I am Richard C. Herrmann, administrator of the Bossier City General Hospital, Boosier City, La.

I appear here today as president of the Louisiana Hospital Association, a nonprofit federation of hospitals, nursing homes, and related health care organizations in Louisiana. The association includes in its membership 147 hospitals which operate 85 percent of the hospital beds in the State.

With me is Raymond C. Wilson, a past president of the association and executive director of the Southern Baptist Hospital, New Orleans, and Mrs. Phyllis D. Eagan, president-elect of the New Orleans district of the association and administrator of the Sara Mayo Hospital, New Orleans.

We are here to express the serious concerns of large and small hospitals throughout Louisiana over certain provisions of H.R. 17550 as passed by the House of Representatives. We are also concerned over

several amendments the committee is considering as possible additions to H.R. 17550.

With your permission, I will ask Mr. Wilson and Mrs. Eagan to assist me in expressing our concerns and the reasons for them.

Before listing some of what we consider major problem areas in the proposed amendments to the Social Security Act, please permit me to say that the medicare program has helped to meet a great need in the United States and in Louisiana, although the need for either a medicare or a medicaid program was much less in Louisiana than in the rest of the United States, thanks to the State's charity hospital system through which free medical care has been available to indigent citizens of all ages since the days of the late Huey P. Long.

Through the medicare program created by title XVIII and the medicaid program created by title XIX, many citizens who previously traveled many miles to secure free medical care at the expense of the taxpayers are now able to receive care in their hometowns in private hospitals which participate in the medicare and medicaid programs.

Rightfully so, the Department of Health, Education, and Welfare is insisting that every participating hospital provide quality care to medicare and medicaid beneficiaries. Unfortunately, while setting standards which require many hospitals to add personnel and necessitate all hospitals becoming involved in additional paperwork, the two programs reimburse hospitals on a proportionate cost basis.

Because of the formula used, some costs have to be passed on to the non-Government patients, contrary to the intent of the law.

In spite of all the emphasis on controlling health care costs, we feel the Department of Health, Education, and Welfare is doing very little to help reduce or control costs, but is, instead, issuing regulations and the Congress is considering legislation to control hospitals rather than costs.

Our testimony today is designed to express our convictions concerning some of the additional problems we anticipate if H.R. 17550 becomes law in the form passed by the House and to offer our recommendations for changes which we think will improve the proposed legislation.

Before discussing the bill as passed by the House, we would like to discuss the amendment which has been offered for consideration by Senator Bennett and a recommendation by the Senate Finance Committee staff concerning tax exemptions for nonprofit hospitals.

To present our position on these two important issues, I would like to call on Mr. Raymond Wilson.

Mr. WILSON. Mr. Chairman, on October 8, 1969, the Internal Revenue Service issued a ruling to the effect that hospitals providing care on a nonprofit basis are considered eligible for 501(C)(3) exemption from Federal income taxes. This ruling was requested by the American Hospital Association because some hospitals were being challenged to show reasonable amounts of charitable services in order to continue to be eligible for the 501(C)(3) exemption.

The Senate Finance Committee staff has recommended that the ruling of October 8 be rescinded and that the position of the Internal Revenue Service be returned to that taken in their earlier ruling, 56–185, under which the problems of hospitals showing certain amounts of charitable services arose.

Hospitals traditionally have provided a certain amount of free care to the indigent members of the communities they serve. Unfortunately, in many cases this has resulted in a Robin Hood type of financing in that the hospitals charged their paying patients more than the bare cost of the care in order to generate an excess of income to cover the cost of the free services given to the indigent.

With the advent of medicare and medicaid and other Government programs, substantial percentages of the patients served by nonprofit hospitals now receive their care on a cost basis, thus greatly reducing the capability of nonprofit hospitals to provide free care for any segment of the population.

The Finance Committee's staff's position on the tax exempt status of hospitals is indeed surprising as it appears to be a vindictive proposal based on the premise that if hospitals are not forced to give free care they might "refuse medicare and medicaid patients with impunity or could limit their services to such patients unless the Government met the hospitals' unilateral cost demands."

The only demands that hospitals, or the American Hospital Association, have made are that they be reimbursed for services rendered on the basis of full cost.

Medicare is not provided for the indigent only, for all persons over 65 regardless of their ability to pay. Hospitals have no magic way of providing free care. There are very, very few hospitals—if any—with private endowments large enough to support free care for the indigent. The only means not-for-profit hospitals have of providing free care is by charging private patients enough to subsidize their charity work.

Hospitals provide free services to many because they feel they must furnish hospital care to patients in need of emergency treatment, including admission to the hospital.

We believe hospitals should be granted tax exemptions on the basis that they provide a community service, are available to serve the health needs of all members of the community, and that no profits or dividends are paid to the owners.

It is our understanding that colleges and universities are not required to provide free tuition to indigent students in order to maintain their nonprofit status and we feel that there should be no discrimination in this way against hospitals.

Denial of tax exemption by the Federal Government would increase the cost to all patients, including medicare and medicaid patients, by the amounts needed to pay real estate, ad valorem, sales and other types of taxes at the State and local levels.

Grants and donations are not a major source of operating income for hospitals, but many institutions do receive substantial sums for construction and modernization from private philanthropy.

The staff report of this committee maintains "there is no substantial evidence that contributors to hospitals will decrease or stop their donations * * *"

We disagree and firmly believe this source of funds will disappear if the contributors cannot deduct their donations.

As you know, the medicare and medicaid cost formula does not include the cost of charity services rendered by hospitals. It is conceivable to us that the Federal Government would require hospitals to

provide free services to indigent patients in order to maintain their tax status and, at the same time, refuse to allow hospitals to include the cost of these free services in their cost of operation.

We strongly recommend that this committee take no action to negate the current tax ruling by the Internal Revenue Service or to modify the basis for tax exemption by hospitals.

Another concern of ours is amendment 851 recently introduced by Senator Bennett to provide for "Professional Standards Review Organizations" by medical societies. While we support and encourage and thoroughly believe in the principle of peer review, we are of the opinion Senator Bennett's amendment is an affront to the integrity of practicing physicians and health care institutions in Louisiana and the Nation and would drastically change the system of health care delivery, and not for the better.

Section 1801 of title XVIII of the Social Security Act provides—

> * * * nothing in this Title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency or person providing health services; or to exercise any provision or control over the administration or operation of any such institution, agency, or person.

The medicare program was sold to the hospitals of this Nation largely because of the assurances contained in section 1801.

Senator Bennett's amendment would be a gross violation of both the spirit and letter of this section. We would like to cite several examples:

1. The amendment removes quality control and utilization review from the hospital staff and places it in the hands of an outside organization, the medical society. Section 1154(d).

2. The amendment requires the maintenance of profiles and constant review of every patient, every physician and every institution, which would be a duplication of hospitals' and physicians' medical records. Section 1155(a). In addition, we have serious questions concerning the legal complications of duplicating patient medical information for maintenance outside the institution.

3. The amendment gives the Professional Standards Review Organization of the medical society the authority to invade the privacy of hospitals' and physicians' medical records, and to inspect facilities and services. Section 1155(a) (3) (4).

4. Most importantly, amendment 185, if adopted, would require approval, in advance, from the Professional Standards Review Organization of any hospital admission, except in any emergency. Section 1155(a) (2).

Mr. Chairman, I submit this would create a serious bottleneck in the admission and treatment of patients and require medical societies to create elaborate and costly staffs to administer the program.

The effect of this amendment would be Government control of medicine, using the medical society as the agent of Government.

Only physicians can prescribe when, where and what medical services are to be used by their patients, and they must have the major role in the control of utilization.

We agree with the overall intent of the amendment, but we believe, however, that medical audits and utilization review are properly

functions of the organized medical staff which operates within an institution.

We believe the Bennett amendment would create more problems than it would solve in its present form and must express our opposition to it.

We are also able to report the House of Delegates of the Louisiana State Medical Society at a special meeting on September 13 voted to oppose the Bennett amendment.

While discussing the amendment, we would like to pose several questions to the committee for study:

Would the requirement for advance approval of all nonemergency admissions also apply to admissions to Veterans' Administration hospitals?

Would advance approval also be required before Members of Congress could be admitted to such facilities as the Walter Reed Hospital for elective surgery?

Would advance approval be required before the State of Louisiana could admit indigent citizens to its State-owned free hospitals for routine care?

As we said earlier in this testimony, a great deal is being said about controlling costs, but most of the action seems to be directed towards controlling hospitals rather than cost because adoption of the procedures required by Senator Bennett's amendment would increase costs rather than reduce them.

The person we have asked to read the next part of our statement is Mrs. Phyllis Eagan, administrator of Sara Mayo Hospital in New Orleans.

Mrs. EAGAN. Sara Mayo Hospital was founded in 1905 in order to provide high quality patient care to individuals who were medically indigent, persons who were not able to pay the full cost of outpatient and inpatient care, but who could pay a portion of this cost.

From that time until March of this year this hospital operated part-pay inpatient and outpatient clinics, supported by grants and contributions from the United Fund, other community agencies and the city and State.

In addition, the clinics were subsidized by the hospital's private inpatients, but when the inpatient medicare census rose to approximately 35 percent, it was necessary to discontinue the clinics because medicare does not reimburse institutions for such clinic costs and the declining number of private patients were having to pay—through billed charges for other services—an increasingly substantial amount per patient day for clinic costs.

Again, in this connection, consider the anomaly of the Federal Government through the Internal Revenue Service insisting on hospitals providing charity services but refusing through its contractual relationship with hospitals under medicare and medicaid programs to contribute anything to the hospital's cost of charity services.

The statement is made by the staff of this committee that—

> * * * unlike most areas in the private economy, no incentives exist to produce or supply a given health service at the most economical price consistent with quality of care. To the contrary, hospitals and extended care facilities can, under present medicare and medicaid reimbursement rules, spend money on virtually anything and be paid for it by Government.

First of all, let me say that there are thousands of community leaders serving without pay as members of boards of trustees of voluntary hospitals all over the United States who are giving freely of their time, counsel, talents, et cetera, setting policies and directing planning activities for nonprofit private hospitals.

I have never met one who was not vitally concerned with controlling costs. These board members provide an incentive to the administrations they employ to keep costs down. The only comparison of costs which we can make is with Government hospitals. From statistics published by the American Hospital Association for the year ending September 30, 1969, we learn that costs for the average length of stay in Federal Government hospitals in our State, in Louisiana, are considerably higher than in the private hospitals.

The two Veterans' hospitals reporting had costs of $1,357 and $1,009 per stay and the U.S. PHS hospital reported an average of $1,142 per stay.

The highest cost per admission of any private hospital in Louisiana was $823, with the average being between $600 and $700.

Secondly, concerning incentives to economy, it is reasonable to assume that no hospital administrator would adopt a fiscally irresponsible policy in order to be reimbursed by the Government for only the proportionate share of that cost as is represented by medicare and medicaid patient days.

Most hospitals do not have a majority of medicare and medicaid patients so the major portion of "unnecessary costs" would not be reimbursable by the Government.

There are all varieties of statistics from reliable sources that can be used to show that hospital costs have gone up no more than the costs of other services and commodities, particularly the cost of owning a home, the cost of education, the cost of insurance and finance, et cetera.

But, hospitals have had an unusual problem. Up until 10 to 15 years ago, the greatest benefactors of hospital patients were hospital employees who worked for pay well below what employees earned in other industries. Hospital costs were as low as they were primarily for this reason.

Who has not heard of the intern who, after spending 7 years getting his medical education, was willing to work long, hard hours for $10 a month, plus some subsistence. Interns now receive pay as high as $500 to $600 a month, plus some subsistence. Compound this phenomena with the fact that approximately 60 percent of the hospital's costs is in personnel and professional services.

Nurses' salaries have gone up in our area from approximately $200 per month in 1956 to $600 today with a shorter workweek. Certainly no one would say nurses make too much money considering their education and responsibilities.

We believe there is a concerted effort by the vast majority of hospitals to control costs. We do not think that attempting to control hospitals is going to contribute to controlling costs, but quite the opposite effect may occur.

Section 223 of H.R. 17550 constitutes a dangerous and unwarranted invasion of the administrative authority of hospitals. This section states that costs for purposes of provider reimbursement under the

medicare program will be limited to "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services."

This section proposes to apply the "prudent buyer" concept to hospitals and other providers of health care and if carried to an illogical conclusion would give the Secretary of Health, Education, and Welfare authority to disallow the cost of carpet in an administrator's office on the basis this was not necessary for quality patient care. We recommend that this entire section be removed from the bill.

We believe section 225 of H.R. 17550 would seriously affect medicare payments to skilled nursing homes, hospitals, tuberculosis, and mental institutions in Louisiana.

According to the commissioner of welfare of our State, if section 225 of H.R. 17550 becomes law, Louisiana in order to maintain the aged who require skilled nursing care in nursing homes will have to spend an additional $4 million in State funds, funds which are not now available and which most probably will not be available in the future.

In addition to practically eliminating the nursing home program in Louisiana, adoption of this legislation will reduce Federal participation payments to hospitals to 60 days. Although the State Department of Welfare now pays only for 15 hospital days in a calendar year, some cases are extended beyond this period of time because of the serious nature of the illness.

One of the five mandatory programs under title XIX is the skilled nursing home program. If Louisiana is forced out of a skilled nursing home program because of a lack of funds, our entire medicaid program will be in jeopardy.

We appreciate the desire of the House and of the Senate to encourage outpatient and ambulatory care and to reduce inpatient care. We agree with the concept, but we believe one should not be increased to the detriment of the revenues available to the other. Although Louisiana does not have a fully developed medicaid program under title XIX, we are extremely interested in section 229 which would authorize each State to determine reasonable cost under the medicaid and maternal and child health program.

At present, States are required to reimburse hospitals under title XIX on the basis as under title XVIII.

In the Senate committee's staff report a survey is cited in which the Governor of each State was asked if this requirement to reimburse under title XVIII, the same as under title XIX, imposed any burden on his State.

Of the 37 States which replied, 26 replied in the affirmative. It is then apparent that these States wish to be allowed to pay less for title XIX patients than costs as defined in title XVIII.

Although our Welfare Commissioner has publicly stated he is in full accord with paying hospitals their full costs, if section 229 becomes law, in all probability hospitals would be required to keep two sets of books, and we have already been assured of this, and we would be constantly negotiating with the State department of welfare in an effort to avoid our providing service below full cost.

Prior to the advent of title XIX, our Louisiana association negotiated with the State department of welfare and other agencies in an

attempt to secure adequate reimbursement under the Kerr-Mills program and before that, other programs. We were constantly faced with the fact that the State welfare department and the State department of health had a limited amount of money to spend on an almost unlimited number of patients and hospitals were expected to take all the patients referred for whatever amount of money was available, even though it meant reimbursing hospitals on a less than cost basis.

Mr. HERRMANN. Mr. Chairman, as president of the Louisiana Hospital Association, I am proud of the fact that our group opposes fraud and abuse wherever it is found. Although we are not able to control the actions of our individual members any more than other voluntary associations can control the actions of their members, we have a record of scrutinizing the standards of institutions prior to accepting them for membership and, on at least one occasion, we have publicly censured a member when we felt the institution deserved such action.

In spite of our strong stand against fraud and abuse, we must express our opposition to section 227 of H.R. 17550 because we believe adoption of this section which permits the Secretary of Health, Education, and Welfare to declare that care was excessive, harmful, or of grossly inferior quality will open the door to an untold number of malpractice suits.

Imagine, if you will, what may happen if a patient is told that the medicare program will not pay for some element of his hospital stay because the Secretary has deemed it in excess of medical need, or harmful, or of grossly inferior quality.

The entire area of quality medical care is hard to define and we believe setting standards to define inferior quality would be very difficult.

Section 237 will correct a very serious problem for extended care facilities. It is our understanding that adoption of this section would mean that termination of payments would be effective only after 3 days' notice to the patient, the physician, and the institution.

At present, the Social Security Administration has been refusing to reimburse some institutions for any part of the cost of the care of a patient in an extended care facility when a utilization review committee found that the patient should not have been admitted to the ECF.

Sometimes this denial was made after the patient had been discharged.

Although we feel that section 237 is highly desirable, we are equally opposed to section 238 which would require the State health agency, or in Louisiana's case, we assume, the State department of hospitals, to be responsible for reviewing the appropriateness and the quality of care and services rendered to medicaid and maternal and child health program beneficiaries.

We believe this would increase the involvement of a State agency in the day-to-day operation of hospitals and is not in the best interest of patient care.

Mr. Chairman, the members of our association have very definite opinions on other provisions of H.R. 17550 and on the operation of the medicare and medicaid programs in general, but we will not presume upon the time of the committee to discuss the rest of them at this time.

We do have one other concern which has already been reported to

the chairman of the committee by our executive director. I am referring to the provision in the bill which would allow the Secretary of Health, Education, and Welfare the authority to increase the amount of taxable wages every 2 years.

As employers of one of the largest groups of individuals in the Nation, we are concerned about the resulting rise in employee taxes which must be met in a like sum by the employer. It is our understanding that under the bill, the taxable wage base would be increased by from $7,800 to $9,000 in 1971 and that estimated increases through 1993 would triple the employee tax from $374 today to $1,365 in 1993.

This cost would also have to be passed on to paying patients. We recommend that the automatic provisions be removed from the bill, leaving the taxing power in the hands of the Congress, where it rightfully belongs.

We appreciate the opportunity to express our views to the committee, and we will entertain any questions.

The CHAIRMAN. Well, let me just say this, Mr. Herrmann and Mrs. Eagan and Mr. Wilson, we will do the best we can to try to work this matter out in ways acceptable to all, and I would expect that I will be communicating with you further as we move along in the consideration of this bill.

Mr. HERRMANN. Thank you.

The CHAIRMAN. We will now call Senator Eagleton. The Congress is holding a joint session. I know Senator Eagleton wants to be there, and I would like to permit the Senator to make his statement here at this time.

Senator, if you want to just go ahead and make your statement.

STATEMENT OF HON. THOMAS F. EAGLETON, A U.S. SENATOR FROM THE STATE OF MISSOURI

Senator EAGLETON. Thank you very much, Mr. Chairman, I appreciate it.

I will try to highlight this for you, Mr. Chairman, and we will put the entire statement in the record.

The CHAIRMAN. Right.

Let us also place in the record at this point, a telegram I have received from the senior Senator from Missouri, the Honorable Stuart Symington.

(The telegram referred to follows:)

[Telegram]

SEPTEMBER 23, 1970.

HON. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.:

Respectfully urge all possible consideration of presentation made by my colleague Senator Eagleton relative to the need for emergency action for Missouri on medicaid.

STUART SYMINGTON,
U.S. Senate.

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

Mr. Chairman, I appear here today in support of an amendment—I do not know if copies are at the desk—No. 921 to the pending bill which would amend section 1902 of the Social Security Act.

As you know, last year, Mr. Chairman, Congress adopted subsection (d) of section 1902 which, in essence, said that no State would be permitted to reduce its expenditures for medical assistance, a maintenance-of-effort clause. I supported that concept, and I would not be here today or at any other time to advocate repeal of that maintenance-of-effort clause.

But we have a peculiar problem, peculiar emergency, indigenous to Missouri, and I hope nowhere else, for which I seek some relief on behalf of my State.

I won't burden you with a recitation of recent Missouri political history, but we have a financial crisis in our State.

In the spring of last year, Governor Hearnes submitted a revenue program to the general assembly, and it was enacted by the legislature. It raised certain revenues which would have adequately provided for our full budget, including medicaid.

However, some opposition to the Governor resulted, of course, as might be expected, when one raises taxes, in this instance the State income tax, and on April 7 a referendum was held on that State income tax increase, and the voters rejected the increase in the State income tax.

The Governor then had to call the general assembly back into session to enact an austerity budget in line with the fact that the voters had rejected the income tax increase. The Governor recommended the same funding for medicaid as he had the previous year, so he would have maintained the same effort.

The house of representatives in Missouri went along with his recommendation. But, lo and behold, in the waning days in the session, for some reason which we cannot really identify, and which came as a surprise to the Governor and everyone else, the senate appropriations committee cut the medicaid fund $3.1 million.

The clock was running out on our session. I do not know how it is in Louisiana, but it is a statutory time, and the clock ticks on. Anyway, that was the final bill that was passed, and the Governor had no alternative but to sign it.

So we are, Missouri, as of the present time, not in compliance with the maintenance-of-effort clause.

Just this morning we have learned that the State has received a letter from HEW, dated September 17, saying that unless the State can get into compliance by September 30—which it cannot—they will have to proceed with the hearing that triggers, eventually, the total cutoff of medicaid funds in Missouri.

There are no funds in the Missouri treasury to be allocated to medicaid. The general revenue of Missouri has been reduced by a number of factors, including a construction strike in Kansas City.

So I have submitted, Mr. Chairman, to your committee, and have introduced an amendment, No. 921, which would attempt to give some relief, based on this emergency situation that we find in Missouri.

I am the first to admit, from a technical point of view, the amendment I propose is less than perfect. It hinges on the certification by the Governor of Missouri, or any other Governor, of the existence of, as we call it, in the amendment, a fiscal emergency and this is, I know, a term that is rather imprecise. It would give the State, if this became the law, or any other State, temporary relief by permitting it a lim-

ited period of time, not to exceed four quarters, to try to get its house in order before medicaid funds were totally cut and obliterated.

We, thus, have this crisis, Mr. Chairman, in Missouri. It is real, it is severe. Even if we were to go ahead and fund medicaid, there would still be a reduction in the moneys because Missouri funded $3.1 million less than they should have, which would trigger off a cut of $3.4 million in Federal matching funds. So it is going to be $6.5 million down in any event.

What we would hope to avoid is the total emasculation of medicaid program in Missouri, which, of course, would have enormous consequences, as the Senator well knows, on the totality of the Missouri populace.

We cite, in the remainder of our remarks, what would happen to the æ thousands of people who are beneficiaries of the various facets of the medicaid program.

It is in that vein, Mr. Chairman, that I submit amendment No. 921 for the consideration of this committee.

The CHAIRMAN. I will try to help you work this out, Senator Eagleton.

As you perhaps know, I was the initial sponsor of that maintenance-of-effort concept when we were passing these increases in Federal matching. We did not want the State legislatures to deny these aged people the benefits that the Federal Government was voting for them.

Senator EAGLETON. I concur with that theory.

The CHAIRMAN. Without reducing their effort.

Since that time we have run into situations where it has not worked out the way it was intended. I, personally, never intended that the maintenance-of-effort clause would continue indefinitely. My thought was to continue it just long enough for the people to get the benefit of the increase that we voted, and after the people realized they had it and had the benefit of it, then if the State wanted to reduce their effort, that would be their privilege. But we did not want to see the kind of thing happening that has been happening where we would vote a big increase, the State legislature would give the people just half of it, cut back on their money and claim credit for the increase.

Senator EAGLETON. Precisely.

The CHAIRMAN. So we wanted to let the people know that they had been benefited. In Louisiana, as the witnesses from Louisiana know, we have the State legislature offset what we did by saying that no benefit voted by the Congress can go into effect without the approval of the State legislature. They are going to take credit for it, even if they had not had a blessed thing to do with it. So we are aware of the problem. If that really means difficulty for Missouri, we will try to work it out.

Senator EAGLETON. I ask unanimous consent that my statement be printed in full.

The CHAIRMAN. Without objection so ordered.

(The prepared statement with attachments of Senator Eagleton follows. Hearing continues on page 1022.)

STATEMENT OF HON. THOMAS F. EAGLETON, A U.S. SENATOR FROM THE STATE OF MISSOURI

Mr. Chairman, I appreciate the opportunity to appear before your Committee today in support of my Amendment No. 921 to H.R. 17550, which would amend

section 1902 of the Social Security Act relating to State plans for medical assistance.

As you know, last year Congress added subsection (d) to section 1902 to insure that no State would be permitted to reduce its expenditures for medical assistance. I supported the enactment of section 1902(d) and I would *not now* support its repeal. I believe there should be no regression in our effort to provide adequate levels of medical care for the needy.

My amendment is designed *not* to permit my State or any other State to reduce its Medicaid effort, *but* to prevent my State or any other State from suffering a complete cutoff of Federal Medicaid funds as a result of a temporary fiscal emergency.

I do not want to burden this Committee with an overdose of Missouri history, but I will outline briefly the events that have brought the State to the brink of losing Federal funds for medical assistance.

In the spring of 1969, Governor Hearnes submitted a revenue program to the General Assembly. It was enacted by the legislature, but subsequently was submitted to a referendum. On April 7, 1970, the voters of Missouri turned down the Governor's tax program which would have increased revenues by some $106 million annually.

The Governor called the General Assembly into special session on April 15 and submitted to it his budget requests for the fiscal year beginning July 1, 1970. He did not recommend any reduction in Medicaid funds. In fact, he asked for an increase of $200,000 over fiscal 1970.

The House of Representatives voted to hold Medicaid expenditures to the level of the previous year—$28.1 million. Then the Senate Appropriations Committee, in a move which apparently came as a surprise to everyone, cut Medicaid funds by $3.1 million. In the conference committee in the final days of the special session, the House conferees tried to restore those funds, but were unsuccessful. The Governor had no choice but to sign the appropriation bill that came to his desk.

On July 13, the Governor submitted to the Secretary of Health, Education, and Welfare a modified State plan which met two of the conditions set forth in section 1902(d) but failed to meet the condition contained in paragraph (1)—that the State not spend less for medical assistance than it had spent in the previous year.

Mr. Chairman, I will submit for the hearing record the exchanges of correspondence between Governor Hearnes and Secretary Richardson.

To date, neither the Governor nor HEW has been able to discover any alternative under the present law to proceeding with a conformity hearing and a cutoff of Federal funds. I have just learned today that the State has received a letter from HEW dated September 17 saying that unless the State can get into compliance by September 30 they will have to proceed with a hearing.

As far as the State is concerned, I am advised that there simply are no funds available in the State Treasury that could be advanced to the Medicaid program. In addition to the failure of the Governor's revenue measure, the State has received $23.3 million less in revenues in the first two months of this fiscal year than it received during the same period last year—a decrease of about 21.5%. A number of factors have produced this result including the general economic slowdown and a long construction strike in the Kansas City area. The present strike in the automobile industry is expected to reduce revenues still further.

My amendment would add to section 1902 a new subsection (e) which would authorize the Secretary to approve a temporary modification of a State plan for medical assistance—

(1) if such modification meets all the requirements of the law other than the prohibition against a reduction in State funds,

(2) if the Governor certifies that a reduction in State funds results from a fiscal emergency, and

(3) if such modification is for a period not to exceed four calendar quarters.

I would be the first to admit that from a technical point of view the amendment I propose is less than perfect. It hinges on the certification of the existence of a "fiscal emergency" and this is a term for which there seems to be no precise definition.

But I believe very strongly—and I hope not illogically—that the intent of the amendment is sound.

We enacted section 1902(d) last year to insure that each State would maintain its medical assistance effort. It seems obvious to me that this goal would be better served by permitting a State in financial difficulty *a limited period* of time

to restore its Medicaid effort than by depriving that State and its needy citizens of all Federal Medicaid funds.

The modified plan that would be in effect during this period would be in conformity with all other requirements of the present law.

The authorization of this temporary reduction in State funds would not impose any additional burden on the Federal government. On the contrary, the reduction in State funds of $3.1 million, if approved by HEW would carry with it a reduction of approximately $3.4 million in Federal matching funds for this fiscal year.

I would also point out that the authorization of a temporary reduction in State funds would not mean that Missouri had averted a Medicaid crisis. After all there would be a total of $6.5 million less for medical assistance this year than last.

Under the modified plan submitted by the Governor, and actually in effect since July 10, there has been a reduction in all Title XIX services. For example, payments for doctors' fees have been reduced by an average of 12%. Payments for nursing home care have been reduced by 12%. Allowable inpatient hospital care days have been reduced from 21 to 14 days. X-ray and laboratory services are being paid for only on an emergency basis. The drug vendor formulary has been reduced from 208 drugs to 178. Full and partial dentures have been removed from the list of dental services.

It is clear then that, even if it can avoid a Federal fund cutoff, the State of Missouri will still be in a difficult position with respect to its Medicaid program and, more importantly, the needy citizens of Missouri will still suffer from the reductions in benefits.

My amendment would *not* result in the avoidance of a Medicaid crisis in Missouri. It *would* prevent total catastrophe.

280,000 residents of Missouri—aged, blind, disabled, mothers, unemployed fathers and children on ADC and those on general assistance—depend upon Medicaid for medical services. If Federal matching funds amounting to $28.6 million for the current fiscal year are withheld, State law would prohibit the expenditure of any State funds for Title XIX medical services. The needy citizens of Missouri would be left without any medical assistance.

What would happen to the 4,500 persons now in skilled nursing homes? What would happen to the 5,500 persons who receive inpatient hospital care each month? Neither Missouri's hospitals nor its nursing homes could bear the financial burden of providing these services on a charity basis.

What would happen to the 52,000 welfare recipients who receive doctors' services each month? Although some physicians would undoubtedly continue to provide service to their elderly patients in many instances these services would no longer be available.

What would happen to the 80,000 persons who receive prescription drugs each month? The drugs on Missouri's limited formulary are those most essential to the acutely and chronically ill.

What would be the effect on the 13,000 persons, many of them children, who now receive outpatient hospital or clinic services each month?

In addition, Missouri presently pays the Medicare Supplemental Medical Insurance premiums for 95,000 welfare recipients age 65 and over. If the Title XIX program comes to a halt, these premiums will no longer be paid and these elderly citizens will be without medical insurance protection.

I do not believe it is an overstatement to say that the results of a Federal cutoff of Medicaid funds to Missouri would be catastrophic.

Mr. Chairman, I urge your Committee to approve an amendment to section 1902 that would permit Missouri, or any other State that may find itself in similar circumstances in the future, a *limited period* of time to restore its Medicaid effort and thus avoid the catastrophe that would result from a cutoff of Federal funds.

EXECUTIVE OFFICE,
Jefferson City, Mo., July 13, 1970.

Mr. ELLIOT LEE RICHARDSON,
Secretary, Department of Health, Education and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: In accordance with the provisions of Section 1902, (d), (1) of the Federal Social Security Act, as amended by Public Law 91-56, I am making this report concerning the appropriations for fiscal year 1971 for Title XIX expenditures in the State of Missouri.

The State of Missouri will be unable to finance the Title XIX Program during the coming fiscal year at the same level as previous expenditures for the same purpose. General revenue, from which Title XIX is financed, will not be sufficient to continue state services on their previous level, and a great many reductions are being made in many different areas of state services. Vigorous efforts were made to pass an income tax revision last spring, but it failed of passage on vote by the people of this state. Under the State Constitution I cannot approve nor can the General Assembly appropriate more money than is available.

The following is a list of the total appropriations of state funds for the Title XIX Program for the current and three previous fiscal years:

1967–1968	$15,952,423
1968–1969	18,748,509
1969–1970	28,112,878
1970–1971	25,000,000

In view of the reduced appropriation of state funds, we have made plans to reduce the various Title XIX services in the following manner:

(1) Inpatient Hospital Care. The primary change is the reduction from 21 to 14 days for which payment will be made for any one admission.

(2) Outpatient Hospital Care. Payment for all outpatient hospital services will be limited to $5.00 per visit.

(3) Independent Clinical Laboratories and X-Ray Facilities. Payment for such X-ray or laboratory procedures will be paid for only when they can be justified on an emergency basis.

(4) Physicians Services.

(a) Payment for all physicians fees will be reduced an average of about 12%.

(b) Non-urgent or elective services or procedures will not be paid for.

(c) Payments of Medicare deductibles and coinsurance will be reduced on a percentage basis.

(d) Payment for physicians visits to a patient in a hospital will be limited to a maximum of 14 days per hospital admission.

(e) With four exceptions, injections or injected medications will not be paid for.

(f) X-ray and laboratory service performed by a physician will not be paid for unless they can be justified as an emergency.

(5) Drugs. The drug vendor formulary is being reduced from 208 drugs to 178.

(6) Dental Services. Full and partial dentures have been removed from the list of dental services for which payment will be made.

(7) Skilled Nursing Home Care. All payments for nursing home care will be reduced by 12% of the amount they have been receiving.

I hereby certify that the State of Missouri is fully complying with the provisions of its state plan relating to the control of utilization and the cost of services. I also certify that the decreases are not being made in one type of service in order to be able to increase the payment level for another type of service.

In view of the $3.1 million reduction by the General Assembly in funds for the Title XIX Program for the current fiscal year, which will result in the loss of $3.4 million in matching Federal funds, and in view of the provisions of the Constitution of Missouri, the State has no alternative except to reduce the amount of payment for medical care services.

Sincerely yours,

WARREN E. HEARNES.

SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., August 10, 1970.

Hon. WARREN E. HEARNES,
Governor of Missouri,
Jefferson City, Mo.

DEAR GOVERNOR HEARNES: This is in answer to your letter of July 13, 1970, concerning the curtailment of your State's Medicaid program necessitated by the $3.1 million reduction of funds for the program.

As you know, section 1902(d) of the Social Security Act provides that approval of any modification of the State plan so as to reduce the amount, duration, and scope of services is contingent upon certification by the Governor of the State that:

1. The average quarterly amount of non-Federal funds expended in providing medical assistance under the plan for any consecutive four-quarter period after the quarter in which such modification takes effect will not be less than the average quarterly amount of such funds expended in providing such assistance for the four-quarter period which immediately precedes the quarter in which such modification is to become effective.

2. The State is fully complying with the provisions of its State plan (relating to control of utilization and costs of services) which are included therein pursuant to the requirements of section 1902(a) (30) of the Act.

3. The modification is not made for the purpose of increasing the standard or other formula for determining payments for those types of care or services which, after such modification, are provided under the State plan.

Your letter of July 13, 1970 did not contain a certification that the State would meet the "maintenance of effort" provision required under 1902(d)(1) of the Social Security Act. On the contrary, it indicates that because of the substantial reduction in the State appropriation made available for this program for the present fiscal year, the State will not be able to finance the program at the same level as it did last fiscal year. Therefore, since the three conditions set forth in section 1902(d) have not been met, I am unable to grant approval to the reduction in services which are described in your letter.

We are deeply concerned, as we are sure you are, for the individuals in your State who receive their medical care through the title XIX program, now jeopardized by the action of your General Assembly. If there is any way in which we in the Department of Health, Education, and Welfare can help you in resolving this grave problem, please let us know.

Sincerely,

ELLIOT RICHARDSON, *Secretary.*

EXECUTIVE OFFICE,
Jefferson City, Mo., August 18, 1970.

HON. ELLIOT RICHARDSON,
Secretary, Department of Health, Education and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: We have reviewed your letter of August 10 advising us of your inability to grant approval to the reduction in services and payments made by Missouri in its Medicaid program.

You have advised us that the failure of the General Assembly to appropriate sufficient funds has jeopardized the Medicaid program in this State, and if there is any way you can help in solving this grave problem to let you know.

Under our State Constitution, I cannot approve, nor can the General Assembly appropriate more money than is available. We have no way to finance deficit spending, and on the basis of our best estimates, we have no alternative except to reduce the amount of payments for medical care services.

We would appreciate your advising us if there are any alternatives that you can propose on resolving this very serious threat to some 280,000 needy Missouri citizens. I am sure there must be other states in the same financial dilemma and it may be that you would want to propose the repeal of section 1902(d) of the Social Security Act to permit the operation of the Medicaid program within the limits of our constitutional provision and the funds available.

In any event, we would like for you to clarify what is implied by the word "jeopardized". Specifically, where do we stand now with respect to continued federal matching funds ?

Sincerely yours,

WARREN E. HEARNES

The CHAIRMAN. The next witness will be Mr. William S. Simpson, who is the chairman of Employee Benefits Committee, speaking for the National Association of Manufacturers.

STATEMENT OF WILLIAM S. SIMPSON, DIRECTOR, CHAIRMAN, EMPLOYEE BENEFITS COMMITTEE, NATIONAL ASSOCIATION OF MANUFACTURERS; ACCOMPANIED BY ROBERT S. LANE, COUNSEL, MOBIL OIL CO.; AND RUSSELL HUBBARD, EMPLOYEE BENEFITS, GENERAL ELECTRIC

Mr. SIMPSON. Mr. Chairman, my name is William Simpson, president of Raybestos-Manhattan, Inc., with general offices in Bridgeport, Conn. Appearing with me are Mr. Robert S. Lane, counsel, Mobil Oil Co.; and Mr. Russell Hubbard, Employee Benefits of General Electric, both located in New York City.

I welcome and appreciate the opportunity to appear before this committee on behalf of the National Association of Manufacturers. I serve NAM as a director and as chairman of its employee benefits committee.

NAM member companies—large, medium, and small in size—account for a substantial portion of the Nation's production of manufactured goods, as well as for the employment of millions of people in manufacturing industries.

In compliance with the time limit suggested for my oral testimony, I will address myself exclusively to those matters concerning OASDI. NAM's views on the health care amendment as well as the more detailed discussion of OASDI provisions are contained in our complete statement already submitted. We would like the statement to be included in the record of the hearing.

The CHAIRMAN. That will be done.

Mr. SIMPSON. Before commenting on specific proposals, the National Association of Manufacturers believes that it cannot be too strongly emphasized that the primary purpose of the social security program should be to provide a basic floor of protection against the covered risks. As in the choice of features for a private retirement plan there are also unlimited features which may seem to be desirable and attractive for a public program such as social security. It is extremely difficult to choose among those features which benefit the greatest number of covered workers and are economically justified. This has been not only the dilemma for those who design a private retirement system, but also for those who are charged with the responsibility for designing and legislating the social security program.

NAM also believes that the social security system should continue to be sustained and supported by payroll taxes. It has been and should remain, a basic retirement program for people who have had an active attachment to the work force. These people have contributed and their employers have contributed toward their eventual retirement. The system's acceptability by the American people was based on this premise and it should not be converted to a welfare system based on the concepts of "relief" or "need". NAM strongly opposes any attempt to finance benefits through the use of funds from general revenues. Such a fundamental change in the financing of the program would destroy its identity and its historic concept and would convert the program to a welfare program bearing little relationship to "earned right".

We think it enlightening to note the tremendous growth in the social security system. In 1950, there were approximately 3½ million people receiving some form of social security benefits. By the end of this year,

one out of every eight Americans—26 million people—will be on the benefit rolls. Since 1950, social security beneficiaries have increased almost eightfold and cash benefits payable have increased by 32 times. The fact is that any change in benefits or liberalized coverage has a vastly greater impact on our total economy today than it did 20 years ago.

While there are many features contained in H.R. 17550, we will limit our discussions to the following areas which in our opinion are the most important.

1. Benefit increases.—H.R. 17550 provides for a 5-percent across-the-board increase in social security benefits effective for January 1971. Last October we supported a proposed recommendation of an across-the-board increase of 10 percent. Congress legislated 15 percent.

While the National Association of Manufacturers believes that another increase is justified in view of the current economic circumstances, we believe, however, that the 15-percent increase made effective for January 1970, together with the proposed 5-percent increase, will be more than sufficient to account for the drop in purchasing power from February 1968 (when the previous increase was made) through and beyond July 1971; and we therefore recommend that the effective date for any new increased benefit be no earlier than July 1971.

2. Retirement test.—Present law provides that a beneficiary under age 72 may earn as much as $1,680 per year and still be paid full social security benefits for that year. Earning in excess of $1,680 to a maximum of $2,880 per year reduce the recipient's social security benefits by $1 for each $2 of earnings within that bracket. Earnings in excess of $2,880 per year reduce the recipient's benefits by $1 for each dollar of earnings.

H.R. 17550 would increase the amount that a retiree under age 72 can earn without any reduction in benefits, from the present $1,680 per year to $2,000 per year. It also provides for a basic change in procedure since there would be only a $1 reduction in benefits for each $2 of earnings in excess of $2,000. There would no longer be any dollar-for-dollar reduction.

The social security program is intended to provide a worker with a partial replacement of his job related earnings when he stops working. Those persons who would receive the additional benefits proposed are those who are obviously able to work and who will continue to work. The Social Security Administration indicates that 90 percent of persons eligible for social security benefits are not affected by the retirement test because they are unable or unwilling to work or are age 72 or over. NAM believes that social security benefits should continue to partially replace income lost by reason of retirement.

NAM believes that there may be some justification for increasing the earnings test to reflect increases in the average earnings level but certainly not to more than $1,800 per year. We fail to see any justification for any change which would modify the basic principle which has been in effect for a decade or more and which would eliminate the dollar-for-dollar reduction in benefits for those earning in excess of a specific amount.

We urge this committee to support the concept of the three-part retirement test, with a possible ad hoc adjustment in the annual exempt amount.

3. Disability benefits and workmen's compensation.—When Congress first enacted disability benefits in the Social Security Act of 1956, it included a provision for deducting from such benefits any benefits under a "workmen's compensation law." This offsetting of workmen's compensation was designed to prevent any doubling-up or duplication of both social security and State workmen's compensation benefits for the same disability.

In 1958, the offset provision was dropped, but it was reinstated in limited form by the 1956 Social Security Amendments. This was done by a provision under which the combined workmen's compensation and social security benefit is in effect, limited to 80 percent of earnings.

It is significant to note that this reinstatement of a form of the original workmen's compensation offset was taken at the initiative of this committee. Your report said that the committee had "taken note of the concern that has been expressed by many witnesses in the hearings about the payment of disability benefits concurrently with benefits under the State workmen's compensation program." The report went on to state "that it is desirable as a matter of sound principle to prevent the payment of excessive combined benefits."

We believe that the committee and the Congress should reaffirm that basic position and should reject the concept as proposed in H.R. 17550 that combined disability benefits under social security should be permitted to equal 100 percent of the worker's average current earnings.

As a matter of fact the present 80-percent offset designed by the committee is more than adequate and could well be reduced to 65 percent to be in keeping with State and social security benefit formulas. Indeed as State workmen's compensation benefit levels increase, there is more need for a full offset provision.

In summary, we believe Congress should do no less than hold the firm to the present 80 percent and should reject section 115 of H.R. 17550, which increases the workmen's compensation offset limit to 100 percent.

4. Financing provisions—taxable earnings base.—The current law provides for an earnings base of $7,800 per year. H.R. 17550 would raise this to $9,000 per year. As was explained in the report of the House Ways and Means Committee (H. Rept. 91-1096), this increase is necessary in order to partially finance the cost of the expanded cash benefits program and to bring the hospital insurance plan into actuarial balance.

The revenue necessary to sustain existing benefit levels and to provide new and liberalized benefits is derived from a payroll tax. The amount of revenue produced is a function of the taxable earnings base and the tax rate. Since 1951, and subsequently in the 1954, 1958, and 1965 amendments, the level of wages subject to social security tax was held to a fairly constant relationship (approximately 80 percent) of taxable earnings to total annual earnings in covered work. The amendments of 1967 caused an increase in the taxable earnings base to $7,800 per year. NAM testified at that time that the $7,800 base was unnecessarily high. The proposal for increasing the earnings base now to $9,000 would maintain the relationship at 82 percent and perpetuate what, in our view, is an excessive level. We recognize that there is some justification for increasing the taxable earnings base when average

taxable earnings of all covered persons increase, but we believe that the current $7,800 base should be maintained at least temporarily.

5. Automatic adjustment of taxable earnings base.—H.R. 17550 provides for automatic escalation of the taxable earnings base based on the general level of average taxable earnings of all persons for whom taxable earnings were reported to the Secretary for the first calendar quarter of the calendar year. This figure would be rounded to the nearest multiple of $600. The first automatic adjustment would take effect in 1973, and thereafter it would be made once every 2 years. No maximum limitation is set in the legislation, and it can be projected that if this Congress votes this provision in 1970 the amount of earnings subject to tax in 1995 will be as much as $22,000.

Based on a conservative assumption that wage levels will rise by only approximately 4 percent annually, the taxable earnings would increase from the unduly high base of $9,000 next year to $11,400 in 1977 and to $18,000 by 1989. This would result in a condition wherein the taxes to pay for the preponderance of future benefit increases and other liberalizations would be taken mostly from people in the middle-income brackets—as well as from their employers. NAM believes that Congress should continue to set the taxable earnings base periodically after examining all the factors involved.

6. Automatic adjustment of benefits.—H.R. 17550 would tie social security benefits directly to changes in the Department of Labor's Consumer Price Index (CPI). In the event that the CPI rises 3 percent or more for the third calendar quarter of a year as compared with the calendar quarter designated as the base period, then social security benefits would be increased by a like percentage amount. This recomputation of benefits would be repeated once a year and adjustment made in the benefit levels payable for the following January.

Such an arrangement appears to be a form of capitulation to the inflationary forces at work throughout our economy. It seems to recognize that inflation is here to stay and will henceforth be an accepted economic way of life. Such automatically escalating benefits would affect one out of every eight persons in the United States in terms of greater benefits, and would also affect millions of persons in the work force who will have to pay for these increased benefits. The impact of automatically increasing benefits would continuously stimulate the economy and tend to institutionalize inflation.

The National Association of Manufacturers is opposed to this provision and strongly urges this committee to reject the concept. Attempting to solve inflation problems through the device of automatically escalating benefit levels for approximately 26 million people may seem to be an extremely attractive expedient, it would create tremendous pressure in other segments of our society for similar automatic relief.

Another apparent attraction of the automatic adjustment concept is hat it would minimize political pressures for benefit increases and other adjustments of the program.

NAM believes that this would not be the case, and it is distinctly possible in our view that the opposite result would occur. One has only to look at the many proposals to liberalize benefits currently before the Congress to illustrate this point.

A review of the record indicates that the Congress has, by ad hoc methods, more than kept abreast of rises in the cost of living by increasing benefits. The complaint that Congress has acted too slowly and that the aged have suffered because of a lag in the adjustment of benefits has some merit, but the recent trend has been toward more frequent reviews which would indicate that the Congress would act in the future as rapidly as any automatic escalation device.

NAM believes that a rigid escalation formula would deny Congress the opportunity and responsibility to determine the level and structure of social security benefits while also keeping in view the entire economy, including economic trends and pressures.

Thank you, Mr. Chairman.

(Mr. Simpson's prepared statement follows. Hearing continues on page 1032.)

TESTIMONY OF WILLIAM S. SIMPSON, REPRESENTING THE NATIONAL ASSOCIATION OF MANUFACTUERS

My name is William S. Simpson, President, Raybestos-Manhattan, Inc., with general offices in Bridgeport, Connecticut.

I welcome and appreciate the opportunity to appear before this Committee on behalf of the National Association of Manufacturers. I serve NAM as a Director and as Chairman of its Employee Benefits Committee.

NAM member companies—large, medium and small in size—account for a substantial portion of the nation's production of manufactured goods, as well as for the employment of millions of people in manufacturing industries.

In my presentation, I will divide my testimony into two distinct parts. I will first present NAM's views on Title I, concerning Old-Age, Survivors, and Disability Insurance benefits and secondly; Part B of Title II, having to do with the Health Care Amendments.

I. NAM VIEWS ON OASDI

NAM believes that the Social Security program should be designed to strengthen and operate as a part of our free economy. Further, it should provide a basic benefit to which private retirement benefits, together with personal savings and investments, can be added to provide overall retirement income for retired workers.

The Social Security Act was enacted by Congress in 1935 and established a compulsory contributory "federal old-age benefits" program designed to pay monthly benefits as a matter of *earned right* to individuals retiring at age 65. It now covers nearly all private employment.

Today the Social Security program is an accepted, almost universal system. It has wide support, because it is recognized as a "social insurance" program to protect eligible individuals in old age. Over the years it has been broadened to cover other risks such as death, total and permanent disability and medical programs for the aged. *Earned right*, which accrues to an individual as a result of his having had a substantial attachment to the work force, and during which generally he and his employer paid Social Security taxes, continues to be the fundamental principle—not relief or need.

The primary function of OASDHI, as conceived by Congress, is to provide a basic floor of protection. NAM believes that this is the proper and appropriate role for the Social Security system.

SOCIAL SECURITY—A PAYROLL TAX SUPPORTED SYSTEM

Before commenting on specific proposals, the National Association of Manufacturers believes that it cannot be too strongly emphasized that the primary purpose of the Social Security program should be to provide a basic floor of protection against the covered risks. As in the choice of features for a private retirement plan there are also unlimited features which may seem to be desirable and attractive for a public program such as Social Security. It is extremely difficult to choose among those features which benefit the greatest number of covered workers and are economically justified. This has been not only the

dilemma for those who design a private retirement system but also for those who are charged with the responsibility for designing and legislating the Social Security program.

Just as employers and employees in the establishment of new provisions and liberalized benefits, must balance them against their costs, so must Congress exercise financial responsibility for the public system. This is one of the principal reasons that we advocate the financing of new or more liberalized Social Security benefits primarily through the use of an increased tax rate. While it might seem expedient to finance then by just increasing the taxable earnings base or by using general revenue, these latter means of financing only mask the true costs of such benefits and mislead participants and the Congress as to the actual relationship between benefits and costs.

NAM also believes that the Social Security system should continue to be sustained and supported by payroll taxes. It has been and should remain, a basic retirement program for people who have had an active attachment to the work force. These people have contributed and their employers have contributed toward their eventual retirement. The system's acceptability by the American people was based on this premise and it should not be converted to a welfare system based on the concepts of "relief" or "need". NAM strongly opposes any attempt to finance benefits through the use of funds from general revenues. Such a fundamental change in the financing of the program would destroy its identity and its historic concept and would convert the program to a giant welfare scheme bearing no relationship to "earned right".

We think it enlightening to note the tremendous growth in the Social Security system. In 1950, there were approximately 3½ million people receiving some form of Social Security benefits. By the end of this year, 1 out of every 8 Americans—26 million people—will be on the benefit rolls. Placing this in a slightly different perspective, during 1950, almost $1 billion was paid out in cash benefits. Again, during 1970, about $32 billion will have been paid out in Social Security benefits. Summarizing these figures, since 1950, Social Security beneficiaries have increased almost eight-fold and cash benefits payable have increased by 32 times. The fact is that any change in benefits or liberalized coverage has a vastly greater impact on our total economy today than it did 20 years ago.

While there are many features contained in H.R. 17550, there are six not including medicare-medicaid, which in our opinion are most important. We will, therefore, limit our discussion to the following areas.

1. *Benefit increases.*—H.R. 17550 provides for a 5 percent across-the-board increase in Social Security benefits effective for January 1971. Last October we supported a proposed recommendation of an across-the-board increase of 10 percent. Congress legislated 15 percent.

While the National Association of Manufacturers believes that another increase is justified in view of the current economic circumstances, we believe that the 15 percent increase made effective for January 1970, together with the proposed 5 percent increase, will be more than sufficient to account for the drop in purchasing power from February 1968 (when the previous increase was made) through and beyond July 1971; and we therefore recommend that the effective date for any new increased benefit be no earlier than July, 1971.

2. *Retirement Test.*—Present law provides that a beneficiary under age 72 may earn as much as $1,680 per year and still be paid full Social Security benefits for that year. Earnings in excess of $1,680, to a maximum of $2,880 per year reduce the recipient's Social Security benefits by $1 for each $2 of earnings within that bracket. Earnings in excess of $2,880 per year reduce the recipient's benefits by $1 for each dollar of earnings.

H.R. 17550 would increase the amount that a retiree under age 72 can earn without any reduction in benefits from the present $1,680 per year to $2,000 per year. It also provides for a basic change in procedure since there would be only a $1 reduction in benefits for each $2 of earnings in excess of $2,000. There would no longer be any dollar-for-dollar reduction.

The Social Security program is intended to provide a worker with a partial replacement of his job related earnings when he stops working. Those persons who would receive the additional benefits proposed are those who are obviously able to work and who will continue to work. The Social Security Administration indicates that 90 percent of such persons are not affected by the Retirement Test because they are unable or unwilling to work or are 72 or over. NAM believes that Social Security benefits should continue to partially replace income lost by reason of retirement.

NAM believes that there may be some justification for increasing the earnings test to reflect increases in the average earnings level but certainly not to more than $1,800 per year. We fail to see any justification for any change which would modify the basic principle which has been in effect for a decade or more and which would eliminate the dollar-for-dollar reduction in benefits for those earning in excess of a specific amount. This would represent a step toward the total elimination of the retirement test. To eliminate the retirement test entirely would cost about 0.66 percent of taxable payroll—more than $2 billion a year—and the additional expenditure would help only a small percentage of the beneficiaries—those who for the most part are already better off than most beneficiaries by reason of the fact that they can and do continue to work.

We urge this Committee to support the concept of the three-part Retirement Test, with a possible ad hoc adjustment in the annual exempt amount.

3. *Disability Benefits and Workmen's Compensation.*—When Congress first enacted disability benefits in the Social Security Act of 1956, it included a provision for deducting from such benefits any benefits under a "workmen's compensation law". This offsetting of workmen's compensation was designed to prevent any doubling-up or duplication of both Social Security and state workmen's compensation benefits for the same disability.

In 1958, the offset provision was dropped, but it was re-instated in limited form by the 1965 Social Security Amendments. This was done by a provision under which the combined workmen's compensation and Social Security benefit is in effect, limited to 80 percent of earnings.

It is significant to note that this reinstatement of a form of the original workmen's compensation offset was taken at the initiative of this Committee. Your report said that the Committee had "taken note of the concern that has been expressed by many witnesses in the hearings about the payment of disability benefits concurrently with benefits under the state workmen's compensation program". The Report went on to state "that it is desirable as a matter of sound principle to prevent the payment of excessive combined benefits".

We believe that the Committee and the Congress should re-affirm that basic position and should reject the concept as proposed in H.R. 17750 that combined disability benefits under Social Security should be permitted to equal 100 percent of the worker's average current earnings. Additional points in support of this are as follows:

A. The 100 percent wage replacement percentage is not in keeping with that generally found under the state workmen's compensation system which provides compensation normally at about a 65 percent level.

B. The present 80 percent offset designed by the Committee is more than adequate and could well be reduced to 65 percent to be in keeping with state and Social Security benefit formulas. Indeed, as state workmen's compensation benefit levels increase, there is more need for a full offset provision.

C. The 100 percent wage-replacement concept also violates basic insurance principles. It weakens the incentives designed to encourage the disabled to return to work and/or to accept speedy rehabilatative procedures.

D. The principal justification for the 100 percent offset as explained in the House Ways and Means Committee Report on H.R. 17550 is not sustainable. This Report argues that workmen's compensation "is not solely a wage-replacement but is in part compensation for pain and loss of function".

Congress does not now directly concern itself with pain and suffering in arriving at the amount of Social Security benefits payable in non-occupational disability. It is just as in appropriate for Congress to concern itself with these factors in the make up of the state workmen's compensation benefit.

In summary, we believe Congress should reduce the offset to 65 percent but do no less than hold firm to the present 80 percent and should reject Section 115 of H.R. 17550, which increases the workmen's compensation offset limit to 100 percent.

4. *Financing Provisions.—Taxable Earnings Base.*—The current law provides for an earnings base of $7,800 per year. H.R. 17550 would raise this to $9,000 per year. As was explained in the Report of the House Ways and Means Committee (House Report No. 91–1096), this increase is necessary in order to partially finance the cost of the expanded cash benefits program and to bring the hospital insurance plan into actuarial balance.

The revenue necessary to sustain existing benefit levels and to provide new and liberalized benefits is derived from a payroll tax. The amount of revenue produced is a function of the taxable earnings base and the tax rate. Since 1951, and subsequently in the 1954, 1958 and 1965 amendments, the level of wages sub-

ject to Social Security tax was held to a fairly constant relationship (approximately 80 percent) of taxable earnings to total annual earnings in covered work. The amendments of 1967 caused an increase in the taxable earnings base to $7,800 per year. NAM testified at that time that the $7,800 base was unnecessarily high. The proposal for increasing the earnings base now to $9,000 would maintain the relationship at 82 percent and perpetuate what, in our view, is an excessive level. We recognize that there is some justification for increasing the taxable earnings base when average taxable earnings of all covered persons increase, but we believe that the current $7,800 base should be maintained at least temporarily.

5. *Automatic Adjustment of Taxable Earnings Base.*—H.R. 17550 provides for automatic escalation of the taxable earnings base based on the general level of average taxable earnings of all persons for whom taxable earnings were reported to the Secretary for the first calendar quarter of the calendar year. This figure would be rounded to the nearest multiple of $600. The first automatic adjustment would take effect in 1973, and thereafter it would be made once every two years. No maximum limitation is set in the legislation, and it can be projected that this Congress will have voted in 1970 to fix the amount of earnings subject to tax in 1995 to as much as $22,000. In addition, there are no provisions for a reduction in the taxable earnings base in the event of a decline in the general earnings level. Based on a conservative assumption that wage levels will rise by only approximately 4 percent annually, the taxable earnings would increase from the unduly high base of $9,000 next year, to $11,400 in 1977 and to $18,000 by 1989. This would result in a condition wherein the taxes to pay for the preponderance of future benefit increases and other liberalizations would be taken mostly from people in the middle income brackets—as well as from their employers.

6. *Automatic Adjustment of Benefits.*—H.R. 17550 would tie Social Security benefits directly to changes in the Department of Labor's Consumer Price Index (CPI). In the event that the CPI rises 3 percent or more for the third calendar quarter of a year as compared with the calendar quarter designated as the base period, then Social Security benefits would be increased by a like percentage amount. This recomputation of benefits would be repeated once a year and adjustment made in the benefit levels payable for the following January.

Such an arrangement appears to be a form of capitulation to the inflationary forces at work throughout our economy. It seems to recognize that inflation is here to stay and will henceforth be an accepted economic way of life. Such automatically escalating benefits would affect 1 out of every 8 persons in the United States in terms of greater benefits, and would also affect millions of persons in the work force who will have to pay for these increased benefits. The impact of automatically increasing benefits would continuously stimulate the economy and tend to institutionalize inflation.

The National Association of Manufacturers is opposed to this provision and strongly urges this Committee to reject the concept. While we are greatly concerned about the hardships suffered by the aged and we agree that such people ought not to be the victims of inflation, we are also concerned about all of the other people in this country who would be adversely affected by continued inflation without the benefit of the same kind of relief. We believe that the ultimate solution is to control inflation for all people—not just for Social Security beneficiaries. Attempting to solve inflation problems through the device of automatically escalated benefit levels for approximately 26 million people is an extremely attractive expedient, but it would create tremendous pressure in other segments of our society for similar automatic relief.

Another apparent attraction of the automatic adjustment concept is that it would minimize political pressures for adjustment of the program. NAM believes that this would not be the case, and it is distinctly possible in our view that the opposite result would occur and that such political pressures would only find relief in other areas of the program. One has only to look at the many such proposals which are currently before the Congress.

A review of the record indicates that the Congress has, by ad hoc methods, more than kept abreast of rises in the cost-of-living by increasing benefits. The complaint that Congress has acted too slowly and that the aged have suffered because of a lag in the adjustment of benefits has some merit, but the recent trend has been toward more frequent reviews which would indicate that the Congress would act in the future as rapidly as any automatic escalation device.

NAM believes that a rigid formula would deny Congress the opportunity and responsibility to determine the level of Social Security benefits while also keeping in view the entire economy, including economic trends and pressures that would assuredly escape the unintelligent and indiscriminate eye of any automatic formula.

SUMMARY OF NAM VIEWS ON OASDI PROVISIONS OF H.R. 17550

1. A general across-the-board increase is justified effective July 1971.

2. There is some justification for increasing the annual exempt amount in the earnings test but to not more than $1,800 per year. The existing procedure for a three-part retirement test should remain as it currently exists. A new schedule should possibly be:

Earnings:	*Reduction in benefits*
0 to $1,800	None.
$1,800 to $3,000	$1 for every $2 of earnings in excess of $1,800.
$3,000 and over	$1 for every $1 of earnings in excess of $3,000.

3. Disability benefits under Social Security when combined with workmen's compensation benefits should not exceed 80 percent of prior earnings. As a matter of fact, even the current level of 80 percent is too high and a more realistic figure would be 65 percent.

4. The taxable earnings base of $7,800 per year should be maintained at its current level at this time.

5. Automatic adjustment of the taxable earnings base would result in a condition wherein those persons already most heavily taxed—the middle and upper-middle income group, would be forced to bear the preponderant burden of financing future Social Security benefit increases and other liberalizations.

6. This bill, H.R. 17550, provides for automatic increases in benefit levels, automatic escalation of the taxable earnings base, and automatic escalation of the retirement test, but no provisions for any increase in the tax rate to maintain the sound financing of the system should the presently scheduled rates prove insufficient. We see a basic inconsistency in this arrangement. Since it would be necessary under the bill to come back to the Congress for any future increases in the tax rate, it would appear just as desirable and logical for the Congress to periodically adjust the taxable earnings base and benefit levels as well.

7. Another general problem that should be mentioned is the impact that a continually and unduly expanding Social Security program will have on the private pension system. More than 50 percent of all workers are now covered by a private pension plan and as the Social Security program encroaches on these plans they will cease growing and will play a less important role in providing economic security to older citizens. This would be an unfortunate result.

8. We urge this Committee to continue the concept of periodic Congressional reviews where comprehensive consideration can be given to the needs of Social Security recipients within the framework of the economy as it currently exists and as trends indicate its future direction.

II. NAM VIEWS ON THE HEALTH CARE AMENDMENTS

We are limiting our comments to Part B of Title II of the proposed Social Security Amendments of 1970. Part B is intended to improve the operating effectiveness of the current Medicare, Medicaid and maternal and child health programs.

Our Association has already expressed to this Committee, by letter from the Chairman of the Government Operations/Expenditures Committee, its concern that the "ground rules" for Medicare and Medicaid be clarified or changed so as to enable these programs to be developed and administered as efficiently and economically as possible. We approve not only of the general intent of Part B, but also of many of the specifics.

Section 221 would implement one of our specific recommendations: the limitation of federal depreciation reimbursement to facilities whose capital improvements have been approved by an appropriate health planning agency. We also see potential for vastly improved administration in, and therefore support, the following recommendations:

1. Sec. 222, which would encourage experiments and demonstration projects to develop incentives for economy in the provision of health services.

2. Sec. 235, which would extend utilization review requirement to hospitals and nursing homes under Medicaid.

3. Sec. 231, which would require institutional planning in the form of overall plans and budgets for hospitals under Medicare.

4. Sec. 237, which would expand utilization review to include question of the initial need for hospitalization.

5. Sec. 225, which through variable federal matching rates would establish incentives for states to emphasize outpatient care under Medicaid programs.

6. Sec. 232, which through federal grants would provide incentives to the states to install and operate claims processing and information retrieval systems under Medicaid.

There are other provisions in this legislation which also exhibit concern for greater efficiency and economy but which, in our view, require simplification and clarification with respect to show they can and will be implemented. For example, there appears to be general agreement among those who have studied the problem that the present "reasonable cost" reimbursement practices offer no incentive to resist inflationary pressures. The question is whether the proposed Sections 223 and 224 can be effectively administered.

Section 223, dealing with limitations on coverage of costs under the Medicare program, recognizes that disallowance of cost *after* services have been provided by institutions creates uncertainty. Therefore, the solution offered is to set limits on a prospective basis, evaluate necessary costs on a class—rather than a case—basis and provide that extra or more expensive services be charged to the beneficiary if he is so advised prior to admission. These steps seem to be logical guidelines for a systematic approach to the definition of "reasonable cost". However, there does not appear to be an adequate body of up-to-date cost data for making the necessary comparison of costs of health care institutions or measuring the efficiency of health care delivery.

Therefore, it has been suggested by the House Ways and Means Committee that the Secretary might be able to set "reasonable limits" sufficiently above average costs per patient day previously experienced by a class of institutions so that only extraordinary expenses would be subject to any limitations. This does not seem to us to be an effective approach to control of inflationary tendencies nor does it provide any real incentive for the institutions to control their costs or for curtailing unnecessary days of hospital care.

One of the findings highlighted in the recent report by your Committee staff on Medicare and Medicaid was that Medicare payments are usually significantly higher than those made by carriers under their own programs. This suggests an approach to the matter of "reasonable" costs. Requiring that these two sets of reimbursements be brought into line—instead of "considering customary and prevailing charges", as in the present statute—would provide a direct guideline without introducing a clumsy administrative apparatus.

Section 224, however, which is an attempt to implement this approach to the "reasonable cost" issue as it applies to services furnished under the supplementary medical insurance program, is indirect and complex. The present administrative policy of using the 83rd percentile of customary charges as the limit of "reasonableness" would be modified by using the 75th percentile as the standard after June 30, 1971. Beyond that, beginning with fiscal 1972, increases in fees would be recognized as reasonable in terms of their relationship to two economic indexes: CPI (exclusive of medical care) and earnings in the area as reported to the Social Security program. Unlike the data required to implement Section 223, these figures are available. However, the formula appears to us to constitute a selective form of wage-price control. In addition to our distaste for such controls, the compulsory regulation of fees is no substitute for incentives for more efficient delivery of health care services. Such an approach might merely discourage practitioners from caring for Medicare patients.

In summary, we support the intent of Part B of Title II. Certain of the amendments appears to have clear and immediate potential for improving the administrative efficiency and economy of Medicare and Medicaid. However, other amendments, although addressed to the important issue of defining "reasonable" costs, seem to involve unnecessary clumsy administrative apparatuses. In our view, these should be simplified and clarified before enactment.

The CHAIRMAN. May I just say this about your statement. When you include medicare benefits as part of the income that people receive under social security, even the chart—that the Department itself

offered when these hearings commenced—showed that the Congress has more than kept up with the rise in prices.

Now, we have not been behind the increase in prices. We are ahead of the increase in prices.

Mr. SIMPSON. That is correct.

The CHAIRMAN. That is when you pick the base most favorable to the administration to make their argument. Even picking the base that would serve them the most, when you put medicare in there we have more than kept up with the cost of living.

Now, if you turn to the next page, page 46, to see how it would work out if you took the automatic adjustments compared to what has actually happened over a different period of time, one can see that from 1952 forward we have been way ahead of the cost of living increase, and that the beneficiary has been better off. The same thing is shown again on the chart just beneath it.

So even if you look at the administration's way, we have been ahead rather than behind the increase in the cost of living.

Mr. SIMPSON. We believe this is your responsibility, and you have fulfilled it adequately.

The CHAIRMAN. Now, the only advantage I can see to having the automatic increase in effect, is that, perhaps, those who want higher benefits can contend that it will help to lead to higher benefits because they will get the automatic increase anyway, and then every Congress will have to vote another social security bill. Every Congressman in the House has to run every 2 years. They will be told they voted against social security if they did not vote for further increases over and above the automatic increase——

Mr. SIMPSON. That is correct.

The CHAIRMAN (continuing). When this thing goes into effect.

Well, thank you very much, gentlemen.

Mr. SIMPSON. Thank you.

The CHAIRMAN. Now, the next witness will be Mr. H. Neil Beller, counsel of the Community Group Health Foundation, Inc., accompanied by Dr. Eddie G. Smith, director of health services.

Mr. Beller, will you proceed, sir.

STATEMENT OF H. NEIL BELLER, COUNSEL, COMMUNITY-GROUP HEALTH FOUNDATION, INC.; ACCOMPANIED BY DR. EDDIE G. SMITH, DIRECTOR OF HEALTH SERVICES

Mr. BELLER. My name is H. Neil Beller. I am associated with the law firm of Arent, Fox, Kintner, Plotkin & Kahn of Washington, D.C.

On my left is Dr. Eddie G. Smith, who is the director of health services at the Community-Group Health Foundation. We appreciate this opportunity to testify before the committee. Our comments will be brief.

Our testimony concerns the Federal tax classification of nonprofit hospitals. The House-passed version of the Tax Reform Act of 1969 contained a provision which would have allowed a hospital to acquire tax-exempt status notwithstanding its failure to provide charitable or below-cost care to the extent of its financial ability to do so. Such provision was contrary to the then official position of the Internal

Revenue Service which held in a 1956 published ruling that tax-exempt status would be denied to hospitals not so providing charitable or below-cost care.

In its consideration of the House-passed version of the Tax Reform Act, the Committee on Finance decided to delete this hospital provision. It stated in its committee report that the matter would be reexamined in connection with pending legislation on medicare and medicaid.

Subsequent to the Finance Committee's deletion of the hospital provision, the Internal Revenue Service issued a new ruling, superseding the 1956 ruling, and withdrawing the requirement that a tax-exempt hospital provide charitable or below-cost medical care.

It is not the purpose of our testimony to either support or refute the wisdom of such ruling or the deleted Tax Reform Act provision which it echoes. We simply desire to bring to the Finance Committee's attention a problem which indicates that, in general, the meaning of the term "hospital" for various purposes of Federal taxation is in need of clarification.

Our specific problem deals with a letter ruling recently received by the Community-Group Health Foundation in connection with the tax on communications services.

Section 4251 of the Internal Revenue Code imposes a tax upon telephone use. Section 4253(h) exempts "nonprofit hospitals" from this tax. While section 4253(h) does not specifically define the term "nonprofit hospital," it does refer to section 170, the income tax charitable deduction provision. That section defines an exempt "hospital" as any organization, the principal purposes or functions of which are the providing of medical or hospital care.

Further explaining this definition, the regulations under section 170 specifically provide that a hospital may include an outpatient clinic.

The Community-Group Health Foundation is a nonprofit organization providing outpatient care in the upper Cardozo area of Washington, D.C. It is funded by the Office of Economic Opportunity for the benefit of over 100,000 citizens who do not have outpatient facilities readily available to them.

At present no fees are charged patients for services rendered. Reimbursement for such services is received from medicare and medicaid as well as from OEO.

The foundation represents a unique concept of medical care treatment in that it focuses on the family as the basis for diagnosis, study and treatment.

The foundation has no facilities for inpatient care other than for emergency situations.

In April 1969, the Community-Group Health Foundation applied to the Internal Revenue Service for a ruling that it constituted a nonprofit hospital for purposes of the communications tax exemption.

On July 31, 1970, the foundation was advised by the Revenue Service that the term "hospital" for purposes of the communications tax exemption includes only those organizations which have inpatient facilities.

Such advice was rendered notwithstanding the income tax regulations providing that an outpatient facility may be regarded as a hospital, and notwithstanding the express language in section 4253(h)

defining a nonprofit hospital in terms of its meaning for income tax purposes.

We ask the committee to rectify this interpretational problem because we do not see how the Community-Group Health Foundation can be a hospital for purposes of deductible charitable contributions, but not for purposes of the communications tax exemption.

For low-income families ineligible for medicaid or medicare, the type of comprehensive outpatient facility operated by the Community-Group Health Foundation provides a source of hospital and medical care not otherwise available. Moreover, it represents a medical care approach which larger costly inpatient facilities are not designed to handle. Such approach should be encouraged on a consistent basis by the Federal tax laws and should not be impeded by artificial or over technical administrative interpretations.

Each dollar of tax which such organizations must pay as a result of such interpretations represents one less dollar available for the rendering of much-needed medical care.

We cannot believe that Congress intended this result, and we respectfully request that existing law be clarified so as to make clear that, for all purposes of Federal taxation, inpatient and outpatient facilities are to be treated on an equal footing.

This concludes our testimony. We have submitted a full written statement which we would appreciate being incorporated in the hearing record.

Thank you for your attention.

(The prepared statement follows. Hearing continues on page 1042.)

STATEMENT BY THE COMMUNITY-GROUP HEALTH FOUNDATION, INC., WASHINGTON, D.C.

Last year, the Committee on Finance deleted from H.R. 13270 (Tax Reform Act of 1969) a provision specifically relating to the classification of "hospitals" for federal tax purposes, stating, however, that the Committee would reexamine this matter in connection with pending legislation on Medicare and Medicaid.[1] The Community-Group Health Foundation, Inc. respectfully requests the Senate Finance Committee's consideration of its statement on the classification of "nonprofit hospitals" and the tax benefits presently accorded such institutions under the Internal Revenue Code. The statement contains the following contents, in the order noted:

A. SUMMARY OF PRINCIPAL POINTS

Since 1966, "nonprofit hospitals" have been specifically exempted under the excise tax provisions of the Internal Revenue Code from the communications tax on telephone services. Community-Group Health Foundation, Inc. has recently received a letter ruling from the Internal Revenue Service, Excise Tax Branch, to the effect that a "hospital" for purposes of the communications tax exemption must be one which provides *in-patient* facilities; the exemption is held not to apply to an "out-patient clinic". This result obtains, notwithstanding the fact that, under its income tax regulations, the Internal Revenue Service

[1] See Senate Report No. 91-552, at 61.

holds that, for purposes of the Code provision allowing a deduction for charitable contributions, an "out-patient clinic" constitutes a "hospital" if its principal purpose is providing "hospital or medical care". Taken together, the effect of these two policy announcements of the Internal Revenue Service is to render the Community-Group Health Foundation a "nonprofit hospital" for federal *income* tax purposes, but not for federal *excise* tax purposes—indeed a strange result in view of the identical statutory language applicable in both contexts.

We do not believe that the relevant statutory provisions or their legislative history provide any basis for distinguishing between hospitals providing in-patient care and hospitals providing out-patient care. Both in-patient and out-patient facilities provide medical or hospital care depending upon the individual needs of particular patients seeking such care. Testifying recently before the House Ways and Means Committee in connection with extension of the federal excise tax on communication services, we requested that the Congress rectify the disparity above-described by clearly providing that out-patient clinics which provide hospital or medical care (such as Community-Group Health Foundation, Inc.) be eligible for the same tax benefits accorded in-patient facilities under the Internal Revenue Code. We wish to call the identical problem to the attention of the Senate Finance Committee as a necessary adjunct to its consideration of H.R. 17550. The problem is relevant to the Finance Committee's promised reexamination of the federal tax classification of hospitals, particularly in light of a 1969 published revenue ruling which removes the "charitable or below-cost" requirement as a condition of tax exemption for hospitals.[2]

B. PURPOSE AND FUNCTION OF COMMUNITY-GROUP HEALTH FOUNDATION, INC.

The Community-Group Health Foundation, Inc. (the "Foundation") is a community-organized organization designed to provide an out-patient medical, dental, and general health care clinic for low-income residents of the Upper Gardozo area of Washington, D.C. With the exception of emergency cases, the Foundation does not plan to provide (i) any in-patient facilities to house and maintain patients; or (ii) any type of non-ambulatory medical care.

The staff members of the Foundation include professionals with specialties in adult medicine, pediatric medicine, surgery, OB–GYN and orthopedic medicine. Other medical specialists, such as radiologists, are available on a consultant basis. The dental staff includes full-time general dentists as well as regular consultants in the various specialties of dentistry. Foundation facilities and services include a complex X-ray department, a completely-equipped ENT room, a small lab, and a nutritional program. A public health nursing staff as well as a complete roster of auxiliary professional and sub-professionals is maintained to implement Foundation activities and services.

The Foundation's clinic is staffed in the normal fashion with doctors, dentists, nurses, technicians, and other hospital and medical care specialists. The clinic's program is designed to provide *family*-oriented comprehensive care, including treatment for episodes of illness as well as preventive medicine and diagnostic studies of family members. Various members of a "medical care team" provide family treatment and studies for both the patient and other members of the family who subsequently might become patients. The concept of comprehensive family care through treatment and study is aimed at short-cutting present hospital and medical techniques for the treatment of illness, thereby lowering the eventual total cost of a family for medical care. The Foundation seeks to avoid the "commitment" syndrome commonly associated with the treatment and study of illness, through the selective use of facilities (e.g., beds), diagnostic tools, and para-professionals organized on a team-treatment basis. Not only does the clinic operate as a facility for the rendition of medical care, but as a base from which such care may be administered at the home of the patient. This innovative concept of hospital and medical care may render obsolete many existing institutions now offering similar services only within the confines of its own facility and without regard to the family of the particular patient.

The main facility of the Foundation is an out-patient, ambulatory center, temporarily established in a former bank building at 14th Street and Park Road, N.W. Temporary facilities of the Foundation now in use consists of

---

[2] See Rev. Rul. 69-545, I.R.B. 1969–44, 10, superseding Rev. Rul. 56–185, 1956–1 C.B. 202, which took the position that a hospital, in order to qualify for tax exemption under § 501(c)(3) of the Code, must, *inter alia*, provide charitable or below-cost care to the extent of its financial ability. Rev. Rul. 69–545 was issued after enactment of the House version of H.R. 13270 (which included a special "hospital" provision).

examination rooms, diagnostic rooms, treatment rooms, dental operatories, conference rooms, administrative offices and a pharmacy. Such temporary facilities will be used for approximately two years while construction is in process for a permanent health care service center. Hours of operation of the clinic are 9:00 A.M. to 7:00 P.M. on Mondays, Wednesdays, and Friday; 9:00 A.M. to 5:00 P.M. on Tuesdays and Thursdays; and 9:00 A.M. to 1:00 P.M. on Saturdays. There are no scheduled operating hours for Sunday.

It is contemplated that permanent facilities will include two emergency rooms where emergency medical or dental care will be available to persons coming in off the street. Present emergency room facilities include "Ritter tables" and examining tables in various examination rooms; however, these cannot be regarded as hospital "beds" in the in-patient sense. In the jargon of the medical trade, the facility has no 'beds". The permanent facility will have "beds," but only for emergency purposes (including obstetrics).

The Foundation is funded by the Office of Economic Opportunity. For program year ended August 31, 1970, the Foundation received a grant of $1,762,968. Projected funding for fiscal 1971 is $2,415,000. At the present time, no fee is charged patients for services rendered. Reimbursement for such services is received through Titles XVIII and XIX of the Social Security Act, as well as from the Office of Economic Opportunity.

The permanent health center is expected to be ready for occupancy and operation in 1971. The facilities of the new center are designed to serve the 110,000 residents of the Cardozo area. Permanent facilities will include two emergency rooms, sixteen consultation rooms, thirty-two examining rooms, a pharmacy, a physical therapy room, and various administrative offices. This center will also have facilities to be used for training medical and paramedical personnel to act as part of medical care teams. Except to the extent indicated above with respect to emergency cases, neither the temporary health center nor the permanent health center has or will have facilities to provide for in-patient care.

C. TAX STATUS OF COMMUNITY-GROUP HEALTH FOUNDATION, INC.

The Community-Group Health Foundation, Inc. is a District of Columbia nonprofit corporation organized and operated exclusively for charitable purposes. On July 25, 1968, the Internal Revenue Service ruled that the Foudation was exempt from federal income tax under § 501(c)(3) of the Code, and that contributions to the Foundation were deductible in computing federal income, estate and gift taxes.

The Foundation is not a "private foundation" within the meaning of § 509 of the Code; it regards itself as an organization described in § 509(a)(1) by reason of its status as a "hospital" under § 170(b)(1)(A)(iii), or IRS Form 4653 (Notification Regarding Foundation Status) will shortly be filed (or at this writing, has been filed) advising the Internal Revenue Service of such classification under § 509(a)(1).

To date, the Foundation has not applied for a ruling that it is a "hospital" within the meaning of §170(b)(1)(A)(iii) of the Code. Given the clarity of the regulations on the point of treating out-patient clinics as hospitals, such a ruling request was thought unnecessary—at least until the exicse tax ruling of July 31, 1970 received by the Foundation.

On April 30, 1969, the Foundation applied for exemption from the communications tax imposed under § 4251 of the Code on the grounds that is a "nonprofit hospital" within the meaning of § 4253(h). On July 31, 1970, the Internal Revenue Service issued a private letter ruling (a copy of which is appended hereto) to the Foundation holding that the term "nonprofit hospital" used in § 4253(h) does not encompass a hospital established and operated primarily as an out-patient clinic. The specific holding of the ruling is as follows:

> The exemption from the communications tax under § 4253(h) of the Code is limited to "nonprofit hospitals". For purposes of such exemption, an organization must be organized and operated as a charitable organization for purposes of providing a hospital for the sick and its primary function is providing hospital care. The exemption does not extend to an organization established and operated primarily as an out-patient clinic.

As the basis for the ruling, the Service cited the legislative history of § 4253(h)[3], stating that references in such history to the fact that private nonprofit hospitals

[3] H. Rep. No. 1285 (February 15, 1966); S. Rep. No. 1010 (March 2, 1966), 89th Cong., 2d Sess. he Committee Reports are reprinted at 1966-1 C.B. 436 *et seq.* Relevant portions of such legislative history are appended hereto for the Committee's consideration.

are to receive the same tax exemption as state or local government hospitals should be read as indicating that Congress, in enacting § 4253(h), wanted only those hospitals which were in the same class as government hospitals to be exempt from the communications tax. By inference, the Service suggests that government hospitals are oragnizations which do not principally (or exclusively) provide medical care thorugh out-patient facilities; rather, they provide care through *both* in-patient and out-patient facilities. While the ruling does note that, with enactment of the Tax Reform Act of 1969, the hospital exemption language for communications tax directly refers now to an organization described in § 170 (b)(1)(A)(iii), no refernce or explanation is made of the fact that the regulations under § 170(b)(1)(A)(iii) clearly allow an out-patient clinic to qualify as a "hospital".[4] Other than its weak reliance upon the inconclusive legislative history above-mentioned, the Service cites no authority in support of its anomalous position that an out-patient clinic may qualify as a "nonprofit hospital" for income tax purposes, but not for excise tax purposes.

D. DISCUSSION OF FEDERAL TAX TREATMENT OF HOSPITALS

Section 4253(h) of the Code provides that no excise tax shall be imposed under § 4251 upon any amount paid by a "nonprofit hospital" for communication services furnished to such organization. Prior to its amendment by the Tax Reform Act of 1969, § 4253(h) defined the term "nonprofit hospital" as a "hospital referred to in § 503(b)(5) which is exempt from tax under § 501(a)." Section 503 (b)(5) of the Code did not use the term "nonprofit hospital" but referred to "an oragnization, the principal purposes or functions of which are the providng of medical or hospital care. . . ." Because of the repeal of § 503(b)(5) by the Tax Reform Act of 1969, the hospital exemption under § 4253(h) now reads as follows:

> (h) *Nonprofit Hospitals.* No tax shall be imposed under section 4251 on any amount paid by a nonprofit hospital for services furnished to such organization. For purposes of this subsection, the term "nonprofit hospital" means a hospital referred to in section 170(b)(1)(A)(iii) which is exempt from tax under section 501(a).

Section 170(b)(1)(A)(iii) deals with percentage limitations upon the amount of deductions allowed individual donors for contributions made to hospitals.

Prior to its amendment by the Tax Reform Act of 1969, § 170(b)(1)(A)(iii) regarded "a hospital referred to in section 503(b)" as an "extra 10% organization" for purposes of the limitations upon individual charitable contributions. Thus, in 1969, the operative provision describing the term "hospital" under § 4253(h) and the term "hospital" under § 170(b)(1)(A)(iii) were identical—i.e., both spoke in terms of "a hospital referred to in § 503(b)(5)."

Effective January 1, 1970, the Tax Reform Act of 1969 amended both § 170(b)(1)(A)(iii) and § 4253(h) with respect to the definition of "hospital".[5] As indicated above, § 4253(h) now defines the term "nonprofit hospital" as an exempt hospital described in § 170(b)(1)(A)(iii). Section 170(b)(1)(A)(iii) now defines the term "hospital" as follows:

> An organization *the principal purpose or functions of which are the providing of medical or hospital care* or medical education or medical research, if the organization is a hospital, or if the organization is a medical research organization directly engaged in the continuous active conduct of medical research in conjunction with a hospital, and during the calendar year in which the contribution is made such organization is committed to expend such contribution for such research before January 1 of the fifth calendar year which begins after the date such contribution is made. (Emphasis supplied).

Although in effect for almost two decades, the Internal Revenue Service never promulgated any regulations under § 503(b) with regard to the scope of the term "hospital" as used in that section. Nor has the Service ever promulgated any regulations on such point under § 4253(h), which section has been in effect since 1966. In 1958, however, regulations were published to deal with and define the term "hospital" within the context of § 170(b)(1)(A)(iii).[6] Specifically, Reg. § 1.170-2(b)(4)(i) provides in pertinent part as follows:

---

[4] Reg. § 1.170-2(b)(4)(i).
[5] Tax Reform Act, Sec. 101(j)(27), amending IRC § 4253(h), and Sec. 201(a)(1)(B), amending IRC § 170(b)(1)(A)(iii).
[6] T.D. 6285, 1958-1 C.B. 127, 135.

(i) *Hospital.* The term "hospital", as used in section 170(b)(1)(A), means *an organization the principal purposes or functions of which are the providing of hospital or medical care. . . .* A rehabilitation institution or *an out-patient clinic may qualify as a hospital if its principal purposes or functions are the providing of hospital or medical care. . . .* (Emphasis supplied).

The expanded definition of the term "hospital" now found in § 170(b)(1)(A)(iii) as a result of the Tax Reform Act of 1969 is directly traceable to the already existing definition of that term in Reg. § 1.170!2(b)(4)(i). With amendment of § 170(b)(1)(A)(iii), the continuing force and validity of such regulation has been strongly reaffirmed. Oddly enough, however, in its letter ruling of July 31, 1970, the Service nowhere intimates that the principal purposes of the Foundation are other than the rendering of hospital or medical care. Since § 4253(h) now refers directly to § 170(b)(1)(A)(iii), the treatment of out-patient clinics as hospitals should be obvious: if the term "hospital" includes out-patient clinics for purposes of § 170, the same should apply for purposes of § 4253(h). As explained above, however, the letter ruling received by the Foundation refuses to treat § 170(b)(1)(A)(iii) and § 4253(h) on an equal basis, holding that, for purposes of the latter, an organization rendering hospital or medical care to the sick or injured *must* utilize in-patient facilities. The alleged distinction is one without a difference and should be rectified.

In addition to its regulations under § 170, the Internal Revenue Service has also issued revenue rulings dealing with the classification of an organization as a "hospital" for purposes of income tax exemption and charitable contribution deductions. Rev. Rul. 56-185[7] sets forth the following conditions for classification as a "hospital":

1. It must be organized and operated as a nonprofit charitable organization for purposes of operating a hospital for the care of the sick.

2. It must be operated to the extent of its financial ability for those not able to pay for services rendered and not exclusively for those who are able and expected to pay.

3. It must not restrict the use of its facilities to a particular group of physicians and surgeons such as a medical partnership or association to the exclusion of other qualified doctors.

4. Its net earnings must not inure directly or indirectly for the benefit of any private shareholder or individual.

Late last year, Rev. Rul. 56-185 was superseded by Rev. Rul. 69-545.[8] In that ruling, the Internal Revenue Service describes, through the use of examples, an organization which would be classified as a "nonprofit hospital" exempt from tax as a charitable organization and another organization which would not qualify for such treatment. The basic thrust of the ruling is to remove the requirement set forth in item (2) of Rev. Rul. 56-185 (see above). There is, however, no inference or suggestion in either Rev. Rul. 56-185 or Rev. Rul. 69-545 to the effect that an organization which provides out-patient facilities only may not be classified as a "hospital." Moreover, prior to the Internal Revenue Service's letter ruling of July 31, 1970 to the Foundation, no other Service pronouncement or judicial decision has ever suggested that a "nonprofit hospital" for any federal tax purpose must be one which provides in-patient facilities in the care and treatment of sick or injured persons.

E. CONCLUSION

For low-income families who are ineligible for Medicare or Medicaid, the type of comprehensive out-patient facility operated by the Foundation provides a source of hospital and medical care not otherwise available. It represents a step towards comprehensive family medical care which the larger, costly, in-patient facilities are not designed to handle. This unique medical care concept should be encouraged through, *inter alia*, the federal tax laws, and should not be impeded or discouraged by artificial and overly technical administrative interpretations.

---

[7] 1956-1 C.B. 202.

[8] I.R.B. 1969-44, 10. We are aware that the Finance Committee Staff is opposed to the standards set forth in Rev. Rul. 69-545. See *Medicare and Medicaid, Problems, Issues and Alternatives*, Report of the Staff to the Committee on Finance, U.S. Senate, February 9, 1970, at pp. 55-58. It is not a purpose of this statement, however, to either support or refute the wisdom of Rev. Rul. 69-545. The Foundation desires only to bring to the Committee's attention the fact that, even apart from such ruling, the precise meaning of the term "hospital" for all purposes of federal taxation is in need of clarification.

The federal excise tax on communication services does not apply in the case of a nonprofit hospital described in § 170(b)(1)(A)(iii). We do not and cannot believe that, for any federal tax purpose, Congress intended to distinguish between a hospital providing care through an out-patient facility and one providing care though an in-patient facility. It is therefore requested that the Committee on Finance clarify the intended treatment of nonprofit hospitals for all federal tax purposes by making more explicit the exemptions and benefits accorded such institutions irrespective of whether their essentially similar purposes and functions are carried out though in-patient or out-patient facilities.

DEPARTMENT OF THE TREASURY,
INTERNAL REVENUE SERVICE,
Washington, D.C., July 31, 1970.

COMMUNITY-GROUP HEALTH FOUNDATION, INC.,
3308 13th Street NW.,
Washington, D.C.

GENTLEMEN: We have a letter from Mr. William J. Lehrfeld requesting a ruling whether the Community-Group Health Foundation, Inc. qualifies as a nonprofit hospital exempt from communications tax under section 4253(h) of the Internal Revenue Code, with respect to proposed payments for communication services.

As a result of a conference held in this office on June 6, 1969, Mr. Lehrfeld submitted additional information in a letter dated July 15, 1969, as well as related documents on the issue involved.

The evidence shows that the Foundation was granted exemption from Federal income tax under section 501(a) of the Internal Revenue Code with reference to organizations described in section 501(c)(3) thereof. This exemption relates only to income tax and does not automatically assure an exemption from other Federal taxes.

The information available indicates that the purposes of the Community-Group Health Foundation, Inc. is to provide an out-patient medical, dental, and general health care service center for low-income residents of the Upper Cardoza area of Washington, D.C. This health care center will be operated in the nature of an out-patient clinic. The Foundation does not plan to have any in-patient facilities to house and maintain patients, nor will there be any type of non-ambulatory care.

It will be staffed in the normal fashion of doctors, dentists, nurses, technicians, and other health care specialists. The general aim of the Foundation and its staff will be to provide a family oriented comprehensive medical and dental care which will include treatment for episodes of illnesses as well as preventive medicine, and diagnostic studies of persons, both as patients and as members of the family who are not then patients but who will be the objects of study by various members of the medical team. The hours of operation of the clinic will be from 9:00 A.M. to 7:00 P.M., Mondays, Wednesdays, and Friday; from 9:00 A.M. to 5:00 P.M. on Tuesdays and Thursdays; and 9:00 A.M. to 1:00 P.M. on Saturdays. The information shows no scheduled operating hours for Sunday.

The proposed temporary facilities of the Foundation will consist of examination rooms, diagnostic rooms, treatment rooms, dental operatories, as well as conference rooms, administration offices, and a pharmacy. It is contemplated that the facilities will include two emergency rooms where emergency medical or dental care will be available to persons who come in off the street. These temporary facilities will be in use for approximately two years while construction is in process for a permanent health care service center.

The permanent health center is expected to be ready for occupancy in 1971. The facilities of the new center are designed to serve the 110,000 residents of the Cardoza area. Such facilities will include two emergency rooms, sixteen consultation rooms, thirty-two examining rooms, a pharmacy, a physical therapy room, and various administration offices. This center will also have facilities to be used for training medical and paramedical personnel who will act as part of medical care teams. It is stated that neither the temporary health center nor the permanent health center will have facilities to provide for in-patient care.

Section 4253(h) of the Code, relating to exemptions from tax on communications, provides that no tax shall be imposed under section 4251 on any amount

paid by a nonprofit hospital for services furnished to such organization. For purposes of this exemption the term "nonprofit hospital" means a hospital referred to in section 170(b)(1)(A)(iii) which is exempt from income tax under section 501(a). Prior to the amendment to section 4253(h) of the Code by section 101(j)(27) of Public Law 91–172, effective January 1, 1970, that term meant a hospital referred to in section 503(b)(5). In either instance, the organization must be a hospital.

The legislative history of section 4253(h) suggests that Congress was using the term "hospital" in what we believe to be its commonly understood meaning. That is an institution providing in-patient care. Section 4253(h) was section 202(b) of P.L. 89–368, The Tax Adjustment Act of 1966, 89th Cong. 2d Sess. The Committee Reports are published in C.B. 1966–1, at 436. References to this provision are at pages 461 and 472. It is stated at page 461 that the purpose of the amendment was to accord to *nonprofit hospitals* the same treatment accorded *Government hospitals* under present law. These references are specifically to nonprofit hospitals and Government hospitals. The language is also specific on page 472 where it is stated that, "Under this amendment, *private nonprofit hospitals* will receive the same tax-exempt treatment on their payments for communication services as is applicable under section 4292 to *hospitals* operated by a State or local government." (Italic added.)

The exemption from the communications tax under section 4253(h) of the Code is limited to "nonprofit hopsitals." For purposes of such exemption, an organization must be organized and operated as a charitable organization for the purpose of operating a hospital for the sick, and its primary function is providing hospital care. The exemption does not extend to an organization established and operated primarily as an out-patient clinic.

In view of the above, and based on the information furnished, it is our conclusion that the Community-Group Health Foundation, Inc., in operating as an out-patient clinic would not be considered a hospital within the intendment of section 4253(h) of the Code. Therefore, the exemption provided by that section would not apply to amounts paid for communication services furnished to the Foundation.

In accordance with the request contained in a power of attorney on file in this office, a copy of this ruling is being mailed to Mr. William J. Lehrfeld, 1815 H Street, N.W., Washington, D.C. 20006.

Very truly yours,

BERNARD H. FISCHGRUND,
Chief, Excise Tax Branch.

EXCERPTS FROM H. REP. 89–1285

(TAX ADJUSTMENT ACT OF 1966)

Page 31:

Exemptions for hospitals.—Your committee's bill provides an exemption from the excise tax for telephone services furnished to nonprofit hospitals exempt from income tax. This is to accord such hospitals the same treatment accorded Government hospitals under present law.

Page 48:

(*b*) *Nonprofit hospitals.*—Subsection (b) of section 202 of the bill adds a new subsection (h) to section 4253. The new subsection (h) provides that no tax shall be imposed under section 4251 on any amount paid by a nonprofit hospital for communication services furnished to such hospital. A "nonprofit hospital" is defined in the new subsection (h) to mean a hospital referred to in section 503(b)(5) which is exempt from income tax under section 501(a). Under this amendment, private nonprofit hospitals will receive the same tax-exempt treatment on their payments for communication services as is applicable under section 4292 to hospitals operated by a State or local government.

[From Washington Evening Star, June 27, 1969]

$1.4 MILLION GRANTED FOR CARDOZO CENTER

The first federal grant for rebuilding in the District's riot-damaged Upper Cardozo area was announced yesterday by the Commerce Department: $1.4 million toward a health center that will serve 20,000 residents.

The grant was called "really good news" by Mayor Walter Washington, who was on hand when the Economic Development Administration announced it. It will be matched by a $1.4 million loan from the Equitable Life Assurance Association.

At the present, the Cardozo area, with a population of more than 111,000, has no medical facilities whatsoever. The new medical center, a glass-front building to be erected near 14th and Irving Streets NW. will have two emergency rooms, 16 consultation rooms, 32 examining rooms, a pharmacy, and a physical therapy room. Fees will be based on the patient's ability to pay.

Development of such a center was originally proposed by the Cardozo Heights Association for Neighborhood Growth and Enrichment (CHANGE), and the center's board of directors will include four members from CHANGE as well as four from the Howard University Medical School and four from the Group Health Association.

The federal grant—and the insurance company's matching loan—are being made to the Community Group Health Foundation, Inc., of 3308 14th St. NW.

The center will also serve as a training ground for 75 medical and paramedical personnel a year. It will provide for teams of physicians acting as personal doctors to neighborhood residents.

Commerce officials said yesterday the center will not be ready for operation for about two years. Interim medical services will be offered in a temporary health office at the Riggs National Bank Building, 14th and Park Road NW, beginning August 1.

[From Washington Post, June 30, 1969]

CARDOZO HEALTH CENTER

Much more than physical rebuilding is involved in the decision to go ahead with construction of the Cardozo Health Center near 14th and Irving Streets, nw. astride the 14th Street riot corridor. There has been a pooling of resources to fund it—$1.4 million in construction money from the Commerce Department, matched by a loan of the same amount from Equitable Life and $1.5 million from the Office of Economic Opportunity to operate it. The center itself is a joint venture of CHANGE, Inc., a Cardozo neighborhood action group; Howard University Medical School and the Group Health Association. Medical service will be provided residents on an ability-to-pay basis and 75 persons a year will be trained in medical and para-medical jobs. Construction will take two years, but meanwhile, medical service will start Aug. 1 in the Riggs Bank building at 14th and Park Road. It is an imaginative effort to meet the needs of the 111,000 Cardozo residents, particularly the 20,000 in Upper Cardozo who, according to Mayor Washington, now lack any medical facilities.

The CHAIRMAN. Thank you very much, sir. We will look into that when we get into Executive Session.

Mr. BELLER. Thank you.

The CHAIRMAN. Now, the concluding witness for today's session will be Miss Ollie Randall, Member of the Citizens' Committee on Aging, Community Council of Greater New York, and Member of the President's Task Force on Aging.

STATEMENT OF OLLIE RANDALL, CITIZENS' COMMITTEE ON AGING, COMMUNITY COUNCIL OF GREATER NEW YORK

Miss RANDALL. Thank you, Mr. Chairman.

As you have indicated, I am Ollie Randall. I appear on behalf of the Citizens' Committee on Aging, Community Council of Greater New York and, with your permission, I would like to briefly summarize the major documents, in view of time, and so forth.

The CHAIRMAN. We will print your entire statement in the record.

Miss RANDALL. I will leave it and this will, I think, be very much more appropriate.

Our committee, as you know, is concerned with all phases of work with older people, but we want to comment on the amendments which you have included in H.R. 17550.

First, we certainly believe in an increase in the benefits which are proposed. But, in our opinion, a 5-percent increase in benefits starting on January 1 is not really adequate. I think you have heard that before this morning.

The old age and survivors insurance program should aim ultimately at benefits which should approximate at least the low living standard of the Bureau of Labor Statistics.

We would like to see a 20-percent increase instead of a 5-percent increase effective January 1, 1971. We believe there ought to be a very adequate base for beenfits for all aging men and women.

Two, we approve of the raising of widows' benefits.

Three, we approve benefits for men based on all years of earnings through age 62.

We believe that a 5-percent increase in the 72 and older special benefits categories is somewhat inadequate.

Four, then, we go on with a kind of formula which the committee apparently drafted. Older persons should be allowed to earn up to $3,000 a year or $250 in any given month before there is a reduction formula which is applied to their benefits. Above this amount we suggest the withholding of $1 for every $2 earned for the next $1,500, up to $4,500, and $3 withheld for every $1 earned above $4,500. But we think also that earnings, public or private insurance and pension benefits and any unearned income should be the basis of formulating an aging, retired person's total income.

Five, a $500 maximum death benefit seems to us long overdue.

Also, I think we found that one of the major concerns of older citizens, and some of us who are concerned about them, is that in many States social security beneficiaries, who are also old age assistance recipients who are also receiving social security benefits, do not receive a cost-of-living or other increase when they are enacted into social security legislation.

It seems to us safeguards must be built into Federal and State legislation for those persons who are receiving old age assistance, and we are told this must be done at the Federal level.

Medicaid, we approve the increase by 25 percent of the Federal matching funds for hospital outpatient services, clinic and home health services.

It seems to us, however, that it is a backward step to reduce the Federal matching for inpatient care, tuberculosis hospitals by one-third after 60 days, general hospitals by one-third after 60 days, and skilled nursing homes by one-third after 90 days, with this 275-day lifetime limit. It does not seem to us that ambulatory care can reduce the needs for skilled long-term care for certain classes of illnesses.

On medicare, we are not going into depth here. We ask for the elimination of the monthly premiums now required of the elderly participants under part B.

Under 9, home health services, for many older persons, part-time health services are far less expensive to the taxpayers than round-the-clock care in expensive and overcrowded institutions.

Furthermore, it is often healthier and happier for many aging persons to remain living in their own homes and their own communities for as long a period of time as possible.

We believe that not only was the initial definition of home care somewhat limiting, but the Federal and State interpretation, and the administration of the statute, has been so restrictive as to seriously hamper the original legislative intent.

Now, one solution to this problem, it seems to us, would be to enact H.R. 13139, which would add a home maintenance or housekeeping service to the program, and thus allow large numbers of older people to remain in their own homes through the provision of such services as shopping, meal preparation, and so forth.

Mr. Chairman, do I have your permission to hurriedly give you some testimony from the Community Service Society of New York?

The CHAIRMAN. Yes.

Miss RANDALL. I will make it as brief as possible.

The Community Service Society of New York, through its Committee on Aging, Committee on Health, are concerned about the amendments to the act. It is a voluntary nonprofit agency which since 1848 has been dedicating itself through its interests in family life and community life.

The Committee on Aging functions within the Department of Public Affairs and is a citizens' committee which is concerned with the problems of older people.

First, in respect to the social security cash benefits program:

We endorse the provisions that would provide an automatic cost-of-living adjustment mechanism, beginning in 1972, to keep benefits current with rises in the cost of living.

We are in favor of liberalizing the retirement test by permitting a beneficiary under age 72, beginning in 1971, to receive full benefits each month if his annual earnings do not exceed $2,000. You can see the CSS and the Community Council were not quite together on this.

We approve increasing survivors' benefits at age 65 from 82½ percent to 100 percent of the deceased spouse's primary insurance amount, the effective date beginning January 1, 1971.

We approve setting the age of 62 as the computation point for figuring benefits and benefit eligibility for men as it now is for women.

We recommend two changes in the provisions of H.R. 17550 that would provide a 10-percent across-the-board increase in monthly cost benefits rather than 5 percent, effective January 1971.

We would also recommend that there be an increase provided in minimum monthly benefits from $64 to $90, effective January 1971. This increase, I believe, has been proposed in other bills introduced in the Senate.

Now, second, in respect to selected medicare provisions where the Committee on Aging is joined by the Committee on Health, we support provisions that would remove the existing requirement that a person must enroll in part B of title XVIII within 3 years after becoming eligible.

We support the provision that would authorize the Secretary of Health, Education, and Welfare to terminate payment for services rendered by suppliers of health and medical services found to be guilty of program abuses including overcharging, furnishing inferior

or harmful or excessive services, or making a false statement to obtain payment.

We also approve the provision that would authorize the Secretary of HEW to establish specific periods of time after hospitalization during which a patient would be presumed to require nursing home or home health services.

We would also approve extending the coverage to include services rendered by a licensed physical therapist in his office up to a limit of $100 per calendar year.

Further, these committees support in principle the provision—but question the utility of a provision—that would allow persons ineligible for part A of title XVIII to enroll for coverage of $27 a month figured to be the full cost of protection currently and subject to increase as hospital costs rise, and require enrollment in part B at an additional monthly fee.

We also urge an additional provision that would incorporate an out-of-hospital drug insurance program out of part A under title XVIII, such a program to include only, for the most part, prescription-requiring drugs prescribed by an authorized prescriber, except for non-prescription drugs, such as insulin, specified by the Secretary of HEW, and being essential to insure the goals of the program.

Third, with respect to the selected medicaid provisions where, again, the Committee on Aging is joined by the Committee on Health, we support the provisions that would provide a 25-percent increase in the Federal matching share for hospital outpatient services, clinic services, and home health services.

We support provisions that would authorize the Secretary of HEW to establish differential rates for skilled nursing homes and intermediate care facilities. Relating reimbursement to the level of care is sound.

We strongly oppose, we are strongly opposed to, provisions that to the 75th percentile of a given area. This kind of provision seems reasonable.

But we also approve Federal funding at a 90 percent level to the States to establish mechanized claims processing and information retrieval systems, and at a 75 percent level for the continued operation of such systems.

We strongly oppose, we are strongly opposed to, provisions that would reduce the Federal matching share for inpatient care in general and tuberculosis hospitals by one-third after 60 days; in skilled nursing homes by one-third after 90 days; and in mental hospitals by one-third after 90 days, with a 275-day lifetime limit thereafter. It seems to us that these arbitrary limits are unsound and dangerous.

We would also oppose the elimination of the requirement that the States establish a comprehensive medicaid program by 1977. The original target date for this requirement was 1975. In 1969 it was advanced to 1977. The goal of a comprehensive program should be constantly emphasized. If practical problems of compliance exist, the date can again be postponed but should not be abandoned.

Now, in conclusion, may I make one other comment? I will take but one-half minute. As a member of the President's Task Force on Aging I would like to suggest, because I am sure your committee, Mr. Chairman, has had the reports of that task force, it seemed to me, as I

listened this morning to the testimony, that many of the issues that are discussed are dealt with in, by recommendations in, that report, and I hope they are filed as a part of the testimony for this group.

The CHAIRMAN. We are fortunate to have on our staff one of the very able staff members who served for quite a while on that group.

Miss RANDALL. Good. It was a very good experience. But I think you have the material, and they were dealt with, I think, with a great deal of care and thought and could be useful to your committee.

Thank you, sir.

(The prepared statements follow. Hearings continue on page 1052.)

STATEMENT OF THE COMMITTEE ON AGING OF THE COMMUNITY SERVICE SOCIETY OF NEW YORK

The Committee on Aging of the Community Service Society of New York submits this statement to the Senate Finance Committee for its consideration in reviewing the proposed amendments to the Social Security Act in H.R. 17550.

The Community Service Society of New York is a voluntary nonprofit agency dedicated since 1848 to the strengthening of family life and the betterment of Community life. The Committee on Aging within the Department of Public Affairs is a citizen's committee concerned particularly about the well-being of the aged.

We have examined H.R. 17550 and the report of the House Committee on Ways and Means in detail together with related material. We find and note below that several of the provisions of the bill are commendable improvements of the social security and health insurance system. But there are omissions and deficiencies, in our opinion, which we call to your attention.

First, in respect to the social security cash benefits program:

We endorse the provisions that would—

Provide an automatic cost-of-living adjustment mechanism, beginning in 1972, to keep benefits current with rises in the cost of living. Across-the-board increases in benefits have been made by Congressional action from time to time. Preferable is the proposal for an automatic adjustment in benefits when the Consumer Price Index has increased three per cent, coupled with a comparable increase in the taxable payroll base to keep the OASDI Trust Funds in balance.

Liberalize the retirement test by permitting a beneficiary under age 72, beginning in 1971, to receive full benefits each month if his annual earnings do not exceed $2,000, instead of $1,680 as of now; to receive benefits reduced by $1 for each $2 of earnings between $2,000 and $3,200 (instead of the current range of $1,680–$2,880) and for each $1 thereafter. The bill would also increase from $140 to $166.66 the amount of monthly wages allowable without loss of benefits. These changes represent a quite modest updating of the retirement test.

Increase survivors' benefits at age 65 from 82½ per cent to 100 per cent of the deceased spouse's primary insurance amount, the effective date being January 1, 1971. This provision recognizes the economic needs of dependent widows and widowers.

Set age 62 as the computation point for figuring benefits and benefit eligibility for men as it now is for women. There is no logic for the existing differential which can result in lower benefits for a retired man than for a retired woman with the same wages.

We recommend two changes in the provisions of H.R. 17550 that would—

Provide a ten percent across-the-board increase in monthly cost benefits rather than five per cent, effective January 1971. A ten per cent increase is considered a modest effort that takes into account the escalation in the cost of living and the level of average benefits which is substantially below minimum needs. By this increase the monthly benefit for an average retired single worker would go from $116 to $127.60; for an average retired couple from $196 to $215.60.

Provide an increase in the minimum monthly benefit from $64 to $90, effective January 1971, rather than to $67.20 resulting from the proposed five per cent increase. This increase has been proposed in other bills introduced in the Senate. It is viewed as a step in the right direction and possible of achievement at this time, although still below a minimum standard of sub-

sistence. It is hoped that, in the future, a program based upon social security payments and payments from other sources will result in an adequate minimum. Since a $90 minimum monthly payments is unrelated to the taxes paid by employees and employers and the self-employed into the Trust Funds, the difference between this amount and the amount that would otherwise be provided by a ten per cent increase should be financed from general revenues.

Second, in respect to selected Medicare provisions where the Committee on Aging is joined by the Committee on Health:

We support the provisions that would—

Remove the existing requirement that a person must enroll in Part B (Supplementary Medical Insurance) of Title XVIII within three years after becoming eligible.

Authorize the Secretary of Health, Education, and Welfare to terminate payment for services rendered by suppliers of health and medical services found to be guilty of program abuses including overcharging, furnishing inferior or harmful or excessive services, or making a false statement to obtain payment.

Authorize the Secretary of Health, Education, and Welfare to establish specific periods of time after hospitalization during which a patient would be presumed to require nursing home or home health services. This provides protection against retroactive denial by fiscal intermediaries of extended care benefits, which has caused hardships for patients and the suppliers of services.

Extend coverage to include services rendered by a licensed physical therapist in his office, up to a limit of $100 per calendar year.

We support in principle, but question the utility, of a provision that would—

Allow persons ineligible for Part A (Hospital Insurance) of Title XVIII to enroll for coverage for $27 a month, an amount figured to be the full cost of protection currently, and subject to increase as hospital costs rise; and require enrollment in Part B at an additional monthly fee. This is a high cost for the uninsured to pay for coverage, and beyond the means of many persons. Is it possible to blanket the uninsured in for hospital insurance as was done for those who attained age 65 before 1968 even though they were not eligible for cash benefits? If not, can other programs be developed which will provide needed protection and coverage of health costs?

We urge an additional provision that would—

Incorporate an out-of-hospital drug insurance program under Part A of Title XVIII, such a program to include for the most part only prescription-requiring drugs prescribed by an authorized prescriber, except for non-prescription drugs (e.g., insulin) specified by the Secretary of Health, Education, and Welfare and deemed necessary to ensure the goals of the program; to call for co-payment of $1 by the beneficiary for each original prescription and re-fill; to provide for reimbursement to the vendor rather than the beneficiary; to become effective at a date that allows sufficient time to set up adequate administrative machinery for efficient processing and for developing utilization; quality and cost controls; to be paid for by an increase in contributions by employees and employers and the self-employed. In our judgment, the inclusion of an out-of-hospital drug insurance program would be a great step forward, reducing the need for higher-cost kinds of care and alleviating a serious financial burden on the elderly.

Third, in respect to selected Medicaid provisions where, again, the Committee on Aging is joined by the Committee on Health:

We support provisions that would—

Provide a 25 per cent increase in the federal matching share for hospital outpatient services, clinic services and home health services. This provides an important incentive encouraging states to develop and use community-based services.

Authorize the Secretary of Health, Education, and Welfare to establish differential rates for skilled nursing homes and intermediate care facilities. Relating reimbursement to the level of care is sound.

Limit increases in physician fees to the 75th percentile of a given area. This seems reasonable.

Provide federal funding at a 00 per cent level to states to establish mechanized claims processing and information retrieval systems, and at a 75 per cent level for the continued operation of such systems. Desirable is this encouragement of efficient and modern administration of a system that is complicated indeed.

We are strongly opposed to provisions that would—

Reduce the federal matching share for inpatient care in general and tuberculosis hospitals by one-third after 60 days; in skilled nursing homes by one-third after 90 days; and in mental hospitals by one-third after 90 days, with a 275-day life-time limit thereafter. Such arbitrary limits, in our judgment, are unsound and dangerous. We are not persuaded of the reasonableness of these limits as advanced by the House Ways and Means Committee. We believe that the present limits should be maintained if they cannot be increased and that reimbursement formulas should not provide a leverage for inappropriate transfers to a lower level of care when this is contra-indicated by a medical diagnosis.

Eliminate the requirement that states establish a comprehensive Medicaid program by 1977. The original target date for this requirement was 1975; in 1969 it was advanced to 1977. The goal of a comprehensive program should be constantly emphasized. If practical problems of compliance exist, the date can again be postponed but should not be abandoned.

In sum and in considered conclusion, we urge the Senate Finance Committee to support constructive changes that will alleviate the burdens imposed on the old and the sick. Amendments to the Social Security have far reaching consequences; should grow out of humane considerations; should meet evident needs in a way that preserves dignity and independence and strengthens family life in these most difficult days.

STATEMENT PRESENTED BY MISS OLLIE RANDALL ON BEHALF OF THE CITIZENS' COMMITTEE ON AGING, COMMUNITY COUNCIL OF GREATER NEW YORK

The Citizens' Committee on Aging of the Community Council of Greater New York is pleased to have the opportunity to testify on certain aspects of HR 17550.

The majority of the retired aging persons in this country are basically dependent on Social Security benefits for their income. Most of these are men and women who have worked a lifetime to support themselves and their families. They were promised that their Social Security contributions (and those of their employers) would provide them with real security in their retirement years.

LEVEL OF SOCIAL SECURITY BENEFITS

It is manifestly necessary to provide the increase of Social Security benefit levels. The small increments included in the Social Security Amendments of 1967 have already been eaten away by increases in living costs. The compromise in 1967 that resulted in the minimum benefit of $55 per month has been particularly inadequate. Aside from the obvious inappropriateness of such amounts as a basic income floor, the wide variety in the administration of State Old Age Assistance programs subjects the elderly poor to the whims of the often degrading public assistance programs that characterize many of our States.

We find it disgraceful that so many elderly Americans are still dependent on this public assistance mechanism. As if being on public assistance were not difficult enough, we hasten to point to the oft-reported fact than many older people will live virtually in starvation rather than subject themselves to the indignities of applying for Old Age Assistance. The significance of this was brought home to us forcefully earlier this year by a Task Force Working Paper prepared for the Senate Special Committee on Aging. That carefully documented report is perhaps the most damning collection of evidence yet submitted on this subject. Among other things, it reported that while three out of ten older people were living in poverty in 1966 and a fourth was on the borderline (a much higher percentage than for the remainder of the population), *many of these did not become poor until they became old.* Thus, our society has somehow managed to pervert the meaning of retirement and old age into a period of trauma and horror instead of the repose and relatively worry-free post-employment years to which we all aspire.

In addition to a great waste of public money in supporting two separate administrations for income assistance to this same group, adequate Social Security payments would eliminate Old Age Assistance at a substantial saving of administration costs. Social Security payments to older people with higher incomes could be recaptured through a realistic tax program.

We attest that a 5% increase in benefits starting January 1, 1971, is not adequate. In May, 1970, the *average monthly benefit* of retired workers was $121.86

and $56.16 for wives and husbands. (Note we have not quoted minimum benefits.) The average retired man living alone receives $1462.32 annually, an average retired couple $2136.24.

It is our opinion that the Old Age and Survivors' Insurance Program should aim ultimately at benefits which approximate at least the Lower Living Standard of the Bureau of Labor Statistics. Several bills introduced in the Congress earlier this year gave promise of achieving this goal. Inasmuch as the OASDHI benefit increases have not yet caught up with the Bureau of Labor Statistics standard, we urge your Committee to keep in view the necessity of a planned increment program to bring beneficaries up to benefit levels approximating current living costs. We call for a 20% instead of a 5% increment effective as of January 1, 1971. (HR 14430, introduced by Congressman Jacob H. Gilbert came closer to our perception of needed changes than any other bill we have seen.)

It would further be our strong recommendation that in addition to the proposed increase in employer and employee contributions as proposed in HR 17550, general tax revenue funds should be appropriated in order to initiate the development of an adequate base of benefits for all retired men and women. The basic maintenance of our almost twenty million older people should not be dependent on the state of well being of the Social Security Trust Fund. We urge upon you as strongly as we can to establish meaningful standards for older people (e.g., a minimum income of $150 per month for persons living alone and $250 for older couples) without regard to the insurance principle. If this requires appropriations from general revenues, it is most important that this step be taken. If such a system were instituted, it would go a long way towards eliminating poverty among our older people; it would virtually supersede the unhappy administration of the Old Age Assistance programs; and it would allow us to say, at long last, that retirement has some prospects of acquiring a positive connotation for most older (and about-to-be-older) Americans.

COST-OF-LIVING INCREASE

The concept of a cost-of-living increase built into the benefit structure is very sound. This cost of living increment, however, should be added to a more adequate benefit base. It is our belief that cost-of-living increases on an inadequate base will only delude aging persons and the public concerning benefit levels.

BENEFITS FOR WIDOWS AND MEN AGED 62

We applaud the raising of widow's benefits to the level of primary benefits. It is high time that widows receive 100% of their dead spouses' benefits if applied for after age 65 and 82½% of such benefits after age 60.

We also laud benefits for men on all years of earning through age 62.

BENEFITS FOR PERSONS AGED 72 AND OLDER

Concerning the "72 and older" special benefits—a 5% increase will raise those monthly benefits to $48.30 per individual and $72.50 per couple. These levels are still totally inadequate. They are also suspended in any month where the recipient obtains public assistance. This is another area where substantial funds from general tax revenues would allow recipients to obtain decent benefits and would remove them from the indignity of deciding between a token payment from Social Security and an application to the Department of Welfare.

EARNED INCOME PERMITTED BY RETIRED PERSONS

One area in which we feel the bill did not go far enough is that of the earnings test. It is a cornerstone of the philosophy of our Committee that older people should have viable choices in all functions of daily living with which they are confronted. It has been our experience that the largest volume of expressed concern from older people with the possible exception of the benefit structure itself, has been in the area of the limitations of their earnings. With more and more people living longer, retaining their vigor and physical capacity to be productively employed for longer periods of time and facing the problem of constantly increasing living costs, we feel it would be more realistic to allow the older person to earn up to $3,000 per year or $250 in any given month before any reduction formula is applied to his benefits. Above this amount, we suggest the withholding of $1 for every $2 earned for the next $1,500 (up to $4,500) and $3

withheld for every $4 earned above $4,500. The totality of earnings, public or private insurance and pension benefits and any unearned income should be the basis of formulating an aging retired persons total income. We suggest that a ceiling should be set on *combined* earnings and benefits which would have the effect of allowing beneficiaries near the lower end of the benefit scale to earn more than those at the upper end. This would achieve the desired social goal of facilitating a higher total annual income for all recipients, with minimal effects on the Trust Fund. At the same time, it would be most helpful to those at the lower end of the income scale, where the need is greatest.

As an example, assume a ceiling of $5,000 of combined earnings and benefits. The individual receiving an OASDHI benefit of $80 per month could earn up to $4,040 without adversely affecting his monthly check. The individual receiving $150 per month would be allowed to earn up to $3,200 before there would be any modification in his benefit.

Both of the above approaches would greatly benefit the older person in ways which are psychic as well as monetary. We also believe this would be helpful to the general economy, by increasing the limited purchasing power of many older people.

DEATH BENEFITS

Another area in which we have failed to keep abreast of realistic needs is that of the death benefit. The maximum allowable benefit has been frozen at $255 for many years. Originally this was based on the monthly benefit structure in effect at the time. The death benefit, for some reason, was not enlarged as increases in the general benefit structure were effected. A $500 maximum is much more realistic and long overdue.

RELATION BETWEEN SOCIAL SECURITY BENEFITS AND OLD AGE ASSISTANCE BENEFITS

The Social Security Act is apparently permissive with respect to the freedom of the States to budget OASDHI benefits as income chargeable against public assistance budgets. That is, many states, New York included, simply deduct OASDHI increments from Old Age Assistance recipients' grants. Thus, older public assistance recipients in those states never receive the benefit of whatever OASDHI increments are enacted into law.

We have tried, but only with partial success, to convince the State of New York to reverse this practice. We know that similar efforts have been made in other States. Under the circumstances, it seems to us that the Congress should be more restrictive with respect to the State options in this matter.

"MEDICAID"

The new provisions concerning Title XIX, "Medicaid," caused us concern. We approve the increase by 25% of Federal matching funds for hospital out-patient services, clinic and home health services. We insist that it is a backward step to reduce Federal matching for in-patient care; in tuberculosis hospitals by ⅓ after 60 days; in general hospitals by ⅓ after 60 days and in skilled nursing homes by ⅓ after 90 days, with a 275 day life time limit. Ambulatory care cannot reduce the need for skilled long-term care for certain catastrophic illnesses. This destroys the concept of medical indigency established by the Kerr-Mills legislation. Is our society so inhumane that it would reduce care for our sickest and most dependent aging citizens? These provisions must be repealed.

"MEDICARE"

The enactment of Title XVIII by the Congress in 1965 was a landmark in social legislation, not only for older people, but, we believe, for everyone in our country. It was the first step towards a system of governmental health insurance for our entire population. Ours is virtually the only western society which does not have such a program. It seems to us that inevitably we will and must have it.

We must acknowledge that the early years of the administration of "Medicare" generally have been fraught with problems, both in terms of the adequacy of coverage and the administration of the program itself. The deductible and co-insurance features work a severe hardship on many older people. The gradually increasing costs of Part B to the participant are regrettable and frequently beyond his capacity to pay. This will be increasingly true if, as we were advised by Commissioner Ball recently, the premiums for Part B will be increased to more than $5.00 per month in 1970.

At the very least, we call for the elimination of the monthly premiums now required of elderly participants under Part B. If the costs of absorbing this cannot be met from the Trust Fund as it is currently financed, additional appropriations should be made from general revenues until such time as the increased wage base deductions from employers, employees and the self-employed can begin to absorb these costs.

If the services obtained by older people under Title XVIII are to be meaningful, out-of-hospital drugs must be included in their entitlement. The absence of this coverage heretofore has been a major problem in the health care of our older population and a major shortcoming of Title XVIII.

HOME HEALTH SERVICES

The Citizens' Committee on Aging is particularly concerned, following three years of concentrated project activity, with what we view as serious weaknesses in the Home Care provisions of Title XVIII. For many older persons, part-time home health services are far less expensive to the taxpayer than round-the-clock care in expensive and overcrowded institutions. Furthermore, it is often healthier and happier for many aging persons to remain living in their own homes and their own communities for as long a period of time as possible.

We believe that not only was the initial definition of Home Care somewhat limiting, but the Federal and State interpretation and administration of the statute has been so restrictive as to seriously hamper the original legislative intent. Initial "Medicare" report figures indicate that only about 1% of all "Medicare" outlays during its first few years have gone to home care costs. We suggest that this was not the Congressional intent. Moreover, there is every indication that the rigidities of the home care program are being further tightened and serivces further curtailed administratively. We thing this is unconscionable in view of he pressures on our institutions and the need for services of all kinds.

One solution to this problem would be to enact *HR 13139*, which would add Home Maintenance (Housekeeping) services to the program and thus allow large numbers of older people to remain in their own homes through the provision of such services as shopping, meal preparation, etc. (For a more detailed discussion of this problem, we refer you to the testimony of Mrs. Susan K. Kinoy, Project Director of our Home Health and Housing Program, who appeared before the House of Representatives Ways and Means Committee in support of *HR 13139* on Oct. 22, 1969.)

"INFLATIONARY" ASPECTS OF SOCIAL SECURITY INCREASES

The Citizens' Committee on Aging of the Community Council of Greater New York challenges the appropriateness of certain statements attributed to Health, Education, and Welfare Secretary Elliot L. Richardson in testimony before your Committee on July 14. Secretary Richardson urged the Senate Finance Committee to use restraint in the passing of Social Security increases because further increments ". . . might upset the delicate balance . . . of our economy." Our Committee also seriously questions whether the Federal budget would be "seriously strained," as suggested by Secretary Richardson, if additional increases in Social Security benefits were enacted.

We would like to point out that this is not the first time that the spectre of inflation or an unbalanced budget has been raised by Administration officials when the Congress has had under consideration necessary upward adjustments of the payments to older people who have contributed during their working lives to their Social Security.

The majority of retired aging persons in this country are basically dependent upon Social Security benefits for their income. Most of these are men and women who have worked a lifetime to support themselves. They were promised that their Social Security contributions would provide them comfortable retirement years. It is inconceivable that these people who have had to live on fixed dollar incomes which constantly shrink in the face of ever-increasing prices should be the targets of the Secretary's concerns for economic restraint. We reaffirm our contention that in order for retired persons to receive truly adequate Social Security benefits, it will be necessary for some of these funds to be obtained through general tax revenues.

What is particularly vexing, therefore, is that Secretary Richardson knows that *the 3.9 billion dollar estimated cost of increases in Social Security benefits*

will not require additional Federal tax revenues. Thus, it will not result in any additional cost to taxpayers. The amount which would be received by aging and disabled persons would be paid from the Social Security Trust Funds which come solely from the contributions of employees and employers and *not from general tax revenues.* The point may also need to be made that these funds are restricted by law to be used only for this purpose.

Secretary Richardson has unjustly left the impression that increased Social Security benefits would lead to increased taxes. One also has to draw the inference from his comments that, in the Administration view, money given to older people to adjust realistically the benefits for which they have contributed is more inflationary than money spent on programs such as roads, space projects, and the anti-ballistic missile, to say nothing of our staggering military budget. We don't recall hearing Administration spokesmen refer to any of these as upsetting the "delicate balance . . . of our economy."

Prior to the most recent Social Security increases, the cash benefit Trust Funds had achieved the highest dollar balances in their history. We have been advised that actuarially, increases currently contemplated pose no threat to the solvency of the Trust Funds. In view of the above and our belief that the real threats to the well-being of our national economy lie well outside the Social Security funding mechanism, the Citizens' Committee on Aging feels that Secretary Richardson has done a grave disservice to the older people of this country.

CONOLUSION

In conclusion, we urge the Senate to work for the passage of Social Security legislation that will begin to meet the true financial and medical needs of our senior citizens. We urge more realistic benefits for our senior, retired men and women who have given of themselves to the development of our country, and who have contributed generously to the OASDHI insurance funds.

We reiterate that if Social Security benefits for all older persons were at an acceptable level such as the Bureau of Labor Statistics Lower Living Standard, it would not be necessary for many older persons to go through the indignities of applying for old age maintenance. Until Social Security benefits reach those levels, we must build in safeguards for those persons receiving Old Age Assistance.

The CHAIRMAN. Thank you, Miss Randall.

In view of the fact there appears to be developing a legislative confrontation with regard to the constitutional amendment that is pending in the U.S. Senate and Senator Bayh, junior Senator from Indiana, has indicated that he will object to the committees meeting during the session of the Senate tomorrow, I will commence these hearings earlier than usual. We will start at 9 o'clock rather than at 10, and we will commence with the American Medical Association and then we will hear from the Pharmaceutical Manufacturers Association. We hope we will be permitted to continue to conduct our hearings so that we may conclude hearing the witnesses on this important piece of legislation, because we simply cannot go into executive session until we have heard the witnesses we were scheduled to hear.

We will stand in recess until 9 o'clock tomorrow morning.

(Thereupon, at 1:15 p.m., the committee recessed, to reconvene tomorrow, Wednesday, September 23, 1970, at 9 a.m.)

SOCIAL SECURITY AMENDMENT OF 1970

WEDNESDAY, SEPTEMBER 23, 1970

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 9 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long (presiding), Anderson, McCarthy, Byrd, Jr., of Virginia, Williams of Delaware, Bennett, Curtis, Jordan of Idaho, and Hansen.

The CHAIRMAN. The hearing will come to order.

We are going to follow a somewhat different procedure this morning, since one of the Senators has indicated that he is considering objecting to committees meeting during the session of the Senate.

I am going to call each witness this morning and request that his statement be printed at this point in the record. Then we will call the witnesses who want to make an oral presentation.*

Is Dr. Lamotte in the room?

Dr. LAMOTTE. Here, sir.

The CHAIRMAN. Your statement will be printed at this point in the record.

I see Mr. Stetler in the room, Mr. Stetler, your statement will be printed at this point in the record.

Is Miss Reeves here?

Miss REEVES. Here.

The CHAIRMAN. We will print your statement at this point in the record.

Is Miss Ruff here?

Miss RUFF. Present.

The CHAIRMAN. Miss Ruff, we will print your statement.

Is Mr. Keaney here? Mr. Keaney is not here. We will call his name later.

Mr. Brickfield.

Mr. BRICKFIELD. Mr. Chairman, I have a correction to make in my statement if there is someone here who can take it.

The CHAIRMAN. Just hand it to the staff. Your statement will be printed at this point in the record.

Mr. Rademacher.

Mr. RADEMACHER. Here.

The CHAIRMAN. Your statement will be printed at this point in the record.

I see Mr. Stringer in the room. His statement also will be printed.

Mr. Martin.

*The statements were received by the Chairman at this point but will appear where the witness presented oral testimony.

Mr. Knebel.
Mr. Muchemore.
Mr. Nangle.
Mr. Walters.

Is there any witness who can summarize his statement and can do it in less than 3 minutes? Former Congressman Karsten.

STATEMENT OF MISS RHODA A. RUFF, PRESIDENT, AFFILIATED GOVERNMENT ORGANIZATIONS; ACCOMPANIED BY FORMER CONGRESSMAN FRANK M. KARSTEN; AND JACK DANIELS, COUNSEL

Mr. KARSTEN. Mr. Chairman, for the purpose of the record, I am Frank Karsten. I am a former Member of Congress. I am presently engaged in the general practice of law in the District of Columbia. It is always a pleasant experience to visit the Senate Finance Committee and I am especially pleased to be here today because my appearance is to further legislation I sponsored when I was a member of the House Ways and Means Committee. I refer to social security legislation to include coverage of Federal employees. A great many people and organizations are interested in this, most noteworthy the Affiliated Government Organizations.

I have with me Mr. Jack Daniels, the counselor of that organization, and Miss Rhoda Ruff, the president of the organization, who is an outstanding expert on this subject and in the Ways and Means Committee we have relied very heavily on her assistance.

The CHAIRMAN. You may have a seat.

Mr. KARSTEN. And Miss Ruff will testify.

The CHAIRMAN. The fact you are under a strict limit does not deny you the right to have a seat. Happy to have you, Congressman Karsten and Miss Ruff. Will you proceed?

Miss RUFF. My name is Rhoda A. Ruff, and I am pleased to serve as president of the Affiliated Government Organizations. This group consists of 27 postal and Federal employee unions and associations, representing more than 40,000 Government employees.

We wish to express our appreciation to the distinguished chairman and members of the Senate Committee on Finance for the opportunity to testify on the subject for social security coverage for Federal employees.

The goal of the Affiliated Government Organizations is the enactment of legislation which would permit all Government employees on the rolls the option to elect coverage under the Social Security System in addition to their civil service annuities. Each system should continue to be financed separately and apart from each other.

We advocate optional group selection for present Government employees and mandatory coverage for future employees which eliminates the possibility of adverse selection. The reason it should be optional for current employees is that social security participation was not required when they first started to work for the Government. New employees will automatically come under the program when they choose to become Government workers.

We do not seek any special privileges. This form of social security coverage has been extended to most of the State and local employees. We seek equal and comparable treatment. There are many precedents

for this coverage which is even extended to other Federal employees such as the military, Federal Reserve banks and Federal credit unions. The Government workers are the only large group denied social security coverage.

The largest employer in the United States denies its own employees coverage while it mandates that all other employers provide coverage for their employees.

Our Federal retirement and survivor benefits are inadequate. Many older Federal employees fear retirement because of constant increases in the cost of living. Federal retirement benefits, after the retiree has recovered his contributions, are taxable for income tax purposes by the Federal Government, his State, and his city, and in many cases more than one-fourth of his annuity goes back for Federal income tax, city and State income tax.

A Federal employee must work about 30 years to earn minimum Federal retirement. It seems unjust that, after a faithful worker has devoted 30 years of service to the Government, he must start all over again to earn social security.

We again express our gratitude for this opportunity to present our views on behalf of the largest group of employees still denied social security coverage. We urge the committee to favorably consider our request for legislation to confer equal and comparable treatment to the Federal worker who has given many years of dedicated service to his employer, the U.S. Government. He has earned the right to an adequate pension which will enable him to retire with dignity and he has earned the right to adequate protection for his survivors.

Thank you.

The CHAIRMAN. Thank you very much. Do you have any questions?

Thank you very much.

(Miss Ruff's prepared statement follows:)

STATEMENT OF RHODA A. RUFF, PRESIDENT, AFFILIATED GOVERNMENT ORGANIZATIONS, JULY 1970

SUMMARY

1. The Affiliated Government Organizations seeks optional social security coverage for Federal employees in addition to their civil service annuities.
2. Each system, the Social Security System and the Civil Service Retirement to be financed separately and apart from each other.
3. Government workers are the only group of employees denied social security coverage.
4. The Government mandates that every other employer grant coverage to their employees but denies it to its own employees.
5. Our civil service retirement benefits do not permit us to retire.
6. The possibility of anti-selection is prevented by mandatory coverage for new employees and optional selection by groups rather than individually.
7. Our civil service retirement system does not provide adequate survivor benefits.

STATEMENT

My name is Rhoda A. Ruff and I am pleased to serve as President of the Affiliated Government Organizations. This group consists of twenty-seven Postal and Federal employee unions and associations, representing more than 40,000 Government Employees.

We wish to express our appreciation to the distinguished Chairman and Members of the Senate Committee on Finance for the opportunity to testify on the subject of Social Security coverage for Federal employees.

The goal of the Affiliated Government Organizations is the enactment of legislation which would permit all Government employees on the rolls, the option to elect coverage under the Social Security System *in addition to their Civil Service*

annuities. Each system should continue to be financed separately and apart from each other.

We advocate optional group selection for present Government employees and mandatory coverage for future employees which eliminates the possibility of adverse selection. The reason it should be optional for current employees is that Social Security participation was not required when they first started to work for the Government. New employees will automatically come under the program when they choose to become Government workers.

We do not seek any special privileges. This form of Social Security coverage has been extended to most of the State and local employees. We seek equal and comparable treatment. There are many precedents for this coverage which is even extended to other Federal employees such as the military, Federal Reserve Banks and Federal Credit Unions. The Government workers are the only large group not permitted to participate under the Social Security program. The largest employer in the United States denies its own employees coverage while it mandates that all other employers provide coverage for their employees.

Our Federal retirement and survivor benefits are inadequate. Many Older Federal employees fear retirement because of constant increases in the cost-of-living. Federal retirement benefits, after the retiree has recovered his contributions, are taxable for income tax purposes by the Federal Government.

A Federal employee must work about thirty years to earn minimum Federal retirement. It seems unjust that after a faithful worker has devoted thirty years of service to the Government, he must start all over again to earn Social Security.

We again express our gratitude for this opportunity to present our views on behalf of the largest group of employees still denied Social Security coverage. We urge the Committee to favorably consider our request for legislation to confer equal and comparable treatment to the Federal worker who has given many years of dedicated service to his employer, the United States Government. He has earned the right to an adequate pension which will enable him to retire with dignity and he has earned the right to adequate protection for his survivors.

The CHAIRMAN. If there is no other witness who feels he can summarize his statement briefly then——

Mr. BRICKFIELD. Sir, I am Cyril F. Brickfield, legislative counsel for the National Retired Teachers Association and the American Association of Retired Persons and, with your permission, we would like our statement to be printed as though it was read in the record and I will just summarize it.

The CHAIRMAN. Yes.

STATEMENT OF CYRIL F. BRICKFIELD, LEGISLATIVE COUNSEL FOR THE NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. BRICKFIELD. We represent 2,300,000 retired people in the United States. When the Bureau of Labor Statistics said in 1970 that the average skilled worker 35 years of age is making $11,000 a year, they also said that the average elderly couple needs $4,500 a year to live, yet maximum social security only pays $3,500 per year.

We think the social security law needs to be updated, and one of the big things is that it has to keep pace with the times.

We support the automatic cost-of-living adjustment as provided in the House-passed bill. However, with this automatic adjustment there should be a sufficient base to begin with, and we think raising the minimum from $64 to $67.20 per month is really doing very little. We think the minimum benefits should be $120 per month. This is what Senator Harrison Williams of New Jersey has put in his bill, S. 3100.

Another item is that we would like to see the earning limitation raised, Senator. It is now $1,680. We would like to see it go to $3,000.

We think the philosophy behind earnings limitations today have changed.

We are pleased with the 100-percent benefits for widows. We hope that the Congress will include the cost of all prescription medicines under medicare. The Senate passed a bill to accomplish this 3 years ago, but it did not get past the House.

We hope, too, that the minimum payment to those over 72 who are not covered by social security will be raised from the present $46 to a more realistic level than provided for it the House bill.

Mr. Chairman, I have prepared a brief written summary of my full statement which I had planned to read this morning. However, because of time limitations I have not read the summary. I request that it appear in the hearing record along with my complete prepared statement.

Thank you very much, Senator Long, and members of the committee.

(Mr. Brickfield's statement follows. Hearing continues on page 1062.)

TESTIMONY OF CYRIL F. BRICKFIELD, LEGISLATIVE COUNSEL, NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS

SUMMARY

Mr. Chairman, with your permission and in accordance with your direction and request of a few minutes ago, I would like to submit my prepared statement for the record and have it printed as though it were read. Further, I would like to summarize that statement in the next few minutes.

My name is Cyril F. Brickfield, Legislative Counsel for the National Retired Teachers Association and the American Association for Retired Persons. These two organizations combined have a membership of 2,300,000 persons, all dues paying members. We are interested in the problems of the elderly, their needs, and securing for them a better and more pleasant way of life for their later years.

I am accompanied this morning by Mr. Peter Hughes, my associate and our legislative representative.

We note that the Special Senate Committee on Aging, headed by Senator Harrison Williams of New Jersey, has been carrying on a series of studies this past year concerned with the economics of aging, in order that all the people may have a full share of abundance in this great land of ours. This is an admirable undertaking. We congratulate the Senator and the Senate and wholeheartedly support this undertaking.

In the year 1970, according to the Bureau of Labor Statisites, the income of the average 35-year old skilled worker was about $11,000 a year. According to the same Bureau, the income needs of an elderly couple, to live comfortably, was $4,500 per year. Yet, the maximum Social Security benefits for a man and his wife is $3,500 a year—an amount, I am sure you will agree, which falls far short of what the Bureau says is needed to live in a decent way. We feel that the elderly American is entitled to a decent way of life for he has earned it in his working years in supporting this great country of ours through income taxes, through service to the country, through raising a family which in turn serves the country. But the cold hard truth is that over one-third of our Nation's elderly—about six million—are living on incomes below the poverty level. Most of these oldsters, when they were active workers, had incomes above the poverty line. Unfortunately, upon the day of retirement or shortly thereafter, they had reduced retirement income which put them below the poverty line. To put it another way, they became poor on retirement as far as income was concerned. They did not become poor while working but they became poor when they became old and retired.

One way of meeting this problem of income is to update the Social Security laws. The difficulty with Social Security is that it does not adjust quickly to keep abreast of rising prices and increases in the cost of living. Rising prices as a matter of experience have outdistanced Social Security increases from year to year and over the years.

There is a criticism that Congress only votes Social Security increases in election years; that there is a political motivation underlying the action of Con-

gress. Whatever the truth is and whatever the facts are, can be of no moment now because the House passed bill (H.R. 17550) has an automatic increase provision tied into the cost of living. The House bill fails, however, to start out with a realistic floor. It proposes a five percent rise in the minimum benefits—from $64 to $67.20 per month. I am sure you will agree that this is a smaller rise than needed. Our Associations favor $120 per month minimum floor. We note that Senator Williams' bill (S. 3100) would bring about this $120 minimum monthly floor by the year 1972, and we support it.

We also note that the earnings limitation of $1,680 per year is not sufficient. It should be, in our opinion, $3,000 per year at least. Times have changed since the earnings limitation was first adopted many years ago. In those days the philosophy was that older people should retire from the labor market in order to give younger people a chance. Whatever the merit of such a philosophy, the fact is today older people are needed in the labor market and should be encouraged to work in order to help this Nation perform its function and in order to permit older persons to work to supplement their fixed retirement incomes.

We are pleased with the 100 percent benefits widows will receive under the bill and also for the uniform method for computing men's and women's benefits. We hope the Congress will include in the bill full cost of all prescription drugs. The Senate passed such a bill in 1966 but it was not acted upon by the House. In addition, a task force created in 1967 in HEW during the Johnson administration and supported by Secretary Finch in the Nixon administration recommends that such prescription costs be included in Medicare. And finally, Mr. Chairman, because I do not wish to take up the Committee's limited time, we favor increasing the minimum payment to those over 72 years of age not under social security, not from $46 to $48.30 which is a mere pittance, but rather to $150 a month.

I thank the Commitee for its allowing our two Associations the opportunity to appear here this morning in support of H.R. 17550 and to recommend the modifications which are set out in specific detail in my formal statement.

STATEMENT

Mr. Chairman, my name is Cyril F. Brickfield. I am Legislative Counsel of the National Retired Teachers Association and the American Association of Retired Persons. Accompanying me today is Mr. Peter Hughes, Legislative Representative for our two Associations.

Our Associations have a combined national membership of more than 2,250,000 older Americans. We are nonprofit, nonpartisan organizations of persons age 55 and over, dedicated to the belief that dignity, independence, and purpose enable the older person to continue a life of meaningful activity, usefulness, and service to others.

We appreciate this opportunity to appear before the Committee in continuation of our Associations' support for the fine work of the Committee on legislation designed to provide economic security for all older and retired Americans.

Mr. Chairman, during the past year the Senate Special Committee on Aging, under the leadership of Senators Williams and Prouty, conducted a study entitled: The Economics of Aging: Toward a Full Share in Abundance. Before this series of hearings began our Associations were well aware of the economic plight of large numbers of elderly persons in this country. The Task Force Report, the Background Papers, and the testimony of dozens of witnesses before this Committee offered additional documentation and forceful dramatization of the harsh realities faced by so many older people. But, the work of the Senate Special Committee on Aging accomplished much more. It has given us an assessment of the great strides we have made in the past and of the tremendous tasks still facing our Nation in dealing with the economic problems confronting all Americans facing retirement years.

Fundamental to creating a meaningful life in old age is insuring sufficient economic resources to support it. While possession of monetary resources does not necessarily guarantee happiness, the absence of such resources can keep people of any age level from dignity, happiness and usefulness.

In 1970 the income in the United States for a 35 year old skilled worker will average $11,000 per year. In the same year the income need of an elderly couple with a moderate living standard is about $4,500. In contrast, one finds that the maximum Social Security retirement benefit which a worker and spouse can receive under the current Social Security law is a little over $3,500. The truth

is that nearly one-third of the more than 20 million Americans 65 years of age and older are living below the poverty level. An even more shocking fact is that many of these people were not poor until they became old.

One of the ways in which we may meet the economic problems of older Americans is by liberalizing and updating the existing Social Security laws. Our Associations are happy to note the passage of the Social Security Amendments of 1970 by the House of Representatives in May of this year. These Amendments are most welcome and our Associations support them. However, we feel that there are major reforms still urgently needed to improve this vital but still imperfect program.

In assessing the current Social Security system in light of immediate and future needs, one characteristic stands out: it does not adjust quickly enough to the fast moving economy of today. The record is clear. First, rising prices have usually outdistanced Social Security benefit increases making older persons more acutely aware of the increased costs experienced during inflationary periods. Secondly, despite the fact that average living standards of those still in the work force have risen year after year, Social Security benefits in real terms have improved very little.

The need to develop a dynamic Social Security system which keeps pace with the changes in the economy is apparent. Of course Congress in the past has periodically adjusted Social Security benefits but the increases have not even kept pace with increases in the general price level.

COST-OF-LIVING ADJUSTMENT

The history of Social Security adjustments is that benefits are voted in election years. What is the overriding motive? Is it to provide justice and equality in keeping with our spiraling economy or is it used as a vote-getting device? If Social Security increases for older Americans are to any degree a political football in election years, the House passed bill has a remedy to offer. The automatic cost-of-living adjustment mechanism which will take effect in 1972 as provided in the House passed bill is urgently needed and most welcome. This provision indicates the willingness of Congress to take Social Security adjustments out of politics and gear such adjustments to our ever increasing national productivity. However, we believe that benefits must be raised to a more realistic level than provided in the House bill before this automatic escalator is employed.

BENEFIT INCREASE

The House bill fails to deal with the problem of minimum benefits. Because of the present inadequate base, a 5% raise will only increase the minimum monthly benefit for a single person from $64 to $67.20. For this reason our Associations urge a minimum monthly benefit of $120. Only through such an increase can we begin to move millions of older Americans out of poverty and ensure that millions more who are on the poverty border are not pushed below it. Such an increase would permit our older citizens to live their remaining years in dignity and free of severe economic hardship. In addition, we believe that the Congress, by adopting our suggestion for a minimum payment of $1,440 a year for the single person age 65 an older, could take the greatest step toward the elimination of poverty among our elderly that has ever been taken in our Nation's history.

Our Associations urge the Senate to adopt the provisions of S. 3100 with regard to benefit increases. This bill, sponsored by Senator Williams of New Jersey, would provide for a 20 percent across-the-board increase in benefits, effective January 1970; and a second 20 percent raise, effective January 1972. Minimum benefits for a single person would be raised to $90 this year and $120 by 1972.

LIBERALIZATION OF EARNINGS TEST

We are very disappointed with the provision contained in the House bill concerning the earnings limitation. Under the present law, an individual who is eligible for Social Security benefits loses $1 for every $2 he earns in excess of $1,680 a year, up to $2,880. He loses dollar for dollar on earned income above $2,880. H.R. 17550 would amend this provision to permit earnings up to $2,000. The eligibile recipient would then forfeit $1 in benefits for every $2 of earned income above that amount up to $3,200.

Such a severe limitation imposed on the earnings of an individual eligible for Social Security benefits acts as a penalty clause and is, in fact a partial

denial of the very basis upon which the Social Security program has been constructed—that basis being one of insurance of retirement income. The proposal contained in H.R. 17550 is little more than a token gesture.

Because Social Security originated at a time when this Nation was trapped in the depths of a great economic depression, it was understandable policy in those years to discourage the continued employment of older Americans in order to open up the ranks of the working force to the thousands of middle-aged Americans looking for jobs.

Today, however, we are facing an entirely different situation. Not only do we have a different labor climate, but many businesses and industries have a vital need for the skills and labor which can be provided only by the older, more experienced worker.

And yet thousands of older Americans who possess these needed skills, who are willing and able to work, will not work because of the penalty which will be imposed upon them by the earnings limitation contained in the present law. Nor will this penalty be meaningfully reduced by the proposed change.

Results of the latest medical research in the aging processes seem to indicate that one of the major problems crucial to the well-being of older people—perhaps almost as important as the slowing down of the physical mechanism—is the inability to contribute. A job, even on a part-time basis, may enhance not only the financial health of an older person, but may be therapeutically and psychologically invigorating as well.

Older Americans simply do not understand why this Country, which is now reaping the fruits of their hard labor, is at the same time denying them the opportunity, indeed the right, to both add to their own financial security and contribute their talents to an environment in which they are needed. Should the right to a job, and with it dignity, a feeling of independence and sense of accomplishment, be legislatively denied to millions of older Americans?

It is our recommendation that the older person be permitted to earn at least $3,000 in the year before he suffers any loss of his Social Security benefits.

100-PERCENT BENEFITS FOR WIDOWS

We were pleased to learn that the House Bill would increase widows' benefits from 82½% to 100% of the deceased husbands' primary benefit. This improvement in the Social Security program is long overdue. This provision alone if enacted by the Congress this year will correct a long-standing inequity for almost three million widows and at a relatively minor cost.

Providing the widow with the same benefit for which the husband was qualified, in addition to the monetary benefit, will provide the widow with an additional measure of self-respect and independence.

UNIFORM METHOD OF COMPUTING BENEFITS FOR MEN AND WOMEN

We are pleased to note that H.R. 17550 provides that Social Security benefits for men and women be computed on the same, identical basis. The increased benefit which would result from such a change is notable; the resulting principle of uniformity may be even more important. We urge your Committee to accept this important suggestion for uniform treatment between the sexes.

OUT-OF-HOSPITAL PRESCRIPTION MEDICINES

We believe that the time has arrived when the Congress must take action to include the costs of prescription drugs for hospital out-patients within the coverage afforded in-patients by the Medicare program.

Under the present program, patients in hospitals and extended care facilities are provided with these drugs. However, out-patients who must have the very same drugs in order to keep themselves healthy and *out* of the hospital are denied reimbursement for their costs.

Although older Americans represent only 10 percent of the population, they use nearly 25 percent of all prescription drugs, and their per capita expenditures for drugs are more than 3 times that of younger Americans.

These proportions take on increased meaning when we note that the Nation's total expenditures for health and medical care, which includes drugs, increased by 11.0 percent during fiscal 1969. This one year rate of increase was more than one-third faster than the growth rate of the gross national product.

The unconscionable burden which this situation has placed upon the millions of older Americans living on fixed retirement incomes is obvious.

The Senate recognized the importance of enacting legislation to remedy this situation in 1966, when it passed a Prescription Drug Program. Unfortunately, the House did not agree. But in 1967, the Congress directed the Secretary of Health, Education and Welfare to study the feasibility of such a program. A Task Force appointed by the Secretary recommended that prescription drugs be covered by Medicare. Soon after assuming office, Secretary Finch appointed a Committee to study the recommendation of the former Secretary's Task Force. Not only did Secretary Finch's Committee agree that Medicare should cover out of hospital prescription drugs, but it urged an even more extensive coverage than had been recommended by the Task Force.

Thus, Mr. Chairman, we urge that the Congress act now to make these changes recommended by the Senate in 1966 and the Special Study Groups of two Secretaries of Health, Education and Welfare.

SPECIAL AGE 72 PAYMENTS

Four years ago, in 1965, Congress established a "Transitional Insured Status" for persons age 72 or over, who were excluded from Social Security benefits because their working lives were completed or substantially completed before coverage was extended to their former occupations.

We are pleased that the House members recognize the need to increase the present meager $46 a month benefit now permitted these older people. However, we feel that the increase of $2.30 to $48.30 is in itself meager.

We do deplore the fact that the blanketing-in amendment added by Congress in 1966 denied the special benefit (now $46 a month) to the 72-year old teacher or other retiree who was drawing as much as $46 a month in any form of public pension. Such a restriction is contrary to the original intent of the Prouty Amendment and should be corrected by the Congress.

We recommend that the Congress eliminate that restrictive earnings limitation and replace it, if necessary, with a more realistic one. Perhaps following the principles embodied in S. 3554, the Older Americans Income Assurance Act of 1970, sponsored by Senator Prouty. If a limitation must be applied to the special benefit for these older persons, we would suggest that they be allowed to receive at least $150 per month in public pension before being denied the meager special Social Security benefit.

Such a restriction would prevent a member of Congress from drawing the benefit, but it would not deny it to the 80-year old teacher, for example, who has qualified for a small pension but has never worked in employment covered by Social Security.

ALL PERSONS WILL BE ELIGIBLE FOR MEDICARE UPON ATTAINING AGE 65

Our Associations traditionally took the position that health insurance benefits did not need to be tied to the Social Security program. However, when the Medicare bill was passed in 1965, eligibility for part A of the Medicare program was made dependent upon eligibility for Social Security, and a cut-off date was set at January 1, 1968, which provided that the person who had not qualified for Social Security benefits by that date, was not eligible for the benefits of Part A of the Medicare program. This provision has worked a genuine hardship and injustice on many thousands of retired teachers and some other persons retired from public retirement systems. Many of these were people who were participants in a retirement system in which the teachers or other members had been permitted by legislation passed by the Congress to exclude themselves from the Social Security program. When Medicare and Social Security were joined in 1965, many of these people had therefore, excluded themselves from the benefits of Medicare.

In each of our Association Conferences, held in nine areas of the Country in 1969, I requested an indication by our retired people of the number ineligible for Part A of the Medicare program. In most areas, at least ¼ of these older retirees are excluded from the benefits of that part of the Medicare program.

It is our position that no person should be excluded from any part of the Medicare program because he made the choice of remaining outside the coverage of Social Security. We are therefore pleased that the House Bill includes a provision which would allow people reaching age 65 who are ineligible for hospital

insurance benefits under Medicare to enroll on a voluntary basis for hospital insurance coverage. While the cost to the individual is high we feel this provision is a step in the right direction.

A BIPARTISAN STUDY OF THE WHOLE SOCIAL SECURITY SYSTEM IN RELATION TO TODAY'S ECONOMY

In addition to supporting the improvements to the Social Security System discussed this morning, the Legislative Council of NRTA–AARP firmly urges that a long range bipartisan study be undertaken to evaluate the development of the total Social Security program to date, to make objective comparisons with the programs of other Nations, with private programs both here and abroad, and to agree upon, if possible, the appropriate philosophy, as well as specific purposes and techniques.

Such a study would encompass many questions. The following are only a few of the most obvious ones:

1. Should our Social Security system constitute a system of complete income maintenance for all older persons?
2. If the target is income maintenance, should it be at the presently recognized poverty level?
3. Should the system, therefore, be a combination of social insurance and welfare?
4. Should the total system cover the existing gaps in Medicare, including prescription drugs, the present deductible items and the co-insurance features in the present law?
5. Should we turn to a greater dependence upon general revenues to supplement the historic payroll deduction to provide a more adequate and, possibly, more justifiable source of the Social Security trust funds?
6. How can we, in the future, relate the level of benefits to changing needs of older people occasioned by rapidly increasing local and state property taxes, hospital costs, drug costs, housing costs, and costs of other inflated necessities of life?

Our Associations, along with many members of Congress, should be and are equally concerned with the retirement future of today's worker as we are with the retired American of today. The retirement security of those presently in the work force will be more directly affected by Social Security reforms than those now retired. These reforms must update and strengthen a system which in its early years served us well but has recently fallen behind the needs of today's fast changing economy.

The CHAIRMAN. Thank you very much.

Mr. BRICKFIELD. May I correct my remarks in the record when they are printed, Senator?

The CHAIRMAN. Yes, you may. We will certainly be glad to do that.

Thank you very much and your entire testimony will be printed in the record.

I believe also—who else wants to summarize his statement briefly? Mr. Rademacher, I believe.

STATEMENT OF JAMES H. RADEMACHER, PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS

Mr. RADEMACHER. Mr. Chairman, my name is James H. Rademacher. I am president of the National Association of Letter Carriers, and I will summarize in 3 minutes. The only purpose for taking this extra time is to point out the problem that we see.

At the outset, Mr. Chairman, I would like you to know that I am accompanied by the director of our health insurance program and our very top staff. We are in complete support of the legislation before this committee, with one exception, and that is section 201, because we are unable to determine who, if anyone, will benefit from enactment of section 201. We do not see how the Government will benefit, since

we will be obligated to a huge expenditure required to implement section 201.

We do not see who the FEHB plan will benefit because they will be liable for millions of benefit payments which rightfully should be medicare's responsibility. We do not see how Federal employee annuitants will benefit because they will be required to assume personal responsibility for unpaid medical expenses, plus higher premiums under the FEHB plan for subsidized medicare. Our exhibits are shown in our testimony. Section 201 discriminates against the FEHB plan because they are the only underwriters required to pay first benefits. In all other cases medicare continues to pay first benefits with the other insurers assuming secondary liability.

The National Association of Letter Carriers urges this committee to do two things: One, delete section 201 from the bill, and (2), to take the lead in bringing together the Congress, the Civil Service Commission, Social Security Administration and the FEHB plan, the purpose to be a change in existing medicare and FEHB acts to enable all Federal employees annuitants and spouses, to be insured by medicare at age 65, with supplemental coverage by FEHB plans at the option of the employee anuitants.

Thank you for allowing us this time this morning.

(Mr. Rademacher's prepared statement follows. Hearing continues on page 1067.)

PREPARED STATEMENT OF JAMES H. RADEMACHER, PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS

Mr. Chairman and Members of the Committee, my name is James H. Rademacher. I am President of the National Association of Letter Carriers (NALC) with headquarters at 100 Indiana Avenue, Northwest, Washington, D.C., 20001. Our organization represents 215,000 letter carriers and other Federal employees.

Since 1891 we have underwritten and operated our own insurance department, offering our members life insurance, loss of pay protection and, more recently, health benefits insurance.

In 1960 we became a charter underwriter under Public Law 86-382, the Federal Employees Health Benefits Act of 1959 (FEHB). Our Plan operates under Contract C.S. 1067 with the United States Civil Service Commission. Our total enrollment is approximately 140,000 employees and annuitants. Including the dependents of these enrollees, our total insured population is about 600,000.

We appreciate the opportunity to record the views of the NALC with respect to one particular section of H.R. 17550, the bill before this Committee.

Specifically, we oppose Section 201 (b) of the bill. The language with which we are concerned begins on Line 8 of Page 74 of the printed bill and concludes on Line 17 on Page 75.

Frankly, Mr. Chairman, we are not at all certain who is expected to benefit from the enactment of Section 201. We do not see how plans operating under P.L. 86-382 will benefit. They are going to be obligated to millions of dollars annually in benefit payments that rightfully are the liability of the Medicare Law.

We admit to a lack of expertise with respect to the Medicare Act. Therefore, we are unable to say with certainty whether Section 201 will or will not benefit that program. Nevertheless, it would appear from a reading of the proposal, beginning on Line 12 of Page 55 of the printed bill, that the Federal Government will obligate itself to the payment of tremendous amounts of funds in order to implement Section 201.

If the proposal is intended to assist Federal employees and annuitants insured under both Medicare and a FEHB plan, we respectfully suggest that a diametrically opposite result is more likely to develop. Later in our testimony we will offer two exhibits in support of this view.

At this point, I should like to refer to House Report No. 91-1096, which accompanied the Report of the House Ways and Means Committee on H.R. 17550.

On page 24 of the report is found the following comment:

"Unlike most employers, the Federal Government has not arranged the health insurance protection it makes available to its employees age 65 and over (active

or retired) so that such protection would be supplemental to Medicare benefits."

It seems to me that it was largely on the basis of the above comment that the House approved Section 201. Our organization respectfully submits that the premise contained in the cited language is not precisely correct.

Shortly after Medicare became operative on July 1, 1966 the Civil Service Commission issued regulations that, for all practical purposes, established a supplemental type of insurance for Medicare enrollees. This was done by permitting an employee or annuitant to change his FEHB enrollment to low option at any time after he became eligible for Medicare.

The purpose and, indeed, the effect of this regulation was to offer eligible employees and annuitants an opportunity to do two things:

1. Reduce their premium cost for the FEHB plan.
2. Maintain adequate supplemental protection.

In our opinion, our low option plan offered very good supplemental protection to Medicare. Accordingly, we actively urged our members to consider changing to low option once they became eligible for full Medicare protection. We have no ready statistics at hand, but we feel certain that many members took our advice. Those who did found that they were adequately insured between Medicare and our low option, at a greatly reduced monthly premium.

For example, the monthly cost of our family, high option plan is $31.70. To that total the Government contributes $8.88 monthly. The Government contributes exactly the same amount to our low option plan, the monthly premium of which is $20.39, or $11.40 less than high option. With a savings of $11.40 monthly, the annuitant could pay his Part B Medicare premium and still have money left over.

In our opinion, the enactment of Section 201 will preclude the continuation of the above example.

As we understand Section 201, it proposes to make all FEHB plans the primary carrier for benefits, with Medicare not duplicating benefits. We further understand from our reading of the bill that Medicare will not follow the so-called "Coordination of Benefits" theory (COB), but rather will simply not duplicate benefits already paid by the FEHB carrier.

As you are aware, Mr. Chairman, there is quite a difference between coordinating benefits and simply not duplicating benefits. When the insurance carriers involved coordinate benefits, the end result is usually payment at 100 percent of the covered expenses between the two insurers. Thus, the patient ends up with a zero balance due, except for such items as are excluded by both carriers. Eye glasses would be an example in this last category.

There is a zero balance, generally, for the patient because it is an industry-wide practice among carriers for the secondary insurer, in effect, to waive his deductibles and co-insure provisions, to consider expenses covered under his contract even though the prime carried excluded the same charges under his policy, and to pay the difference between total covered expenses and the amount allowed by the prime insurer, which would be Medicare in our case. In no circumstances would the combined payments exceed 100 percent of the total covered charges.

When the COB practice is not followed, which is to say the second carrier simply does not duplicate the allowances of the first insurer, what happens? The "primary carrier" follows the terms of his own contract to the letter. The "secondary carrier" will pay benefits for (1) the balance of charges for expenses it also covers and (2) its contract allowance for expenses not covered by the "primary carrier" but covered under its contract. Further, the "secondary carrier" will not pay any benefits toward charges covered by the "primary carrier" but not covered by its contract as is the case with COB. In practically every instance, the patient will end up with a sizable personal obligation.

To demonstrate this point, we attach two exhibits—A & B—to our statement.

Exhibit A reflects the claims history of a patient insured by Parts A & B of Medicare, plus our Low Option Plan. Amounts as charged are shown. Next is shown the method of processing currently in effect between Medicare and our Plan, whereby Medicare pays first and we coordinate our benefits. It will be noted under Column 4 that under the COB method the patient pays nothing; between the two carriers the covered expenses are paid at 100 percent of the incurred cost. This despite the fact that certain expenses normally would have been excluded and not considered by each insurer.

In the last three columns are shown the figures that would be developed from the very same claim were Section 201 to be enacted. If Medicare simply does not

duplicate our benefits, which is to say Medicare does not follow the COB method, the patient is going to end up with a personal responsibility of $718.37.

Exhibit B presents the same example, except that the patient would be covered only by Part A of Medicare; he is still under our low option plan. Here again the patient will owe nothing at the end of his illness; providing, the present arrangement continues between Medicare and our Plan—and all other FEHB plans. Under the change proposed by Section 201, the same patient will end up with a $1,207.12 personal obligation.

It demands powers of persuasion far beyond the ability of the present witness to convince our members and their families that a proposed change in the Medicare Act will be to their advantage, if I must tell them that personal payment of $718.37 or even $1,207.12 is the price they must pay to effect the change.

One thing puzzles me. I cannot understand why the proposed change is directed only at FEHB plans. Why is the health insurance program of the Federal employee singled out? As I understand the bill, Medicare will continue to pay first benefits without respect to any other insurance the claimant may have, unless he is a Federal employee or annuitant. That is the thing I cannot puzzle out. Why is it proposed that Medicare treat Federal personnel differently than all other citizens.

The approval of Section 201 will not only cost the person insured under both Medicare and a FEHB plan. It will also cost each and every Federal employee and annuitant, regardless of his Medicare status. This cost will take the form of additional premium to support the increased benefit payments of FEHB plans.

Take our own experience, for example. In 1969, we processed by actual count claims from 3,108 different members who also certified to Medicare insurance. Had we been obliged to assume prime carrier liability on those 3,108 claims—as Section 201 stipulates—we would have reduced the solvency of our Plan by $862,828.45. To offset that amount we would have been required to increase our biweekly premium by 48 cents for a family man with high option. The family man with low option would have had to pay an additional 31 cents each biweekly payday. (Over 95% of our total enrollment is family plan, the majority of which is under high option.)

Based on estimates furnished by the Plan's consulting actuary, it can be expected that in 1970 the benefit figure referred to will go up to about $1.5 million. The 48-cent premium hike would be increased proportionately.

Perhaps it will be more meaningful if these figures are considered from another angle. What we have said is simply that less than 3% of our total enrollment filed Medicare claims with us in calendar year 1969. We readily concede that each of the claimants involved received some benefit from his dual coverage. It is also true that whatever benefits were realized by reason of two policies, it cost the claimant only the monthly premium charge for Part B of Medicare.

In the process, our Plan was relieved of benefit payments in the amount of $862,828.45.

Equally important, the remaining 97% of our subscribers were not taxed a red cent by way of increased premium to pay for the benefits paid to Medicare-FEHB enrollees.

On the other hand, if Section 201 is enacted, with our Plan the prime carrier and Medicare simply does not duplicate our benefits, what can be expected?

First, the Medicare claimant is going to be hit twice—once in the form of a personal responsibility to a balance due on his medical bills.

Secondly, he is going to be obligated to additional premium on his coverage with us, because we will be, in effect, subsidizing, in part, the Medicare program.

The 97% not covered by Medicare will fare a little better, but they will be obligated to pay us more premium. They will do so without realizing one single, solitary benefit from their additional premium payment.

I think it is important at this point, Mr. Chairman, to note one thing with respect to premium structure of our Plan under P. L. 86-382. I am inclined to suggest that the same thing holds true for most, if not all other FEHB plans.

In establishing our premium rate, we give cognizance to the fact that Medicare will be prime carrier on Medicare claims, and our Plan will be secondary carrier. As previously indicated, this arrangement added in excess of $800,000 to our solvency in 1969. Had we paid that additional amount, we would have been required to add 48 cents per enrollee, per biweekly payday to our premium rates. We estimate that the benefit figure will reach approximately $1.5 million in 1970.

I have no idea what the cumulative figure would be for the 36 plans under P.L. 86-382, if Section 201 is enacted. If our figure turns out to be $1.5 million in 1970 an educated guess would put the cumulative annual figure between $30 and $40 million for all plans by 1972.

What it will cost the individual employee-annuitant in balance due medical bills, plus additional premium is anyone's guess.

We respectfully suggest another deficiency in Section 201, in our opinion.

Not only will it fail to help the fellow who does not have Social Security credits (or the fellow who is not yet age 65, regardless of his ultimate social security status) it makes no provision for the spouse or the family of the employee or annuitant. It is not at all uncommon for a spouse to be under age 65 by several years, even when the enrollee is well past age 65 by several years, even when the enrollee is well past age 65 and perhaps eligible for full Medicare coverage. What happens to the spouse? The supplemental coverage envisioned by Section 201 may or may not take care of the annuitant. But surely it will be totally inadequate for the spouse who is not eligible for any part of Medicare. Is the Government going to pay the employee or annuitant—

> ". . . a contribution in an amount at least equal to the contribution which the Government makes toward the health insurance of any employee or annuitant enrolled for high option coverage under the Government-wide plans . . ."

and also contribute toward the premium cost of a separate plan for the spouse who has not yet attained age 65.

Suppose for the sake of discussion, the Secretary of Health, Education and Welfare finds on January 1, 1972 that all FEHB plans—

> ". . . offer protection supplementing the combined protection under Parts A and B . . ."

What or where in the Section will prevent an employee or annuitant from declining to switch over to the supplemental plan. Suppose he opts to continue with continue with his regular high option coverage? He has, or presume, freedom of choice to spend his own money as he sees fit.

We agree that a problem exists in the area of adequate and reasonable coverage for Federal employees and annuitants at age 65 and over. As we have tried to indicate in this testimony, we do not agree that enactment of Section 201 is the solution to the problem.

Over the past couple of years, our organization has spoken in favor of a proposal that would transfer Federal employees and annuitants at age 65, and their spouses, to Medicare. Frankly, we have never gotten beyond the talking stage with the general idea. Nevertheless, the Social Security Administration has gone into the matter. If my memory serves me correctly, an official report was made by that agency to the Chairman of the House Ways and Means Committee early in 1969. It may be that this Committee also received a copy of that report; I do not know.

The problem for the employee-annuitant is that he works all his life, contributes to a retirement fund and at age 65—when he probably needs medical attention most—he finds himself paying $22.00 to $35.00 a month for health insurance that his neighbor pays $5.30—the current cost of Medicare, Part B.

From the point of view of the FEHB program itself, including the individual participating plans, it does not make insurance sense to have the same benefit and premium structures for all subscribers, regardless of age and other factors. That is simply an actuarial fact of life, one which, I understand, an independent actuarial firm engaged by the Civil Service Commission a few years ago agreed with.

It is our hope that some means will be found to bring together all parties interested in a long range solution to this problem. We would include in the term "interested parties" the Congres, Civil Service Commission, Social Security Administration and the insurance carriers under the FEHB program.

No doubt exists in my mind that a workable plan can be devised if all those concerned will just get together. The first step is agreement that it can be done; the next logical step is see to it that it is done and done as soon as humanly possible.

This witness does not wish to place himself in the middle of an intramural fight. Nevertheless, it does seem to me that Section 201 has Social Security saying, in effect, to Civil Service:

"Shape up our way, by January 1, 1972, or else!" There must be a better way!

CONCLUSION

In conclusion, Mr. Chairman, permit me to sum up the position of the National Association of Letters Carriers as follows:

1. We submit that enactment of Section 201 is not the best avenue of approach to the problem in attempts to reach.

2. We urge your distinguished Committee to delete the Section from H.R. 17550, and urge the House of Representatives to go along with the Senate version of the bill in this specific area.

3. We ask your Committee to take the lead in bringing together all interested parties in a program that will make Medicare available at age 65 to all present and future Federal annuitants.

4. We submit the suggestion next above should be done separate and apart from the bill under consideration. To attempt to incorporate it in H.R. 17550 would surely delay it. That we certainly do not have in mind.

Thank you.

EXHIBIT A.—INSURED COVERED BY PTS. A AND B OF MEDICARE AND LOW OPTION OF NALC HEALTH BENEFITS PLAN

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
		As charges are now paid			As charges would be paid		
	Amount charged	Medicare allowance	NALC allowance	Paid by patient	NALC pays	Medicare pays	Patient pays
Hospital charges:							
(a) Room and board, 84 days.	$4,875.10	$4,511.10	$364.00	0	$3,856.32	$1,018.78	0
(b) Pathology	75.00	75.00	0	0	56.25	18.75	0
(c) Radiology	50.00	50.00	0	0	37.50	12.50	0
(d) Laboratory and EKG	150.00	120.00	30.00	0	112.50	37.50	0
Surgery: Our code 3181	950.00	720.00	230.00	0	600.00	350.00	0
Physician charges	255.00	204.00	51.00	0	153.75	101.25	0
Special nursing	1,125.00	0	1,125.00	0	843.75	0	$281.25
Out-of-hospital drugs	578.50	0	578.50	0	433.88	0	144.62
Extended care facility, 65 days at $35 daily	2,275.00	1,982.50	292.50	0	0	1,982.50	292.50
Total	10,333.60	7,662.60	2,671.00	0	6,093.95	3,521.28	718.37

EXHIBIT B.—INSURED COVERED BY PT. A OF MEDICARE AND LOW OPTION OF NALC HEALTH BENEFITS PLAN

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
		As charges are now paid			As charges would be paid		
	Amount charged	Medicare allowance	NALC allowance	Paid by patient	NALC pays	Medicare pays	Patient pays
Hospital charges:							
(a) Room and board, 84 days.	$4,875.10	$4,511.10	$364.00	0	$3,856.32	$1,018.78	0
(b) Pathology	75.00	75.00	0	0	56.25	18.75	0
(c) Radiology	50.00	50.00	0	0	37.50	12.50	0
(d) Laboratory and EKG	150.00	0	150.00	0	112.50	0	$37.50
Surgery: Our code 3181	950.00	0	950.00	0	600.00	0	350.00
Physician charges	255.00	0	255.00	0	153.75	0	101.25
Special nursing	1,125.00	0	1,125.00	0	843.75	0	281.25
Out-of-hospital drugs	578.50	0	578.50	0	433.88	0	144.62
Extended care facility, 65 days at $35 daily	2,275.00	1,982.50	292.50	0	0	1,982.50	292.50
Total	10,333.60	6,618.60	3,715.00	0	6,093.95	3,032.53	1,207.12

The CHAIRMAN. Thank you very much, sir. Of course, your entire statement appears in the record in addition to your summary.

Is there anyone else who feels he can summarize in that brief a period?

STATEMENT OF JOHN D. STRINGER, WASHINGTON COUNSEL, AMERICAN MUTUAL INSURANCE ALLIANCE; ACCOMPANIED BY JAMES S. STICKLES

Mr. STRINGER. Mr. Chairman, and members of the committee, my name is John Stringer. I am the Washington counsel for the American Mutual Insurance Alliance, a voluntary association of over a hundred mutual property and casualty insurance companies.

I am accompanied by Mr. James Stickles, specialist in workmen's compensation and secretary of the alliance's workmen's compensation and social insurance committee.

I want to thank you for the privilege of appearing before you. I would like to confine my testimony to just one aspect of H.R. 17550, the workmen's compensation social security offset.

In the interest of saving time, I will present just the summary of the statement.

Mr. Chairman, section 224(a)(5) of the Social Security Act provides that socal security disability benefits must be reduced when workmens' compensation is also payable and the combined payments exceed 80 percent of average current earnings before disablement. Section 114(a) of H.R. 17550 strikes out "80 percent" and thus would raise the combined benefits which could be paid to such beneficiary to 100 percent of average earnings preceding disability. The alliance opposes this amendment because it, (1) will destroy incentive for rehabilitation, (2) will hamper the upgrading of State workmen's compensation laws, and (3) is not necessary.

The arguments advanced for changing the combined benefits limitation are unsound:

It is argued that this change is necessary to keep the benefits in line with the increase in the cost of living.

This argument ignores the fact that beneficiaries are assured of automatic benefit increases. This is accomplished in two ways:

First. Every social security benefit increase enacted by Congress is automatically added in full to the benefits paid by social security regardless of the 80-percent limitation; and

Second. The law requires that the average current earnings be redetermined periodically to insure that the base for the beneficiary's combined benefits is updated to the level of current earnings.

The argument is made that a worker's disability will usually give rise to substantial medical and related expenses.

The fact is, that all but 10 State workmen's compensation laws provide for the payment of unlimited medical benefits. Even those States which have limitations on medical benefits in workmen's compensation cases provide very generous benefits.

Finally, it is claimed that workmen's compensation benefits are paid to compensate for pain and loss of function for which the disabled worker might otherwise secure recompense through legal action against his employer. The answer to this is that State workmen's compensation laws uniformly deny payment of benefits for pain. When payment is made for loss of function, it is made on the basis of expected future wage loss.

Let me cite some reasons for retaining the 80 percent combined limitation of benefits:

Mr. Chairman, section 114(a) reverses an objective sought by the Senate Finance Committee in 1965 when it established a combined benefit limit of 80 percent of wages. At that time, this committee stressed the desirability of avoiding the payment of excessive benefits pointing out that a disabled workman receiving through combined benefits more than preinjury take-home pay had little incentive toward rehabilitation;

Consider also that a major objective of today's workmen's compensation system is the rehabilitation of the seriously injured and their return to gainful employment. The effect of this change would be to seriously impair this goal. Since both social security and workmen's compensation benefits are tax-exempt, the result of the enactment of section 114(a) would be to allow payment benefits in excess of preinjury take-home pay.

Finally, this change would reduce the incentive of State legislative bodies to improve their workmen's compensation laws. This, in time, would bring about a weakening and eventually the destruction of the State systems.

Thank you very much, Mr. Chairman.

(Mr. Stringer's prepared statement follows. Hearing continues on page 1079.)

STATEMENT OF THE AMERICAN MUTUAL INSURANCE ALLIANCE

I am Andre Maisonpierre, Vice President of the American Mutual Insurance Alliance, a voluntary association of over 100 mutual property and casualty insurance companies. Alliance companies write about $1.5-billion annually in protection against income and medical losses. They have constantly helped the American public reduce the affects of disabilities and illnesses through programs of total medical management and rehabilitation.

We are appearing today to urge that extreme care be exercised by Congress in expanding the scope and function of the social security programs. The programs should not inadvertently reduce the effectiveness of efficiency of other systems, also aimed at replacing loss of wages or at providing health care protection, by duplicating the functions already being fulfilled.

FUNCTIONS AND OBJECTIVES OF SOCIAL SECURITY LAW

The Social Security system has been most efficient in providing the American worker severed permanently from the labor market with the certainty of a wage replacement floor. In many instances, it has encouraged individual initiatives to add to this floor through a combination of avenues made available by the private insurance industry.

Thus, we have witnessed over the past thirty years the growing use of life insurance by all classes of our society. Likewise, the phenomenal growth of private pension plans has been made possible by the fact that Congress has very wisely insisted that the social security retirement benefits structure be flexible enough to allow the purchase of additional benefits by individuals.

We do not believe that when Congress broadened the social security law in 1956 to provide for benefit payments to the permanently totally disabled, it did, as some have stated, broaden the basic concept of the use of social security funds. What Congress did was to recognize that a permanent disability is just as much a permanent withdrawal from the labor market as retirement and death. Thus, the expansion of social security benefits to the totally disabled was in line with the philosophy upon which the social security system was established.

Additionally, we believe that Congress has, through its actions, demonstrated its intent that the social security system not be used to duplicate existing private or government programs. It will be recalled that in 1965 specific recognition was given to state workmen's compensation programs by prohibiting the payment of medicare benefits to any persons entitled to similar benefits under state workmen's compensation laws. In this same legislation Congress provided for the coordination of workmen's compensation and social security disability

benefits payable for the same disability. Thus, provision was made for requiring a reduction in social security benefits if the total benefits payment exceeds 80% of the beneficiary's average current earnings.

Unfortunately, this action to coordinate workmen's compensation and social security benefits is now being threatened by a provision of H.R. 17750.

Also, there are indications that pressures are developing to change the basic thrust of the social security system by involving it in benefit programs aimed at replacing wages lost as a result of *temporary disability*. Such a major expansion of the social security philosophy would add substantial costs and would also do irreparable harm to a number of existing programs, both public and private, having similar objectives.

FUNCTIONS AND OBJECTIVES OF STATE WORKMEN'S COMPENSATION LAWS

State workmen's compensation plans are particularly vulnerable to the intrusion of social security. The concern is not what happens to workmen's compensation as a system. It is that the beneficiaries of workmen's compensation are likely to fare much worse if the system upon which they depend is squelched by social security. Let us see how the disregard for workmen's compensation benefits and the expansion of social security coverage to the temporary disabled workers would affect workmen's compensation beneficiaries.

As we have said before this Committee on a number of occasions, today's broad objectives of the state workmen's compensation programs consist of keeping our working population on the job, through well-managed safety programs and intensive medical and vocational rehabilitation of those who have had the unfortunate experience of sustaining occupational injuries or diseases; and to provide continuing medical care and cash income replacement benefits for those who are incapable of being restored to useful functions. Nearly everyone is familiar with the latter traditional objective of workmen's compensation—an objective that is inherent in the name of the system. However, the unique accomplishments of the system toward the preservation of our working population should be considered in greater detail.

The genius of the state workmen's compensation system is that it has attacked the very root of the necessity for its existence—the occurrence of accidents. What other social insurance program can make a similar claim?

The workmen's compensation system has enjoyed great success in accident prevention by making workmen's compensation a part of the competitive private business enterprise system. It has done this by basing rates on the principle that the costs of industrial injuries should be borne by the employer. Employers were quick to recognize that it is better management to spend some time and some money on safety than a great deal more time and money on the results of accidents themselves. The maintaining of safe working conditions is no longer just a humanitarian goal, it is an economic necessity.

This competitive drive to reduce workmen's compensation costs has helped substantially in reducing industrial injuries. Since 1926 the frequency rate has dropped 77%. The severity rate has been reduced by 74%. In terms of human lives saved, based on the growth of our working population and the reduction in the percentage of fatalities, 3,000 workers were not killed last year in industrial accidents because of the improvement in the work environment generated, to a large degree, by the incentives built into the state workmen's compensation system.

Rehabilitation is another area which is being used extensively to reduce costs and where business, economic and humanitarian elements are made to mesh in order to achieve a desired objective.

It was the need to restore losses brought about through industrial injuries which gave major impetus to rehabilitation. Indeed, it is the business of the state workmen's compensation system to help injured men and women to return to their jobs. The control of disability through maximum restoration of a disabled person has become the challenge of every injury.

It is a truism that when effectively met this challenge is beneficial to everyone concerned—the injured employee who regains his self respect by returning among the ranks of the wage earners, his family and the state which is now being supported by the individual rather than supporting him, and the employer who again has acquired the use of an experienced employee and whose workmen's compensation premium costs have been reduced. The social effects of rehabilitation are too obvious to need further elaboration.

On the financial side of the picture, maximum rehabilitation means minimum losses to industry, in both monetary costs and mass production. The savings resulting from properly administered rehabilitation programs are passed on to employers in the form of reduced workmen's compensation rates. Thus, again we see a built-in incentive in the workmen's compensation programs which encourages both employers and their insurance carriers to maximize rehabilitation facilities all possible cases. This is the reason workmen's compensation has used the rehabilitation process to such overwhelming advantage.

We are not making any claim that the workmen's compensation system has reached its utopia. We are most conscious that many state laws are still lagging in their benefit level. Many individuals, as well as groups, have been working toward upgrading these benefit levels. In many states, great success has been achieved. However, continued improvement is needed to keep up with the increases in the cost of living and improved wage scales as well as higher medical costs.

EFFECTS OF OVERLAPPING SYSTEMS

Section 114 of H.R. 17750 poses a serious threat to the vitality of the future of the state workmen's compensation programs. What this amendment to the existing law does is to allow combined workmen's compensation and social security benefits paid for the same disability to reach 100% of the beneficiary's average current earnings. This provision reverses an objective sought by the Senate Finance Committee in 1965 when it established a combined benefit limit of 80% of wages. At that time, this Committee stressed the desirability of avoiding the payment of excessive benefits. It pointed to the fact that a disabled workman receiving through combined benefits more than pre-injury take-home pay had little incentive toward rehabilitation. A classic example of this deterrent was called to our attention by a member company. They have a file in their office, where the claimant, age 33 when injured, will not try to return to work. He earned $77 per week prior to his injury. He now receives $20 per month from county welfare, $119 per month from state welfare, $201 per month from social security and $169 per month from workmen's compensation. By not working, he has increased his income from $337 per month to $508 per month—an approximate 50% increase in his income which is now all non-taxable.

So it is obvious that even paying benefits equalling gross earnings exceeds substantially the beneficiary's take home pay in that social security and workmen's compensation benefits are tax exempt.

Thus, a major objective of today's workmen's compensation system—the rehabilitation of the seriously injured and their return to gainful employment—will be impaired if Congress enacts Section 114 of H.R. 17750.

Furthermore, enactment of this Section will have adverse effect on the upgrading of state workmen's compensaiton benefits.

Although sophisticated employers are willing to accept reasonably higher workmen's compensation costs to ensure that their injured employees will receive adequate support when injured, they are demanding greater efficiency in the benefit distribution mechanism. Particularly, employers today are demanding that benefits paid under workmen's compensation do not duplicate those being paid under some other social insurance system over which they have no control. When such duplication occurs, one witnesses great reluctance to upgrade state workmen's compensation laws.

Let me cite you a few examples: workmen's compensation laws have been severely criticized because of inadequate provision being made for widow benefits. The criticism is well taken—but only if workmen's compensation is examined in a vacuum. Widow benefits are low. However, widows are generally thought to be also entitled to social security benefits. Employers reason that it is needless to extend workmen's compensation benefits because the social security system seems to have preempted the area.

The receipt of social security benefits by the disabled and by widows has been advanced as an argument against attempting adjustments of the benefit rate of any person whoh has been totally and continuously disabled for over a number of years. Workmen's compensation benefits are supposed to make public assistance unnecessary and, to a large extent, the program does accomplish this goal for those whose disability is of a temporary nature. The program has fallen short, however, in those cases where the accident happened many years ago and the injured person or his widow is drawing compensation based on the benefit rate that was in effect at the time of the accident. Those who oppose the upgrading of benefits to the current level point to the fact that social security also is

providing benefits to the widows and to those who suffer from long term disabilities. These arguments are hard to refute.

Also, there are those who argue—rather convincingly—that workmen's compensation benefits should be reduced by social security benefits when the disabled is entitled to receive benefits from both sources. This argument relates to cost. Those who argue this line point to the fact that this would reduce employer operating costs by saddling part of the cost of workmen's compensation on employees themselves. It should be remembered that employees pay 50% of the cost of social security, but employers pay the total cost of workmen's compensation. Thus, some employers see a way by which they can pass on to employees part of the cost of workmen's compensation. It is interesting to note that employers who most often urge the reduction of workmen's compensation benefits by the social security benefits are those who have the least sophisticated safety programs. Thus, these employers would stand to gain not only by having their employees assume part of the cost of workmen's compensation, but also, they would escape the penalties of being charged higher than average workmen's compensation rates because of inadequate safety programs. The adverse effect which the social security benefits structure has had on state workmen's compensation laws is detailed in Appendix (A). It will be noted that in many cases permanent total disability benefits have not kept up with the level of temporary total disability benefits. A most unfortunate effect of the use of social security benefits to subsidize workmen's compensation benefits is that many individuals receiving permanent benefits under the state laws are not eligible for social security benefits. Thus, these individuals are receiving totally inadequate benefits for their disabilities.

INCREASING THE BENEFIT CEILING FROM 80 PERCENT TO 100 PERCENT OF AVERAGE CURRENT EARNINGS IS NOT NECESSARY

The major arguments advanced for the increase of the benefits ceiling from 80% to 100% of average current earnings are that the combined benefits soon become outdated in our inflationary economy and that a worker's total disability will usually give rise to substantial expenses in addition to the families' continuing regular expenditures.

Both of those arguments have no foundation.

When this Committee proposed to coordinate social security and workmen's compensation benefits it took into consideration the fact that unless benefits were subject to periodic redetermination they would become outdated. Accordingly, Section 224(f) of the Social Security law provides for periodic recomputation of benefits to take into account rises in national earnings level. As Appendix (B) clearly indicates, the redetermination formula is so structured as to give the disabled beneficiary a substantially larger benefit increase than is warranted by the cost of living increase. In fact, using 1965 as the base year, by 1969, whereas the cost of living had increased 16.2%, the average taxable wages of all persons paying social security taxes, the basis for the recomputation formula, has increased by 26%. (See Appendix (C).)

In addition, Congress provided that beneficiaries receive in full any statutory benefit increases[1] enacted following the date of disability. As Appendix (D)—a Social Security Administration Bulletin—clearly indicates, legislative increases in social security benefits are paid to the disabled receiving workmen's compensation benefits, regardless of the 80% limitation imposed by Congress.

Thus, benefits which are subject to limitation under Section 224(a)(5) are periodically updated by a combination of statutory increases and through the redetermination formula established by this Committee in 1965. Accordingly, the recipient of combined social security and workmen's compensation benefits is assured that his combined benefits will not become outdated as a result of inflation.

The argument that total disability gives rise to substantial expenses in addition to the families' continuing regular expenditures is not valid when the disability arises out of an industrial accident. These additional expenses pertain to medical and related costs. In all but ten states, workmen's compensation laws provide for the payment of unlimited medical benefits. However, as Appendix (E) indicates even those workmen's compensation laws which limit medical benefits are quite generous.

---

[1] In 1968 benefits were increased by 13% and again in 1970 benefits were increased by 15%.

It has also been said that the limitation in combined benefits is unfair because workmen's compensation "is, in part, compensation for pain and loss of function for which the disabled worker might otherwise secure recompense through legal action against his employer." This argument does not stand up under close scrutiny. State workmen's compensation laws uniformly deny payment of benefits for pain. And, when payment is made for loss of function, it is made on the basis of expected future wage loss. Thus, it is futile to argue that benefits paid under workmen's compensation laws do not solely represent replacement of lost earnings.

We firmly believe that if Congress retraces its steps and overrides the action which it took in 1965 to protect the state workmen's compensation system and its objectives from being encroached upon by the social security system that irreparable harm will be done to the state compensation programs and we join Commissioner Ball who has recently warned this Committee that a change in the present law may have unfortunate consequences.

REVIEW OF OTHER PROPOSED CHANGES

Let me comment briefly on a number of proposals which have been advanced to liberalize the social security benefit program by reducing the waiting period, or by making an applicant eligible for benefits after six or even three months' continued disability regardless of the expected duration of such disability.

It is obvious that such proposals would drastically alter the thrust of the social security system. No longer would the social security system be aimed at replacing wages for those who are permanently separated from the labor market. It would establish a brand new federal program aimed at replacing wages for the temporary disabled. It is obvious that the ultimate reach of such program will be to pay social security benefits to anyone disabled, for any length of time.

It might be hard to argue against such a program if no improvement had been made in replacing loss of wages for the temporarily disabled worker. But this is not the case. On the one hand, all fifty states have workmen's compensation programs which protect workers against wage losses resulting from industrial accidents or diseases. In addition, five states have enacted legislation requiring employers to provide temporary wage replacement benefits, regardless of cause. Also, one cannot ignore the tremendous growth in voluntary wage replacement programs which today have insured 80% of our working civilian population with funds upon which they can depend if unable to work because of a disability arising out of any cause whatsoever.

Not only did the number of wage earners protected against any income loss increase by almost 50% from 1955 to 1967, but the percent of the civilian labor force covered increased by almost 20% during the same period of time (see Appendix (F)). There is no question that if the disability provisions of the present law are expanded to thrust the social security system into the temporary disability field that private initiative to provide insurance for temporary disability will come to a halt. No employer will want to duplicate such coverage if his employees are entitled to the protection under the social security system, and the latter will ultimately have to absorb the $1.2-billion now being paid to workers for their temporary inability to work due to non-industrial disabilities. (See Appendix (G).) It may be noted that the overwhelming percentage of these benefits are paid by employers through group insurance or formal paid sick leave. If absorbed into the social security system, 50% of the cost of these benefits would have to be paid by employees themselves. (See Appendix (H).)

In addition, it is likely that such legislative action would also hamper the drive to upgrade workmen's compensation benefit payments. After all, where would the incentive be for the states to increase workmen's compensation benefit levels—hence the cost of workmen's compensation insurance to employers within the states—if injured workmen entitled to workmen's compensation benefits also become entitled to social security benefits? Why should a state saddle its industrial community with a cost which the federal social security system volunteers to accept?

Enactment of legislation to broaden the scope of the disability provisions of the social security law would create a rather incongruous situation in Congress. On the one hand, the House and Senate Labor Committees have demanded the upgrading of state workmen's compensation benefits. On the other hand, action by this Committee to broaden the scope of the disability program would make such demands almost impossible to accomplish.

Finally, we must look at costs. The Alliance believes that it is a fair statement to make that neither workmen's compensation nor social security benefits have reached desirable levels. The primary reason for this is cost. It would thus seem that before expanding into new areas, social security should meet the obligation which it has undertaken to provide: adequate wage replacements for those who have separated themselves permanently from the labor force. This is especially true in this case since there is no urgent social need for expanding social security benefits to the temporary disabled employee. This is so, not because the temporary disabled can get along without wage replacement, but because their wages are being replaced by other systems at this time. It is difficult to project the potential cost increase involved if the twelve months' disability prognosis were to be relaxed. Analysis of workmen's compensation figures for the states of Wisconsin, California, and New York, the only states which keep accurate disability statistics, indicates that if the disability prognosis were reduced to six months, the number of beneficiaries entitled to social security disability benefits would increase by 250%, and if the disability prognosis were reduced to three months, the number would jump by 800%. (See Appendix (I).) In fact, there are countrywide about 100 times as many workmen's compensation temporary total disability claims as there are permanent total claims, and the cost of these temporary disabilities is in excess of ten times the cost of the permanent disabilities. (See Appendix (J).)

CONCLUSION

In conclusion, we urge that Section 114 of H.R. 17750 be eliminated. We firmly believe that this Committee, in 1965, acted in the best long-term interest of the disabled by providing a sound coordination between workmen's compensation and social security benefit payments. We do not believe that there has been a single argument advanced since 1965 to warrant reconsideration of this issue. In fact, in retrospect, the Committee should be congratulated for having had the foresight to anticipate and care for some of the problems which the coordination of benefits might have created.

We also believe that the social security system should not thrust itself into the temporary disability area. If this is done, the growing development of private wage replacement programs, as well as the healthy growth of workmen's compensation benefits would be throttled. We believe that rather than broadening the base of distribution for social security benefits priority should be given to upgrading benefits for those who are dependent upon it as a means to remain off the welfare roles.

APPENDIX A

IMPACT OF SOCIAL SECURITY BENEFITS ON STATE WORKMEN'S COMPENSATION LAWS

(States which are subsidizing permanent total disability benefit rates by social security benefits (permanent total disability benefit rates are lower than temporary total disability))

State	Permanent total disability benefit	Temporary total disability benefit	Original year of enactment of difference
Alaska	$73.45	$127.00	1959
California	52.50	87.50	1959
Illinois	71.00	91.00	1959
Iowa	(1)	(1)	1959
Missouri	58.00	63.50	1959
New York	80.00	95.00	1968
Ohio	56.00	[3] 63.00	1967
Oregon	62.50	80.00	1959

[1] 46 percent State average weekly wages.
[2] 50 percent State average weekly wages.
[3] Payable for 1967 first 12 weeks of disability.

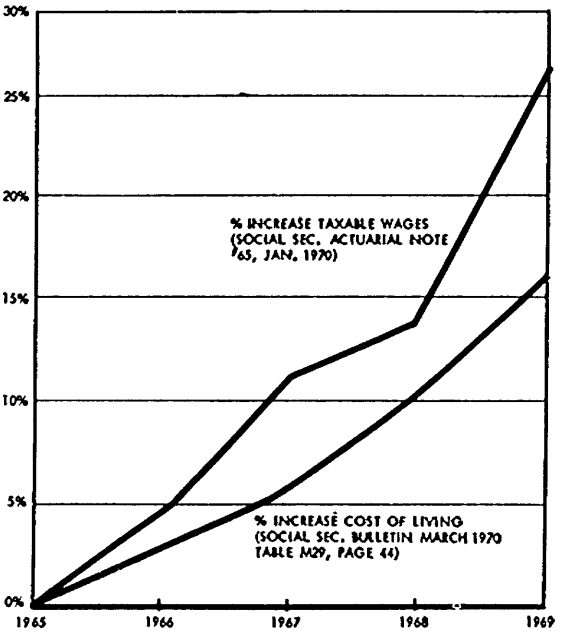
2. States which reduce workmen's compensation benefits specifically when Social Security Benefits are payable.

State and explanation:

New York: Benefits may be awarded for loss of earnings in addition to loss of function—but these additional benefits are offset by 50% of any benefits paid by Social Security Administration (effective date 1969).

Colorado: Any benefit payment is reduced by 50% of Social Security Benefits (effective date 1963).

RECOMPUTATION BASIS OF AVERAGE CURRENT EARNINGS COMPARED WITH COST OF LIVING INCREASE



APPENDIX C

REDETERMINATION OF AVERAGE CURRENT EARNINGS

Sec. 224(f) of the Social Security law requires that average current earnings be redetermined periodically to take into account rises in national earnings levels.

The redetermination formula requires that the average current earnings immediately preceding the onset of disability be multiplied by the ratio of the average earnings for covered employees for the first quarter of the year the redetermination is made to the average earnings for covered employees for the first quarter of the year of onset of disability.

Beneficiaries who became subject to the coordination of benefits in 1966 had their average current earnings increased in 1968 by 13.8%. The 80% limit on combined benefits was accordingly raised and additional Social Security benefits were paid. (See Appendix B.) Redetermination is to be made again in 1971.

Average earnings for covered employees have increased as follows:

	Amount	Percent increase
1965	$1,026	
1966	1,071	4.4
1967	1,131	11.0
1968	1,219	13.8
1969	1,282	26.0

APPENDIX D

SSA PROGRAM CIRCULAR—DISABILITY INSURANCE

REDETERMINATION OF DISABILITY OFFSET CASES

Certain beneficiaries who are subject to the disability offset (due to receipt of workmen's compensation) will receive an increase in their March 3 checks. New award notices are being mailed to the beneficiaries involved, showing the revised rates and giving a brief explanation of the increase. However, it is likely that district offices will receive some inquiries as a result of the change. Thus, this circular is directed primarily to DO personnel.

The law provides that all cases subject to disability offset shall be recomputed in the second calendar year after the year in which offset was first imposed; and in each third year thereafter, to take into account rises in national earnings levels (CM 6075). Any increase in the amount of benefits payable is effective with the following January.

As the offset became effective in 1966, beneficaries whose benefits were first offset in that year are entitled to a redetermination effective January 1969. Approximately 2,500 DIB beneficiaries and their auxiliaries will be affected. These redeterminations are currently being processed, and it is anticipated that the majority of cases will be completed in time for the increase to be included in the March 3 check. Since the new rates are effective with January, this check will include the increase in payment for two months.

Under the redetermination, the average current earnings figure (ACE) used in the offset computation (CM 6072(a)(3)) is increased in proportion to the rise in national earnings levels. This is done by finding the ratio between the average monthly wage for all covered earnings reported for the first calendar quarter of the year in which the redetermination is made (in this case 1968) and the average monthly wage for all covered earnings reported for the first calendar quarter of the year in which offset was initially imposed (1966). This ratio is then applied to the ACE, and the resulting revised ACE is used in the new offset computation.

The ratio between the applicable average monthly wages for 1968 and 1966 has been established as 1.138 (i.e., earnings levels increased by 13.8 percent). Therefore, the ACE used in 1966 offset computations will be multiplied by 1.138 to obtain the revised ACE.

Example: In 1966 the WE and his family became entitled to the following benefits:

HA	$122
HB2	61
HC1	61
Total	244

(CM holders in Regional Offices, District Offices and Branch District Offices; DISM holders.)

(Disability Program Circular No. 15 received limited distribution.)

The WE was receiving WC of $200 per month. The ACE, based on the high-5 years, was $390; thus the limit on combined benefits was $312 (80% of $390), and $112 of the social security benefits was payable ($312 less 200=$112).

Applying the redetermination ratio of 1.138 to the ACE results in a revised ACE of $443. The new limit on combined earnings becomes $354.40 (80% of $443) permitting $154.40 to be paid to the family beginning January 1969 ($354.40 less 200=$154.40).

The redetermination is designed to bring the benefits payable into line with current wage levels when no other change has done so. Therefore, if the statutory increase which was effective in February 1968 resulted in payments as high as or higher than those permitted under the redetermination, the family will not receive an additional increase. In the example above, the 1967 amendments would have raised the total family benefit to $275.90 ($137.90+69+69), an increase of $31.00, which would have been added to the $112 already being paid. (See CM 6074 for an explanation of the effect of statutory benefit increases on offset cases.) Therefore, at the time of the redetermination the family was receiving $143.90. Since the redetermination resulted in $154.40 payable, the family would receive an additional $10.50.[1] However, if the benefits payable to the family after

[1] An additional $.10 would be payable to the family as each auxiliary's benefit would be rounded upwards to an even dime.

the statutory increase had been as high as or higher than the $154.40 resulting from the redetermination, they would not receive an increase.

The 1967 amendments also provided for a recalculation of offset cases to take into account earnings in excess of the maximum in computing the ACE (CM A6055). In these cases the ACE which resulted from this amendment will be deemed to have been used in the initial offset computation for redetermination purposes.

Example: A WE who was receiving workmen's compensation of $205 became entitled to a DIB of $132.70 in 1966. His wife and child were entitled to $66.40 each, making total family benefits of $265.50. Based on his high-5 years of $4,800 each, the WE's ACE was $400 and the limit on combined benefits was $320 (80% of $400), permitting $115 to be paid after offset ($320 less $205=$115).

Under the 1967 amendments a new ACE of $491 was established based on the WE's total earnings, disregarding the $4,800 maximum. The limit on combined benefits then became $392.80 (80% of $491) permitting $187.80 (actually $187.90*) to be paid to the family. ($392.80 less $205.)

Under the redetermination, the 1.138 ratio is applied to the $491, resulting in a revised ACE of $558, and permitting $241.40 to be paid (80% of $558=$446.40 less $205=$241.40).

The statutory increase effective February 1968 had raised the total family benefits to $300, an increase of $34.50, which was added to the $187.90 payable after the ACE had been refigured under the 1967 amendments. Thus, at the time of the redetermination the family was being paid $222.40. Since under the redetermination they may be paid a still higher amount ($241.40) they will receive the increase of $10.00 effective January 1969.

Appendix E

Medical benefits payable under State workmen's compensation laws

Alabama	$10,000.
Alaska	Unlimited.
Arizona	100 months.
Arkansas	Unlimited.
California	Do.
Colorado	$35,000.
Connecticut	Unlimited.
Delaware	Do.
Florida	Do.
Georgia	$5,000.
Hawaii	Unlimited.
Idaho	Do.
Illinois	Do.
Indiana	Do.
Iowa	Do.
Kansas	Do.
Kentucky	Do.
Louisiana	$25,000.
Maine	Unlimited.
Maryland	Do.
Massachusetts	Do.
Michigan	Do.
Minnesota	Do.
Mississippi	Do.
Missouri	Do.
Montana	Unlimited in total disability case.
Nebraska	Unlimited.
Nevada	One year after disability.
New Hampshire	Unlimited.
New Jersey	Do.
New York	Do.
North Carolina	Do.
North Dakota	Do.
New Mexico	$25,000 within 5 years of disability.
Ohio	Unlimited.
Oklahoma	Do.
Oregon	Do.

Medical benefits—Continued

Pennsylvania	Unlimited as long as care restores earning capacity.
Rhode Island	Unlimited.
South Carolina	Do.
South Dakota	$21,700.
Tennessee	$5,000 within 2 years of disability.
Texas	Unlimited.
Utah	Do.
Vermont	Do.
Virginia	Thirty-nine months after disability.
Washington	Unlimited.
West Virginia	Do.
Wisconsin	Do.
Wyoming	Do.
District of Columbia	Do.

LOSS OF INCOME PROTECTION FOR NON-INDUSTRIAL DISABILITIES

	Number of covered workers	Total civilian labor force	Percent of coverage
1955	39,500,000	62,100,000	60
1960	42,400,000	65,700,000	63
1965	50,800,000	71,100,000	71
1967	57,900,000	74,300,000	79

Sources: 1968 Source Book of Health Insurance Data. Handbook of Labor Statistics 1969.

APPENDIX G

Non-Industrial Disability Benefits Paid

1955	$617,000,000
1960	839,000,000
1965	1,046,000,000
1967	1,221,000,000

Source: 1968 Source Book of Health Insurance Data.

APPENDIX H

NUMBER OF PERSONS WITH DISABILITY INCOME PROTECTION, BY TYPE OF PROGRAM, IN THE UNITED STATES, 1946-67

[In thousands]

End of year	Grand total	Insurance companies			Formal paid sick leave plans [2]	Other [3]
		Total [1]	Group policies	Individual policies		
1946	26,229	14,369	7,135	8,684	8,400	3,460
1950	37,793	25,993	15,104	13,067	8,900	2,900
1955	39,513	29,813	19,171	13,642	8,500	1,200
1956	41,688	31,688	20,860	13,682	8,800	1,200
1957	42,939	32,739	21,399	14,539	9,000	1,200
1958	41,870	31,670	20,472	14,356	9,000	1,200
1959	42,665	32,365	20,894	14,707	9,200	1,100
1960	42,436	31,836	20,970	14,298	9,500	1,100
1961	43,065	32,065	21,186	14,301	9,900	1,100
1962	44,902	33,602	22,313	14,854	10,200	1,100
1963	46,956	34,956	23,418	15,182	10,900	1,100
1964	48,171	36,171	24,434	15,443	10,900	1,100
1965	50,804	38,004	26,518	15,113	11,700	1,100
1966	54,374	40,774	28,698	15,890	12,500	1,100
1967	57,912	43,512	31,459	15,859	13,300	1,100

[1] Net total of people with insurance company protection—eliminates duplication among persons with more than 1 insurance policy.
[2] People with formal paid sick leave plans but without insurance company coverage.
[3] Includes union-administered plans and employee mutual benefit associations.

Source: Health Insurance Council and Health Insurance Institute.

APPENDIX I.—TOTAL DISABILITY PERIOD DISTRIBUTION (WORKMEN'S COMPENSATION)

	3 to 6 months	6 to 12 months	Over 12 months
Wisconsin	707	132	22
New York	5,749	2,184	1,102
California	8,800	2,500	850
Total	15,254	4,816	1,924

Source: State industrial insurance commissioners.

APPENDIX J.—WORKMEN'S COMPENSATION LOSSES, BY TYPES OF DISABILITY

	Number of claims	Indemnity cost
1960:		
Permanent and total	618	$11,354,773
Temporary total	533,107	165,630,253
1965:		
Permanent and total	589	14,944,216
Temporary total	590,204	196,261,477
1967:		
Permanent and total	663	18,649,050
Temporary total	605,581	220,350,393

Source: National Council on Compensation Insurance New York, New York

The CHAIRMAN. Thank you very much. I want to assure you, Mr. Stringer, I for one, am going to carefully study your statement. I think you made some very good points here.

Any further questions, gentlemen?

Thank you very much, sir.

Mr. STRINGER. Thank you, Mr. Chairman.

The CHAIRMAN. Now, is there anyone who thinks he can summarize his statement in 5 minutes? All right, then we will go to those who are going to require 10.

I will call Dr. William O. LaMotte, Jr., in behalf of the American Medical Association. Will you proceed, sir?

STATEMENT OF DR. WILLIAM O. LaMOTTE, JR., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, LEGISLATIVE DEPARTMENT; AND BERNARD P. HARRISON, DIRECTOR, DIVISION OF MEDICAL PRACTICE

Dr. LAMOTTE. Thank you, Senator. I am Dr. William O. LaMotte, Jr., a physician practicing in Wilmington, Del., and I am here as chairman of the Council on Legislation of the American Medical Association. I have with me Mr. Harry N. Peterson, who is director of the AMA's legislative department, and Mr. Bernard P. Harrison, director of the AMA division of medical practice.

We understand the time limitations imposed by the committee on all witnesses, and this oral testimony summarizes the views of some 26 pages of our submitted testimony. We believe all the comments contained in the more complete statement are pertinent to consideration of the provisions of H.R. 17550, and should be carefully considered by this committee.

The CHAIRMAN. Doctor, I will assure you we will do that. We are very much aware of the significance and importance of certain sections

of this legislation to the American Medical Association, and I will assure you that your entire statement will be thoroughly considered.

Dr. LAMOTTE. Thank you, Mr. Chairman. So, we will proceed with section 239 of H.R. 17550, which provides authorization for a single medicare payment, covering both parts A and B services, which is to be made to a health maintenance organization on a prospective per capita basis.

We support a pluralistic approach to the delivery of medical services, whether they be furnished by group practice, or by the individual practitioner, or otherwise. However, before any HMO program is initiated nationwide through legislation and held out as a realistic benefit available to all medicare beneficiaries, we believe that cost and utilization data should first be developed with controlled demonstrations testing the capability of such a program to accomplish its purpose. There are questions regarding intact cost savings, as well as the quality of health care which may be provided when there are economic incentives to providers to reduce utilization. We would wish to assure that medicare patients uniformly receive the best quality care.

To this point of quality care, we have one additional concern. As defined in the bill the HMO may be a "for profit" organization and one managed, controlled and operated by lay individuals. Under such circumstances, the incentive for profit and/or lack of the basic essentials of knowledge, training and experience in medical matters, could result in the patient being furnished less than the optimum of quality care. To avoid such result, we recommend that organizations delivering health care should be under the control and guidance of medical personnel.

Section 224 provides certain limitations on physicians' "reasonable charges". The language used clearly indicates that physicians' charges are to be controlled under the medicare program.

We, as physicians, share the concern of the public and the Congress concerning rising health care costs. Nevertheless, we must oppose this section which establishes an arbitrary statutory limitation on the charge the physician may make for his professional service. When enacted, the original medicare law required the physician's charge to be reasonable if full payment was to be made under the program, and the term reasonable was carefully defined in the law and in subsequent regulations. Now, while the factors underlying increased costs are complex, the proposed remedy is strikingly simple: merely establish an arbitrary percentage of physician charges which will be allowed as reasonable.

We know of no such control of prices or wages or charges in any other private sector of the economy.

Other comments included in our full statement to the committee relate to these provisions:

Section 222, which requires the Secretary to develop experiments for making payments to providers on a prospective rather than retrospective basis. The American Medical Association has in the past supported the testing of mechanisms which are introduced for the purpose of improving Government-financed health care programs. We continue in that support. At the same time, however, and most important, is our concern that the quality of care should not be compromised for the sake of economy.

Section 223 authorizes the Secretary to exclude from an institution's reimbursable "reasonable cost" any expense he finds to be unnecessary in the efficient delivery of needed health services. Will this section create different classes of services based upon the ability or desire of patients to pay for additional services? A goal of medicare was to make available to all persons over 65 the same level of health care available to other individuals. Has that goal now been changed?

Section 263 authorizes a study of the coverage of chiropractic services under title 19 to determine if such services should be included under title 18. We have seen a 1967 study by the National Advisory Commission on Health Manpower, a 1968 study of independent practitioners under medicare made by former HEW Secretary Wilbur Cohen, and a 1970 HEW appointed task force on medicaid and related programs. All have come to the same firm conclusion that chiropractic services should not be included in the program.

Section 233 provides for automatic extended care and home health coverage for certain physical conditions and for limited periods. We support, with modifications suggested, this provision.

We similarly support section 237 providing for limited coverage before termination of payment for unnecessary hospital admission, and section 234 which would prohibit reassignment of claims, except in certain instances. We also support section 254 providing for physical therapy services, and section 235 calling for utilization review requirements for hospitals and skilled nursing homes under titles 5 and 19. Further, we favor the proposed changes in the cost-sharing requirements under medicaid, and, in addition, urge the adoption of an amendment which would extend to all under title 19 the direct billing option. We also favor the provision of part A benefits for uninsured individuals in section 202, and the requirement that the reimbursable costs of institutional providers under titles 18, 19, and 5 could not be greater than their regular charges (section 230).

Section 228 would eliminate the requirement that States have comprehensive medicaid programs by 1977. We are aware that the elimination of the 1977 requirement is realistic. We are similarly aware of, and we share, the concern of the Congress with respect to the payment for the services of teaching physicians (section 226).

Section 232 would provide 90 percent Federal payment to States for installation and operation of claims, processes and information retrieval systems. We ask that the language here be made clear to provide that States wishing to use private facilities, such as now developed by some insurance carriers, be allowed to do so.

Section 225 changes the Federal matching percentages, increasing the Federal part for certain outpatient services, and decreasing the Federal contribution for long term institutional care. While we support emphasis on ambulatory care, we believe that present levels of institutional support should be maintained, and the increased Federal support for certain outpatient services should also extend to services performed in physician offices. The weighting against physician offices and in favor of the clinic and outpatient hospital settings would take medicare patients out of the mainstream of health care and could, as well, defeat the objectives of achieving maximum savings.

That, Mr. Chairman, brings us to section 227, which authorizes the Secretary to terminate payments to certain providers of services.

We object most forcefully to this provision which would have nonmedical groups act as review teams and make medical judgments. Instead, we have proposed, and would again comment on, our own suggestion for Peer Review Organization. And to make the discussion even more useful, I would like to include comments regarding the amendment introduced by Senator Bennett for a Professional Standards Review Organization.

PRO, the AMA proposal, would have the Secretary of HEW enter into agreements with State medical societies for the carrying out of a review of, the need for, and quality of services provided, and the reasonableness of charges. The State medical society would develop a plan under which it would appoint a commission which, in turn, would assign local review panels to carry out the immediate peer review functions.

The members of the State PRO Commission, as well as the local review panels, would be physicians and advisory councils at both the State and local levels, would include representatives of consumers, providers of health care, and carriers administering the part B medicare program.

PRO calls for review first by the local panel with recommendations for disciplinary action forwarded to the commission. Upon review and concurrence, the PRO commission would forward the recommendation to the Secretary who could suspend or exclude the physician from the program.

The amendment for a Professional Standards Review Organization has a similar objective and as such is indeed laudatory. However, in our opinion, significant changes should be made to amendment 851 if it is to be enacted.

There is no assurance that the review of a physician's services will be done by his peers. True, the amendment gives first priority to the local medical society to act as the PSRO, but if the Secretary finds that the society is not qualified or willing, he may designate a public or private organization or agency which he accepts as qualified. It may or may not be a peer group and the members of that group doing review need not be physicians.

We believe that the organizational structure contained in our PRO would provide for a more workable and effective program. PRO calls for an agreement between the Secretary and the State medical society under which the medical society would carry out a planned operational system of peer review. The plan would be more flexible than the rigid requirements of PSRO and would allow effective local efforts to continue and even be strengthened. At the same time, by providing the State medical society—rather than any number of local groups—with the prime responsibility of carrying out the plan, the success of the program is more readily assured.

Another provision in PSRO requires advance review of admissions to health care facilities for elective procedures. We submit that the application of such a requirement would often create difficulties and not be in the best interest of the patient. There are serious questions of legal liability and we wonder if the benefits proclaimed from such a practice are not more apparent than real.

PSRO calls for the review of the services of not only physicians, but also all institutional providers of health care service. Here, again,

it differs from PRO. We believe the provision in amendment 851 is too broad, and that peer review should be confined to services of the physician, and such other services over which he has direct control and responsibility.

Another PSRO provision creates norms of health care services for various illnesses or health conditions. While the section allows for a variation of practice different from the norm established, a tendency for adherence to the publish norm carries within itself a potential detriment to the provision of higher quality care.

Additional provisions call for a monetary fine and for government ownership of profiles of patients and physicians. We believe that the confidentiality of these files should be protected and that the profiles should be under the continuing jurisdiction of the review body and should not become Federal property. As to the monetary penalty, we believe that such fine subverbs the purpose of peer review. Fundamentally, peer review is an educational mechanism and this aspect is, indeed, the ongoing positive benefit which redounds to the program. The imposition of a fine, on the other hand, changes the character of the program to one with criminal aspects. While we see no place for a monetary fine in peer review, we recognize that where the facts warrant, separate civil or criminal action could be instituted. Our PRO bill so provides.

Mr. Chairman, the concept of peer review as a structured mechanism is still new. The American Medical Association House of Delegates last June endorsed Peer Review Organization. Later, the association took strong objection to section 227 of H.R. 17550. Today, we find fault with certain provisions of amendment 851.

We believe, that if the committee cannot accept the Peer Review Organization proposal contained in the medicredit bill, the question of review of services as to quality and charges should lay over to the next Congress. There are different approaches to this important problem and many organizations in the medical and paramedical fields are now becoming involved in varying plans for peer review. We suggest that it may be wise not to cast its future direction in statutory language at this time.

Mr. Chairman, this concludes our summary of our longer paper, and the two gentlemen here with me and I will attempt to answer any questions that you and your committee may have.

Thank you very much.

(Dr. LaMotte's prepared statement follows. Hearing continues on p. 1092.)

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION PRESENTED BY WILLIAM O. LAMOTTE, JR., M.D.

Mr. Chairman and Members of the Committee: I am Doctor William O. LaMotte, Jr., a physician in practice in Wilmington, Delaware, and presently the Chairman of the Council on Legislation of the American Medical Association. With me are Mr. Bernard P. Harrison, Director of the AMA Division of Medical Practice, and Mr. Harry N. Peterson, Director of the Legislative Department.

We are pleased to appear before this Committee again to present the American Medical Association's views on the Medicare and Medicaid Programs and specifically concerning certain provisions of H.R. 17550, the Social Security Amendments of 1970, as they relate to the two programs.

Last June, representatives of the AMA and the National Medical Association appeared before you to discuss the provision of health care through these programs. We also presented our own Medicredit Program for the provision of

health care to our citizens. We included a discussion of our peer review proposal, designed to accomplish some of the goals of this Committee in reducing the costs of the program. We shall speak more about our proposals, but shall first address ourselves to certain provisions of H.R. 17550 and provide you with our suggestions for modifications. Some of the provisions of the bill relate merely to procedural or benefit changes; others have a potential far-reaching effect on the future of these programs and upon the provision of health care for everyone.

We will limit our remarks to those sections which we deem to be most significant.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATION (SEC. 239)

Under this section, authorization is provided for a single Medicare payment to a "Health Maintenance Organization" to be made on a prospective, per capita basis covering services provided under both Parts A and B. Such organizations could provide comprehensive health services, but would have to include all of the Medicare benefits. Payment is not to exceed 95% of the amount which the Secretary estimates would be payable for both Part A and B benefits normally furnished. Beneficiaries would have the option of seeking to have Medicare benefits furnished through such an organization, or could continue to receive benefits as at present. While payments for these services would come from both Part A and Part B Trust Funds, it is to be noted that the Part B Fund would pay its full premium share on behalf of the beneficiary, and any reduction in costs arising from the 95% payment would accrue to the Trust A Hospital Fund.

Mr. Chairman, it should be made clear at the outset that the American Medical Association supports a pluralistic approach to the delivery of medical services, whether they be furnished by group practice or by individual practitioner, or otherwise. The furnishing of comprehensive health services through health maintenance organizations has existed for a number of years, but their development has been more pronounced in limited geographical areas. On its face, negotiation for comprehensive services at a figure which appears to show a savings to the program is patently salutary. However, before any such program is initiated nationwide and held out as a realistic benefit available to beneficiaries under the Medicare program, it is our recommendation that cost and utilization data should first be developed. Acceptable controlled demonstrations should test the capability of such a program to accomplish its purpose and to be implemented nationwide.

If such a determination is to be valid, it is necessary, of course, that the costs of the A and B Programs be compared with an HMO cost for across-the-board Medicare beneficiaries in open enrollment, and not for a group which may be selected for this purpose. Interestingly, there appears to be some question concerning the cost benefits of HMO. While it appears that one of the main purposes is to achieve a financial saving in the program, in the Report of the Committee on Ways and Means it is stated that under this new approach there is expected to be a small increase in the first year or two in the amount of payment by the program, but that if additional beneficiaries enroll in either existing or newly established health maintenance organizations, there is a likelihood of cost savings to the program.

Besides the consideration of whether the HMO provision will in fact result in cost savings to the program, there is the paramount consideration of the health care which will be provided to the beneficiary. We are not alone in the serious concern about a program which provides incentives to providers for lower utilization of benefits, and this aspect of the program—under-utilization—must be watched very closely so that the beneficiaries receive the best quality care. Moreover, it is important that the control and operation of the HMO be under the direction and supervision of physicians so that high quality care is provided. Operation of the health maintenance organizations should not be sanctioned under the direction of individuals or groups not competent in the health field.

In addition, if this section is adopted, provision should be made so that the public is properly informed as to the reality of their ability to elect to come under such a program. As you know, such organizations are limited in number; and such a benefit, if adopted nationwide, will not be realistically available to most beneficiaries. Much disappointment has already ensued where present benefits, such as home health services, are not locally available to beneficiaries of the program. There could be considerable dissatisfaction, to say the least, where an optional program service might not be available, with public pressure encouraging

the development of hastily organized groups capable of providing only substandard care.

Mr. Chairman, I would like to make one further point under this section. This Committee is aware of the interest of medical societies and other groups in the implementation of this section. If this section is adopted, the opportunity to qualify as such an organization should be open to state and local medical societies as well as medical foundations.

LIMITS ON PREVAILING CHARGE LEVELS (SEC. 224)

This section provides that for physician services rendered after July 30, 1970, and before July 1, 1971, a "reasonable" charge could not exceed the higher of: (a) the prevailing charge level existing in June 30, 1970; or (b) the prevailing charge level covering 75% of the customary charges made for similar services in the same locality during the calendar year 1969. For services rendered after June 30, 1971, the prevailing charge levels could only be increased above the 1969 levels, to the extent that the Secretary finds, "on the basis of appropriate economic index data," that such adjustments are justified by economic changes.

Mr. Chairman, we are fully aware of the great concern of the Congress and the public concerning rising health care costs. We as physicians share this concern. Nevertheless, we oppose this section, which establishes an arbitrary statutory limitation on physicians' charges under Medicare. While the factors underlying increased costs are complex, the proposed remedy is strikingly simple: merely pay a percentage of the customary charges. Even in this highly inflationary period, we know of no such control of prices, wages or charges in other private sectors of the economy. The proposed limitation may attain a measure of cost control to the program; however, it should be kept in mind that a corresponding effect of this provision would be to shift this part of the burden of the program to the beneficiary.

AUTHORIZATION OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES (SEC. 227)

The Secretary would be authorized to terminate or suspend payments for services under Medicare where a person: (a) has made false representations; (b) has submitted bills in excess of the person's customary charge; or (c) has furnished services determined to be substantially in excess of the needs of the patient or to be harmful to him or of a grossly inferior quality.

The Secretary, after consulting with appropriate State and local professional societies, as well as with others, would appoint program review teams composed of physicians, other professional personnel in the health care field, and consumer representatives. The Secretary's determination as to (b) above would require the concurrence of the Program Review Team, and, as to (c) above, would require the concurence of the professional members of the reviewing team.

The Association has many times stated that abuses in the program should be eliminated. The most effective way to review the services of physicians is through the medium of other physicians. Professional services, whether they be legal, medical, or otherwise, should be evaluated by professional peers. Only physicians should be called upon to review the services of other physicians. This is the essence of peer review. And it should be kept in mind that this process, while disciplinary in character, is also educational, wherein is found the continuing positive benefits of program review. The bill does not provide for appropriate peer review. We urge you to reject Section 227.

EXPERIMENTS AND PROJECTS IN PROSPECTIVE REIMBURSEMENT AND INCENTIVES FOR ECONOMY (SEC. 222)

This section requires the Secretary to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under Title 18, 19, and 5, as contrasted with the present system of retroactive reimbursement. He would report to the Congress by July 1, 1972, the results of the experiment programs, and include recommendations with respect to the specific methods which could be used in a full implementation of a system of prospective payment. In addition, the present provisions for incentive reimbursement experiments would be revised to authorize the following types: (a) payment based on negotiated rates; (b) payment to organizations and institutions capable of providing comprehensive health care services

(in addition to Medicare benefits); (a) payments based on rates applicable to State health care programs; (d) payments based on a single combined rate or charge for the teaching activities and patient care rendered by residents, interns and supervisory physicians; and (e) a determination as to whether utilization review and medical review mechanisms established on an areawide or community-wide basis would provide more effective control.

Mr. Chairman, our Association has supported provisions which are designed to test mechanisms, on an experimental basis, and which are introduced to improve government supported programs. While continuing in such support, we believe that these experiments must be carefully evaluated before they become an integral part of any of the programs—particularly those which have the potential for substantial change in the character of the program. Most important, of course, is the consideration that the quality of care should not be compromised for the sake of achieving some economy. We note that the experiments are to be submitted to the Committee on Ways and Means and to this Committee before being put into effect. We believe that it would also be beneficial if the proposal were to be submitted to organizations and groups which would be affected, so that the Secretary and the Committee may be informed of their views concerning the experiment.

LIMITATIONS ON REASONABLE COST TO MEDICARE PROGRAM (SEC. 223)

Under this section the Secretary would be authorized to exclude as reimbursable part of an institutional provider's "reasonable cost" any incurred cost which he found to be unnecessary "in the efficient delivery of needed health services." For those services deemed to be unnecessary, the provider could make a direct charge to the beneficiary if (a) the Secretary has provided notice to the public of such excess charges and (b) the provider identifies the charges to the individual.

This section has a potential for substantial changes, not only in the Medicare program, but also in the provision of health care to the public generally. While the intent of this section may be to reduce costs and standardize services among comparable providers, we view with concern the authority of the Secretary to determine the costs necessary for efficient delivery of needed health services under Title 18. Will this section, for instance, create different classes of services based upon the ability or desire of patients to pay for additional services?

One of the original goals of the Medicare program was to make accessible to the over-65 persons the same level of health care available to other individuals. We believe this section, with this unprecedented authority in the Secretary, would tend to do otherwise. On the other hand, we understand the concern about rising institutional costs in the Medicare program. Accordingly, we recommend that the Congress and all health organizations maintain careful surveillance over implementation of this section so that benefits to the patient are not arbitrarily reduced, in relation to those furnished other patients.

STUDY OF CHIROPRACTIC COVERAGE (SEC. 263)

Under this section, the Secretary would be authorized to conduct a study of the coverage of services performed by chiropractors under Title 19, in order to determine whether and to what extent these services should be covered under Part B, Title 18. He would be required to report to Congress within two years his findings and recommendations.

Mr. Chairman, three important and reliable government studies of chiropractic already have been made and have all reached the same basic conclusion: Chiropractic services are not quality medical care.

These studies are:

(1) 1967 report by the National Advisory Commission on Health Manpower;

(2) Independent practitioners under Medicare—a 1968 report to Congress by former Secretary Wilbur J. Cohen; and

(3) The 1970 Report of the Task Force on Medicaid and Related Programs.

The first report found chiropractic to be a significant hazard to the public. The second report, after a study ordered by Congress, recommended unequivocally that chiropractic service should not be covered in the Medicare Program. The third report and one, incidentally, upon which it appears that many of the modifications to the Medicare and Medicaid Programs are predicated in H.R. 17550, does not contain any recommendation for the proposed study but, *on the contrary*, states:

"A legislative amendment should be enacted denying financial participation in medicaid payments to chiropractors and naturopaths."

The conclusions reached independently by these three studies have the full support of the medical profession—of the scientific community as a whole. In addition, they are supported by many organizations *outside* medicine.

For example, numerous organizations interested in health care for the elderly have strongly supported the findings on chiropractic of the HEW study. Included are the American Federation of Labor and Congress of Industrial Organizations (AFL–CIO), the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW), the National Council of Senior Citizens, the nation's largest organization of Medicare recipients, and the Consumer Federation of America, representing 184 local, state and national consumer-oriented organizations with millions of members throughout the country.

Among the many other organizations which have supported these findings are the American Hospital Association, the Association of American Medical Colleges and the American Public Health Association, to single out just three. At the APHA convention last November, its Governing Council formally adopted a resolution calling upon Congress to continue to exclude chiropractic and naturopathy from covered Medicare services and also recommended that Congress amend Title XIX so federal funds would "not be used to match State Medicaid expenditures for chiropractic or naturopathic services."

In the light of all this, we believe that another study would be unjustifiably repetitive, involving the already scarce time of professional people and unnecessary expenditure of funds. We believe the facts on chiropractic are all in, and a proper conclusion reached. Section 263 should be deleted.

ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE (SEC. 233)

In order to overcome the situation where patients, after being admitted under an extended care or home health program, were later denied coverage, this section provides for automatic coverage for certain physical conditions and for limited periods as designated by the Secretary. We support this provision, which alleviates any financial hardship which otherwise would fall upon the patient. One part of this section should be modified, however. It would deny payment for services furnished to an individual where the Secretary had determined that the physician has submitted "with some frequency" erroneous certifications or inappropriate plans for services. This provision places an inappropriate burden on the patient for acts of the physician. The matter should be referred for peer review action, with approriate notice to the physician's patients so that they will be aware, in advance, of any payment limitations.

TERMINATION OF PAYMENT FOR UNNECESSARY HOSPITAL ADMISSIONS (SEC. 237)

Under this section, if the utilization review committee of a hospital or extended care facility, in its review of admissions, finds a case where institutionalization was unnecessary, the payment would be cut off after three additional days. This provision is similar to the one in present law which terminates payment after three days' notice where services are found to be no longer necessary. We support this provision.

LIMITATION ON FEDERAL PAYMENT FOR CAPITAL EXPENDITURES (SEC. 221)

This section provides that reimbursement amounts to providers of health services under Medicaid, Medicare, and Maternal and Child Health Care for capital costs, such as depreciation and interest, would not be made with respect to capital expenditures (in excess of $100,000) which are determined to be inconsistent with State or local health plans.

The Association recognizes the need for effective planning of health care facilities and the need to prevent unnecessary duplication of facilities. We believe, however, that if this section is adopted, the exercise of the authority granted should be carefuly scrutinized so that the development of desirable facilities is not impeded. In any event, facilities should have open to them the right of judicial review of the Secretary's decision. The language prohibiting such review should be eliminated and such right should be clearly expressed.

CHANGES IN FEDERAL MATCHING PERCENTAGES WITH RESPECT TO CERTAIN SERVICES (SEC. 225)

Under this section, federal Medicaid matching for certain outpatient services would be increased and the federal matching with respect to long-term institutional care would be decreased and certain other limitations would be imposed. Specifically: (a) the Federal matching percentage for outpatient hospital services, clinic services and home health services would be increased by 25%; (b) the Federal percentage after the first 60 days of care in a general or TB hospital would be reduced by one-third; (c) the Federal percentage after the first 90 days of care in a skilled nursing home would be reduced by one-third; (d) the Federal matching for care in a mental hospital after 90 days of care would be reduced by one-third and no Federal matching would be available after 275 days of such care during an individual's lifetime; and (e) the Secretary would be authorized to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

We recognize that in a program with a limited amount of funding the government may wish to allocate the available monies among certain services. The Association supports the use of least costly services, and accordingly, where feasible, ambulatory services should be used instead of institutional care.

We believe, however, that the purpose of the provision can be effected without the reduction of federal matching for continued institutional care, which reduction may result in the unavailability of benefits for *needed* institutional care. Utilization review requirements under Medicaid should eliminate unnecessary institutionalization of patients. In addition, an increased outpatient benefit should motivate an increased usage of that benefit.

However, recognizing that the design of the Medicaid program may be reviewed next Congress, as indicated by the changes contemplated by the Administration and increasing interest in a new insurance approach for the Medicaid recipient, we believe it would be well not to reduce, for the persent time, the levels of Federal support.

In any event, since the provision for increased support for outpatient benefits restricts such support to outpatient hospital services, clinic services and home health services, maximum benefit would not be realized. This restriction could result in state programs requiring that medical care under its Medicaid program be furnished only in outpatient hospitals and "clinic" settings in order for the States to take advantage of the additional Federal funding. Any such "weighting" of payment against services furnished in *physicians' offices* would defeat the objective of achieving maximum savings in the program, and would also deny to the patient the ready accessibility of the physician's office and separate him from the mainstream of medical care.

PAYMENT FOR SERVICES OF TEACHING PHYSICIANS UNDER MEDICARE PROGRAM (SEC. 226)

This section would change the basis of reimbursement for teaching physicians' services from a fee-for-service basis to a cost-reimbursement basis where the services are furnished in a setting in which any one of the following circumstances exist: (1) the non-medicare patients are not required to pay the reasonable charges for physicians' services even when they have private insurance or are otherwise able to pay for such services; or (2) medicare patients are not required to pay any charges for physicians' services; or (3) medicare patients are required to pay reasonable charges for physician's services but payment of deductible and coinsurance amounts applicable to such services is not generally obtained from them or in their behalf.

We are aware of difficulties that have arisen with respect to the administration of provisions governing the payment of teaching physicians under Medicare. When the Medicare program was adopted, it was our understanding there was no intent to interfere with existing mechanisms of supporting medical edcation in the teaching hospitals. The Association has expressed its concern to the Social Security Adminstration on previous occasions concerning measures which might affect the teaching programs. It is imperative that adequate support of teaching programs not be diminished in any way, lest the quality of our teaching programs be affected.

There exists a diversity of situations in various teaching hospitals with respect to support of medical education, and the total effect of the proposed amendment is unknown. It might be well that this proposal be adopted with limited

application, through the experimental section of the Medicare program, so that its effects might be tested. In any event, we recommend that any implementation of this section be watched closely for its potential effect upon the program of medical education, so that they will not be adversely affected.

FEDERAL PAYMENT UNDER MEDICAID TO STATES FOR INSTALLATION AND OPERATION OF CLAIMS, PROCESSES AND INFORMATION RETRIEVAL SYSTEMS (SEC. 232)

This section provides that Federal matching at a 90% rate would be available for the States to set up mechanized claims processing and informational retrieval systems. Continuing operation of such systems would be supported at a 75% level. We understand that some states at the present time rely on carriers for this information. Under this section, a question is raised whether a state which might contract with carriers or other private enterprise to provide this information system would be eligible for increased federal support. We recommend this section should be made clear to provide that States wishing to use private facilities, such as insurance carriers, could do so.

ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS (SEC. 228)

This section would remove the mandate, presently in Title 19, which requires the States to broaden the services and liberalize eligibility with a view towards furnishing by July 1, 1977, comprehensive care and services to all individuals and persons who meet the eligibility standards. Our policy has continuously supported a goal of making comprehensive health care available for all persons. We are aware, however, of the financial problems of the States and Federal governments with respect to current Medicaid programs, and accordingly it is recognized that a desire on the part of Congress to eliminate the 1977 requirement is now realistic.

PHYSICAL THERAPY SERVICES UNDER MEDICARE (SEC. 254)

Under Part B this amendment would provide coverage to beneficiaries for up to $100 per calendar year for physical therapy services furnished by a licensed physical therapist in his office or the patient's home under a physician's prescription. We also support this modification.

USE OF STATE HEALTH AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS (SEC. 238)

This section provides that in addition to the responsibility for establishing health standards for institutions in which recipients of medical assistance may receive care or services, the State Health Agency shall be responsible for review, by appropriate health personnel, of the appropriateness and quality of care and services furnished. The section adds a new dimension to the role of the State Health Agency in reviewing services provided. While we support the purposes embodied in this section, we submit that review of physicians' services as to quality and appropriateness could better be accomplished through peer review established by the state medical society as formulated in AMA's PRO proposal. PRO also provides for state and local advisory councils, with broad community representation, to participate in the program.

UTILIZATION REVIEW REQUIREMENTS FOR HOSPITALS AND SKILLED NURSING HOMES UNDER TITLE 5 AND TITLE 19 (SEC. 235)

This section would require hospitals and skilled nursing homes under Title 19 and 5 to have in effect a utilization review plan which meets the requirements for such review under Medicare. We also support this section.

ELIMINATION OF COST SHARING REQUIREMENTS UNDER MEDICAID (SEC. 236)

The present law permits a State to charge a medically indigent person (not one receiving cash benefits) a cost-sharing amount, but requires that this amount be related to the individual's income. This requirement, we understand, has been extremely difficult to administer. The proposed section would now allow the imposition of a flat deductible or cost-sharing amount. The Association supports the concept of an individual contributing towards his medical obligations where

he is financially able to do so. Accordingly, we recommend that his section be adopted.

We have a further suggestion to offer which we feel is aligned with this section. In the report of the House Ways and Means, it is stated: "even a small charge gives the recipient (of services) a sense of participation and can reduce tendency to excessive use of services". We agree with this statement, and it was to further instill this sense of responsibility and participation, and to place the recipients in the same mainstream of care, that we had requested the provision be made permitting payment to recipients of services under Medicaid. While the Congress did provide an option to the states for direct billing as to recipients who were not receiving cash benefits, we believe that the provision should be extended to include all Title 19 recipients, and we urge the Committee to provide for such an amendment to the program.

PART A BENEFITS FOR UNINSURED INDIVIDUALS (SEC. 202)

This section provides that persons not eligible for Part A benefits could voluntarily enroll for such benefits upon paying a monthly premium of $27 (to be adjusted if costs increase), if they are enrolled under Part B. We do not have sufficient information as to whether a monthly premium of $27 adequately covers the cost of the Part A program, but, in considering that much of the insurance coverage which is available to persons 65 and over is only supplemental to Medicare, we believe that the extension of Part A benefits to ineligible individuals 65 years and over is salutary.

AMOUNTS OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST (SEC. 230)

Under this section, payments for services by institutional providers under Titles 18, 19 and 5 could not be higher than the charge regularly made by them for those services. We support this provision.

INSTITUTIONAL PLANNING UNDER MEDICARE (SEC. 231)

This section would require hospitals to have in effect a regular plan including an operating budget and capital expenditures budget. While beneficial aspects are apparent in such a requirement, we are concerned whether all hospitals will be able to meet such requirements, and whether as a consequence some hospitals might lose their eligibilty for continued participation in the program.

NATIONAL DRUG FORMULARY

Mr. Chairman, at this point we would like to briefly reiterate our concern for any proposal to restrict the availability of drugs under government supported health care programs, though we recognize that the bill under consideration does not contain any such limitation. This Committee is aware of our position on this subject, most recently submitted in a letter to the Chairman last month. At this time I will merely restate its essence: In the best interests of the patient's welfare, the physician, in prescribing for his patient, should not be denied the availability of the full range of drugs, regardless of whether the patient's care is supported by payments from federal programs.

MEDICREDIT

I will now turn briefly to our Medicredit proposal, which was presented to this Committee at the time we appeared in June. Since then it has been introduced in the House of Representatives, and has received the sponsorship of twenty-eight members. Under this tax credit program the federal government would assist in the financing of medical and hospital care for individuals and their dependents through participation in the cost of qualified insurance policies of their choice—100% premium payment for the low-income groups, and graduated participation in the payment of premiums for other persons, based on their federal income tax liability.

I shall not go into full details of this program, because they are already before you, and because your current hearings center on H.R. 17550 which we have discussed. However, the portion of Medicredit relating to Peer Review Organization (PRO) is particularly germane to these hearings.

PRO was incorporated with Medicredit because the medical profession recognizes the need for an appropriate means of providing surveillance over the provision of medical services rendered within the program. PRO would act to review the reasonableness of charges made, as well as the need for and quality of the medical services provided.

Under this program, the Secretary would enter into agreements with a state medical society (or any organization designated or established by a state medical society), which, under a plan approved by the Secretary and the society, would provide a system of peer review of medical and other health services rendered under Titles 5, 18, and 19. The state program would be administered by a PRO Commission, consisting of five members who are doctors of medicine or osteopathy. The society would appoint an Advisory Council, composed of persons who are representatives of consumers, providers of health care, and insurance carriers. Local Review Panels consisting of physicians appointed by the State Commission are designated to administer the plan locally. A Local Advisory Council, created to advise the Panel, would include persons who are representative of consumers, providers of health care, and carriers administering Part B of Medicare.

Matters for review would first be heard by the Local Panel, which after notice and hearing, would make the initial determination of the case. Any recommendation for censure or discipline would be reviewed by the PRO Commission. A finding of the Commission for discipline would be forwarded to the Secretary of HEW who may implement the Commission's recommendation of discipline or, if he deems the recommended discipline to be excessive, may modify such recommendation. Discipline would include suspension or exclusion from further participation in the health programs. The right of judicial review is provided.

Mr. Chairman, the foregoing presents the essence of PRO, but does not include all of its provisions. The full program is contained in material already provided to you.

AMENDMENT NO. 851

This Committee has before it Amendment No. 851 for a Professional Standards Review Organization (PSRO). The amendment would establish a broad program for review of all services provided under Titles 5, 18 and 19. While its objective is similar to that of our PRO and such is laudatory, we find that significant changes should be made to Amendment 851.

The amendment provides that the Secretary should enter into agreements with qualified organizations to act as the Professional Standards Review Organization in a local area. While the amendment provides for the designation of a medical society as the PSRO, there is no requirement, as in PRO, that this should be the state medical society. Where the Secretary finds that the medical society is not qualified or willing, he may then designate such other public, nonprofit private, or other agency or organization, which the Secretary accepts as qualified to act in the area. The composition of the Professional Standards Review Organization is not specified in the amendment, and consequently there is no assurance that a physician's services will in fact be reviewed by his practicing peers. This is necessary if the profession is to be held accountable for its performance. This is necessary if the recipients of services are to be assured of quality care.

Another provision of the amendment requires that admissions to health care facilities for elective procedures, as well as extended or costly services, be reviewed in advance, and that prospective determination also be made whether contemplated inpatient hospitalization should be provided on an outpatient basis or at a less expensive facility. Mr. Chairman, we submit that the application of this requirement would often create difficulties and would not be in the interest of the patient. Corollary questions of responsibility and legal liability are also raised, as well as questions concerning the role of the institutional medical staff and the local PSRO concerning services provided in the institution. We believe that the provision for advance approval should be eliminated.

PSRO also provides for the review of services of not only physicians and other health care practitioners, but also all institutional providers of health care service and here, again, is an area where PSRO differs from our PRO. We believe that the PSRO requirement is too broad; physician review of services should be confined to services of the physician and such other services over which he has direct control and responsibility.

Another provision of the amendment creates "Norms of Health Care Services for Various Illnesses or Health Conditions." Such national or regional norms

must be approved by the National Review Organization. At the local level, each review organization, agency or person performing review functions shall utilize the norms developed as a principal point of evaluation as to whether the services are medically necessary, whether the quality meets professional standards, or whether inpatient services could be provided on an outpatient basis or more economically in a facility of a different type. Norms of treatment as to a particular illness or condition would further indicate appropriate methods and sites for treatment.

While the section provides for variation of practice different from the norm established, a tendency for adherence to the published norm carries within itself a potential detriment to the provision of higher quality care. On one side of the norm may be lower cost services as contrasted with a different service at a higher level of care. A review group looking to the costs of the program could find a level of institutionalization or treatment medically unnecessary. A physician may for these reasons, or reasons stemming from concern for legal ramifications which may arise from departure from such norms or for fear of subjecting himself to the penalty and refund provisions, find compulsion to conform to these standards in derogation of better care. We believe that the imposition of such national norms may impede, rather than strengthen, the development of the health programs. The imposition of such norms could well be looked on as a floor of acceptability, with an attendant lessening in quality care. Mr. Chairman, we believe that this provision for national norms, backed by the force of law, should not be adopted without an opportunity for a thorough evaluation of its consequences.

The amendment further provides under certain circumstances for a monetary fine on a physician or provider of up to $5,000 for continued eligibility under the program, or for a refund of charges where the services were determined by PSRO to be medically improper or unnecessary. We believe that this imposition of a monetary fine subverts the purpose of peer review. Fundamentally, peer review is an educational mechanism, and this aspect is a positive benefit which redounds to the program. This new inquisitional character of peer review, however, based on the criminal aspects and fines, would change the character of the program and we believe that the beneficial aspects would suffer. While we see no place for a monetary fine in peer review, we, of course, recognize that where the facts warrant, separate civil or criminal action could be instituted.

Other provisions, relating to the acquisition, ownership and control of profiles of patients', physicians', and providers' records of participation in the program, as well as concerning data required by the Secretary to be collected relevant to its functions and information, also differ from those in PRO. We believe that the confidentiality of these files should be protected and that they should be under the continuing jurisidiction of the appropriate review body, and should not become federal property.

The amendment also authorizes demonstration projects under which the PSRO would assume the responsibility and risk with respect to the review and payment of claims. It would appear to us an inappropriate mixing of functions—combining an underwriting concept with peer review.

In summary, then, Mr. Chairman, we believe that Amendment 851, introduced on August 20, 1970, requires additional critical evaluation. The amendment carries a potential for vast changes in the provision of health care programs. Differing views have been expressed from many quarters concerning the various proposals pending before you in the form of section 227 of H.R. 17550, PRO, and PSRO. Peer review itself is now ongoing. The concept of peer reveiew as a structured mechanism is still new.

We believe that if the Committee cannot accept the Peer Review Organization proposal contained in the Medicredit bill, consideration of review of services as to quality and charges should lay over to the next Congress. The future direction of peer review should not be cast in the statutory language of either section 227 or PSRO.

Mr. Chairman, we wish to thank you for this opportunity to present the Association's views on this important legislation, and we will at this time attempt to answer any questions which the Committee may have.

The CHAIRMAN. I think you have done a good job, Dr. LaMotte, in summarizing a very able statement that I, for one, will certainly carefully study, and we will certainly see that these points are considered as we go through this bill.

I do not believe we have any further questions.

Senator BENNETT. May I have just a minute or two, since I am the author of the PSRO amendment and, of course, since the AMA should know that the basic concept behind the amendment is theirs, it seems to me we are talking about details of operation and not principles.

We are not locked into the language of the amendment, and I am sure as we study your suggestions we will try to develop whatever changes seem to be wise.

I think it would be very foolish to put this thing off because we are now working on the problem. It may be 5 years before we can get back to it again and the alternative to peer review is Government control and, as far as I see it, we are giving the medical association the medical fraternity, an opportunity to police itself through the peer review mechanism.

The mechanics of what kind of a peer review organization we set up and exactly how it operates are subject to study and change. But I hope the American Medical Association will not desert its own child and say now, "that there are so many troubles with it that we would rather you went back to something else," and I hope the committee will study the proposal, which has been carefully worked out with many of the factors in the situation, including the American Medical Association. Its officers have been consulted along the line, as this program has developed. We have not always agreed with them.

There are three comments that I would like to make today where changes might be made: First, there is probably no reason to cause the PSRO to maintain separate patient profiles as long as these records are readily available for review as necessary. It seems sufficient that carriers and the intermediaries have the patient records so that they can be made available.

Second, some of the superstructure of the PSRO arrangement probably can be dispensed with to streamline the administration, and to provide a more effective statewide supervision of local PSRO's.

Third, the preadmission certification procedure can be streamlined to make it clear that only reimbursement under medicare is at stake, not the health of the patient and not the right of the doctor to put his patient in a hospital; and, second, to give the PSRO discretion to waive preadmission certification for diagnosis when they feel that the area is more or less obvious or when they are dealing with a doctor whose pattern indicates that his judgment can be trusted.

I think the PSRO organization should have the right of review under any circumstances, but I think practical experience will dictate that it will not be a required procedure in every case, but will only be used when there is some indication that this review is necessary.

There are other things in your statement that I am going to study very carefully. It hit me pretty fast. I did not have an opportunity to see it in advance.

I do want to say we are not anxious to set up a rigid system which will so circumscribe the physician in his practice or the hospital in its service to the patient that we will lower the quality of medcal services. But I am sure you are aware that there have been rather gross misuses of the system. There has been overutilization that has been serious. I was not here yesterday, but I understand we had testimony that there are many physicians who have used medicare not only as a

means of increasing their income but as a means of evading taxes, and we have a responsibility to bring these things under control.

So, I think your fears are more imaginary than real, and certainly we recognize that 80 percent of the money paid by the Government for services to medicare recipients is, in fact, ordered by a physician, and under those circumstances we think we should look to the physician for the review of the expenditures that he orders and which we pay, and we want to continue to do that, realizing that the alternative is the development of another Federal bureaucracy to do all these things, some of which in your statement you think are a little too rigid or too difficult.

So, I am going to try to work as long and as hard as I can to protect the right of the doctor to serve his patients. But when the doctor takes advantage of both his patient and the Federal Government then we have to have some kind of a mechanism to step in to stop it.

Dr. LAMOTTE. Mr. Chairman, may I respond to the Senator, Sir?

We certainly commend you for your interest and your understanding of this problem, and your willingness to support an amendment for a structured peer review mechanism.

The American Medical Association could not agree with you more that physicians must be responsible for improving the mechanisms of delivery of health care and eliminating, where possible, the abuses where they do exist, and has long said so.

Indeed, while in many areas of the country, as Senator Williams perhaps can tell you in his own State, there have been effective voluntary mechanisms of peer review developing to accomplish these purposes, because it is not everywhere, the association is officially on record that there should be a structured mechanism in a statutory sense, as you have suggested in your own amendment.

It is, I think, a question of how it is to be structured. Some things which may seem to be paramount to us may seem insignificant to others. I think we are all going in the right direction. We all want this to happen. We want to do it the best we can, to share our ideas to make it happen in the best way for the patient. You would agree with that.

Certainly, as far as your three or four suggested amendments are concerned, or variations in your requirements, we would like to have an opportunity to see those and to work with you on developing those changes, which sound commendable to us.

Senator BENNETT. There may be more, of course, as we go along.

Dr. LAMOTTE. Yes, sir. So, sir, we will certainly work with you on this because I think our goals are the same.

However, there is just one thing: What we are talking about is quite a different thing from what exists in section 227 of the basic bill, H.R. 17550, because that is a mechanism structured from the top down, and while it utilizes the consultation, the opinions of local groups, it does not specify that physicians in their organizations would be the peer reviewing mechanism. We are, therefore, opposed to section 227 because this is not the way in which we feel that good effective peer review can be carried out. We must use existing mechanisms supervised and undertaken by physicians at the local or State level, or only if they are not so functioning or so capable, other mechanisms, but still including the physician as the peer mechanism for

other physicians. This is why we are against section 227 and favor your type of use of existing local organizations or the PRO mechanism of the AMA. This, I cannot emphasize too strongly, Senator Long.

Senator CURTIS. I am concerned about the whole proposal. I happen to live in a rural county, where population is less than 8,000. We have four very outstanding doctors. They are capable physicians and surgeons, they are good citizens, they are honest. I think they will act more in the interest of the Federal Treasury than the bureaucracy in Washington. Now, those four doctors happen to office together, and operate the Minden Clinic. How are you going to apply, how would these three proposals apply, to a situation like that, because we would like to have some of their time left to cure the sick and to take care of the people who need to be relieved from their pain and suffering?

Would peer review mean that we have got to get three or four people to sign where now one is signing or to make a decision? What will the AMA's proposal do and what will section 237 do and what will Senator Bennett's proposal do in the rural practice of medicine?

Dr. LAMOTTE. Well, Senator Curtis, the plan must be carried out, because it is essential regardless of the various ideas, and certainly different sections of the country will certainly have to be treated differently.

The plan would be to set this up on a State society level with the creation of local panels of physicians where it is possible to do so, and where it is impossible to do so to have an overview at the county or State level.

I agree with you that physicians must be left time to treat the sick.

Senator CURTIS. But we have got other counties where there is only one physician in the county, and maybe one physician in each of the adjoining counties. There are some which do not have any, and you would have to go a hundred miles or more to get an independent peer committee.

Now, what I want to know is just how would rural communities be treated by these three different proposals. You have got some ideas. There was something in the House bill, and Senator Bennett has got some.

Dr. LAMOTTE. I would submit that, probably from a mechanical point of view, maybe that which is in the original proposal would handle this better because it would be something appointed by the Secretary to cover all health care services. But the mechanics would cloud the issue of this thing, and we would not have peers reviewing peers. That is why we are against that.

Senator Bennett's proposal, because I think that it emphasizes an arrangement between the Secretary and smaller units within the State, such as a county medical society, might find that there were areas not covered by this program.

Our proposal hopes to function on a statewide basis, with the State medical association setting up local panels, where it is possible to set them up. Where it is not possible to handle this on a local level it can be handled on a State level. Therefore, this program is much more flexible and retains the peer to peer relationship.

Senator BENNETT. May I interrupt at that point? My proposal says that where it is impossible to set up a local panel the Secretary may

choose the State medical association so the two then become identical.

Dr. LaMotte. Right.

Mr. Harrison. May I add something to that, Senator? One advantage in the PRO bill is the opportunity to begin with a plan that may be established by the State medical society in agreement with the Secretary. Under a plan in more rural States, perhaps the plan for peer review would be one which would recognize that in many areas of the State there are not sufficient personnel, medical personnel, physicians, that is, to conduct the review, and so the plan would incorporate a system of review by the State medical society or the PRO commission itself and in that plan, the necessary investigations of patient allegations can be made, can be set up in such a manner that we will not be disturbing the very necessary time of the physicians that is involved in providing medical care in the area.

Senator Curtis. What are you going to review? Are you going to review those cases where somebody makes a complaint? Are you going to review on a spot check basis or are you going to review all cases?

Dr. LaMotte. I think that, ultimately perhaps, the latter might be the goal but I doubt if we will ever get to it. But certainly, the first two that you mentioned.

Senator Curtis. Why should that be the ultimate goal? Here is a fellow who decides that he wants to practice medicine out in the ranch country and there is not another doctor within 40 or 50 miles, and if he was not a dedicated servant he would not choose to serve.

Dr. LaMotte. I would agree with you, Senator.

Senator Curtis. And why we have to transport somebody miles to watch him, I think there are more people in Washington who need watching.

Dr. LaMotte. I agree with you. But the best medicine, many of us believe, is practiced with your peers looking over our shoulder. Now, this does not mean that we are spying. This does not mean that 90 percent of physicians cannot practice good medicine without that.

Senator Curtis. I thought the Department was asking for this for the purpose of policing the charges.

Dr. LaMotte. This is only a small part of it.

Senator Curtis. I see.

Dr. LaMotte. This would be a function in regard to this type of legislation. But, in terms of peer review and professional evaluation and education of the physician, the very existence of such a mechanism will have a moral persuassive force on the few people who are perhaps deviating from normal practices of medicine.

Senator Curtis. Would you not agree with me that there no doubt are rural areas where this should not be imposed at all on local and county units?

Senator Bennett. May I make a comment at this point? We are talking only about the admission of patients to hospitals under medicare. We are not talking about the general practice of medicine.

Senator Curtis. I understand that.

Senator Bennett. May I ask is there a hospital in Minden County?

Senator Curtis. Yes.

Senator Bennett. Is it operated by these same four physicians?

Senator Curtis. No; it is operated by the county.

Dr. LaMotte. Senator Bennett, we interpret peer review as the responsibility of the physician wherever his services may be rendered, in the office, nursing home, home, and hospital.

Senator Bennett. But you cannot develop the medicare benefits for an individual now without putting him in the hospital for 3 days.

Dr. LaMotte. Institutionally you are talking about.

Senator Bennett. Or in an institution and, of course, as a part of that there is the opposite idea that he should not have been institutionalized, so to that extent peer review affects practice in the doctor's office.

Dr. LaMotte. Yes.

Senator Bennett. But we are fundamentally dealing with the process by which medicare patients are institutionalized on the order of a physician, and after they get in, the extent to which services are ordered by the physician for his patient, and in which the institution may be overutilized or there may be unnecessary medical or surgical services.

Dr. LaMotte. This is indeed an important part of it, Senator.

Senator Bennett. That, I think, is the heart of it.

Dr. LaMotte. But the whole vast spectrum of practice of medicine is also a very important part of it, and I think both of our amendments probably would hope to deal with that aspect of it as well as the institutional aspect.

Senator Bennett. The Federal Government is only going to be called upon to pay for the kind of services I have described.

Mr. Harrison. Senator, the medicare program, as such, under the part B portion, provides for, covers, services to patients outside of the hospital, in the physician's office or in the home and so forth. In our proposal, I think, as well as yours, this other aspect is also included under the peer review concept.

Senator Bennett. But we are dealing only with medicare patients.

Mr. Harrison. Medicare patients.

Senator Bennett. We are not dealing with the rank and file and the run of the physician's regular patients.

Senator Curtis. Well now, I will readily agree that the exchange of ideas between doctors and discussing a case with a fellow has great educational value and it all ends up for the benefit of the patient.

The fact remains this peer review setup will not be limited to voluntary educational work on the part of the medical associations or merely checking the charges of doctors. It will be passing judgment on the judgment that has been made by the practicing physician, is that not right?

Dr. LaMotte. It could be.

Senator Curtis. That is all, Mr. Chairman.

Dr. LaMotte. But this is being done by his peers and I would say——

Senator Curtis. But it is not forced on him by Washington.

Dr. LaMotte. No; neither will this be unless there is a peak from some computer which shows a variation in a pattern of practice.

Now, I can assure you that in our own State, where we have been at this voluntarily for the better part of a year in an active way, that while we are just as interested as the Federal Government and everybody else in seeking out those few who are abusing, those few who are

overutilizing and the question of medical necessity, by and large, what the mechanism has done, has shown that the pattern of practice in a large majority of cases, while varied, is basically sound and good. So, this peer mechanism is not going to unjustifiably criticize a physician who is doing a good job.

Senator CURTIS. Then the answer to my question is that they will only have a review where a case is shown up to show some possible abuse.

Senator BENNETT. They will have to review in order to find it.

Senator CURTIS. Will they?

Dr. LAMOTTE. This is probably the first clue.

Senator CURTIS. He said they would review the case that the computer told them.

Dr. LAMOTTE. This does not necessarily mean that the computer shows a single excessive charge.

Senator CURTIS. Yes.

Dr. LAMOTTE. It is a pattern of practice which can be peaked. This becomes a clue which the third party carriers today have found it impossible to pursue. The creation of a peer mechanism, peer to peer, inresolving these things on an educational basis and determining what the pattern of payment in some cases would be, but primarily an educational basis, is the thing that we feel will rebound to a better pattern of health delivery and medical practice and help weed out, with probable minimal necessity of referral to the Secretary for disciplinary action, weed out those and bring them down into an expected pattern of practice without force other than moral.

Senator CURTIS. That is all, Mr. Chairman.

The CHAIRMAN. Any further questions?

Senator WILLIAMS. I have no questions, Dr. LaMotte. I want to thank you for your testimony. You have made some constructive suggestions and they certainly will be taken into consideration by our committee.

Dr. LAMOTTE. Thank you very much.

Before I close, I would like to acknowledge, Senator Hansen, our awareness of your having submitted yesterday S. 4381 and we appreciate that, and we will be with you in support of this piece of legislation.

Senator HANSEN. Mr. Chairman, if I might be permitted just a word, I appreciate the kind remarks of Dr. LaMotte. I did not introduce the bill I did yesterday convinced that it is the last word but rather that it does represent a satisfactory sincere effort on the part of doctors in this country, an effort to which he subscribes, to present some good alternatives and viable alternatives to the American public.

I hope that it will be considered. I think it does have merit. I have no doubt at all but what it can be perfected. But I am well aware, as are many Americans, of the increasingly expensive costs of some of the programs that have been undertaken by the Federal Government, and to me this seems to be a very worthwhile alternative, and I appreciate your kind words.

Dr. LAMOTTE. We thank the Senator and thank you, Mr. Chairman and members of your committee.

The CHAIRMAN. Thank you, Dr. LaMotte. Very happy to have you, Doctor.

Now, the next witness will be Mr. C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association.

Mr. Stetler, I am pleased to welcome you here before the committee. You and I seem to have a difference of opinion with regard to how we should handle drugs under medicare and medicaid, but I respect you as a very able spokesman for your industry, and will be pleased to carefully consider everything you have to say here and I am sure that applies to all the other members of the committee.

STATEMENT OF C. JOSEPH STETLER, PRESIDENT OF THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION; ACCOMPANIED BY MR. BRUCE J. BRENNAN, GENERAL COUNSEL; AND DR. ROBERT K. QUINNELL, DIRECTOR, OFFICE OF MEDICAL RELATIONS

Mr. STETLER. Thank you, Mr. Chairman and members of the committee. I am C. Joseph Stetler, president of PMA. I have with me this morning Bruce Brennan, general counsel of our association, and Dr. Quinnell, director of medical affairs.

Realizing your time limitations I will be extremely brief. I will cover it in less than 10 minutes.

The CHAIRMAN. I, for one, can assure you, Mr. Stetler, I will read every word of it and respond to it just as you have shown me the same consideration in regard to the speeches I made dealing with your industry.

May I say that, in all fairness, I think you are a very able representative of a very fine industry.

Mr. STETLER. I will try, in my testimony, to confine my remarks to the amendment 929 to 17550, which was introduced in the last couple of days, relating to drugs.

This amendment does vary only in minor details from a proposal that was before this committee in 1967, and was rejected by the Senate Finance Committee. Frankly, we believe that the arguments against it which prevailed in 1967 are even more valid today.

The CHAIRMAN. How did we make out on the floor on that same amendment?

Mr. STETLER. It was accepted on the floor and rejected in conference.

The CHAIRMAN. We got a part of it, but we did not get what we wanted, I concede that. Go right ahead, sir.

Mr. STETLER. The heart of this proposal, in our belief is the assumption—supported by no responsible Government or scientific authority that we are aware of—that there is an assurance of uniform quality and therapeutic equivalence of drug products with the same generic name irrespective of their source.

Studies which have been conducted by various reputable authorities in and out of Government, have shown that chemical equivalency does not mean therapeutic equivalency. Rather, formulation variations do result in differences in biological activity in nearly all the products that have been examined to date.

Scientific literature on this is quite voluminous, it is increasing in terms of the number of articles making the same point. We have an attachment A which you have indicated will go into the record. It is a complete elaboration on the scientific issues which have been raised in this controversy.

We do believe the whole weight of these events is on the side of avoiding the kind of assumptions this amendment seeks to impose on

doctors and pharmacists. It could not be clearer, in our opinion, that now is the time to demand that doctors and pharmacists use their experience and their judgment to protect consumers from bad bargains rather than to encourage them to abdicate their profesisonal responsibilities to a Government committee.

Now, the amendment, among other things, does provide for the establishment of a formulary committee and a Federal formulary.

In our opinion, the formulary committee envisioned by the amendment would be presented with an impossible task in carrying out its specific assignments. There already exists, as you know, under the Federal Food, Drug, and Cosmetic Act, comprehensive authority to monitor the safety and effectiveness of drug products on the market. To superimpose upon this existing system, even with its imperfections, an altogether new set of standards and a new administering agency could not fail to lead to great confusion, substantial additional expense, delay, and uncertainty.

It is clear, in our opinion, therefore, that a national formulary cannot be justified scientifically or medically. In the light of the complexities and subtleties of the problems in this area which are vital to the national welfare, we believe that the proposal is not only unnecessary and undesirable but that it could be dangerous to the Nation's health care system, if enacted.

Another feature in the amendment is the authorization that it would give to the Secretary of HEW to publish a guide showing the "reasonable acquistion cost range" of each qualified drug listed in the formulary.

The Secretary would presumably carry out this sweeping authority by looking at the market—as narrowed by the formulary—to determine the prevailing prices of given drug products. He would then publish a guidebook or a list showing the price range established. In an individual transaction the dispenser of the drug product would be reimbursed in accordance with the dictates of the guidebook.

Beyond the sweeping economic controls over drug products proposed in this section, producers and suppliers—by the terms of the proposal—would be required to accept the administrative decisions as to price made by the Secretary or his representative without any right to administrative review or any right to a hearing.

Even in the short run, the ceiling price, determined by the Secretary on the basis of products offered at lower price, may not enable the full service producer to compete successfully. Thus, the standard of performance for the drug industry would be lowered to that of the minimum producers.

Finally, the amendment proposes that the FDA be given additional authority which, for all practical purposes, could force a particular product off the market—or to close a plant without giving the manufacturer an opportunity to be heard. This most extraordinary authority is included in what might appear to be a simple system of requiring manufacturers to place their registration number on their products.

With respect to the estimated savings and the associated costs of the amendment, the testimony presented to this committee to date, with respect to potential savings and administrative costs incident to the amendment is really quite meager and to us quite confusing. It is imperative, in our opinion, that the full information be obtained as

soon as possible from either the Bureau of the Budget or the Department of Health, Education, and Welfare.

In the absence of such data at the present time, we have attempted in attachment B to our complete statement, to estimate gross savings to be expected and the costs of implementing and administering the proposal.

In addition, we believe, when comments are solicited from HEW, the request should seek the current views of the Department on the substantive elements of the amendment. Nothing in the record of these hearings indicates the Department's views on a Federal formulary on drug equivalency, or on fixed reimbursement schedules for prescription drugs. The findings of the "Dunlop Committee" so-called, which was appointed to critique the work of the Task Force on Prescription Drugs, I believe, reflect the current position of the Department on these issues.

In brief summary, we are obviously opposed to this amendment, and we are opposed because we believe that it will reduce the quality of medical care for social security beneficiaries; that it sets up an involved and expensive scheme that would be difficult, if not impossible, to administer fairly and successfully; that it would interfere unduly with physicians and pharmacists providing the best possible medication for patients under social security programs; that it would jeopardize the ability of quality, research-oriented pharmaceutical companies to continue to perform efficiently and effectively.

Finally, it is our belief from the data we have or from what we know, which is obviously incomplete, that the costs of implementing the proposal would exceed any possible savings.

Thank you, Mr. Chairman.

(Mr. Stetler's prepared statement follows. Hearing continues on page 1115.)

STATEMENT OF C. JOSEPH STETLER, PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION, REGARDING AMENDMENT NO. 929 TO H.R. 17550

Mr. Chairman and members of the committee, I am C. Joseph Stetler, President of the Pharmaceutical Manufacturers Association, on whose behalf I welcome the opportunity to appear before you today. Accompanying me are Bruce J. Brennan, General Counsel of the Association, and Robert K. Quinnell, M.D., Director of the PMA Office of Medical Relations.

PMA is a voluntary, non-profit trade association composed of some 120 companies engaged in the development and production of prescription drug products. These firms account for approximately 95% of thse products made and sold in the United States today.

Among our members are those companies, significantly engaged in pharmaceutical research, which are primarily responsible for making available the great number of life-saving and life-sustaining medicines that have come into use during the past 30 years.

Our member companies have facilities in nearly all of the states and employ more than 130,000 workers, including a high percentage of scientists and research specialists. These companies have an annual payroll of more than $1 billion and pay taxes of approximately $700 million annually to federal, state and local governments. In addition, PMA companies have sales in foreign countries approaching $2 billion and operate hundreds of manufacturing facilities abroad.

Our member companies vary greatly in size. Several do an annual pharmaceutical business of less than $200,000, while others have drug sales of $200 million or more. Approximately one-half of th PMA member companies would qualify as "small business" as that term is defined by the Small Business Administration.

The drug industry is not a corporate monolith representing the concentrated power of a handful of large firms. Rather, it consists of many companies, large

and small. No one firm accounts for more than 7 percent of the total prescription drug sales in the United States which last year amounted to $4.3 billion.

Few, if any, other manufacturing industries of comparable size are as broadly based. This has given rise to competitive rivalry in the marketplace marked by the constant striving by individual firms for recognition through new discoveries and the overall excellence of their performance. Benefits to the public have been enormous, for from such competition has come a strength and viability of great value to medial progress over the years.

In today's testimony, I shall discuss the Association's position with respect to Amendment No. 929 to H.R. 17550, 91st Congress. The proposed amendment differs only in minor details from a proposal which the Finance Committee rejected three years ago. The arguments against it which prevailed in 1967 are even more valid today.

At the outset, let me say that the drug industry acknowledges the government's proper interest in holding down the rising costs of health benefits under various Social Security programs. We stand ready to assist in a constructive search for ways in which this goal can be reached without adversely affecting patient care and without demolishing the system on which the nation's tremendous record of progress has been built. The industry is convinced that the measure which concerns us here does not meet these criteria.

Instead, we feel strongly that enactment of the amendment in question would establish an impractical and inequitable method of controlling federal drug expenditures; that it would impair competition in the drug industry; and that it would adversely affect the quality of health care provided under the Social Security Act.

Under the terms of this proposal, these elderly and financially unfortunate Americans would become a disadvantaged class of patient. The number and variety of drug products now provided them at government expense would be limited by executive decrees, irrespective of the medical decisions of their physicians. The entire range of drug products on the market would, however, remain available to other Americans.

No one can disagree with the concept of prescribing economy as a laudable objective. But would it be sound public policy for the government to make drug prices a principal test of rational drug prescribing and dispensing? Yet, in the final analysis, that would be the effect of the amendment.

The heart of this legislation is the assumption—supported by no responsible government or scientific authority that we are aware of—that there is an assurance of uniform quality and therapeutic equivalence of drug products with the same generic name irrespective of their source.

Studies conducted by various reputable authorities, in and out of the government, have shown that chemical equivalency does not mean therapeutic equivalency. Rather, formulation variations do result in differences in biological activity in nearly all the products examined to date. Important differences in drug products, with the same generic name, marketed by different firms, have been recognized by the FDA, the Academy of Pharmaceutical Sciences, and the National Academy of Sciences. The scientific literature, too, is showing an increasing number of articles making the same point. Attached is a paper (Attachment A) entitled "Medicines—Brands, Generics, Quality and Cost—The Continuing Debate After Ten Years", which elaborates on the scientific and economic issues raised in this controversy.

The whole weight of these events is on the side of avoiding the kind of assumptions this amendment seeks to impose on doctors and pharmacists. It could not be clearer, in our opinion, that now is the time to demand that doctors are pharmacists *use* their experience and judgment to protect consumers from bad bargains rather than to encourage them to abdicate their professional responsibilities to a government committee.

Turning now to some of the specific terms of this legislation, we feel strongly that its passage would create significant administrative difficulties. Many of these were pointed out to the Committee in some detail in 1967 by the very HEW officials who faced the ultimate responsibility for carrying out the program had it been enacted at that time.

We are convinced that the proposed program would jeopardize the future development of new medicines for yet unconquered diseases; that it would improperly inhibit the physician's choice of drug products that his individual experience and training have indicated are best for his patient. And that it would unfairly penalize the patient whose physician prescribed a drug product

that is familiar to him and in which he has faith but which is not listed among the drugs for which the government will provide reimbursement.

The measure would: (1) establish a Formulary Committee in the Department of Health, Education, and Welfare with the power to determine which drug products would be qualified for reimbursement under Titles XVIII and XIX of the Social Security Act; (2) require the Secretary of HEW to establish and publish a "reasonable acquisition cost range" guide for most qualified drug products and establish permissible fees for pharmacists; and (3) modify the present compulsory registration system for prescription drug manufacturers and through this and other provisions vest in the Food and Drug Administration substantial additional statutory responsibilities.

FORMULARY COMMITTEE AND THE PUBLICATION OF A U.S. FORMULARY

The Formulary Committee would be comprised of nine members, two being government officials designated by the Secretary and seven other persons not in the regular employ of the federal government, to be appointed by the Secretary. The Chairman of the Formulary Committee would be elected from among the non-government members.

The Formulary Committee would be required to compile, publish, and periodically revise an alphabetical listing by established name of "those prescription and nonlegend prescription drugs which the Formulary Committee *finds are necessary*" for proper patient care.

The amendment would also provide that the Committee *may* include among other things in the Formulary: (1) a list of included drug products by "diagnostic, prophylactic, therapeutic or other classifications", (2) the brand names under which a listed drug product is sold and the names of each supplier of such drugs who is certified by the FDA as producing or distributing such drug in conformity with the Federal Food, Drug, and Cosmetic Act, (3) prescribing information which promotes the safe and effective use of listed drugs (including conditions of use required in the interest of rational drug therapy), and (4) a guide as to "reasonable cost ranges".

The Formulary Committee would also be empowered to require testing and the establishment of procedures to determine "the propriety of the inclusion or exclusion" of any drug in the Formulary.

In our opinion, the Formulary Committee would be presented with an impossible task, in carrying out not only these assignments but also in attempting to determine:

(1) Which drug products currently in general use under existing law should nonetheless be excluded from the Formulary because they are found "not necessary for proper patient care";

(2) Which products are to be accepted for full reimbursement in that they have "distinct therapeutic advantages";

(3) What to include as prescribing information which promotes the safe and effective use of listed drugs (including conditions of use required in the interest of rational drug therapy).

There already exists, under the Federal Food, Drug, and Cosmetic Act, comprehensive authority to assure that only safe and effective drug products are on the market. But, realistically we all know that this ideal remains considerably beyond FDA's grasp. It is physically impossible for that agency to monitor adequately the activities of hundreds of manufacturers, or for that matter, even to know who or where they are.

To superimpose upon this existing system, with its obvious imperfections, and altogether new set of standards could not fail to lead to great confusion, substantial additional expense, delay, and uncertainty.

With reference to the first point, suppose the Committee finds that certain drugs are "not necessary for proper patient care".

Which of those currently approved and marketed drug products would the Committee exclude from the Formulary and in effect condemn to extinction? Which ones would be granted a viable commercial life, virtually free of competition? On what basis would this decision be made?

Surely a part-time government committee should not be empowered to decide the life or death of a particular drug product which is lawfully on the market.

As noted, the amendment would also provide that the Formulary Committee *may* include proprietary names in the Formulary, if the manufacturer has been certified by the FDA as producing such drug in conformity with the Food, Drugs, and Cosmetic Act.

In other words, a brand name is not entitled to a listing in the Formulary unless the producer of the trademark product is certified by the Food and Drug Administration.

One can only wonder why the institution of trademarks, which is fundamental in the American economic system, as a means of identifying the producing source should thus be selected for special prejudicial attention in connection with drug products only.

THE FEDERAL FORMULARY DELUSION

Considerable confusion has been generated by the extraordinary reliance which is placed on a restrictive national drug list or "Formulary". Supporters claim that Formulary legislation would achieve program economy and "rational" drug use. They make much of the fact that formularies have been successful in many large hospitals in reducing drug procurement costs, without apparent sacrifice in the quality of treatment. Hence, they argue that a monolithic federal Formulary would achieve important savings by limiting reimbursement to less expensive formulations of the same chemical composition deemed to be of acceptable quality. This is a fundamental error.

The legislation fails to recognize that the essential features which make hospital formularies reasonably successful bear little or no relationship to retail pharmacy. In a well-managed hospital, procurement can be centralized and the pharmacy stocks can be restricted to a list of products chosen by a committee of physicians on the hospital staff and the hospital pharmacist. A hospital Pharmacy and Therapeutics Committee is by experience acutely aware of quality differences among "chemical equivalents". It knows which products are available, and their sources. It also reflects the opinion and desire of the doctors involved. Price is considered, but not at the expense of quality.

Under these conditions, physicians are free to veto the purchase of drugs manufactured by firms of uncertain or unknown repute and may, whenever their judgment suggests, prescribe products not included in the Formulary. The sort of national Formulary suggested by this measure gives the prescriber no voice in the decision to exclude certain drugs. Rather, it would tend to restrict prescribing according to arbitrary federal standards. It would base drug coverage on the presumption that the lower-priced drug is equivalent to all others on the market.

Such a proposition is untenable and patently harmful to medical practice and the public health. It would also be destructive of innovation within the pharmaceutical industry. Its effect would be to reduce all competition in the industry to price alone, on the false theory that the government can with one hand hold prices down and with the other assure quality.

The provisions of the amendment are all the more surprising when it is considered that all existing federal drug programs—those of the Department of Defense, Public Health Service, and the Veterans Administration—have one characteristic in common. They use drug lists as guides to the procurement and stocking of drugs in their own hospitals and clinics, but they employ quality criteria and controls much stricter than those of the FDA. At the same time, not one of them attempts to apply the type of Formulary proposed in this measure to programs operating through community pharmacies. The Department of Defense, for example, has consistently opposed the Formulary system for its outpatient drug program. The explanation is that the DOD has no way of assuring, for the products sold in civilian pharmacies, the same high standards that exists in its own hospitals; hence, it will not risk subjecting military personnel dependents and retirees of the armed services to second-class medicine.

It is clear that a national Formulary cannot be justified at the present time scientifically or medically. In the light of the complexities and subtleties of the problems in this area which are vital to the national welfare, we believe that the proposal is not only unnecessary but that it would be dangerous to the nation's health care system, if enacted.

EFFECT OF FORMULARY ON MEDICAL PRACTICE

In addition to the above, the amendment would result in pressures to limit the physician's freedom of choice in prescribing those drug products which his training and experience indicate as best for his patients.

We agree with the proposition, endorsed by the medical profession itself, that physicians should consider price in selecting drug products as well as any other medically-indicated procedure or treatment. But all would agree, we believe,

that the physicians' primary consideration should remain the selection of the particular drug products, diagnostic procedure or treatment best suited for the individual patient's medical problem. As far as pharmaceuticals are concerned our position has always been that the physician should be completely free to exercise his professional judgment in selecting the drug product which he considers most beneficial for his patient.

Some will point to the fact that this legislation does not specifically compel generic prescribing or dispensing, and does not purport to limit the prescribing practices of physicians.

How free would the physician really be in drug prescribing if the Formulary Committee determines that the products of his choice are not "necessary for proper patient care' or that they are not produced or distributed "in conformity" with the Food and Drug Act or that he is acting in accordance with "prescribing information (including conditions of use required in the interest of rational drug therapy)" as determined by the Committee?

PRICE CONTROL

The amendment would also authorize the Secretary of HEW to establish and publish a guide showing the "reasonable acquisition cost range" of each qualified drug listed in the Formulary. The reasonable cost would be the amount at which the product is generally available. The "reasonable charge", with respect to prescription drugs, means the lesser of the approximate or average cost of the drug to comparable dispensers (within the reasonable cost range), plus a reasonable fee or charge for dispensing as compared to the usual or customary charge.

The Secretary would presumably carry out this sweeping authority by looking at the market—as narrowed by the Formulary—to determine the prevailing prices of given drug products. He would then publish a guide book or some kind of list showing the price range established. In an individual transaction the dispenser of the drug product would be reimbursed in accordance with the dictates of the Guidebook.

Thus, under the so-called "reasonable cost range" provision of the measure, not only would the manufacturer, retailer, and wholesaler be faced with fixed ceiling prices, but also a price regulation system which would drastically limit prompt and flexible adjustment in prices to take care of changing material, labor costs or any other development.

Beyond the sweeping economic and price controls over drug products in this legislation, producers and suppliers—by the terms of the proposal—would be required to accept the administrative decisions as to price made by the Secretary or his representative without any right to administrative review or any right to a hearing.

This provision can be seen then as an anti-competitive price-fixing measure that would discourage competition at the manufacturer and retail levels. It would tend to give unjustified status to a few drug prdoucts in each therapeutic class where many now compete.

Even in the short run, the ceiling price, determined by the Secretary on the basis of products offered at lower price, may not enable the full-service producer to compete successfully. Thus, the standard of performance for the drug industry would be lowered to that of the minimum producers.

"FULL SERVICE" DRUG MANUFACTURER

There is another important aspect of the proposal to limit government reimbursement for drug products to "generic" price levels that deserves comment. This is the assumption that there is no valid reason for a drug product manufactured by one pharmaceutical company to be priced higher than even a comparable product made by another firm. This observation overlooks the vital differences among drug producers with respect to related activities and services performed.

The "full service" firms in the pharmaceutical industry are those that are committed to the following services in behalf of the health industry:

(1) Continuing research and development, seeking not only new therapeutic breakthroughs but also broadened clinical experience with existing drug products.

(2) Rigorous quality controls throughout the production prices.

(3) Preparation of the product in a wide variety of strengths and dosage forms to meet particular medical needs, rather than only the most profitable formulations.

(4) Nationwide product distribution, assuring 100% availability of the medicine.

(5) Around-the-clock preparedness to disseminate extensive information and advice including the experience of other medical practitioners, when questions arise in the use of a particular product.

(6) Extensive promotion of new products, serving the purpose of providing important information to the health professions on the latest developments while enabling manufacturers to strive for acceptance in the market place so that they may remain profitable and creative.

(7) Production and distribution of "service drugs" essential for the treatment of rare diseases or poisoning but of minimal or no commercial value to the manufacturer.

These services are all expensive. They represent "added values" which quality-conscious, research-oriented firms provide with their products.

In the pharmaceutical industry there are other companies which perform none or only a fraction of these services. They are the low price houses because they are the low expense houses. They are the minimum producers mentioned earlier.

It is certainly not unknown in other industries for houses such as these to surface after others have creatively responded to the needs of the market, and to attempt to obtain a share of that market through product imitation and price reduction, based on reduced services and corner-cutting manufacturing practices.

The situation speaks for itself. Enactment and implementation of the legislation in question could result in the slow death of the research-oriented, quality-based full-service segment of the pharmaceutical industry as we know it today. In the long run, it would not be possible for the "Full Service" manufacturers to maintain their current operations and at the same time compete successfully.

Quality firms would inevitably be forced to cut back on research and development, and on a number of their other service commitments for the simple reason they could no longer be afforded.

Research-oriented, innovating drug manufacturers, in sum, perform a vital role in protecting the nation's health. The "product" provided by these companies to physicians, pharmacists and to society—in terms of new and effective medicines, information and research and service— is, in the last analysis, a very different one from that provided by the imitator. Any action by Congress which would reduce incentives to companies offering high "total product" value and incentives to others to invest capital and resources in such companies, should be approached with great caution. The health of all of us and of future generations is dependent on the continued growth and vitality of a progressive and successful United States pharmaceutical industry.

DRUG PRICES

Statements with respect to drug prices have created the impression that drug product price levels are rising as much or more than other products.

This false impression has been created by the staggering rise in total health care costs during the past decade. Informed that the overall price of medical care has risen faster than any other component in the Bureau of Labor Statistics Consumer Price Index, the public is quite naturally receptive to allegations of "high drug prices" as being part of the total picture.

Too often prescription drugs are not mentioned as a separate sector. Yet the government maintains separate price indices for both wholesale and retail prescription drug prices. The retail prescription drug index, as of last May, showed an increase of 2.1% over May 1969, compared to an increase of 6.2% for all consumer prices. And even then it was 9.5% *below* the base period of 1957–59, while all consumer prices were 34.6% *above* that base.

The rise in prescription drug prices at the wholesale price level was even more modest. Last April the ethical drug index was slightly less than that of April 1969, compared to a rise of 4.2% for all wholesale commodity prices.

Some critics, who are quite willing to rely on the BLS price indices as a proper measure of other prices insist that when it comes to drug products, we should use another indicator, that of the average prescription charge, which rose moderately in the past decade. But, it is important to remember that the average prescription charge ignores some important non-price elements, most

notably the fact that the content and the size of the unit—the prescription has changed. It is really a measure of unit expenditure, not of price alone. Yet even this standard rose at a much lower rate than the All Items Consumer Price Index. On a per tablet or capsule basis, the prices of prescription products have declined, according to a recent study of average prescription charges.

There are other limitations in using averages. For example, the medication used to fill a 1970 prescription very possibly did not exist in 1960; and the cost of researching, producing, distributing and dispensing that medicine has changed vastly since then. Similarly, the level of care given in the doctor's office or in the hospital today reflects the impact of new medicines and new techniques so that value received today may be considerably more than that received a decade ago.

That is why a price index is the most meaningful measure of price change over a period of time. By this measure, our industry needs make no apologies for drug price performance.

Even beyond the blessing of health and relief from pain, it should also be borne in mind that drugs have brought innumerable social and economic gains to our fellow citizens. They have been largely responsible for steady reductions in the lengths of hospital stays, the closing of tuberculosis sanitariums, and a savings of over $7 billion in mental hospital construction costs that would have been incurred since 1953, had effective new medicines to treat mental illness not been developed.

EXPANDED AUTHORITY IN FDA

Finally, the legislation would wrongfully permit the Food and Drug Administration, for all practical purposes, to force a particular product off the market—or to close a plant without giving the manufacturer an opportunity to be heard. This most extraordinary authority is included in what might appear to be a simple system of requiring manufacturers to place their registration number on their products.

While we believe that the registration number and the name of the manufacturer or distributor should be placed on the label of each package or container of a drug product, this measure would go much further. It would provide that if the Secretary of HEW, or some other person in that Department, makes an inspection and concludes that a product is adulterated or misbranded within the meaing of other provisions of the Food and Drug Act, the manufacturer would be prohibited from placing his assigned registration number upon any of the drug product packages involved. This administrative action could be taken by an official of HEW *without according any hearing to the manufacturer.* The manufacturer would, under this language, be entitled to a hearing only after the action was taken.

The net effect of this procedure would be to ban a manufacturer's product from the market by administrative action, without a hearing. It is immaterial whether by precise legal interpretation this provision applies across the board to the sale of drug products generally or only under one of the Social Security programs, since the manufacturer's product would be effectively foreclosed from whatever private market may remain. A prudent wholesaler or retailer could not tolerate being placed in the position of selling a product to a regular patron which has been labeled "illegal" by a government official, for Social Security purposes.

Under existing law, a drug product believed by the FDA to be adulterated or misbranded is subject to seizure, but only pursuant to a Court order.

We simply cannot understand why there should now be proposed this extraordinary procedure for taking a drug product off the market, without the right of an administrative hearing or even without a Court order based upon a determination of "imminent hazard to the public health."

ESTIMATED SAVINGS AND ASSOCIATED COSTS

Testimony presented to the Committee to date, with respect to potential savings and administrative costs incident to the amendment, is meager and confusing. It is imperative in our opinion that this information be obtained as soon as possible from the Bureau of the Budget or the Department of Health, Education, and Welfare.

In the absence of such data at the present time, we have attempted in the attached memorandum (Attachment B) entitled "Estimate of Possible Savings

Compared to Associated Costs" to estimate gross savings to be expected and the costs of implementing and administering the proposal.

Based on the figures available to us, it is our conclusion that administrative and associated costs would exceed any possible savings.

SUMMARY AND CONCLUSIONS

In summary, we are opposed to the amendment because we believe that it will reduce the quality of medical care for Social Security beneficiaries; that it sets up an involved and expensive scheme that would be difficult, if not impossible, to administer fairly and successfully; that it would interfere unduly with physicians and pharmacists providing the best possible medication for patients under Social Security programs; that it would jeopardize the ability of quality, research-oriented pharmaceutical companies to perform effectively for society as a whole; and finally, because it is our belief that the administrative costs of implementing the proposal would exceed any possible savings.

MEDICINES, BRANDS, GENERICS, QUALITY AND COST, THE CONTINUING DEBATE AFTER TEN YEARS

The "Brand versus Generic" issue is an inaccurately characterized and generally misunderstood controversy about the way medicines are named, prescribed and dispensed. It has been in process for many years and, in the past decade, has been the object of mounting public attention.

The purpose of this paper is to review the controversy briefly, to summarize some of the scientific evidence that has been gathered, to clarify the elements of the dispute, and to identify appropriate courses of action.

THE PRIMARY MOTIVATION: CLAIMED ECONOMY

To a very substantial degree, the controversy is economic in origin, although other issues are involved. These include fundamental questions about medical and pharmaceutical practice and drug quality. But the most prevalent assertion on behalf of generic prescribing is that it holds out the prospect of significantly lower prescription drug costs.

Contrary to this assertion, experience indicates that economies involved in generic prescribing have not been large. Further price differences[1] have narrowed so materially recently that overall savings are now, at best, marginal. The reasons for the narrowing are various; it is evident, for example, that when producers of very low-cost products are required to meet acceptable standards of quality and availability, their prices rise. Further, when physicians do prescribe generically (about one prescription in ten is so written), the pharmacist typically exercises a high level of care in selecting the product—he dispenses a medicine of recognized quality. For these and other reasons, it is clear that the savings projected through generic prescribing are minimal now and could disappear within the current decade.

If this development seems surprising, it is largely because advocates of generic prescribing have tended to generalize about the matter on the basis of a handful of unrepresentative examples. They have erroneously implied that millions of dollars could be saved simply by ending the use of trademarks or brand names in prescribing.

THE PARAMOUNT ISSUE: DRUG QUALITY

Advocacy of generic prescribing relies flatly on the assumption of equal quality of all products offered for sale. Indeed, unless all products with the same generic name can be shown to be equivalent, advocacy of generic prescribing and dispensing is untenable.

The generic or established name of a drug describes or refers only to the pharmacologically active ingredient of the drug product—not to the finished product itself, which may be a tablet, capsule, injectable, ointment or elixir. Whatever the form, other substances are mixed with the active ingredient to

---

[1] Between 1959 and 1969, the average prescription charge rose 22.5 percent, but the average generically-written prescription soared *63.2 percent*, according to R. A. Gosselin & Co., a market research firm.

produce the medicine itself, and then it is processed into its final form in accordance with each manufacturer's own quality standards and procedures.

This is the central point to remember. For it is on this point that the argument of "drug equivalency", advanced by proponents of generic prescribing and dispensing, begins to crumble.

Manufacturers' processes are not uniform. Substances added to the active ingredient by one producer may be omitted or may be unlike those used by another producer. There can be variations in the active ingredients; e.g., degree of fineness, crystalline state, etc., even assuming compliance with the official standards. It is apparent, therefore, that a medicine supplied by one manufacturer may differ to a significant degree from a medicine supplied by another, although both may contain the same generic-named active ingredient. But there is no guarantee that they will produce the same result in a patient.

In the early 1960s, very little was said publicly about quality differences in the nation's drug supply, while very much indeed was publicized about the differences in price between different formulations of a handful of prescription products.

By the mid 1960s, however, the literature on biopharmaceutics had grown sufficiently to indicate that a wide-spread need existed for a re-examination of assumptions about the chemical-physical standards for drugs, manufacturing practice regulations, formulation techniques, and the regulatory standards involved in the clearance of duplicates of established products.

In the same period, FDA began publicizing drug recall lists, which show that more than 600 lots of differing drug products are recalled each year, due to manufacturing errors, loss of product stability, or other failures rendering the drug unsafe for use.

And the Department of Defense, early in the decade, found it necessary to establish an elaborate product-and-plant inspection program in order to protect military personnel from inferior products purchased on the basis of low cost. Significantly, the military quality assurance program record shows that approximately 45 percent of the plants and products inspected are rejected, though the facilities, and the drugs they produce, are presumably operating without interference from the FDA.

Finally, toward the end of the decade, serious attention was given to the detection of clinical differences between supposedly equal preparations, as determind by controlled experiments in humans. The first product so investigated by the manufacturers of the standard product and later by the government was chloramphenicol. In both studies, substantially lower blood levels were reported for the purported generic equivalents of the original preparation, and millions of doses were removed from the marketplace, despite earlier batch-by-batch certification by the Food and Drug Administration.

FDA-SPONSORED STUDIES ON EQUIVALENCY

A similar experience occurred with claimed equivalents of the original oxytetracycline, and a variety of other products. FDA thereafter recognized the need to fund scientific studies on the implications of formulation differences in drugs with the same generic name. A major FDA study was undertaken by the Laboratory of Clinical Pharmacology of Georgetown University School of Medicine, under Dr. Christopher Martin. In his first public report on the study on April 20, 1970, Dr. Martin told the American Society for Pharmacology and Experimental Therapeutics that his findings "raised serious doubts about the equality of different products of the same drug for the treatment of disease."

Dr. Martin's warning was echoed, and in some cases preceded by similar statements by the nation's leading pharmacologists, either on the basis of their own clinical experience or as a result of similar controlled tests. One of the acknowledged leaders in this field, Dr. Alfred Gilman of Albert Einstein Medical College, wrote to Senator Gaylord Nelson in July 1967, that he was seeing "more and more instances" of "a marked change in therapeutic efficacy as evidenced by patient response" when drug products of presumed equality are interchanged.

Similar warnings had been issued as early as 1960 by Dr. Gerhard Levy of the University of Buffalo, School of Pharmacy and in 1961 by the late Dr. Eino Nelson, Associate Professor of Pharmacy at the University of California, in each case supported by specific examples involving important drugs. More recently, at a symposium of pharmacologists held in the Spring of 1969, Dr. William Barr of Buffalo listed 30 forms of 21 drugs on which clinical differences had been found. The HEW Task Force on Prescription Drugs also recognized differences

in drug equality. It published a list of 27 drugs about which equivalency questions could be raised. More than 24 million prescriptions were written for these products in 1966 for the elderly alone. On page 34 of its Final Report of February 7, 1969, the HEW Task Force stated:

> In the case of chemical equivalents available from two or more sources, we are convinced that the primary objective should be to provide the physician with every reasonable assurance that all chemical equivalents of the same drug on the market—when administered in the same manner and in the same dose—will give essentially equivalent clinical results. Unless the drugs perform reliably in the clinical situation, the physician will find himself in an intolerable situation, with the possibilty that he may be placing the health or even the life of his patient in jeopardy.

FDA ACKNOWLEDGES NEED FOR PROFESSIONAL JUDGMENT

There is general agreement that the Food and Drug Administration is in no position today, nor will it be in the foreseeable future, to give the nation's doctors the assurances which are essential for generic prescribing. In the Spring of 1970, the Commissioner of FDA, Dr. Charles Edwards, stated that "it has become increasingly apparent that drug products, which purport to be equivalent and which may satisfy chemical or other analytical tests of equivalence, may not be therapeutically equivalent." And he warned his audience, the Academy of Pharmaceutical Sciences, that this "is almost certain to be a continuing problem, one that requires constant attention, rather than one that can be resolved once and for all with any degree of confidence."

From its fiscal 1971 appropriation request, it is quite apparent that the FDA recognizes that much more study must be made of the formulation of drug product with the same generic name before that agency can give assurances as to the degree of quality possessed by each product it studies. In his statement before a subcommittee of the House Appropriations Committee on April 16, 1970, Commissioner Edwards described as "another important research project" the FDA's studies on "drugs that are chemically identical but not therapeutically equal when administered to patients." He revealed that in 1969, the FDA conducted 65 clinical tests to evaluate dosage forms of tetracycline and oxytetracycline. Other studies in 1969 were concentrated on certain cardiovascular and antibacterial drugs. An additional $40,000 (making a total of $240,000) to expand these studies to include certain neuropharmacological products, has been requested.

Former-Secretary of HEW Robert Finch wrote on June 23, 1970, that the government is not in a position to assure the equality of all drug products:

> We would be reluctant to impose constraints on prescribers until such time as the Department has acceptable answers to the question surrounding the equivalency of drug products. The problem is considerably more difficult than we had anticipated and will require substantial time and effort to resolve.

THE ROLE OF THE USP AND NF

For well over a century, the professions of medicines and pharmacy have published what are now recognized as the best of the world's compendia of official drug standards—the United States Pharmacopeia and the National Formulary. Privately-published but governmentally-recognized, the USP and NF list and describe, in brief form, the chemical structures of about 2,000 drugs and dosage forms. Importantly, the books provide detailed descriptions of the physical tests that can be performed in order to determine the identity, purity, potency and related characteristics of most of the drugs they contain.

However, it is important as well to note that the books *do not* describe hundreds of other preparations of major importance, and they provide virtually no data on the means of proper preparation of *most* medicines. Nor do they describe good manufacturing procedures or biological tests including clinical evaluations that indicated the therapeutic reliability of the products described. This is as it should be since none of these latter functions is suitable for coverage in a compendium. They are functions of pharmaceutical chemistry and engineering, pharmacology and other sciences, and are functions directly related to industry practices and responsibilities. They are also *equally essential* to quality drug manufacturing: the standards cannot be relied upon alone, in view of the importance of, among other things, the in-process quality control procedures they do not contain. Conversely, of course, quality control efforts, formulation ex-

pertise, clinical experience and manufacturing skills cannot be considered successful unless the end-product meets the compendial tests for physical and chemical characteristics.

It is this *contextual* relationship that is essential to an accurate appraisal of the roles of the drug standards. This inter-relationship has been obscured to some degree during the controversy over prescribing. On one extreme, it has been implied that any product meeting the standards will provide therapeutic benefits equal to other products, any other considerations notwithstanding. On the other hand, it has been contended that compliance with USP and NF is of minor consequence. Plainly, the standards and quality assurance practices by industry are both important.

In fact, the past decade has shown that there may have been some tendency to rely too heavily on conformance to chemical and physical standards as evidence of therapeutic quality. Recognizing this, the USP and NF have recently set up a collaborative program to develop more sophisticated standards.

Nevertheless, there will always be a need to permit doctors and pharmacists to look beyond the standards in selecting drug products. There is no way of determining, on the basis of conformance to USP or NF tests, that a product was really manufactured according to satisfactory standards.

SHARED RESPONSIBILITY INDICATED

It might be hoped that the regulatory processes of FDA could be relied upon to fill in where USP and NF leave off, through the establishment and enforcement of good manufacturing practice regulations, and no doubt much can be accomplished in this direction. It should be recognized, however, that a joint effort to employ the standards of USP and NF, together with the regulatory functions of the FDA, are not sufficient to protect the public. A logical extension of the effort must be made to include a continuation of high standards of performance in pharmaceutical manufacturing, the experienced judgments of individual physicians and pharmacists, and the sharing of experiences among them. Such a joint effort is, in fact, very clearly the approach of professionalism in pharmacy and medicine. It is entirely consistent with the objectives of the scientific community and will serve the public interest.

The Congress, along with the Departments of Defense and Health, Education, and Welfare, have actually been through the question of generic drug usage before, as have other government agencies here and overseas. In every instance, in the American experience at least, the government has elected to resist the temptation to stand between the health professions and patients, in the elusive pursuit of imaginary savings.

In 1965, one of the most intensely-debated pieces of social legislation in history, Medicare, was adopted. Under this program, the staff of the hospital in which the patient is treated is relied upon to make intelligent decisions about the sources of the drug products to be dispensed there. That is also the procedure used in military and naval hospitals, Veterans Administration hospitals, and OEO clinics as well.

Undoubtedly, many hospital physicians would testify to the value of this practice, even though the very cheapest drugs are not often obtained under it. In many hospitals, scores of products are purchased only from one or two particular companies, even though they could be purchased from a dozen others at lower prices; firsthand staff experience has indicated that in those cases, the lower-cost products were unsatisfactory. The policy of purchasing only from trusted sources also provides some protection for the hospital against liability actions that might be lodged for administering drugs of inferior quality.

It would seem indefensible to continue the sound policy of in-patient drug usage now in practice under Federal programs, while acting irresponsibly with respect to drugs dispensed *outside* the hospital—to let doctors and pharmacists *in* hospitals use their experience to choose not only which drug the patient needs but which firm can be relied on to supply it at a consistently high level of quality—but to hamper or deny that privilege to the same doctor or the same pharmacist, perhaps in serving the same patient *outside* the hospital

The current Medicare drug procedures are essentially sound. The public, the professionals and the Congress should make sure that they are preserved, and that any extensions of drug benefit programs be made compatible with them.

Estimate of Possible Savings Compared to Associated Costs

GENERAL APPROACH

To ascertain whether any economy would result from the enactment of the drug amendment to H.R. 17550, 91st Congress, it is necessary:

(a) To determine the universe of relevant expenditure, i.e., the amount of present federal and state payments for drugs which would be affected; and

(b) To apply to this universe the percentage differential in costs which one might reasonably expect.

The gross differential thus ascertained should then be matched against the cost of implementing and administering the proposal to obtain the net savings, if any. This is the traditional way in which the government and private industry examine expenditure proposals.

GROSS DIFFERENCE

The Amendment in question, in spelling out the scope of the proposed federal Formulary, provides, in part that:

> The term "qualified drug" means a drug—"(a) which (1) is listed in the Formulary, or (2) is furnished to a patient by a hospital which (A) is accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association and (B) utilizes a formulary system established by a pharmacy and therapeutics committee (or equivalent committee) in accordance with standards established by such commission or association, or (3) is a prescription legend drug prescribed in the handwriting of a lawful prescriber by its established name together with the name of the manufacturer of the final dosage form thereof. . . ."

In a subsequent section of the Amendment, it is provided that the federal government shall not be liable to assist states in paying for drugs which are not "qualified drugs" as defined in the Amendment.

Because of conflicting language in the Amendment, it is not certain which hospital-dispensed medicines are covered. For purposes of this analysis, we assume that the Amendment applies primarily to outpatient beneficiaries under Title XIX.

According to the Prescription Drug Data Summary of the Office of Research and Statistics, Social Security Administration, actual federal and state expenditures for drugs, for ambulatory patients, under this Title in fiscal year 1969, amounted to at least $311 million.

It is difficult to estimate the appropriate percentage of cost difference, if any, to apply to this universe because it is impossible to tell what the net would be when the overall figure was reduced by:

source products which the Formulary Committee decides offer "distinct

(a) The inclusion in the Formulary of higher-priced versions of multiple therapeutic advantages";

(b) Elimination from the Formulary of products found to be violative of federal requirements. FDA recall records suggest that this would particularly affect the lower priced products;

(c) The minimal or no-effect which the Formulary would have in states which now have a restrictive Formulary under their Title XIX programs;

(d) Price increases required for products of certain low-cost manufacturers to retain eligibility under the registration provisions;

(e) Expenditure increases resultant when two or more separate prescriptions are written in place of single prescriptions for combinations not acceptable to the Formulary Committee.

For the sake of simplicity, we may for the time being disregard this factor. We would then seek to estimate the maximum possible saving from the utilization of the least expensive product.

The HEW Task Force on Prescription Drugs, in its examination of possible savings, applied a more restrictive set of assumptions. Instead of examining the effect of generic prescribing, the Task Force examined the effect at retail on prices actually paid for the 409 leading products prescribed for the elderly if, in the case of each multiple-source product, the doctor had prescribed and the pharmacist had dispensed the least expensive product in the *Red Book*. It should be emphasized that the Task Force specifically excluded any examination of any aspect of quality, or service, or whether the cheapest product was in fact

available in national distribution. The result was an estimated saving of 5 percent on the assumption that retail pharmacy markups averaged $2.00.

If the Task Force percentage is applied, the total gross savings possible on 1969 Title XIX drug expenditures subject to the proposed Amendment would have been approximately $15.5 million (i.e., $311 million x 5%).

COST

The PMA is not in as favorable a position as government experts to estimate the level of incremental costs, mostly administrative costs, required to implement the subject proposal. But it is quite possible to appraise the differences between the sharply contrasting government estimates of these costs, made to date.

In reply to a request for departmental comments, HEW Secretary Gardner, in a letter to Senator Russell Long dated September 1, 1967, listed itemized expenditures totaling $111.6 million as required to implement S. 2290, 90th Congress, a bill quite similar to the Amendment now before this Committee. It is apparent from the Secretary's letter that it covered (a) incremental administrative costs associated with the Formulary system, and (b) other expenditures, on equivalency testing and plant inspection, which might be useful or desirable generally but which would also be indispensable if the bill's main provisions, for a Formulary and for product registration, were to be adopted.

Secretary Gardner listed the following specific first year cost items:

Cost of operations of Formulary Committee annually (each of first three years)	$10,000,000
Federal costs of planning, State plan review, evaluation technical assistance to states more than	600,000
Increased Federal-State costs of administering program	6,000,000
Costs of printing, maintaining and distributing Formulary	3,000,000
Costs of improved quality control; mostly for additional 2,000 FDA inspectors	25,000,000
Clinical testing ordered by Formulary Committee ($67 million first year, $50 million annually next five years	67,000,000
Total	111,600,000

The first four items comprise incremental administrative costs due to the introduction of the Formulary system. It should be noted that together they total $10,600,000 or substantially more than the gross savings of $15.5 million estimated by the HEW Task Force on Prescription Drugs.

In another section of its Final Report (page 44) the HEW Task Force on Prescription Drugs commented:

"Any necessary increases in Federal expenditures for the improvement of drug standards and quality control will have benefits which apply to all users of prescription drugs and should not be attached to implementation of cost standards for drugs supplied in Federally-assisted programs."

The Task Force thereupon substituted the following reduced estimate of the incremental costs of a substantially similar bill, S. 3323, 90th Congress:

"Significant costs would be incurred, however, solely from the enactment of the proposed legislation. If the provisions of S. 3323 were to take effect in fiscal year 1972, we estimate that the net incremental costs to the Department of Health, Education, and Welfare and the State programs would be as follows:

[In millions]

	Fiscal year 1972	Subsequent years
Determination of appropriate drugs	$1.3	$0.7
Determination of product costs	1.4	.6
Determination of dispensing allowances	.9	.5
Publication of drug lists guides, and other information materials	1.2	1.2
Technical assistance to State agencies and compliance review (titles V and XIX)	1.6	.6
Incremental costs of State agency audit (titles V and XIX)	.4	.4
Review of drug providers (for exemption from provisions of the act—title XVIII)	.5	.3
Costs of administration to nonexempt providers (title XVIII)	.4	.3
Total administrative costs	7.6	4.6

It should be noted that S. 3323 made no provision for a Formulary Committee, the preparation and publication of a Formulary, and did not increase the authority and responsibility of the Food and Drug Administration.

Because of these differences in the two proposals and the different approach adopted by the authors of the two estimates, this array of cost items cannot be directly compared with those in the Gardner letter. Mr. Gardner's staff was more inclusive and, in our opinion, more realistic.

For example, for the more narrowly defined administrative charges—technical assistance to state agencies and compliance review; incremental costs of state agency audit—the Task Force estimates a total of only $2 million. This contrasts with the earlier HEW estimate of $6 million for "Increased Federal-State costs of Administering Program."

In our opinion, the Task Force grossly underestimated the incremental costs of imposing and policing these restrictions in the face of possible or probable resistance from prescribers. The HEW staff, in a memorandum attached to Secretary Gardner's letter, quite appropriately warned:

"Using limitations on federal matching as the mechanism of control means that the financial risks inherent in so novel an effort (such as the risk of non-cooperation by prescribing physicians) would fall either on the states or on the recipients of health care. In the absence of effective control over the writing of prescriptions, the bill affords no assurance over the incurring of substantial costs in which the Federal Government would not share."

The direct administrative costs would also be increased substantially, and to an extent that the HEW Task Force apparently did not appreciate.

It is ludicrous to suggest, as the Task Force did, that the "Incremental Cost of State Agency Audit (Titles V and XIX) would amount to only $400,000 annually. This item certainly does not include an estimate of the cost of increased field audits. Before accepting this figure, the Senate Finance Committee should solicit the opinion of experienced administrators of state drug benefit programs under Medicaid.

THE ISSUE OF EQUIVALENCY TESTING

In an effort to estimate the cost of a Formulary approach, the costs of testing for equivalency must be considered—a task which Secretary Gardner's letter estimated as costing $67 million for the first year.

We are told by the HEW Task Force on Prescription Drugs that it would not be necessary to conduct such tests on all chemical equivalents, only on the most important drugs, particularly those of low solubility, where there was reason to suspect lack of therapeutic equivalency due to formulation factors.

Despite the language of the current Amendment, which attempts to assess the cost of quality and equivalency testing on the manufacturer, the enactment of the proposal would still require substantial additional government expenditures in this field. Whether that cost should be assigned as a charge against the Formulary proposal or as a continuing charge for the regular activities of the FDA is debatable. What is certain is that the amount which the FDA has been spending annually for internal and outside studies is far below what would be required to provide FDA with the evidence which the Task Force admitted was needed.

If the Amendment in question is enacted, it will not merely be desirable, but absolutely essential that substantial additional funds be appropriated.

In addition to the $67 million which he deemed necessary for equivalency testing, Secretary Gardner estimated that an additional 2,000 plant inspectors, costing $25,000,000 annually would be required to provide the continuing assurance of product quality required for the proposed Formulary and to implement the registration provisions of the proposal. Whether this resulting expense is labeled as an administrative cost chargeable to the Amendment or to be covered in an increased Food and Drug Administration Budget, it is still an expenditure not now scheduled which must be incurred if the proposal is adopted.

As indicated earlier, the HEW Task Force, in its Fourth Interim Report, estimated that approximately $15 million might be saved by 1971 on existing Titles V and XIX Social Security programs by using the least expensive product of acceptable quality generally available.

The Task Force also estimated a further $30 million—or 10 percent—saving from the elimination from the Formulary of duplicative or combination drugs. Nowhere does the Task Force substantiate this truly astonishing estimate. If the duplicate is indeed a chemical equivalent, then such savings as may be possible by eliminating the more expensive brands has *already been counted*

in the first exercise designed to estimate savings through the reduced reimbursement provision. They should not be counted twice. As for the combinations, it is equally difficult to see how the program is to save money by requiring a doctor to write two prescriptions instead of one.

Further, questions need to be asked about what happens when a particular product is excluded from reimbursement. Only rarely does this mean that nothing will be prescribed. Rather, the prescriber usually chooses a therapeutic substitute. If fixed combinations were excluded from reimbursement, the doctor would probably write two or more prescriptions instead, thus reconstructing the fixed combination. In addition to the material, inconvenience and possible hazards of medication error to which the patient would be exposed in this situation the government would pay the additional costs involved in purchasing two or more prescriptions. Thus, there is as much reason to suppose that the elimination of these products would increase net costs, as there is to suppose that a reduction would take place.

SUMMARY

In estimating the probable savings and costs of the Amendment in question, we find that under the most favorable assumptions, the selection of the least expensive product, *without regard to quality or availability*, would not save more than 5% *gross* (i.e., $311 million × 5%=$15.5 million).

These gross savings would probably be exceeded by any estimate of the administrative costs of compiling, publishing and distributing a Formulary and enforcing its restrictive conditions on the nation's doctors and pharmacists. Thus, even if one were to agree—which we do not—that administrative costs should not include the $92 million which Secretary Gardner estimated as the first year costs of equivalency testing and inspection, the proposal before the Finance Committee would still not show a net financial benefit over costs. And using Secretary Gardner's estimate of the costs, they would be many times greater than estimated gross savings.

The CHAIRMAN. Mr. Stetler, some time ago we had a difference of opinion about the way that some members of your association had been merchandizing tetracycline around the world. I contended they ought to be prosecuted criminally and made to pay. How much a capsule were they collecting for that tetracycline?

Mr. STETLER. How much for what?

The CHAIRMAN. How much per capsule were they charging for tetracycline in that combine between Pfizer, Squibb, Lederle, Bristol-Myers on which they are now in the process of paying over $120 million in settlements?

Mr. STETLER. I have no idea of what the per capsule price was. I would only add to the comment you have made that the legal issue, although there was a settlement in advance of a final adjudication of the case, that there has been a reversal of that initial decision, and these companies have been exonerated.

The CHAIRMAN. Were they not criminally convicted? I contended they ought to be criminally prosecuted at a time when they were trying to accept a plea of nolo contendere, and I was successful insofar as I was concerned. I was successful in seeing that that criminal prosecution was carried on and they were criminally convicted, were they not?

Mr. STETLER. That conviction was reversed, Senator, I believe, on appeal. The second circuit about 5 months ago reversed that conviction.

The CHAIRMAN. I understand that was reversed after they were found guilty and reversed for a different reason.

Now, that was after they had agreed to settle for the overcharges that they had made. They are now in the process, by their agreement, of paying out $120 million, are they not?

Mr. STETLER. They decided for a variety of reasons, some because of the multiplicity of civil suits, that they should settle these cases. However, their conviction was reversed after the decision was made to settle these cases, as I say, 5 months ago in the second circuit court. In that settlement, Senator, there was no admission of guilt on the part of the parties who were involved.

The CHAIRMAN. I understand that, but are you contending they are paying out that $120 million for humanitarian reasons?

Mr. STETLER. Not for humanitarian reasons but sometimes for solid business reasons. If the number of suits involved and the costs involved in defending those suits are high enough, you may make settlement. This is not for humanitarian reasons and it is not because you are guilty.

The CHAIRMAN. They were certainly working in concert. You do not deny that, do you?

Mr. STETLER. I do deny it.

The CHAIRMAN. I put my evidence in the record, and they were convicted before a jury of working in worldwide concert to charge the people of the whole world what amounted to about 40 times their cost of production for tetracycline. That is a very essential product—one of the best.

Mr. STETLER. No question about the quality of the drug. It is very effective—good product.

The CHAIRMAN. If you take a drug like tetracycline, the formulary committee would decide which brand name product met all available quality standards. The Secretary would then take that list and look at the price. The price might vary from 5 cents a capsule to 40 cents. The Secretary would then determine a reasonable price range, taking into account factors such as national availability. He might decide that the Government would pay no more than 12 cents a capsule.

Now, that is what we would be willing, to pay. And, furthermore, the way this amendment is written, if that doctor still wants to prescribe Pfizer's tetracycline all he has to do is write tetracycline, Pfizer, on the prescription and he can still get the Government to pay 40 cents, if that is the price. What is wrong with that?

Mr. STETLER. First of all, there are many manufacturers of these various products and some of them do charge significantly less than a full service research-oriented company. But some of them do perform in an inferior way. In other words, there is no way, at the moment that you or the public can assume that because a product is marketed by a company that it is a quality product.

To base your reimbursement schedule on either the cheapest or the one at the lower spectrum of these charges has to be based in part on the assumption that these are quality products or that they are equivalent. Otherwise you would not buy them for yourself. Nor would you buy them for a Government beneficiary. That assumption cannot be made validly. That is the point we try to make in this attachment.

On your second point in providing for an opportunity for a doctor to escape from the strictures of a formulary if he writes it out in his own handwriting and if he specifies the name of the company. In actuality, we know, and you know, that doctors do not prescribe that way. For good or bad, their prescribing habits dictate how they write prescriptions.

The CHAIRMAN. Is that not how they are taught to prescribe in medical school?

Mr. STETLER. They may be taught that in medical school but from the time they write prescriptions they do not do it that way. Nine out of 10 are written by brand name, not generic name. Furthermore, there are some products you do not write that way. In other words, if you were to try to accommodate that provision in the amendment in a combination situation, the doctor would have to write down all the generic names for a combination. In other words, there is not an established name for all of those products but only a brand name.

Actually, if they are really——

The CHAIRMAN. Is it not recommended that most of those drugs be pulled off the market?

Mr. STETLER. No, sir, that is not true.

The CHAIRMAN. Well, how many of them have the National Academy of Sciences recommended being taken off the market?

Mr. STETLER. Well, we do not really know because the recommendations of the National Academy of Sciences have not been publicized. Now, FDA is in the process of reviewing them. There are thousands of these NAS recommendations. FDA has only gone through a small percentage. There is no doubt they have questioned some of the combination products but it is really an overstatement to say that most of them have been recommended to come off the market.

The CHAIRMAN. Well, they publicized at least a hundred of the best sellers being taken off the market, is that not correct?

Mr. STETLER. No, that is not my understanding.

The CHAIRMAN. We will let the record speak for itself.

I wanted to read, what you said in opposing my 1967 amendment:

> We also believe that Congress will be in a better position to appraise all possible approaches to the questions which have been raised relating to the reimbursement for drug products under federally financed programs after the Department of Health, Education, and Welfare has completed its comprehensive study of this subject and has made its report available to Congress and the public.

Well now, that task force has, made its study, made its recommendations, and it recommends just the kind of thing that I have in the bill.

Mr. STETLER. However, there have been developments since that report was submitted to you, Senator. There have been additional studies in HEW and that is why I suggest very sincerely that those studies, the results of those studies, and the critique of that task force report which has been accomplished, has been submitted to the Department of HEW be made a part of the record of these hearings. That is the last word on that subject and certainly it should be available to this committee.

The CHAIRMAN. Are you a member of the body that criticized that task force report?

Mr. STETLER. I was a member of the Dunlop committee as were all of the other interests, the pharmacists, the labor unions, the senior citizens groups, the doctors. It was chaired by John Dunlop of Harvard. In my opinion, it did a fine job and I think its results should be available to you.

The CHAIRMAN. How many millions of dollars would be saved if the formulary committee did nothing more than to exclude all of those

combination drug products which the National Academy of Sciences has found inappropriate for proper drug therapy?

Mr. STETLER. It is a very questionable fact for this reason. Obviously, I cannot answer that nor can anybody else, but you cannot assume that because you stop a doctor from prescribing a combination that drugs will not be prescribed. As a matter of fact, you may force him into a prescribing situation where he has to make two or three prescriptions to accommodate the medication that he has to have for his patient.

You might end up really by having a more expensive drug bill for a patient by that procedure than by going the route of the combination. So, I do not think it is possible to answer what the savings would be, and I would conjecture that there may be no savings.

The CHAIRMAN. Mr. Stetler, you represent a lot of manufacturers, I believe you said 120 companies, and those are all very fine companies. Do any of them ever produce inferior products?

Mr. STETLER. I am sure that every company on occasion has produced products that are inferior. But whether you are dealing with drugs or whether you are dealing with any other products that are manufactured you have to look to the capabilities, the credentials of that company, their ability to perform on a consistent and sustained basis. If you put up the credentials of our companies, their facilities and their personnel you will find that they consistently do a good job. There are other companies that consistently do a poor job. Those are the odds one faces.

The CHAIRMAN. Which one manufactured that contaminated candy bar they just took off the market?

Mr. STETLER. Candy bar?

The CHAIRMAN. Yes.

Mr. STETLER. Fortunately, I am not responsible for that, but I believe that it was a subsidiary of Warner, Lambert.

The CHAIRMAN. It was "Oh Henry."

Mr. STETLER. Right.

The CHAIRMAN. How can a doctor tell, when somebody comes to him representing Pfizer or Lederle or Lilly, and says, "All right, here is this tetracycline. It is the best. It is just the best there is."

How can that doctor tell whether that is any better than another company's product?

Mr. STETLER. The doctor can only tell by virtue of his education, his experience in the field of pharmacology, and his experience with the product of that producer. If he has consistently gotten good results, if it has been consistently a quality product, he can tell. He cannot do a chemical analysis of that product in his office. He does not have that capability. He has to rely to some extent on the Food and Drug Administration that has authority for continuing surveillance over manufacturers, and it does the best job it can. But there are many companies that FDA never has inspected at all.

The CHAIRMAN. Well, I have a good friend who likes Squibb products, and so he would rather consistently prescribe Squibb products. How would he know that that is doing his patient any more good than he would be doing the patient if he were using Bristol-Myers products?

Mr. STETLER. I suppose there are several products from different manufacturers that could do the patient good. But a doctor is not preoccupied, I would think, with that kind of an evaluation of all products. He does know that Squibb's product is doing the job. It is helping his patient. If he is satisfied with it there could be others——

The CHAIRMAN. Well, for that matter, just to be absolutely candid, how does he know the patient would not have gotten well anyway? [Laughter.]

Mr. STETLER. I cannot answer that. Dr. Quinnell may like to comment on that. I do not like to comment on the medical profession.

Dr. QUINNELL. The question is, Senator, would you like him to take that chance and just let him get well by himself or would you rather you did something?

The CHAIRMAN. All I am asking you is, as a doctor, if you are only prescribing Squibb products, how do you know the patient might not have been better off if he had taken Pfizer's products?

Dr. QUINNELL. In an individual case I might not, but you see, my learning experience in the practice of medicine includes not only mine but that of my colleagues, and if I find my colleagues' patients using Pfizer's products are getting well faster than Squibb's products, I, quite obviously, would consider them better but if they are not I would see no reason to change.

The CHAIRMAN. There is no way that you can know that your patients are, as a group, any sicker or in any better health than the other fellow's patients. How can you know whether the pills that your colleague gives that are manufactured by Pfizer are clearing up a bacterial infection any quicker than the pills you might be giving manufactured by Squibbs or whoever you want to name? How can you know that if you had given the other manufacturer's pill the fellow would not have gotten well just as quickly? How could you have any basis for an informed judgment?

Dr. QUINNELL. The question is theoretical but, as I said before, you do not practice medicine in a vacuum. You do it with the learning experience of your own over a period of years as you do with those of your colleagues. Quite obviously, physicians when they get together talk shop just as, I am sure, other professions do. You learn what the other fellow has done, and if he is getting consistently better results you might wonder why and change to something he is doing. If he is not getting consistently better results then perhaps what you are doing is quite adequate. This is how you learn. You cannot, as in a vacuum, just say this is doing better than that. You have got to appraise it over a long haul, and with a number of patients and under different circumstances.

The CHAIRMAN. The President of the United States goes to Walter Reed Hospital where the drugs that are prescribed are drugs that the Government bought under bid. What is wrong with that procedure?

Dr. QUINNELL. Under those circumstances it seems to work for them, I think probably nothing is particularly wrong with it although, I think they testified that they have had difficultues under their own system. They have run into problems with some drugs under some circumstances that did not operate as good as they would wish and, of course, they have a supply difficulty procedure.

The CHAIRMAN. If the drugs that are being bought for use out at Walter Reed are actually being tested by the Government in addi-

tion to the testing that is done by the company and by the FDA, would not that doctor prescribing those drugs for the President of the United States at Walter Reed be in a position to know a little more about the quality of drugs that the President is getting than you would when you are not testing?

Dr. QUINNELL. Well, if he knows of the results of the tests he would be better informed, surely.

Mr. STETLER. Senator, the important thing is if you look at the drugs being used out there, you will find they are using Squibb and the better products, in other words they are not giving the President or people who go out there some inferior generic products.

The CHAIRMAN. Well, I would suggest that we would do the same thing. But they do not use Squibb exclusively; Squibb bids just like everybody else.

Mr. STETLER. Nor does a doctor use exclusively Squibbs. You do not find a Squibb doctor. He may use Squibb for one thing and some other reputable product for another thing. Medicine is not practiced like that.

The CHAIRMAN. You testified that your member companies sold some 95 percent of all generic drugs. Are those inferior drugs being sold by those firms?

Mr. STETLER. No, but there are a thousand or more manufacturers selling drugs by generic name and some are selling them cheaper than others.

The CHAIRMAN. As long as we have careful testing to see that products are what they are supposed to be, how can anyone complain about your competitor selling his product just as you sell yours?

Mr. STETLER. Well, the fact of the matter is today we do not have careful testing. That is my point with respect to FDA's capability. FDA has the authority. Theoretically, drug manufacturers are inspected every 2 years, in actuality that does not happen. There are literally hundreds of manufacturers who are not inspected every 2 years. FDA operates just as you or I would. They take the force they have, and they concentrate it on the largest producers. In other words, our companies that manufacture most of the drugs have a lot of inspections. I think I would do it the same way if I had a limited force. But it does leave you with a situation where you cannot make broad statements or make broad assumptions with respect to uniform quality of all drugs on the market.

The CHAIRMAN. Well, I would be the first to agree, though I do not see you here recommending it, that we provide for even closer inspection than we are providing now. Nobody has any business foisting on the public drugs that are inferior, and both of us do agree on that, do we not?

Mr. STETLER. No question about that. We do recommend more inspection, more authority, more budget, more staff for Food and Drug.

The CHAIRMAN. Now, your people were checking this to see if you could bring a rejoinder to it, but was it not true that on a sample test made by the Food and Drug people the small manufacturers came off about as well as the big manufacturers with regard to the drugs that they manufactured? In other words, in terms of quality the tests that I put in the record, which you have undoubtedly read, indicated that these little, small manufacturers seemed to be performing as well on quality as the big manufacturers. That particular test

indicated that they were even performing a little better than your big manufacturers.

Mr. STETLER. No, sir, that is not a fact. I know what you are talking about.

The CHAIRMAN. Well, you have seen it, I put it in the record, you must have read it.

Mr. STETLER. I would like to have you put in the record our refutation of that test which we have done, and I could make it available to you today, but it belongs in the record right beside that study because those conclusions from that FDA study are invalid.

The CHAIRMAN. Well, I will be glad to make both of them available.

Mr. STETLER. If you would look at the recalls——

The CHAIRMAN. Could I ask the question this way: Is it not true that even your members have on occasion marketed inferior products?

Mr. STETLER. Yes, I answered that before and said absolutely it happens. But if you look——

The CHAIRMAN. As a matter of fact, at the time we started the polio immunization there was some vaccine they put out that was actually giving the children polio rather than making them immune; is that correct or not?

Mr. STETLER. And those products where they had the trouble were approved by the Government.

The CHAIRMAN. Who manufactured them?

Mr. STETLER. Our facilities, our companies. We were the only ones who had the facilities but it was under Government auspices, Government control and direction.

The CHAIRMAN. All I am saying is that we ought to see that no one is marketing an inferior drug that is dangerous to the public. You and I agree on that.

Mr. STETLER. Absolutely.

The CHAIRMAN. But, on the other hand, once we agree that the product is everything it is supposed to be, and that it is what it says on the label, why shouldn't anybody who can manufacture a quality drug be permitted to market his product in competition with your people or vice versa?

Mr. STETLER. And once we got to an agreement and got to a situation where we could make these assumptions as to quality and equivalency, a major part of our objection to your amendment as discussed in exhibit A, would probably not be appropriate.

The CHAIRMAN. If we are providing the drugs to treat the President of the United States, Members of Congress, and all members of the armed services buying those drugs on a competitive basis, why should we pay the highest price somebody wants to demand for his drug when we are paying somebody else's medical bill with our taxes? I do not pay that much money when I am paying to treat the President, I do not pay that much money when I am paying to treat myself, why should I pay that much when I am paying to treat someone under medicare?

Mr. STETLER. Well, you have an entirely different system, obviously. The drugs that are available to individual patients and society, even under title XIX are purchased in drugstores. You are not talking about a central procurement system. I do not think there is any question where you have the Government, the Federal Government, as the purchaser—whether you are talking about automobiles or anything

else, there is obviously a better deal to the Government because of its status as a purchaser, the volume it buys, and its ability to get lower bids on anything. So, it is not a comparable situation. Nor do you suggest in your amendment 929 that there be any central procurement arrangement which would be comparable to the way that the Armed Forces buy their drugs.

The CHAIRMAN. Well, Mr. Stetler, I want to compliment you on the high tone in which you have conducted your share of the debate and I will try to keep mine on the same basis.

Mr. STETLER. May I say the same thing.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. Mr. Stetler, I have one question. If this amendment went through how many additional employees do you think would have to be required?

Mr. STETLER. It is a difficult question for me to answer. It might be difficult for HEW. Only one statistic on this point has been submitted at any time. As we have said between 1967 and the present time there have been four different formulary and pricing proposals, before this committee. Back in 1967, there was a bill, S. 2299 on which the HEW Secretary Gardner made an estimate of its costs. It amounted to $111.6 million. He had one item in his estimate concerning additional inspectors by FDA. He placed the figure at 2,000 and the cost at $25 million. What it would cost to prepare and provide a formulary, publish it, police it, revise it, release it, I do not know. But from the experience I have I think it would be a fairly significant new operation in the Department of HEW. It would be a large job.

The CHAIRMAN. Mr. Stetler, your people went down to HEW and undertook to convince the people that there was an expense of $111 million involved here to duplicate what is already being done. We convinced those people that there is no point in duplicating what we are already doing, so that $111 million did not belong in the cost estimate.

HEW has now corrected that estimate.

Are you still relying upon that misinformation you gave those people when they themselves knew that was wrong?

Mr. STETLER. I think that comment deserves a reply. I had no knowledge nor did anybody in the PMA, our board or any of our employees have any knowledge of the estimate of $111.6 million that you received from Secretary Gardner in 1967 on S. 2299. I did not know of that figure until I read it in the record of the proceedings of this committee. To assume——

The CHAIRMAN. Did you have any knowledge of Secretary Finch's letter that we received the last day he was in office?

Mr. STETLER. You mean this year?

The CHAIRMAN. Yes.

Mr. STETLER. Absolutely. But you are talking about an estimate that came to this committee in 1967 of $111.6 million. I had nothing in the world to do with that nor did anybody in our industry. That was an estimate that came to you, by what computations I have no knowledge, but it was HEW's estimate, not my estimate. It was on a bill, S. 2299. You later received an estimate of $7.7 million through the task force on another bill, S. 3323, a different bill. They had no formulary, had no formulation.

What we are saying now is that it is high time HEW take a firm look at the current estimate and give you a solid estimate. These are

not our figures but HEW's. We have a right to know their accuracy as have you, and the matter of these figures should be straightened out.

The CHAIRMAN. Are you aware now that that $111 million figure was in error. It was based on assuming that the Government was going to have to do what the FDA was already doing? Are you aware that was in error?

Mr. STETLER. I am aware that you can charge $67 million, which Secretary Gardner said was the cost of testing, and $25 million, which he said was the cost of new inspectors in FDA work, a total of $92 million in either one of two ways. You can either charge it to this amendment if it were enacted or you can charge it to the activities, the daily activities, of Food and Drug.

I can tell you now that the total budget for the Food and Drug Administration this year is something in the magnitude of $85 million, and the amount they have appropriated for equivalency testing is something like $500,000.

If the bill passes—and this has to be done whether you say FDA has to do it or some other entity—somebody has to come up with some dollars. I cannot defend $67 million or $25 million, but some significant amount of money, far in excess of what FDA is now expending, more than their whole appropriation, will have to be produced. Maybe it should not be assessed against your amendment, but it has to be assessed against something. The dollars have to come from somewhere.

The CHAIRMAN. Well, whether we agree to my amendment or not, we should do enough testing on all these drugs to assure they are all what they are supposed to be. If we are going to do it anyway, whether my amendment carries or not, how can you assess against my proposed amendment the cost of testing when you have to do it anyway?

Mr. STETLER. Well, you say you have to do it, but it is not being done.

The CHAIRMAN. You should do it.

You came here to advocate that it be done, did you not? Didn't you just testify that you did that?

Mr. STETLER. Well, even Food and Drug, in their request for appropriations, have only requested $500,000. I do not know what kind of a job you can do in this area with $500,000.

The CHAIRMAN. Whatever testing it is, we ought to do it, to guarantee that the drugs the public is buying are what they are supposed to be. How can you charge this amendment that I propose as being responsible for that cost when you have to do it anyway?

Mr. STETLER. I have not said that. I said there is a question as to whether it should be charged to your amendment. I just said it is going to take dollars. I have not made that assertion here nor will you find it in our full statement.

The CHAIRMAN. Any further questions?

Senator WILLIAMS. No questions.

The CHAIRMAN. Thank you very much, Mr. Stetler.

Mr. STETLER. Thank you, Senator.

The CHAIRMAN. I will be discussing this with you further, as you are well aware.

Mr. STETLER. I know.

(The following letter with attachments was subsequently received by the committee:)

PHARMACEUTICAL MANUFACTURERS ASSOCIATION,
Washington, D.C., September 29, 1970.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I want to offer my sincere appreciation, and that of my colleagues, for your kindness last Wednesday in receiving our testimony concerning Amendment No. 929 to H.R. 17550, 91st Congress.

In the course of our testimony, you raised questions concerning a 1966 FDA study on drug potency, and the record of prescription drug recalls over the years. You indicated that you would be pleased to have the PMA's comments on these matters for insertion in the record.

Enclosed are two documents which we would appreciate your inserting in the appropriate place in the hearing record.

Sincerely yours,

C. JOSEPH STETLER.

I. FDA 1966 "DRUG POTENCY STUDY"

On June 8, 1966, the Commissioner of FDA, speaking before the Drug and Allied Products Guild, stated, "We have concluded that one out of every fourteen drug units manufactured is violative just on potency alone".

The statistics offered as proof of this claim came from a study of approximately 4500 drug products referred to as the FDA 1966 Drug Potency Study. The PMA has branded this study as invalid, grossly inaccurate and has demanded that the FDA "repudiate the survey outright".

This so-called "potency study" has, in PMA's estimation, caused considerable damage to the reputation of the quality-conscious firms and has furthered the false assumption that all drug products available in the United States are of the same level of quality, regardless of source.

The statistics from this study which are repeatedly quoted, indicate that slightly less than 8% of the generic name drugs were found to be deficient, and slightly more than 8% of tradename products were found to be deficient. An official of the FDA rephrased these statistics as follows: "I might point out that in a recent drug testing program that was carried out by the Food and Drug Administration on over four thousand drugs, the number of products produced by major manufacturers, which failed to meet liberal potency standards, was over 8 percent. Those made by minor manufacturers failed to meet the standard in just under 8 percent—virtually the same".

If it can be assumed that all products are equally good or bad, then the claim by PMA member firms that significant quality differences occur among products of different manufacturers, and that quality must be a consideration in the selection of drug products, is no longer tenable. For this reason and in the interest of protecting the public from deficient drugs, PMA has continued to attempt to correct the record on this issue and to point out the false assumptions that have been created. To date, the FDA has refused to repudiate the Drug Potency Study even though it is and has been aware that any use of the statistics was invalid. The FDA has refused to cooperate in releasing data on the study and even at this late date, PMA has been forced to contemplate instigating a law suit in order to stimulate the FDA to release certain data in its possession.

In the interest of accuracy, the following summary is submitted for the record.

At the time of the drug potency study, PMA had 138 members. Approximately 2000 products produced by 84 of these member companies were involved in the FDA study. (Approximately 2500 products of 162 non-PMA companies were also involved.) Of the 2000 products of PMA member firms, 119 products were stated by the FDA to be in violation of FDA potency standards. When the FDA finally responded to requests for lot numbers of these 119 products, 102 were reassayed by our member firms from stock samples reserved for such purposes. Of these 102 products, only 18 were found to be in violation. Only 8 of the 102 products resulted in some action by the FDA and only 3 resulted in recall or seizure.

It is of further interest to note that only 6 of the 49 PMA member firms which FDA claimed had violative products were notified of these violations within the first seven months after the study was reported. In the eighth month, 13 more were suddenly notified. Nine months after the study was released, and following repeated requests from the PMA for lot numbers, the FDA finally agreed to make these available to the manufacturers on request. Requests for information as to where and when the products were obtained were answered with the FDA statement that, "We do not believe we would be justified in expending the time

and funds required to obtain and list the specific source of each sample". It was not possible, therefore, to determine if perhaps conditions of storage may have been a contributing factor in the small number of products that were actually in violation of potency standards.

Finally, the PMA offered as an alternative that the matter could be resolved by a cooperative re-evaluation of the alleged violative samples in FDA possession. PMA was advised that most of the samples had been destroyed and that a re-analysis could not be made.

It came to the attention of PMA in 1968 that the work sheets associated with the study would provide proof that many of the tests were inadequately accomplished. Further, the PMA was informed that the FDA district officials conducting the test believed that they were to do a rapid screen of products and that precision was not an important consideration; that no check analyses were done in many cases; and that one district laboratory experimented with assembly line assays during the study because its personnel believed the operation was intended to be a rough survey and not an enforcement program.

As a result of this information, PMA requested that the work sheets be saved from destruction and, along with certain other documents, be turned over to PMA for review. Release was requested under the Freedom of Information Act. The FDA refused to release the work sheets and an appeal has been made to HEW for reconsideration of this decision.

The following is a detailed chronological review of the four and one half years of effort by PMA to learn the truth about the FDA 1966 Drug Potency Study.

CHRONOLOGICAL HISTORY

June 8, 1966.—Commissioner Goddard reports on the "Drug Potency Study" in an address before Allied Products Guild, Ellenville, N.Y. Claims widespread deficiencies in drug products.

June, July and August 1966.—Considerable publicity appears in the trade press on Commissioner Goddard's claims. No notification of deficient products sent to manufacturers involved.

August 22, 1966.—PMA sends first letter to Commissioner Goddard requesting further information on the study in order to determine what corrective action, if any, was needed.

August 25, 1966.—PMA sends second letter further outlining the request for information.

September 1, 1966.—Deputy Commissioner Rankin responds, "We . . . will be in touch with you later."

October 15, 1966.—Deputy Commissioner Rankin repeats charges in an address to the American College of Apothecaries, Boston, Mass. This is followed by an FDA news release on Rankin's speech the same day. Still no response to PMA's request for more details.

October 21, 1966.—Senator Hart in a Senate Floor speech inserts Deputy Commissioner Rankin's presentation in the Congressional Record.

October 27, 1966.—Third PMA letter is sent to FDA reminding Commissioner Goddard that PMA and its firms have not yet received the information requested.

October 29, 1966.—Deputy Undersecretary of HEW, Dean Coston speaking before the Drug and Allied Products Guild, states "However, a recent study by the FDA indicated, at least as far as potency is concerned, that there is little difference in the number of violations found in brand name drugs and generic drugs. The generics, in fact, were a little bit better (but not statistically significant)." There still has been no response to PMA's request for information and no PMA firms have been notified of violations.

November 1, 1966.—PMA meets with Commissioner Goddard and is promised that the information requested would be forthcoming.

December 1, 1966.—Fourth PMA letter is sent to FDA requesting data on the potency study including:

1. The nature of the sampling technique and design of the study
2. The sources of the samples selected
3. The lot or control numbers of the products found to be subpotent
4. The method of analysis used
5. The limits of potency used for non-official drugs

January 31, 1967.—FDA press release which reasserted the potency statistics is published. The release also included some of the information requested in PMA letter dated December 1, 1966.

February 1, 1967.—FDA replied to PMA letter of December 1, 1966. FDA refuses to supply lot or control numbers of products claimed to be deficient. PMA

firms thus unable to confirm or deny FDA allegations. In news releases and other publicity, FDA claimed that 49 PMA firms had violations. Only six firms to date had been notified of such violations.

February 3, 1967.—PMA news release states: "Because of FDA's failure to provide meaningful information about its 'pilot survey' on drug potency released on January 31, it is impossible to determine its validity or to judge whether it can be used by quality-minded manufacturers to help improve their products", PMA again asked FDA for meaningful data on the potency study.

February 9, 1967.—Commissioner Goddard again uses drug potency statistics in a speech to the Philadelphia Chapter of the Defense Supply Association.

February 1967.—Commissioner Goddard again uses statistics from the "potency study" in an interview printed in the *D.O.*, a publication of the American Osteopathic Association.

February 16, 1967.—Commissioner Goddard agrees to provide lot numbers. They are to be produced not to PMA, but to firms involved, upon request. The fact still remains, however, that eight months after the potency study, the FDA has not notified most of the companies that they had deficient products which presumably would subject to seizure, recall or some other action.

February 23, 1967.—Thirteen more PMA firms suddenly notified of deficiencies.

February 1967.—Commissioner Goddard's February 1 news release quoted by various trade and lay press

February 24, 1967.—PMA sends fifth letter to FDA requesting further data on the study so that its member firms can recheck stock reserved for such purposes.

February 28, 1967.—National radio network programs (CBS-Charles Kuralt) quotes the FDA drug potency statistics in depth.

March 8, 1967.—Senator Montoya makes address to the Senate, quoting *Science Newsletter* for March 4, 1967, inserts the drug potency statistics again in the Congressional Record.

March 15, 1967.—Commissioner Goddard confirms in writing that FDA will provide lot numbers of deficient products to manufacturers on request. He refuses, however, to provide information on the specific source of each sample tested.

April 21, 1967.—Senator Russell B. Long in a letter to the Editor, *Medical World News*, quotes the drug potency study statistics and further states, ". . . nine of the 14 advertisers (in the February 17 issue) produced unacceptable products".

April 26, 1967.—Senator Nelson, in an address to the Senate, quotes the drug potency study statistics and further states "But the point is that such problems (potency and purity) are not limited to low-priced drugs sold under generic names. . ." .

May 4, 1967.—Deputy Commissioner Rankin again uses the drug potency study statistics in an article in *FDA Papers.*

May 7, 1967.—*Washington Post* article quotes drug potency statistics.

May 11, 1967.—The reason for FDA reluctance to release data on the drug potency study becomes apparent. Eight out of every ten potency tests conducted by the FDA in which a product of a PMA firm was claimed to be in violation were wrong. Of the 119 products of PMA firms which FDA claimed were in violation only 18 were found to be so. Further, only eight of these products resulted in some sort of action by FDA and only 3 resulted in recall or seizure.

PMA issues a news release demanding the FDA repudiate the survey outright. FDA apologizes to only four companies. PMA commenting on these apologies stated, "Public charges followed months later by private apologies scarcely seem appropriate on sufficient".

May 12, 1967.—FDA in news release refuses to repudiate findings in the drug potency study. Indeed. FDA ". . . reaffirmed its general findings".

May 16, 1967.—PMA news release states, ". . . the situation with respect to the FDA study remains intolerable". The news release demanded a prompt Congressional inquiry.

June 1, 1967.—PMA corresponds with FDA to complain about the continued use of the drug potency study statistics (in *FDA Papers*).

June 6, 1967.—Commissioner Goddard dismissed the complaint.

June 12, 1967.—PMA appeals to John W. Gardner, Secretary of HEW, for assistance in obtaining a responsible reply from FDA to clarify the record and to correct the erroneous conclusions which have occurred because of the study.

PMA offers as an alternative to cooperate in a reanalysis of the alleged violative samples.

June 27, 1967.—Commissioner Goddard, replying for HEW Secretary, claims the samples have been destroyed and reaffirms the general findings of the study.

August 28, 1967.—PMA appeals to Undersecretary of HEW, Wilbur Cohen, for assistance in resolving the drug potency problem.

September 7, 1967.—HEW transmits drug potency problem to Task Force on Prescription Drugs.

December 5, 1967.—FDA official uses the drug potency study statistics in a presentation at the Midyear Clinical Meeting of the American Society of Hospital Pharmacists.

March 1968.—PMA letter to the Editor setting forth the true facts on the drug potency study printed in the *American Journal of Hospital Pharmacy.*

March 1968-March 1969.—Repeated reference to study in professional, trade and lay press. No further response from HEW or Task Force.

May 2, 1969.—Because of the resurgence of references to the drug potency study, PMA makes a request to Commissioner Ley for release of certain information including all assay work sheets relating to the study.

July 2, 1969.—Commissioner Ley refuses to release the information claiming that it is not subject to disclosure under the Freedom of Information Act. Further, Commissioner Ley states that he regards the issue as relatively unimportant, stating, "I am most unwilling to take the time from . . . important pressing problems to go into this past history".

July 28, 1969.—PMA submits a formal request to HEW under the Freedom of Information Act for release of the assay work sheets and other data.

November 7, 1969.—HEW provides some information, but refuses to release the work sheets.

December 5, 1969.—PMA appeals the above refusal to supply the work sheets (now pending).

April 28, 1970.—Senator Nelson uses the drug potency statistics in hearings on a drug code bill.

1966 FDA DRUG POTENCY STUDY COMPARATIVE ANALYSIS

	FDA results	[1] PMA results
I.		
1. Number of PMA firms in study	84	84
2. Number of PMA firms with violations	49	13
3. Number of violative products	119	18
4. Percent of PMA firms in study with violative products	58.3	15.4
5. Percent of violative products (brand and generic)	6.0	[2] 1.0
6. Percent of brand violations	[2] 8.2	1.0
7. Percent of generic violations	[2] 7.7	1.0

	PMA	Non-PMA
II.		
1. Number of firms in study	84	162
2. Number of products in study	1,933	2,640
3. Number of firms with alleged violations	49	78
4. Number of alleged violative samples	119	257
5. Number of alleged brand violations	94	82
6. Number of alleged generic violations	25	175
III.		
1 Number of PMA firms which reanalyzed samples	42	
2. Number of products reanalyzed	102	
3. Number of firms with violations	13	
4. Number of products found OK on reanalysis	84	
5. Number of brand products OK on reanalysis	71	
6. Number of generic products OK on reanalysis	13	
7. Number of actual violations	18	
IV.		
1. Number of PMA firms which did not reanalyze	7	
2. Number of products not reanalyzed	17	

[1] Does not include firms or products listed in IV.

[2] It should be noted that a failure rate of 1 percent was described as acceptable by FDA Commissioner Goddard, in a talk before the Philadelphia chapter of the Defense Supply Agency, Feb. 9, 1967.

[3] PMA and non-PMA firms aggregate percentages.

II. PRESCRIPTION DRUGS RECALLS

PMA MEMBER FIRMS COMPARED TO NON-PMA FIRMS

The Food and Drug Administration has published recall data since June of 1966. From that date to the end of August, 1970, according to the FDA figures, there have been a total of 2,027 drug recalls. Of this number, PMA firms accounted for 435 (21%) while non-members had 1,602, or 79%.

As is well know, PMA companies produce about 95% of the prescription drugs sold in the U.S. This means that the non-PMA producers, accounting for only 5% of the drug supply, were responsible for 79% of the recalls. The ratio of five non-PMA firm recalls for each one made by a PMA firm has remained consistent over the 50-month period.

Examined from another perspective, it can be said that since PMA firms produce 19 times the amount of drugs that non-member firms do, it would follow that if the PMA firms' recall rate was similar to that of the non-members, based on production volume, then the PMA firms would have had over 18,000 recalls.

One other way of interpreting the data would be to relate it to dollar value of finished drug products. In that sense, PMA firms had one recall for every $30 million worth of products manufactured, while non-members had a recall for each $500,000 in drug products they made.

It should be recognized that many PMA firms have a relatively large product line, and offer many dosage forms, strengths and package sizes of a given product; one such firm offers about 1,500 different products, strengths, and packages. This level of capacity carries with it substantially greater opportunities for error than is the case for the firms whose product lines are confined to only one or two forms of perhaps no more than 20 of the most popular, and established, medications.

There are important limitations that should be recognized before any generalizations are made about the above information; they relate primarily to the fact that FDA makes no attempt to weight the recalls in terms of relative seriousness.

Their shortcomings notwithstanding, the recall figures clearly demonstrate that the recall record of PMA firms is distinctly better than that of the rest of the pharmaceutical industry.

The CHAIRMAN. Senator Allen is in the room here. He wanted to introduce a witness who will testify next. The Senator will be needed elsewhere.

Senator, I think I would suggest that you introduce your witness at this point and then we will call her.

STATEMENT OF HON. JAMES B. ALLEN, U.S. SENATOR FROM THE STATE OF ALABAMA

Senator ALLEN. Thank you, Mr. Chairman and members of the committee.

I appreciate this accommodation and I do apologize to the other witnesses for asking to be taken out of turn.

I would like to present at this time and ask if she would kindly stand, Miss Edna M. Reeves. She is the director of the State Agency for Social Security in Alabama, and has been for some 10 years. She is secretary of the National Conference of State Social Security Administrators.

For some five terms she has been chairman of the legislative committee of this national conference, and she enjoys the distinction of being one of only two ladies among the 50 administrators over the country, and we are very proud of her in Alabama.

I know that the testimony she will give will be interesting and informative.

I might say that Miss Reeves, in reaching the office of distinction that she holds, did not have to wait on the equal rights amendment to attain this position. She has done it by her ability and her initiative and her dedication. I do commend to the committee her testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Allen.

The witness then will be Miss Edna M. Reeves.

STATEMENT OF EDNA M. REEVES, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL CONFERENCE OF STATE SOCIAL SECURITY ADMINISTRATORS; ACCOMPANIED BY S. M. VAN DENTON, PRESIDENT; AND B. E. "BUS" FRIDAY, CONSULTANT, ARKANSAS STATE EMPLOYEES RETIREMENT SYSTEM

Miss REEVES. Thank you, Mr. Chairman.

After Senator Allen's introductory remarks, I feel as though I should be introduced to myself.

I have with me Mr. Sidney Van Denton, president of our national conference; and Mr. B. E. "Bus" Friday, representing the State of Arkansas.

The CHAIRMAN. All right, Miss Reeves, you may proceed.

Miss REEVES. My name is Edna M. Reeves. I am chairman of the Legislative Committee of the National Conference of State Social Security Administrators, as well as administrator of the State Agency for Social Security for the State of Alabama.

Our national organization represents over eight million public employees. I welcome and appreciate the opportunity to appear before this committee today in behalf of the National Conference of State Social Security Administrators.

In presenting the Conference objections to the enactment of section 202(d) of H.R. 17550, as you know this amends section 103 of the 1965 Social Security Amendments dealing with health insurance for retired State and public employees age 65 and over in its present form.

First, let me make the position of the States and the national conference position clear. We do not oppose anyone having medicare protection providing they pay their share of the cost. These people have had the same privilege that all other employees have had since 1955, but they themselves have seen fit to reject the coverage until such time as they reach retirement age. That is the point that we object to.

We States that have gone through the process of selling social security and medicare programs are now being placed in a rather embarrassing position because we have continued all these years the thing needed in social security in order to obtain medicare.

The States will be required to assume unknown liabilities because someone—and I feel sure it will be the States—will have to enter into a contract or an agreement for the administering of this program. I feel sure that the employees and, perhaps, the sponsors of the legislation feel that it will be less expensive on their State than in its present form.

Another problem that we are running into or will continue to run into is from the young people. They are protesting in many cases in

groups in Alabama as to the cost of social security. They say, "We have got to pay all of these years and here is Mr. Smith over here, he is almost at retirement age and he won't have to pay anything, or practically nothing, but yet we will be paying some 50 years or longer."

Well, of course, we try to tell them about the benefits, try to sell them on the benefits of social security because of the survivor benefits. They say, "We can buy Government bonds and make money in the long run."

I asked one of them, I said, "Do Government bonds provide survivor insurance or if you become totally disabled, to take care of your children until they reach age 18 or 23, if they are still in school?"

We feel that this special legislation for a special group is setting a precedent. Then, if some of these other pressure groups come along—and they will be back, mind you—then they will want the same consideration.

Now, do these people know, these retirees know, that they are eligible for medical insurance under part B in its present form of the Social Security Act? I am wondering if they do.

So that is our whole objection in opposing this type legislation. We feel that these employees have had the same opportunity all of these years, and they themselves have controlled it, and they did not want it, and now they need it, and they are trying to get something for nothing.

Let me state one further thing, make one other statement. The legislative committee and the conference as a whole will not oppose legislation for retirees providing the following words are deleted from the proposed amendment, "State or any other public or". In other words, if the section had been written to let the retirees contract with some private organization to handle their medicare, that is just fine, we do not object.

All that we States are objecting to is what we will have, in the unknown liabilities that we will have, to assume.

(The prepared statement of Miss Reeves follows. Hearing continues on p. 1134.)

STATEMENT OF THE NATIONAL CONFERENCE OF STATE SOCIAL SECURITY ADMINISTRATORS

The membership of the National Conference of State Social Security Administrators, as the name implies, is composed of State officials. These officials have administrative responsibilities under master Federal-State coverage agreements entered into pursuant to Section 218 of the Social Security Act. Through this agreement, Social Security coverage is currently enjoyed by over eight million employees of State and local governments.

The plain statement that coverage under Section 218 of the Social Security Act has increased to the substantial amount of over eight million State and local governmental employees does not do justice to the full story of the administrative and, as many members of the Committee know, legislative developments in the nineteen years that Section 218 has been in existence. In some states, the extension of Social Security coverage has been extremely controversial, and continues to be controversial with respect to many classes of employees. In fact, in several areas, it has been necessary for Congress to specify individually those states in which certain enabling coverage provisions shall apply.

In addition to those situations where the States have come to Congress for assistance in making coverage possible, it has been necessary for State Administrators to come to the Congress from time to time to seek assistance in solving

problems caused by the complexity of Section 218 and the existence of conditions that were not contemplated when basic legislation was enacted. For example, Congress has several times extended deadlines governing periods of retroactive coverage. Special provisions were added to the Social Security Act to alleviate problems caused by the special nature of sick leave payments in public employment. A statute of limitations on assessments and refunds and a procedure for court review of decisions by Federal officials has been provided. A long list could be compiled—the 89th Congress gave us assistance in meeting problems related to hospital employees in California, teachers in Maine, school districts in Alaska, engineering aids in Oklahoma and student services in Iowa and North Dakota and just in the last Congress, the 90th, you gave us assistance in meeting problems arising from emergency services, election officials, fee basis officials an option to provide retroactive coverage as a part of a coverage group for former employees whose earnings were erroneously reported to Internal Revenue Service, if no refund had been made, as well as other measures applicable to individual states.

It is in the same spirit that we appear before you today to present the problems that can arise in the administration of Section 218 with the enactment of Section 202(d) of HR 17550. As you know, this amends Section 103 of the 1965 Social Security amendments by adding a new Section (e). This section provides that a State or any other public agency may be permitted to pay monthly benefits for retired age-65-and-over employees who are eligible for and have been enrolled for hospital insurance protection provided by the new Section 103(a)(2).

This type of legislation has been unanimously opposed by the Legislative Committee and the Conference as a whole for the past four years. I should like to make clear the position of both the Legislative Committee and the Conference; both of whom do not oppose Social Security and Medicare for anyone, our position being let all make contributions to the program.

We States who entered the program in 1951, and others entering subsequently have consistently extended Social Security to all non-retirement personnel and all retirement personnel since the 1954 amendments. However, many employees have continuously rejected the advantages extended by Social Security.

First: To permit a group to come in only when it is in need of certain benefits completely disrupts the normal processes of our Federal-State program. I would also go as far as to say that if this piece of legislation is passed, it will place most, if not all, State Administrators in a most embarrassing position since we have used as part of our promotional material the fact that the only way Medicare could be obtained was through Social Security coverage. I would say that a great percentage of the coverage for teacher retirement personnel we have extended in this past five years for Social Security was based solely on the fact that the older teacher would have to have Social Security coverage in order to protect himself for Medicare. You can readily see that this legislation would completely place State Administrators in a position of misrepresenting facts.

Second: To extend coverage of this type to groups of retirees who have not seen fit to participate in the general Social Security program when such coverage was made available to them, completely defeats the action of the State Administrators in attempting to make available to public employees all the benefits of the Social Security Act, and would greatly weaken the States' programs.

Third: This would require States to assume unknown liabilities. We feel the States should not be burdened with such liabilities, since it is felt that this plan would be materially more expensive than the program that each State now has in effect.

Another problem of major concern would be placed on the States. As you know, the General Assemblies and/or Legislatures of the various States meet at different times—some once each two years while others meet annually, and, of course, before this amendment could be put into effect, State legislation would have to be enacted in order for the State's Federal-State contracts with the Department of Health, Education and Welfare to be amended.

Fourth: All States are increasingly aware of the strong opposition from younger people to the paying of Social Security contributions (taxes). Their belief, of course, is that for the same amount of money, they may perhaps have more to show for it in the way of private investments. The fact that they could qualify for Medicare without being a member of the Social Security system would, of course, greatly strengthen their desire to get out from under coverage—a desire which may extend to many of the older people as well.

At this point, I would like to state that I have had several meetings with various groups, particularly city governing bodies, where the younger people are

trying every angle to be deleted from the program. I have tried to settle the unrest and dissatisfaction among the younger employees, many of whom have raised the particular question why the engineering personnel could not be removed from the group's contract—this bearing out what I have just stated. The presently covered employees would, in many cases, especially the young, begin proceedings to have their coverage cancelled since the majority feel now that they are required to finance programs for many employees who have made no contributions at all to the financing of the program.

Fifth: To enact special legislation at this time for a special group sets a precedent and, if any other group or class of employees should decide investment of their money over the years between now and retirement age would give them greater retirement benefits than Social Security, then they should be given the same privilege—obtain legislation to withdraw since they would be in position to obtain Medicare without contributing toward the program.

Sixth: Special legislation for a special group is just the beginning of wrecking or destroying our present Social Security program, because other pressure groups will arise and their wishes should be handled in the same light as the pending problem. It is felt that in all fairness to public employees who fought and tried for eighteen years to gain this added protection, and many have been contributing since January 1, 1951, this special legislation should not be enacted.

Most retirement personnel who are members of public agencies have had the same privilege of earning this Medicare protection, together with Social Security Insurance, since the amendment of 1954 and have rejected the coverage, but now that they have retired, they can readily see their unwise decision, and feel that they should be handled differently; in other words, they wish the better of two worlds without sharing their portion of the cost. Frankly, I feel that this is one of the most unfair pieces of legislation that has been introduced in the Congress.

I would like to make one further statement: I have made a survey and have found that the groups pressuring for the passage are from states that have not seen fit to impose this coverage on these individuals. In other words, the employees themselves have controlled the issue. In these states, only token coverage exists—this being controlled by the employees.

As I have stated previously, what this proposed legislation boils down to is treating these employees as a special privileged group. Why should special legislation be enacted to arrange for Medicare for those selfish individuals who have refused the coverage and have not made any contribution at all to the program—a program that others have been paying for over a period of many years and whose contributions have been raised many times and will continue to be raised many times prior to retirement? In other words, special legislation for a special group to obtain Medicare is most inequitable.

"It is the first step toward complete wreckage of the entire program. If this special type legislation is enacted, mind you, in no time at all some other disgruntled group will be back demanding enactment of legislation to suit their particular wish.

"Please let me reiterate the Legislative Committee and the Conference as a whole do not wish to oppose Social Security and Medicare for any individual. Our position is to let all pay their share of the contributions and share Medicare on the basis of earned protection."

The Legislative Committee and the Conference will not oppose legislation for retirees provided the following words are deleted: "State or any other public or". In other words, if the section is rewritten as follows, then the retirees may arrange with some private agency or organization to handle their Medicare program:

"Section 202(d) of the bill further amends Section 103 of the 1965 amendments by adding a new subsection (c) to provide that a private agency or organization will be permitted to pay monthly premiums on behalf of retired age-65-and-over employees who are eligible for and have enrolled for the hospital insurance protection provided by the new Section 103(a)(2). Such group premium payment will be under a contract or other arrangement entered into between the agency or organization and the Secretary, and will be permitted only where the Secretary determines that such a method of premium payments is administratively feasible."

The Legislative Committee and the Conference unanimously oppose any legislation which will materially cost the States more in contributions for any special group not heretofore covered—both from the standpoint of the additional cost to the States to say nothing of the unfair position in which those employees would be placed who have been covered and who have been paying their share of premiums all through the years.

Finally, the Legislative Committee and the Conference as a whole will not oppose legislation for retirees provided the Section is rewritten as stated previously, thereby completely relieving the States of any liability and permitting the retirees to contract with a private carrier for their Medicare coverage.

If they do not wish that approach, then it appears that under the amendments of the last Congress all individuals who are sixty-five (65) years of age and are citizens of the United States (unless they are or have been listed on the small list of subversives) can voluntarily enroll in Medical Insurance, commonly known as "Part B".

Too, if Medicaid requirements are met, and I believe most States have a Medicaid program, their State will purchase this "Part B" Medicare for them.

It is entirely possible that the two above provisions are not known to the retirees as well as the sponsors of the proposed medical insurance provisions now before the Congress.

Perhaps a detailed review of Section 218 and its administration by your Committee would be worth while. There have been nineteen years of development, and new programs such as those under the Economic Opportunity Act, the Mutual Education and Cultural Exchange Act of 1961, changes in retirement plans, and many more provisions affecting coverage (but not contemplated at the time Section 218 first came into existence) suggests that perhaps a new fresh look should be taken at the objectives of Section 218.

In closing, we would again like to express our appreciation to this Committee and the Congress for the careful and sympathetic consideration you have given to the State Administrators in this difficult, complex, and challenging area of Federal-State equal partnership. I would like, at this time, to introduce the representatives from the other States who are with me endorsing our objections and views. They are: Mr. S. M. VanDeventer, Oklahoma; Mr. Robert A. Healy, Delaware; Mrs. Hazel P. Gloer, Alabama; Mr. B. E. Friday, Arkansas; Mrs. Helene W. Rakatzky, Connecticut; Mr. James D. Holohan, Missouri; and Mrs. Betty Lujan, New Mexico.

We appreciate the opportunity to make this presentation.

EXPLANATION OF REASONS FOR OBJECTION TO ENACTMENT OF PENDING LEGISLATION
H.R. 17550

First: All States who have gone through the process of selling Social Security and Medicare protection to employees are now being placed in an embarrassing position due to the fact that one of the most important selling points was the fact that in order to obtain Medicare it would be necessary to take advantage of Social Security protection.

Second: This type legislation for retirees who have rejected Social Security in its general form completely defeats the action of State Administrators and will greatly weaken the State's program.

Third: The States will be required to assume unknown liabilities. You may say this will be optional; however, once the law is enacted another pressure campaign will be started to make it mandatory for the State to pay the biggest portion of the premiums. This, of course, would be far more expensive than the employer portion of the contributions presently required.

Another problem that is sure to arise many States will be burdened with the inability to enter the program until some subsequent date due to required legislation not being on the Statutes at the present time.

Fourth: Should this type special legislation be enacted for retirees, the younger employees will become more dissatisfied than they are at present and will make demands for opping out of the program and retaining their money until such time as they too reach sixty-five (65) years of age since they will be eligible for Medicare at retirement without contributing anything toward the program.

Fifth: Special legislation such as this will set a precedent and other disgruntled employees should be given the same protection of getting their wishes on the Statute.

Sixth: Special legislation for special groups after a very short while completely wreck the Social Security program. It is felt that in all fairness to we who have been contributing toward the program for eighteen years and will continue for many years to come, and in order to protect our interests, this special legislation, as well as any other, for a privileged few should never be enacted.

Seventh: Another unfair point is the States who have not seen fit to offer this added protection to their employees are now urging for the enactment of this legislation. It, I am sure, is their opinion that it will be much cheaper on their State to secure this type Medicare than to pay the employer share of the contributions for all employees over many years.

Eighth: Do these employees know that they are eligible for Medical Insurance at the present time under Part "B" of the Medical Insurance Program? Then too there are many of them who are eligible for Medicaid and then the State will pay the premiums for that portion of the program. Perhaps the retirees and the sponsors of this special legislation are not aware of these provisions.

The CHAIRMAN. Thank you very much for a very logical statement.

Any questions?

(No response.)

The CHAIRMAN. Thank you very much for your presentation today.

Miss REEVES. I would like to introduce some other members who are with me today.

Mrs. Gloer from Alabama; Miss Betty Lujain from New Mexico; Miss Helene Rokatsky, I believe. We have some others who were planning to be here whose names are listed in my statement, but they were not as smart as we were, they did not leave when we did, so they found out they had to stay at home and keep the home fires burning today.

Thank you, sir.

The CHAIRMAN. Thank you.

The next witness will be Mr. John V. Keaney, chairman of the Federal-State Relations Subcommittee, International Association of Industrial Accident Boards and Commissions.

STATEMENT OF JOHN V. KEANEY, CHAIRMAN, FEDERAL-STATE RELATIONS COMMITTEE, INTERNATIONAL ASSOCIATION OF INDUSTRIAL ACCIDENT BOARDS AND COMMISSIONS; ACCOMPANIED BY HARRY W. DAHL, INDUSTRIAL COMMISSIONER OF IOWA

Mr. KEANEY. Thank you, Mr. Chairman.

By way of further introduction, I am also presently the chairman of the Maine Industrial Accident Commission, a past president of the international, and currently its chairman of Federal-State relations.

With me today also is Commissioner Harry Dahl, the industrial commissioner of Iowa, and presently the secretary-treasurer of the international.

The statement originally presented was brief, but in the interest of time we will attempt to brief it a little further.

Our international is made up of the State Administrators of Workmen's Compensation, Canadian Provential Administrators, and several foreign jurisdictions.

We also have others interested in the field of workmen's compensation that hold membership as associate members. But the views expressed here this morning are the views of the State administrators only.

With respect to H. R. 17550, we are in objection to the proposal to change section 224(a) (5) of the Social Security Act to permit a beneficiary to receive social security disability benefits along with State Workmen's Compensation benefits as long as the combined

benefits do not exceed 100 percent of his average creditable weekly earnings before he became disabled.

Under present law, a worker receiving both workmen's compensation and social security benefits is limited to a total not to exceed 80 percent of his average earnings before becoming disabled.

This Senate Committee on Finance, as you are aware, provided for this offset in 1965 to prevent payments of excessive combined benefits.

Now, this proposal to change the 80 percent offset to 100 percent offset has a rather serious import insofar as State administrators are concerned.

Rehabilitation of an injured workman is one of the prime considerations of a State administrator, and the experts in rehabilitation are all in agreement that in order for a disabled man to be rehabilitated he must be motivated, he must have the desire to be rehabilitated. This is created by a desire of the man to become self-supporting and to take care of his family.

Now, this incentive is destroyed when a worker is paid more off the job than he received while working.

Right at present, many beneficiaries who receive workmen's compensation and social security benefits totaling 80 percent of their former gross wages are already receiving their former take-home pay, or probably even better off because these payments are subject neither to taxes nor to deductions.

Now, since its inception; workmen's compensation has always been based on the principle and philosophy that the cost of workmen's compensation will be merged into the cost of the end item being produced. In other words, the employer pays it and eventually the consumer in the price.

With the social security payments, we have changed that now so that where he received combined benefits, some of his benefits are paid for by the employee under his payroll tax, his social security tax and this, we feel, is repugnant to the whole idea and philosophy of workmen's compensation.

In addition, duplication of benefits has resulted in changes in the States. Prior to the enactment of the social security disability law, payments for permanent total disability were the same as for temporary total disability. Since the enactment of the disability benefits in social security, nine States have reduced the weekly amounts paid through permanent totally disabled persons, and I think the State of New York is the best example of it this past year where they raised their weekly maximum for temporary total to $95 a week. But those who are permanently and totally disabled, including your blind, your paraplegics, are restricted to $80 a week.

If any of these permanently and totally disabled workmen are not subject to social security disability payments, they are losing $15 a week.

In its report, the Ways and Means Committee in the House estimated that the liberalized workmen's compensation offset would cost approximately $7 million for the first year, and that it would involve about 60,000 people. But these 60,000 people are just a small segment of the industrially disabled workers throughout the country who are not subject to the duplicate payments. This is the reaction of the States because how do you get a legislature, a State legislature, and your

lobbying groups and your employer groups to increase weekly benefits for an injured workmen when they feel that the social security is picking up the difference, is picking it up.

They will say, "We will freeze our compensaton benefits at current levels."

So the International Association of Industrial Accident Boards and Commissions is unequivocally opposed to the change in the offset provision to 100 percent of wages as proposed by H.R. 17550.

We concur most heartily with the sentiments expressed by Commissioner Robert Ball of the Social Security Administration when he stated to this committee last July, and I quote, "It is important benefits not exceed present earning capacity."

You will recall that he also asked this committee not to go along with the House provision.

The International Association likewise joins and asks this committee not to go along with the revision of section 224(a)(5) of the Social Security Act.

We appreciate this opportunity to appear before you this morning.

(The prepared statement of Mr. Keaney follows:)

STATEMENT OF JOHN V. KEANEY, REPRESENTING THE INTERNATIONAL ASSOCIATION OF INDUSTRIAL ACCIDENT BOARDS AND COMMISSIONS

Mr. Chairman, my name is John V. Keaney. I am Chairman of the Industrial Accident Commission of the State of Maine, a Past President of the I.A.I.A.B.C. and currently Chairman of its Federal-State Relations Committee.

The International Association of Industrial Accident Boards and Commission is an organization of professional workmen's compensation administrators of the various states, Canadian provinces and several foreign jurisdictions. Its Constitution spells out its objective which is to develop and recommend standards for improving and strengthening workmen's compensation laws and their administration, and to approve and promote the acceptance of such standards. For the past 56 years, the Association's recommendations, forged in the crucible of hard administrative experience, have benefited state governments in legislation concerned with workmen's compensation. The Association also has representatives of the legal and medical professions, management, labor and the insurance industry as Associate members, but the views expressed in this statement are the views of our state administrators, Active Members only.

H.R. 77550 presently before the Committee proposes to change Section 224 (a)(5) of the Social Security Act to permit a beneficiary to receive Social Security disability benefits along with state workmen's compensation benefits so long as the combined benefits do not exceed 100% of his average creditable weekly earnings before he became disabled.

In 1956, Congress enlarged the scope of the Social Security Act to provide for payment of benefits to covered employees who were permanently and totally disabled. Disability was then defined as inability to engage in any substantial gainful activity because of any mental or physical impairment which was expected to result in death, or to be of long continued or indefinite duration. It was then recognized by Congress that these benefit payments might duplicate other social insurance programs such as state workmen's compensation so an offset was provided. Then, a deduction was made from Social Security payments for any amounts paid under workmen's compensation program. Where workman's compensation benefits exceeded those paid by Social Security, no federal payments were made. In 1958, this offset provision was removed.

Under present law, a worker receiving both workmen's compensation and Social Security disability benefits is limited to a total not to exceed 80% of his average earnings before becoming disabled. This Senate Committee on Finance, as you are aware, provided for this offset in 1965 to prevent payment of excessive combined benefits.

Under the House amendment, a beneficiary receiving combined benefits would be allowed up to 100% of his average weekly earnings as received prior to his disability. What is the serious import of this proposed change?

Rehabilitation experts agree unanimously that successful rehabilitation depends on the desire of the injured person to be rehabilitated. His attitude will determine success of the program. The incentive to be rehabilitated is created by a desire to become self-supporting again, able to meet the financial desires and needs of his family. How do we rehabilitate a worker who receives more money off the job than he earned while working? Many beneficiaries who receive workmen's compensation and Social Security payments totalling 80% of their former "gross" wages are already receiving their former "take-home" pay or better, especially since these benefits are neither taxable nor subject to deductions.

Since its inception, the state system of workmen's compensation has been based on the principle that the cost of workmen's compensation will be merged into the cost of the end item being produced, the employer pays all. Where Social Security picks up some of the cost of the benefit structure, cost is shifted half to the employer and half to the employee through payroll taxes. Thus, the employer's legitimate obligation is partly financed by his employee. In addition, the employer's contribution is at a fixed rate without regard to the hazard of the employment and without recognition of safety effort. This also violates one of the basic doctrines of workmen's compensation.

Duplication of payments for disability has served to adversely effect state workmen's compensation benefits. Prior to the enactment of Social Security disability benefits, under the state systems payments for *permanent* total disability were the same as for *temporary* total disability. Subsequently, nine states have reduced benefits for permanent total disability. In the state of New York this year, the weekly maximum benefit for temporary total disability was increased to $95.00 but those permanently and totally disabled receive only $80.00 per week. If any of the latter beneficiaries are not entitled to Social Security benefits, they lose $15.00 a week though permanently disabled. This is one area where the states might be led to freeze benefits at current levels if combined benefits equal 100% of wages. In its report, the House Ways and Means Committee estimates that the "liberalized workmen's compensation offset" will cost only $7 million more during 1971 covering approximately 60,000 beneficiaries. The latter are only a fraction of the workmen's compensation beneficiaries throughout this Nation who are not eligible for Social Security benefits but as in New York and eight other jurisdictions are subject to a freeze at current state compensation levels.

The International Association of Industrial Accident Boards and Commissions is unequivocally opposed to the change in the "offset provision" as proposed by H.R. 17550. We concur most heartily with the sentiment expressed by Commissioner Robert Ball of the Social Security Administration when he stated to this Committee last July that "it is important benefits not exceed present earnings' capacity". You recall he also asked this Committee not "to go along with the House provision".

SUMMARY

The International Association of Industrial Accident Boards and Commissions concludes with its reasons for opposing the change in Section 224(a)(5) of the Social Security Act as follows:

1. The return to work and rehabilitation incentives are lost where a worker receives more for not working than for working. Changing the offset from 80% to 100% tax free introduces a profit motive into workmen's compensation which is repugnant to all its social purposes.
2. H.R. 17550 will extend the undesirable trend to change the Social Security law into a workmen's compensation law. A competing federal system of workmen's compensation must result in weakening or total destruction of state administered workmen's compensation. The destruction will leave a system in which the worker pays half the cost while under state administration he pays no part of the cost.
3. When benefits are paid from taxes on payroll and wages, safety incentives are destroyed.
4. There is a place for welfare and support payments under Social Security and a separate place for state administered workmen's compensation. Social Security is adapted to payment of benefits for those who are not part of our labor force while workmen's compensation is adapted for those of the labor force who are unfortunate victims of occupational injury or disease but subject to rehabilitation and return to gainful employment.

Senator ANDERSON (presiding). Thank you very much.
Do you have any questions?
Senator BENNETT. No questions.
Senator ANDERSON. Thank you for being here.
Mr. Joseph Martin.
Mr. Knebel.
Mr. Muchemore.

STATEMENT OF G. ROBERT MUCHEMORE, VICE PRESIDENT AND GENERAL COUNSEL, MUTUAL OF OMAHA INSURANCE CO.; ACCOMPANIED BY JOHN H. BAKER, DIRECTOR OF PLANNING AND RESEARCH, GROUP ASSISTANCE DEVELOPMENT DEPARTMENT, JOHN HANCOCK MUTUAL LIFE INSURANCE CO.; PATRICK REDMOND, ADMINISTRATIVE ASSISTANT, CLAIMS DIVISION, MUTUAL OF OMAHA INSURANCE CO.; AND KENNETH D. ALLEN, ASSISTANT WASHINGTON COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. MUCHEMORE. Mr. Chairman, my name is G. Robert Muchemore, vice president and general counsel of Mutual of Omaha Insurance Co. I am accompanied by John H. Baker, director of planning and research, Group Systems Development Department, John Hancock Mutual Life Insurance Co., on my right; and on my left Pat Redmond, of Mutual of Omaha, and Mr. Kenneth Allen of the Health Insurance Association of America.

We are appearing before you today on behalf of the American Life Convention, the Health Insurance Association of America, and the Life Insurance Association of America. These three trade associations represent about 90 percent of the private accident and health insurance business of the country.

Our appearance today is in response to testimony before you last Monday by the Treasury Department in which they proposed that insurance companies report on assigned payments, that is, on payments which the insured have assigned to doctors, and also to report on payments made to an insured in reimbursement of medical bills presented to them.

We want to make it clear that the companies do not condone tax evasion nor are they interested in shielding anyone attempting to evade taxes.

We oppose these reporting requirements primarily because of the costs and the operational difficulties that are involved for the companies. Those costs would be incurred in producing what we consider to be valueless information for the Treasury Department.

The companies have never had to report these payments. A Revenue ruling was issued in November 1969 which would require, starting January 1, 1970, that reporting be made on those payments which are assigned by the insured to the doctors, and paid directly by the company to the doctors. The Treasury Department is asking that this be written into law.

The Treasury proposal Monday had some modifications or innovations over previous discussions. Their new proposal would be that the companies would aggregate and report on payments made to a doctor

which exceeded $100 for the first 2 years; after this, $50 for the next 2 years, and then go to a floor of $25. The present reporting floor of $600 a year on all information reporting would be eliminated.

Last February, a joint Internal Revenue Service and Insurance Industry Task Force was formed to examine the problems. They have done so, and the task force report was submitted along with the Treasury Department's testimony last Monday. We will from time to time refer to material in that report.

We, first oppose it because we believe that the information that may be obtained will be valueless. At the same time, it would require the insurance industry to expend millions of dollars and impose very grave operational changes on the task of handling claims to policyholders.

We will present our cost estimates and discuss some of these problems later. However, we want to first examine the question of the usefulness of the information to the IRS.

The task force, which has reported,* did not concern itself with the merit of these requirements. They were instructed to deal only with the problems themselves.

Now, the Treasury Department did present what they considered to be three useful purposes of this information. First, they indicated that the information would be used to detect those providers who failed to file an income tax return.

The Treasury Department has had many years of designing, and setting up, methods of determining whether a taxpayer has failed to file a return, and it seemed to us that it would be unnecessary to add this very burdensome method on top of all of those.

If a provider has ever filed a tax return in his life, certainly the records of the Internal Revenue Service would indicate that he failed to file a return in a given year.

The Treasury Department, secondly, indicated the information reports will improve the ability of the Internal Revenue agents to effect a thorough and speedy audit. Frankly, we are unable to comprehend the usefulness of the information in this regard. The agent will have on hand documents indicating that certain insurance carriers have paid certain specified amounts to a health care provider or to one of his patients. There is not going to be any relationship between this information and the provider's records to indicate what particular patients were involved, and no way, therefore, for the agent to trace the amount into the provider's records.

Even if the provider does record his receipts in the name of the actual payee, this will only serve to enable the agent to trace the payments made directly to the provider by an insurance carrier.

The whole basis of this the unassigned reporting is to report billed amounts, that is, based on the bill to the doctor, and we think this would be particularly valueless since the provider would not know which insurance company insured which patient.

Therefore, neither the provider nor the patient would be able to detect the particular patient involved. Thus, it would seem, the information reports would be useful only if the carrier supplied the patient's name, and to do this would just be an unbearable burden on the insurance carrier to do so.

Finally, the Treasury Department indicated that an analysis of the information returns "will lead to the identification of special return

*The report appears as appendix B, p. 1347 of this volume.

selection criteria which will facilitate the selection of high yield returns for audit."

That is a very vague statement, and we have considerable trouble in understanding how any useful broad guidelines can be established from the information that is going to be furnished.

In support of its conclusion that information reporting on health insurance payments will be extremely valuable, the Treasury Department pointed to the large improvement in reporting of interest income when the floor on that was reduced to $10. We do not believe this is a valid comparison.

The information reporting system applicable to interest results in most, if not all, of an individual's interest income being reflected on information returns. Therefore, under reporting can be detected merely by matching the two accounts.

However, only a portion of a doctor's income is going to come from payments from an insurance company, and we do not believe there is any possibility of matching this up as you do in the case of interest returns.

We come now to the companies. The outlay would be substantial and it would occur at a time when major segments of the industry are faced with accelerating health care costs and continued high claim loss ratios. Normally, a company could just add a little bit on to the price it is charging for its products and cover such costs. But this is not true of the insurance industry. Not only is it difficult, it is impractical and sometimes impossible to obtain premium rate increases, and even if obtained, they may take 2 and 3 years in the process.

We estimate that the nationwide costs to the industry in establishing the system on which such a reporting would be based, just the system alone, would be $18.4 million.

Senator ANDERSON. Who gave you that estimate?

Mr. MUCHEMORE. We estimated these from the figures that we compiled from a survey of member companies.

We estimated that the annual operating costs, and, I might say, these estimates were based on the prior understanding of the reporting system before Monday's testimony to the insurance carriers would be approximately $32 million.

Now, the proposed Treasury Department's system differs in four major respects from what we had considered before. Three of these changes would increase the annual costs, and they are as follows:

1. Copies of the information reports would be given to the providers of medical care.

2. We would have to report on proprietary hospitals.

3. All amounts over a certain floor, for instance, the $25 after 4 years, must be reported without a $600 floor.

The fourth change which would indicate that we would only have to take into consideration payments over $25, would reduce the annual costs of reporting.

Now, we have had a very brief time to try to revise our estimates since Monday.

Frankly, we do not have what we consider accurate figures. But the best we can ascertain is that if the proposal were put into effect, when it would become fully effective, the annual net operating costs would be raised about 10 percent.

The cost of creating the system would remain the same, however. Thus, we estimate that our annual costs under this proposal would be in excess of $35.5 million.

These cost estimates do not include the expense required for the handling of additional correspondence from the providers which would be caused by request for information so that they could reconcile their accounts with ours, and additional correspondence with the Treasury. These would result in untold costs, in our opinion.

Finally, and apart from the costs, we believe this would severely disrupt the normal service to the policyholders in the payment of claims. It would increase the period of time in which we would make payment of claims and unduly complicate the entire process.

Now, the companies have a great many practical problems which arise from reporting of this nature. Ordinarily, we pay directly to an insured. Companies will generally honor a written assignment from the insured to someone else. An insurer may be licensed in only one State, and it may issue a group contract that covers people in the 48 or 50 States. Thus, any company may potentially have to report on payments to providers anywhere in the United States.

Again, we wish to refer to the comparison made by the Treasury Department on interest and dividend payments. We believe they have little in common. There is no direct business relationship in the case of the insurance company and doctor as there is in the case of the bank or the company and the recipient of such interest or dividends. For them the securing of proper taxpayer identification numbers is relatively simple. For us it would be terribly complicated.

They only need to look at one account to put all of their information together. They do not have to aggregate multiple accounts. The information they obtain would be obtained from information which is valuable for them in their normal operation, and that is not true with us. None of these things is true with the insurance industry.

The task force report does not indicate the magnitude of the practical application of this reporting system on the companies. Our objections really do not go to any single point, although we note all of those, but to the total administrative burden to be assumed by the companies would be tremendous. It would be a system of information reporting that is vastly more complicated than anything currently used.

One of our difficulties is determining where the reporting responsibility lies because of the various claims processing and payment systems. There is no really satisfactory solution, as is noted in the task force report.

Any system of this nature is going to be dependent upon an accurate taxpayer identification number, and the problems associated with obtaining a correct number in the case of the insurance industry are tremendous because of the variety of business arrangements under which providers conduct their professional practices.

The taxpayer identification number will have to be sought and secured by insurance companies with respect to each payment transaction in order to identify, match and store these figures. Providers will be deluged with constant requests from insurance companies for identification numbers, and we can anticipate reverse correspondence.

We have a very difficult time trying to aggregate items. It will require a tremendous system and enormous expenditures of time and energy. Almost every carrier of any size has very decentralized sys-

tems, sometimes highly compartmentalized, and to try to tie all these together is something which would just completely disrupt our normal operations.

The maintenance of supporting records is going to be very difficult. The task force report would indicate that we are able to respond to most inquiries by simply stating the check number, the date of payment, and the amount paid. If that were true, you could take that off a payment record. But that is not the case. Such a response is not going to be satisfactory unless the name of the patient involved in each transaction is furnished, and insurance companies maintain this only in their claim files. It would require, therefore, a manual search and itemization in each event which would increase the costs of the mechanics involved.

The patient's name is the key to the account records of every provider, as I am sure you are aware.

In addition to maintaining records on payments to, and statements from, providers for audit trails to the claim files would be a voluminous task.

The problems associated with assigned payments, those where the insured has assigned the payment to the doctor or the hospital, and the company pays to them, are difficult. But those involved with indirect or unassigned payments are infinitely more difficult.

In addition, an expansion of statutory authority to include information reporting on unassigned payments would represent a significant change in tax policy. You no longer would confine these reports to actual payments to an individual for services rendered but to someone else who, we hope, is going to pay the one who rendered that service.

We firmly believe that the information reporting on unassigned payments would provide misleading information to the Treasury Department. The problems involved to the companies include the existence of multiple company coverages, the strong possibility of mismatch for the year for which the information is reported and the year it is actually paid to the providers; the identity of the actual provider performing the service, and other facts which cause this type of reporting to be three to five times as difficult as assigned payment reporting.

These are but a few of the examples of the difficulties carriers will experience under this sort of a system.

We cannot really determine all of those difficulties now. We can meet some of these problems, to a certain extent. However, the impact on all of these problems, trying to solve them and work with them, is going to be an extremely costly administrative quagmire for the companies.

For these reasons, we respectively urge the committee to reject the proposals of the Treasury Department, and that the provisions of the Internal Revenue Code be amended to clearly exclude payments under private accident and health insurance contracts from any information reporting requirements, whether imposed by this proposed bill or under an administrative basis by the Internal Revenue Service.

Our request takes no position with reference to payments made under Government programs.

Thank you.

(The prepared statement of Mr. Muchemore follows. Hearing continues on p. 1149.)

STATEMENT OF G. ROBERT MUCHEMORE, VICE PRESIDENT AND GENERAL COUNSEL, MUTUAL OF OMAHA INSURANCE CO.

Mr. Chairman and members of the committee, my name is G. Robert Muchemore, and I am Vice President and General Counsel of the Mutual of Omaha Insurance Company. I am accompanied by John H. Baker, Director of Planning and Research, Group Systems Development Department, John Hancock Mutual Life Insurance Company; Patrick Redmond, Administrative Assistant, Claims Division, Mutual of Omaha Insurance Company, and Kenneth D. Allen, Assistant Washington Counsel, Health Insurance Association of America.

We appear before you today on behalf of the American Life Convention, the Health Insurance Association of America, and the Life Insurance Association of America. These three insurance trade associations include as their members health insurance companies, life insurance companies, and casualty insurance companies which write approximately 90 percent of the total amount of private accident and health insurance written by insurance companies[1] in the United States.

Our appearance is in response to the testimony presented to this Committee on September 21 by the Treasury Department in which they proposed an amendment to the Internal Revenue Code of 1954 to require insurance carriers to file information reports on payments to, and bills received from, health care providers and facilities performing services covered under government health care programs and private accident and health insurance contracts.

We strongly oppose such reporting requirements insofar as they apply to private health insurance contracts. While we do not on any basis condone income tax evasion, we earnestly do not believe this new information reporting procedure will furnish the Internal Revenue Service with any significant amount of information which will be helpful in detecting such evasion. Moreover, any slight benefit it may produce is clearly outweighed by the heavy additional costs and administrative burdens that will necessarily be imposed on insurance carriers to record and report the required information.

We would like to emphasize at this point that the objections of the insurance business to this Treasury proposal are based solely upon the grounds that we do not believe the costs and complications imposed by this proposal will produce a commensurate benefit to the government. The insurance business is not attempting in any way to "shield" health care providers who may be either avoiding or evading the payments of their proper taxes.

SCOPE OF PRESENT LAW AND PROPOSED AMENDMENT

Until the issuance of Revenue Ruling 69-595 in November, 1969, insurance companies were not required to report payments made under accident and health insurance policies. Section 6041 (Information at Source) of the Internal Revenue Code of 1954 requires all persons making payments in the course of a trade or business of fixed or determinable gains, profits and income, to report the amount of such payments to the Internal Revenue Service. Revenue Ruling 69-595 interprets Section 6041 as requiring insurance carriers to file annual information reports with respect to payments made *directly* to individual providers and other suppliers of medical care services.

The ruling requires that a separate Form 1099 must be furnished to the Internal Revenue Service by each carrier for each provider to whom it makes payments aggregating $600 or more during any calendar year. With the exception of payments made under the Medicare and Medicaid programs, the provisions of the ruling do not apply with respect to payments made by insurance companies prior to January 1, 1971.

The primary purpose of the Treasury proposal is to expand the information reporting requirements to also encompass information derived from documents used by the insurance carriers in making payments to the insured on the basis of amounts paid or payable to a health care provider for medical services rendered by that provider.

Specifically, a claim generally consists of the receipt by an insurance carrier of a statement from the insured which is accompanied by a report of an attending provider and the bills or itemized statements of each provider rendering services. Even though the insurance carrier may make the payment to the insured in this instance, the Treasury would require that the insurance carrier

[1] Excluding Blue Cross and Blue Shield Plans or other service type organizations.

file information reports reflecting the amounts contained on the bills or statements of the individual providers.

As an additional part of this legislative proposal, the Treasury Department would include a specific provision in the law codifying the substance of Revenue Ruling 69-595, requiring insurance carriers to file information reports on payments made directly to health care providers.

The Treasury proposal includes some innovations which are intended to ease the administrative burden and cost of this information reporting procedure. Basically, an insurance carrier would be required to record, aggregate, and report only amounts above a specified level ($100 for the first two years; $50 for the next two years, and $25 thereafter). The usual rule under Section 6041 applicable in other reporting situations is that an information return must be filed on the total amounts paid to a particular person if they exceed $600. The $600 reporting floor would not be applicable under the Treasury's proposal.

JOINT TASK FORCE STUDY

Last February, a joint Internal Revenue Service/Insurance Industry Task Force was formed to examine the systems and procedures of carriers with the objective of identifying problems requiring action by the Internal Revenue Service or the industry to facilitate the reporting of direct payments under Revenue Ruling 69-595. In addition, the task force was requested to examine the problems which would be encountered if the reporting requirements were expanded to include reporting on unassigned payments.

We understand that this joint effort was a precedent in Internal Revenue Service-private industry relations. We feel the undertaking was beneficial as it did serve to formulate the issues and to produce a better understanding of the problems. The task force did make a number of recommendations to facilitate reporting under the ruling. These recommendations, however, are not to be construed as guaranteed solutions to the problems. They may ease certain situations, but not eliminate them entirely.

In our discussions of the Treasury proposal, we will refer to material contained in the report of the task force which was submitted to the Internal Revenue Service on July 28 and incorporated in their testimony.

LACK OF VALUE TO INTERNAL REVENUE SERVICE

The basis for our opposition to the proposed information reporting system is simple and straightforward. The requirements would impose on the insurance industry the annual expenditure of millions of dollars and would impose additional complications upon the task of handling claims of policyholders—all to produce information which we do not believe will be of significant value to the Internal Revenue Service. We will present our cost estimates and a discussion of the operating problems later in our statement. First, however, we would like to examine in some detail the question of the usefulness of the information to be reported.

The task force did not weigh the merits of the requirements since the Internal Revenue Service took the position that it was beyond the scope of their study to explore the benefits, if any, of such a reporting system to the Service. Although we have attempted on many occasions to discuss this question with officials of the Internal Revenue Service and the Treasury Department, we have been unsuccessful in obtaining any response as to the real value of the information in the form it will be reported by insurance carriers.

The Treasury Department did present some indications as to the use of this information in their testimony before this Committee. We think a careful analysis of the three uses they mention will prove each of them to be of little merit.

First, the Treasury Department indicated that the information will be used to detect those providers who fail to file an income tax return.

The Internal Revenue Service has had for a number of years various methods of determining whether taxpayers (including health care providers) are failing to file returns. It certainly does not seem necessary to institute a complicated and costly procedure of information reports by insurance carriers to determine whether a provider has filed an income tax return for the year. It would appear that the Internal Revenue Service should currently have the ability to make this type of determination from its own records just as accurately and more economically. For instance, they may obtain current directories of health care providers from state medical societies, or similar sources, and run annual checks

to see if the returns are being filed. In fact, if a provider has ever filed a return, the Internal Revenue Service should have the capability from its own records to check to see if he continues to file returns.

Second, the Treasury Department indicated that the information reports will improve the ability of an Internal Revenue Agent to effect a thorough and speedy audit.

We are unable to comprehend the usefulness of the information (in the form it is to be reported) in this regard. The agent will have on hand documents indicating that certain insurance carriers have paid a specified amount either to the health care provider or to one of his patients for services rendered. There will be nothing to indicate the particular patients involved in these payments and, therefore, no way for the agent to trace the amounts into the provider's patient records.

Even if the provider records his receipts in the name of the actual payee, this would only serve to enable the agent to trace those payments which are made directly to the provider by an insurance carrier.

The reporting of "billed amounts" would be particularly valueless since the provider, in most instances, would not know which insurance carrier insured which patient. Therefore, neither the provider nor the agent would be able to detect the particular patients involved.

Thus it would seem apparent that the information reports would only be useful if the insurance carriers supplied the name of the patient in each instance of payment. This would place an almost intolerable burden on the insurance carrier to retrieve, record, and report that information with respect to each transaction.

Finally, the Treasury Department indicated that an analysis of the information returns "will lead to the identification of special return selection criteria which will facilitate the selection of high yield returns for audit." This is indeed a vague statement. Moreover, we have considerable trouble in understanding how any useful broad guidelines can be obtained from the information to be filed.

Insurance payments represent only a portion of the income of providers of health care and there is a great variation among individual providers as to the percentage of their gross receipts which arise from insurance coverage. Depending upon a provider's particular field of medicine, and his geographic location, much of his practice may not involve fees that are reimbursed by accident and health insurance.

For instance pediatricians receive a considerable portion of their income for services relating to the prevention of disease. These are areas which currently are either not covered or where the charges often do not total an amount which is reimbursable under insurance policies. On the other hand, surgeons may have a substantial portion of their fees covered by insurance policies. Because of these variations resulting from individual provider practices, it does not appear that any meaningful overall guideline as to the relationship of insurance payments to total income can be produced by the Internal Revenue Service against which information reports on insurance payments can be applied.

In support of its conclusion that information reporting on health insurance payments will be extremely valuable, the Treasury Department pointed to the large improvement in reporting of interest income which resulted when the reporting floor was reduced to $10 in 1962. We do not believe that this is a valid comparison. The information reporting system applicable to interest results in most, if not all, of an individual's interest income being reflected on information returns. Therefore, under-reporting can be detected merely by matching the information returns against the amount shown on the individual's income tax return. As we have already established, only a fraction of a doctor's receipts will appear on the information documents which have been proposed by the Treasury Department with the result that an overall matching will not be possible.

Thus, we seriously question the usefulness of reporting health insurance payments. We strongly believe that it is incumbent on the Treasury Department to explain its thinking on this matter as a prerequisite to obtaining the legislation it has requested. In this regard, it is not enough that they establish merely a marginal benefit. As we will not discuss, the Treasury proposal will involve heavy costs for our member companies. Sound tax policy would require that the benefits to be obtained be commensurate with these costs. We cannot imagine that they will be.

COST TO COMPANIES

The cost to insurance carriers to establish and maintain an accurate system for information reporting would be substantial. This additional outlay would also occur at a time when major segments of the health insurance business are faced with accelerating health care costs and continued high claim loss ratios. In normal business enterprise activities, such increased costs can generally be passed on to the consumer through an immediate adjustment in retail prices. The health insurance business, however, has certain inherent practical and regulatory problems which may either preclude or delay such premium adjustments.

We estimate that the nationwide cost to insurance carriers to develop a reporting system for both assigned and unassigned payments of the type assumed in the Task Force Report would be approximately $18.4 million. The estimated annual operating and maintenance costs to insurance carriers of such a reporting system would be over $32 million.

The proposed Treasury Department reporting system differs from the assumed task force reporting system in four major respects. Three of these changes would increase the annual cost of the reporting system, and they are as follows:

(1) Copies of the information reports would be given to providers of medical care;

(2) Information reporting would be required for payments to proprietary hospitals, and

(3) All amounts over a certain amount (e.g. $25) must be reported without a $600 floor.

The fourth change—the requirement that only amounts over a specific dollar limitation (e.g. $25) must be reported—would reduce the annual cost of reporting.

In the limited time available since the Treasury Department appeared before this Committee on Monday, we have not been able to accurately determine the individual costs of these four items. However, the cost data we have been able to obtain indicates that when the Treasury Department proposal is fully effective the additional net operating costs would be at least 10 percent over those estimated in the Task Force Report. Thus, we believe when the proposed Treasury Department system is fully effective our annual operating costs will be in excess of $35.5 million dollars.

These cost estimates do not, however, include the expense required for the handling of additional correspondence from the providers which would be caused by requests for information to reconcile accounts. The volume of retrieval expenses and the necessary costs for the handling of records which may be requested by the Internal Revenue Service in the event of an audit or review of a provider's tax return are also not included. These items could result in untold additional costs.

Finally, and even aside from the cost implications, these new reporting requirements would severely disrupt the normal operating procedures of insurance carriers. The inevitable result will be a delay in the processing of claims with the consequent inconvenience to the policyholders.

PROBLEMS RELATING TO REPORTING

Accident and health insurance contracts issued by commercial insurance companies generally provide for benefit payments to be issued to the insured. Insurance companies generally permit an insured to request that the payment be made directly to the provider on the basis of a written assignment.

Insurance companies may issue contracts covering insureds living anywhere in the nation. Even though a carrier may be limited to issuing policies in only one State, it may pay for health services rendered anywhere in the nation to one of its insureds. Thus, any insurance company can potentially make a payment, and therefore possibly be required to file an information return, on any provider in the United States.

The requirements for the reporting of interest and dividend payments are often cited as analogous to the system which would be imposed on insurance companies under the Treasury proposal. To the contrary, these reporting methods have little in common.

With respect to interest and dividend reporting, there is a direct business relationship between the reporting entity and the person on whom the information return is being filed. Because of this direct contact, the securing of

the proper taxpayer identification number is relatively simple. Moreover, the normal business procedures of banking institutions and stock companies require that all files concerning interest and dividend transactions be maintained in the name of the payee and, therefore, they need only look to a single account for all of the necessary information to complete the amount to be reported. In this regard, the regulations do not require that multiple accounts be aggregated for information reporting. Finally, unlike insurance company reporting, the amount reflected on an interest and dividend report is drawn from information which is otherwise of value to the operations of the bank or company.

This is definitely not the case with insurance companies. The absence of direct contact with the provider-payee requires a more complicated solicitation of the proper taxpayer identification number. The records of insurance companies are not maintained in the name of the providers involved; instead, even the payment documents are maintained by type of contract, by policyholder or beneficiary, or by the date of issuance. Moreover, these payments may emanate from several sources, such as different divisions within a company (i.e., group contracts, individual contracts, etc.), and from the policyholders themselves in cases where they administer their own contracts. Thus, the problems of aggregation and consolidation for reporting by insurance companies are immense.

Even though the data to be reported on direct payments may be extracted from the payment documents, and with respect to indirect payments from the statements submitted with a claim, it will require a number of additional steps and procedures to secure and store this information which are not now conducted by insurance companies and which have no value to their processing or accounting systems. A reporting system of this nature is dependent upon the accuracy and precision of every link to the eventually filed information return. This includes the accumulation and maintenance of the proper taxpayer identification number; the capturing of individual transactions; the aggregation of amounts; the filing of a consolidated return on an individual provider; and the reconstruction of the data in the event of inquiry.

The recommendations and discussions by the task force do clarify certain problem areas and will facilitate reporting. The Task Force Report does not, however, indicate the magnitude of the practical application of such a reporting system on the operations of companies. Our objections are directed not to any single difficulty, but to the total intricate administrative burden which companies will have to assume. It is a system vastly more complicated than any other information reporting presently required by law.

Determination of Reporting Responsibility [2]

Many insurance companies have a variety of claims processing and payment systems and various types of insuring arrangements. Even the task force concluded that there is no wholly satisfactory solution to the problem of pinpointing the proper entity for reporting responsibility in each situation.

Taxpayer Identifying Numbers [3]

Any information reporting system is dependent upon the accumulation and accurate reflection of the apropriate taxpayer identification number. The problems associated with defining the correct number to be furnished are tremendous in view of the variety of business arrangements under which providers conducting their professional practices. Insurance companies cannot be expected to have personnel with the necessary expertise to distinguish between the various identification numbers and the business arrangements to assure proper identification for reporting purposes.

Unlike interest and dividend reporting, the taxpayer identifying number will have to be sought and secured by insurance companies with respect to each payment transaction in order to identify, match, and store the proper amounts. Providers will be deluged with constant requests from insurance companies for the identification number.

Aggregation [4]

The Reporting Requirements dictate that insurance companies must file Form 1099; however, there are tremendous practical difficulties, and enormous expenditures of time and energy will be required to achieve and perfect an aggregation system. Decentralized carrier processing systems are numerous and

[2] See pages 16–20 of the Task Force Report.
[3] See pages 27–30 and 44–46 of the Task Force Report.
[4] See pages 32–36 of the Task Force Report.

complicated. In most instances they are separate and distinct operations which coordinate and exchange data with other divisions within an insurance company in only specific instances (operations, such as Medicare may have no relationship with the other divisions of a carrier).

To aggregate payments made by all such functions will require extensive changes in the current procedures and accounting systems of insurance companies. This expenditure to be shouldered by insurance companies is actually an effort to reduce the costs to the Internal Revenue Service by decreasing the volume of their paperwork.

Maintenance of Supporting Records [5]

The Task Force Report states that insurance companies should be able to respond to most inquiries concerning the information returns (from providers and the Service) by simply supplying the check numbers, dates of payment and the amounts paid. All of this information can be extracted from the payment document.

We maintain, however, that such a response is not satisfactory unless the name of the patient involved in each transaction is also furnished. That information is contained only in the claim files and would require a manual search and itemization which drastically increases the cost and mechanics involved in the retrieval system. In most instances, it is impossible to add the patient name to the payment documents of insurance companies because of other required accounting information. It is also an additional burden to record the name of the patient with respect to the bills submitted by providers.

The patient's name is the key to the account records of providers. The check numbers only indicate the identity of the bank involved and there may be several insurance companies (and numerous patients) using the same bank for payment purposes. The provider may also receive a number of payments on the same date which are also in an identical amount. In order for providers to verify their records, and for the Service to be accurate in its audits, the name of the patient would have to be supplied in nearly every instance.

In addition, to maintain records on payments to, and statements from, individual providers, with audit trails to the claim files involved, would be a voluminous task. The storage capacity of insurance companies is also limited and open-ended retention requirement is a grant burden on insurance companies. It is our understanding that the Internal Revenue Service has no regulations governing the time period for proper retention and disposal of such records.

ADDITIONAL PROBLEMS RELATING TO UNASSIGNED CLAIMS

The problems associated with information reporting of unassigned, or indirect, payments are infinite. The difficulties to be experienced with respect to assigned payments reporting are multiplied and compounded in the area of extracting data from unassigned claims as indicated in Section VIII of the Task Force Report.

In addition, an expansion of statutory authority to include information reporting on unassigned payments represents a significant change in tax policy. The information reporting requirements would no longer be confined to actual payments made to the person on whom the information is being filed, but would be expanded to include the material calculations utilized by a business in determining a payment—even though the specific payment may be made to an entirely different person.

We firmly believe that information reporting on unassigned payments would actually provide the Service with misleading information which would generate confusion and perhaps needless audits of providers. Companies would ultimately be placed in the middle of all confrontations between the Service and providers based on information which carriers had been required to supply—information which they by no means certify as actually reflecting the income of a provider.

The problems involved include the existence of multiple company coverages;[6] the strong possibility of a mismatch between the year for which the information is reported and the year it is actually paid (and taxable) to the providers;[7] the identity of the actual provider performing the service,[8] and other facts which

[5] See pages 36–37 of the Task Force Report.
[6] See pages 54–56 of the Task Force Report.
[7] See pages 56, Ibid.
[8] See pages 46–48, Ibid.

cause this type of reporting to be from three to five times as difficult as assigned payment reporting. Our opposition to a requirement for information reporting on unassigned payments is absolute.

* * * * * * *

These are but a few of the examples of the difficulties carriers will experience under such a reporting system. Although each problem may be met to a certain extent, it is the total impact of the procedures which must be implemented that make this a costly task and an administrative quagmire.

For these reasons, we respectfully urge the Committee to reject the proposals of the Treasury Department and that the provisions of the Internal Revenue Code of 1954 be amended to clearly exclude payments under private accident and health insurance contracts from any information reporting requirements, whether imposed by this bill or on an administrative basis by the Internal Revenue Service. Our request takes no position with respect to payments made under government programs.

Senator ANDERSON. Is this statement by the American Life Convention also?

Mr. MUCHEMORE. Yes.

Senator ANDERSON. They fully support this testimony?

Mr. MUCHEMORE. Yes.

Senator BENNETT. I have just one question, Mr. Chairman.

Does the industry have any alternative methods or proposals to suggest to us which might accomplish a part, at least, of the goal that we seek to accomplish?

Mr. MUCHEMORE. We have not. I do not believe we have been asked to study that at all. I do not know whether it would even be possible to come up with any alternative system.

Senator BENNETT. Thank you.

Senator CURTIS. Mr. Chairman, I am sorry I came in late, but I am familiar with what you are testifying about, and I have your complete statement.

Do you feel that what this amounts to is that the Government would be calling on you to account for something in regard to a payment that you never make; is that right?

Mr. MUCHEMORE. That is correct, on the unassigned payment, which is the majority of the payments.

Senator CURTIS. I think it is one thing to require of our business community a report transactions that they have, but to require a business to report information concerning which company making the report has had no dealings whatever with the person involved, is quite a departure, is it not?

Mr. MUCHEMORE. That is true.

Senator CURTIS. The other day the Treasury said this was not done in any other situation in our tax law, no other segment of our economy is being asked to report something they did not handle.

Now, in reference to unassigned claim, the insurance company has no contract or dealings whatever with the doctors or the hospitals or the clinics or the laboratories involved; is that right?

Mr. MUCHEMORE. That is correct.

Senator CURTIS. Tell me this, in using modern business machines, banks, data processing, and computers is the supporting material that is before the examiner when he approves an unassigned put that into the computers when the check is disbursed?

Mr. MUCHEMORE. We do not.

Senator CURTIS. You do not.

Mr. MUCHEMORE. None of the information taken in the manual handling of the claim file is converted into computer information. Naturally, the company keeps its overall statistical records on such computers.

Senator CURTIS. But if a claim agent sits down to ascertain what the company's liability is for a claim filed, that examiner will look at the supporting material which will include it, doctors' statements, as well as their bills——

Mr. MUCHEMORE. That is correct.

Senator CURTIS (continuing). To be paid. But once it is determined that you owe x dollars on that claim, does it not then go to another office for check disbursal?

Mr. MUCHEMORE. In most companies it would be paid by whoever determined the amount to be paid, whether it was in the field or in the home office.

Senator CURTIS. But the material that you consider for ascertaining the amount of your liability for the claim does not go into your machines?

Mr. MUCHEMORE. No; it does not.

Senator CURTIS. That is where a substantial part of this cost would be?

Mr. MUCHEMORE. That is where the vast majority of the costs and the administrative difficulty will be.

Senator CURTIS. If this is enacted, will it raise the cost to the insured people——

Mr. MUCHEMORE. Yes.

Senator CURTIS (continuing). To the insured people for hospital and medical care?

Mr. MUCHEMORE. Well, over the long run we are going to have to consider these costs in determining rates. As I indicated, over a shorter term it is extremely difficult to raise any premium rates.

Senator CURTIS. Then you do not have any income except that which you get from your policyholders?

Mr. MUCHEMORE. That is correct. Ultimately, we will have to——

Senator CURTIS. It is going to add to the cost of insurance; is that right?

Mr. MUCHEMORE. Yes.

Senator CURTIS. That is all.

Senator JORDAN. No questions.

Senator ANDERSON. Thank you very much.

Mr. MUCHEMORE. Thank you.

Senator ANDERSON. Mr. Nangle.

STATEMENT OF JOHN NANGLE, WASHINGTON COUNSEL, NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

Mr. NANGLE. Mr. Chairman and members of the committee, I am John Nangle, Washington counsel for the National Association of Independent Insurers.

As a member of the joint insurance/industry task force, I also represented the American Mutual Insurance Alliance and the American Insurance Association. These three associations represent approximately 90 percent of the property and casualty insurance written in the United States today.

Our concern was initiated by Mr. Meade Whitaker's testimony of the 21st which recommended legislation requiring insurance company payments made to beneficiaries or third parties—other than the provider—be reported to the IRS on form 1099. The report would be on the provider.

We are unqualifiedly opposed to such legislation as costly, complex, and unnecessary.

We are not under attack by IRS as a segment of potential fraud—the medical profession is—however, we are asked to bear the bitter consequences of seemingly aiding the regulators in their quest to detect fraud.

While we do not on any basis condone income tax evasion, we earnestly do not believe this new reporting procedure will furnish the IRS with any significant amount of information which will be helpful in precisely detecting the evasion. Moreover, any slight benefit it may produce is clearly outweighed by the heavy additional costs and administrative burdens that will necessarily be imposed on insurance carriers to file these annual information reports.

Mr. Whitaker's testimony would lead you to believe that a change in the reporting floor of $600 to a sliding scale of reportable items of $100 for 2 years, $50 for the next 2 years, and $25 forever would greatly lessen our workload and reduce, in his words, "the number of items that the insurance industry will have to process."

This would not necessarily be substantial because each bill, each item will still have to be pulled out, looked at, and a determination of its eligibility be judged. For whatever small saving this may incur, the cost to our industry will be enormous. Based upon present estimates with a $600 floor after tooling up and after starting costs the second and ensuing years involved in reporting by the entire industry for each year are: $9.95 million to report assigned payments and $68.3 million to report unassigned payments. This amazing differential is even more dramatic with the companies we speak for today. That is, $250,000 to report assigned payments against $13.8 million to report unassigned payments.

We were represented on the joint IRS/industry task force committee which addressed itself to this problem. Three industry representatives—representing all of the insurance industry—and two representatives of the Internal Revenue Service comprised this committee. The report has been filed, Mr. Chairman, if it has not been officially filed, I ask leave to file the report at this time.

Senator ANDERSON. It has been filed.

Mr. NANGLE. Thank you.

Mr. Chairman, when Senator Long asked Mr. Whitaker Monday whether his "request letter—to testify—was based on this joint study," he answered, "They are based substantially on the joint study."

All I can say is that after full and careful examination of the entire problem, this report as written—and signed by all—by its factual content and tenor of its writing, it would lead reasonable minds to come to only one conclusion. That is, to require reporting of unassigned payments for health, care providers would be costly, confusing, and of very little value to the usage for which it was intended.

Information reporting an unassigned payment would actually provide IRS with misleading information which would generate confu-

sion and needless audits of providers. For example, a provider sends a bill for services to a beneficiary and the beneficiary has two or three collateral sources of reimbursement. The provider would be reported multiple times, but receive payment once, if at all.

Obtaining Treasury numbers, SSN's or TIN's for reporting purposes by industry would be almost impossible. The company is not in privity with the provider—indeed the provider has on interest in an entity which seeks his TIN for the sole purpose of reporting him.

We do not believe that such information reporting will produce data to the service the value of which even equals the cost and energy to be expended by the insurance business. In addition, current information reporting provisions in the Internal Revenue Code, for example the reporting of dividend and interest income, do not impose burdens or complex procedures upon any other business as will be shouldered by insurance carriers concerning payments to health care providers.

Thank you, Mr. Chairman. That is the extent of my statement.

Senator ANDERSON. Any questions?

Thank you very much for your testimony.

Mr. Knebel.

STATEMENT OF JAMES D. KNEBEL, ASSISTANT EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS; ACCOMPANIED BY JOHN ALEXANDER, VICE PRESIDENT; AND DR. RALPH W. SCHAFFARZICK, CHIEF MEDICAL ADVISER, CALIFORNIA BLUE SHIELD

Mr. KNEBEL. Mr. Chairman and members of the committee, I am James Knebel, assistant executive vice president of the National Association of Blue Shield Plans. With me is Mr. John Alexander, vice president of National Association of Blue Shield Plans; and Dr. Ralph W. Schaffarzick, a practicing internist, a member of the clinical faculty of Stanford University School of Medicine, and chief medical adviser of California Blue Shield. Dr. Schaffarzick will assist me in attempting to answer any questions that you may have on professional standard review organizations, and Mr. Alexander will assist me on the Internal Revenue Service matters.

At your request, we are submitting our respective statements for the record and, with your permission, I will summarize on H.R. 17550 our position and comment on two proposed amendments to that bill, namely, Senator Bennett's proposal to establish professional standard review organizations, and the Treasury Department's proposal to require reporting of payments by third parties to providers of health care.

On section 239, payment to health maintenance organizations, we have supported provisions in section 239 which would provide medicare payments on a capitation basis to accrued health maintenance organizations. We have expressed concern here that section 239 may not adequately meet the need for improved quality and availability of comprehensive care in underserviced areas.

On section 224, which provides limits on prevailing charge levels, in our formal statement we called attention to the probability of a significant increase in the number of unassigned claims resulting from the establishment of a charge level at the 75 percentile. We are concerned

with the beneficiary's standing of his benefits, and have urged that he be informed of this change.

In section 232, Mr. Chairman, this section would authorize the Federal payment of 90 percent of the costs incurred by the States in the design, development, and installation of mechanized claims processing and information retrieval systems in the respective medicaid programs.

The Federal Government would also pay 75 percent of the costs of operating such systems.

At present Federal-State matching formulas for medicaid cost sharing authorize that 50 percent of the administrative costs will be borne by the Federal Government whether the program is self-administered or administered by fiscal intermediaries.

Section 232 would modify those provisions when States redesign, develop, and install a new system. It would commit the Federal Government to pay 75 percent of the allowable costs of the ongoing new operation.

Mr. Chairman, to the extent that section 232 provides incentives to improve the capability of title XIX administration, it is a constructive move and we support it. However, we are concerned that the States may interpret it to mean that they could receive increased financial assistance only by terminating their carrier arrangements and developing their own processing capacity where none had existed before.

This would result in a needless expenditure of a great deal of money.

In the belief that this is not the intent of section 232, we endorse the provision. We ask that the committe report make clear that this is, in fact, not the intent of this section.

On amendment 851, professional standards review organizations, we support the purpose that Senator Bennett's amendment seeks, and we respect his efforts to make certain that maximum use is made of the health care dollar in Government-financed programs.

In introducing the amendment, Senator Bennett graciously asked that interested parties study his proposal and make comments and suggestions.

Mr. Chairman and Senator Bennett, our observations are as follows:

While we support the increased assumption by medical organizations of the responsibility for peer review, we believe this amendment does not take into account the interdependence of claims review and peer review in the utilization review process and the extent to which claims review is a necessary function of the carrier.

Carriers and professional organizations have natural capabilities to complement each other, and that are not easily separated; in general, and in our opinion, most local medical organizations have neither the interest, the expertise, nor the resources to engage productively in claims review. Their interest and expertise are certainly extremely important to peer review.

To get the greatest productively from each function, it is necessary to define how claims review and peer review relate to each other. This is not a simple question. Our organization had asked the American Medical Association to join with us in establishing a task force to bring claims processing and medical expertise together to work out a national prototype for the most effective interface of those respective skills and to provide ongoing assistance support for both processes.

This action by our board of directors is attached to our statement for your information as exhibit A.

We have testified before this committee in the past that utilization review is not a fully developed science, and that more work needs to be done to make it as productive as it eventually will be. We are forced to the conclusion that the establishment of parallel systems with fragmented responsibilities will be a step backward.

We think that it would be unwise at this time to enact specific detailed legislation to fix responsibility for functions which are, to a considerable extent, still emerging.

We believe the purposes of amendment 851 will be satisfactorily achieved if section 1842 of the Medicare Act were amended to require carriers to establish formal linkages with professional standard review organizations, and once established to work cooperatively toward the development of the most effective possible utilization review.

Professional standard review organizations could then be made integral parts of the administrative processes of medicare.

If necessary Government funding were made available for the development of these functions, the Government could then audit the processes to establish the propriety of the expenditures. Such an amendment would offer far more promise of dynamic evolution in utilization review without the need to retrace developmental steps for new agencies at considerable expense to the taxpayers.

Mr. Chairman and Senator Bennett, we do want to make it clear that while we consider the basic goals of amendment 851 sound with respect to approved peer review, we think that administration on the amendment's terms would be impractical for reasons of the fragmentation, the administrative costs, the staffing requirements, the dubious cost-benefit relationships, and other factors.

Mr. Chairman, we were advised last Friday by Mr. Vail, your chief counsel, that the committee would like our comments on the Treasury Department's proposal to require reporting of payments by third parties to providers of health care services. Our testimony provides a statement regarding Blue Shield's concern over the impact these requirements might have on our operations.

I must add, however, that we are hampered by the fact that the proposed amendment has not been drafted and, therefore, we cannot comment in detail. We would hope when such language is drafted we would be given an opportunity to comment.

In their statement last Monday, the Treasury Department proposed legislation that would require reporting to the Internal Revenue Service of Health Insurers' payments on so-called unassigned claims. An unassigned claim is a payment made directly to the patient rather than to the physician.

Because of the way Blue Shield operates, most of our payments are made directly to physicians.

Section 6041 of the Internal Revenue Code of 1954 requires an annual report from us of these amounts on the IRS Form 1099. Blue Shield plans are and have been regularly reporting this information, and these reports cover the bulk of the Blue Shield payments. The balance of our benefit payments are made directly to subscribers. We have the technical capability also to report information on this data on IRS form 1099.

However, it will require the development of a new system, together with a massive computer program effort.

We would like to bring to the attention of the committee the findings of a special IRS-Health Insurance Industry task force that was established to study our problem. That task force was comprised of IRS staff, technical experts of Blue Shield and Blue Cross, and representatives of the commercial insurance industry.

Mr. Chairman, a copy of the task force report has been made available to your staff. We urge that the report be given careful consideration by your committee.*

The report estimates that the additional annual operational expenses of Blue Shield-Blue Cross would be $24 million a year. The report of that task force also indicates that the insurance companies will incur an even greater cost.

These additional costs of Blue Shield and Blue Cross must necessarily be passed on to subscribers since it has not been indicated what source of funds would pay for this proposed detection of information.

The necessary costs and the time involved in making the change might be warranted if it were clearly apparent that the information reported would be of appreciable value.

Mr. Chairman, that concludes our oral testimony. We appreciate the opportunity to appear and testify before your committee today. If you or any member of the committee have any questions we would be more than happy to try to answer them.

Thank you.

(The prepared statements of Mr. Knebel and Dr. Schaffarzick, follow. Hearing continues on p. 1162.)

STATEMENT BY JAMES D. KNEBEL, ASSISTANT EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

Mr. Chairman and Members of the Committee, I am James D. Knebel, Assistant Executive Vice President, National Association of Blue Shield Plans. It is my privilege today to present the views of the Association on H.R. 17550, the Social Security Amendments of 1970, and on two related matters—Amendment 851, and the Treasury Department's proposal to require reporting of unassigned payments for medical services. With me is Dr. Ralph W. Schaffarzick, a practicing internist, a member of the clinical faculty of Stanford University School of Medicine, and Chief Medical Advisor of California Blue Shield, who will assist in attempting to answer questions you may have. Dr. Shaffarzick is also submitting for the record a separate statement.

The National Association of Blue Shield Plans is the coordinating body for 73 Blue Shield Plans in the United States and Puerto Rico. We serve 63 million persons in our private programs, and an additional 16 million Americans under Medicare, Medicaid, and the CHAMPUS program for dependents of military personnel. In all, Blue Shield Plans are involved in the health care financing of 79 million persons—roughly 38 per cent of our population.

Today, with increasing public attention on the delivery and financing of health care, you are considering amendments to the Social Security Act which could have significant and long-lasting impact. We appreciate this opportunity to comment on these amendments.

HEALTH MAINTENANCE ORGANIZATIONS

We believe that no one system of health care delivery and financing can meet the total needs of our Nation. Our society has become too complex. And we believe in pluralism to make the best use of the capabilities of both the private and governmental sectors.

If true reform is to come, it can best be achieved by allowing individuals to exercise their choice in selecting the health care delivery system they prefer.

*This appears as appendix B, p. 1347 of this volume.

For this reason, we support Section 239, which would provide Medicare payments on a capitation basis to health maintenance organizations.

Even before the HMO concept was announced, Blue Shield Plans were examinging the concept of prepaid group practices and how Blue Shield could provide this alternative to its subscribers. Experiments are underway or under consideration by several Blue Shield Plans, and we are watching their development very closely.

We support the provision in Section 239 which stipulates that to be an approved HMO, the organization must have enrolled at least 50 per cent of its membership from individuals under age 65. This provision will safeguard the equality of services provided to Medicare beneficiaries.

We are concerned, however, that Section 239 may not adequately meet the need to encourage improved quality and availability of comprehensive care in underserved areas.

Payment of 9 per cent of the average per capita Federal expenditures on Parts A and B in the area may tend to encourage development of HMO's in the most affluent "safe areas", since HMO's would receive more per beneficiary where payment levels are higher, even though need for and utilization of services may be lower. Exceptions may be necessary to provide incentive for HMO's willing to locate in areas with inadequate medical resources.

Finally, we would caution that care must be taken to make certain that proper health services are not denied to the elderly who opt for HMO's because of inordinate interest in profits, or for other reasons. While overutilization is a serious problem, underutilization can also be a major problem in terms of human suffering and lives.

LIMITS ON PREVAILING CHARGE LEVELS

Mr. Chairman, Part B Medicare benefits were originally structured as a coinsurance program, requiring the beneficiary to pay only 20 per cent of a reasonable charge after the $50 deductible had been satisfied.

We recognize that from the outset, physicians were allowed to collect more than 20 per cent, provided they did not take assignments. But this presumably affected a small percentage of the beneficiaries.

On December 17, 1968, the Social Security Administration sent a letter to Part B carriers instructing them to use the "mean plus one standard deviation" method of determining prevailing charges.

In explaining the action, the then Secretary of Health, Education, and Welfare Wilbur Cohen said: "This is expected to result in a maximum payment of approximately 83 per cent of the fee range of all physicians for a given service as opposed to as much as 90 per cent or more of the fee range for a given service adopted by some carriers."

Thus, through regulation, up to 17 per cent of the beneficiaries could now expect an additional charge over the 20 per cent coinsurance.

Section 224—if enacted—will establish the prevailing charge level at the 75th percentile. As a result, the level of protection extended to the program's beneficiaries will again be re-defined.

Mr. Chairman, we recognize that the Congress has both the prerogative and the duty of determining the Government's level of liability in this program. We do not challenge the propriety of exercising that right. However, as Part B carriers for 11 million Medicare beneficiaries, we are concerned not only with the cost of the program, but with the beneficiary's understanding of his benefits. It is probable that lowering the prevailing charge range will increase both the number of physicians who do not take assignment and the number of beneficiaries who do not have 80 percent of their bills met. To avoid misunderstanding, we urge that the Government inform Medicare beneficiaries that there is an increased probability of personal liability in excess of 20 per cent of charges, and that this results from modification of the payment process.

It is also important to note—to avoid disappointment later—that the move to the 75th percentile, with prevailing charge levels increased according to general wage and price movement, will not necessarily mean stable costs in relation to the general economy. Given the expanding capacities of and demand for medical care, the utilization of services will continue to increase, resulting in further escalation in the cost of the program, both absolutely and relatively.

PAYMENTS TO STATES FOR INSTALLATION AND OPERATION OF CLAIMS PROCESSING SYSTEMS

Mr. Chairman, Section 232 would authorize Federal payment of 90 per cent of the costs incurred by the states in the design, development and installation of mechanized claims processing and information retrieval systems in Medicaid programs. The Federal Government would also pay 75 per cent of the cost of operating such systems.

We recognize that one of the principal aims of Congress and the Administration is to operate any program as economically and efficiently as possible. But we wish to point out that at the present time, 31 states have entered into agreement with private carriers to administer the claims processing and informal retrieval functions. Federal-State matching formulas for Medicaid cost-sharing authorize that 50 pre cent of the administrative costs will be borne by the Federal Government, whether the program is self-administered or administered by fiscal intermediaries. Section 232 would modify those provisions when states redesign, develop and install a new system. It would commit the Federal Government to pay 75 per cent of the allowable costs of the ongoing operation.

Mr. Chairman, to the extent that Section 232 provides incentives to improve the capability of Title XIX administration, it is a constructive move, and we support it. However, we are concerned that states may interpret it to mean that they could receive increased financial assistance only by terminating their carrier arrangements and developing their own processing capacity where none had existed before. This would result in the needles expenditure of a great deal of money.

The complexities and costs of systems development are considerable. Blue Shield and Blue Cross are pooling their resources to meet this challenge, and we urge Government to recognize the importance of this private sector activity. We hope that Government will encourage worthwhile private efforts, and allow the development of government-owned and operated systems only to the extent that the private sector fails to meet the need. In the belief that this is the intent of Section 232, we endorse the provision. However, we ask that the committee report make clear that this is, in fact, the intent of the Section.

FEDERAL EMPLOYEE PROGRAM

Mr. Chairman, Section 201 proposes policies for providing benefits to those persons covered under both the Medicare program and a Federal Employee Health Benefits Plan. As we understand it, the preferred solution to this problem would be that the Federal Employee Health Benefits Plan be modified to make available coverage supplemental to Medicare for those persons eligible for both, and to continue to contribute the same amount for that coverage. We support that approach and stand ready to develop a supplemental coverage program for eligible federal employees enrolled in Part B if the Congress requests it.

Section 201 proposes that in the absence of such supplemental coverage, available Federal Employee Health Benefits shall be provided before any application of Medicare benefits can be made. Blue Shield does not object to provisions that Federal Employee Program benefits are to be provided before any application of Part B benefits can be made. However, we believe that because Part A is earned through employment covered under Social Security, the entitlement to Part A benefits should not be abridged. Accordingly, we believe that Part A benefits should be provided to all eligibles and that Federal Employee Program benefits should be used to supplement Part A.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. Chairman, we would like to comment on Amendment 851, Professional Standards Review Organizations, proposed by Senator Bennett. We support the purpose the amendment seeks, and we respect Senator Bennett's efforts to make certain that maximum use is made of the health care dollar in government-financed programs. His focusing of attention on claims review and peer review will be beneficial.

In introducing the amendment, Senator Bennett graciously asked that interested parties study his proposal and make comments and suggestions.

While we support the increased assumption by medical organizations of responsibility for peer review, we believe this amendment does not take into account

the interdependence of claims review and peer review in the utilization review process, and the extent to which claims review is a necessary function of the carrier. Carriers and professional organizations have natural capabilities that complement each other, and that are not easily separated.

Claims review is a necessary function of the carrier, as it discharges its responsibility to provide benefits in precise compliance with the contract. It requires a substantial commitment of personnel and equipment, necessary to the discharge of the duties of a carrier, as defined in Section 1842 of the Medicare Act. Section 1842 A(2)B of the Act defines the carrier's responsibilities for utilization review as:

"Assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals . . . to make reviews of utilization."

In general, and, in our opinion, most local medical organizations have neither the interest, the expertise, nor the resources to engage productively in claims review. Their interest and expertise it, certainly, extremely important to peer review.

Claims review produces, in addition to the information necessary to the administration of benefits, a large data base for the study of patterns of care, both of the community and of the individual practitioner. To a considerable extent, these data can be analyzed and interpreted by skilled, non-medical mmebers of the carrier's staff. The application of these interpretations should, to the extent possible, utilize the special knowledge and guidance available only through peer review. But conversely, peer review cannot be effective except in the most limited circumstances of geography and claims volume without the carrier's analysis and interpretation of its data.

To get the greatest productivity from each function, it is necessary to define how claims review and peer review relate to each other. This is not a simple question. NABSP has asked the American Medical Association to join in a task force to bring claims and medical expertise together to work out a national prototype for the most effective interface of these skills, and to provide ongoing systems support for both processes. This action of our Board of Directors is attached for your information as Exhibit A.

We have testified before this Committee in the past that utilization review is not a fully developed science, and that more work needs to be done to make it as productive as it eventually will be. We are forced to the conclusion that the establishment of parallel systems with fragmented responsibilities will be a step backward. We think that it would be unwise at this time to enact specific, detailed legislation to fix responsibilities for functions which are, to a considerable extent, still emerging.

The purposes of Amendment 851 will be achieved faster and better, we believe, if Section 1842 of the Medicare Act were amended to require carriers to establish formal linkages with PSRO's to work cooperatively toward the development of the most effective possible utilization review. PSRO's could then be made interal parts of the administrative processes of Medicare making available government funding as necessary for the development of their functions, and giving government access to audit processes as necessary to establish the propriety of the expenditures. Such an amendment would offer far more promise of dynamic evolution in utilization review without the need to re-trace developmental steps for new agencies at considerable expense to the taxpayers.

We suggest that this could be accomplished by amending the duties of the carrier as defined in Section 1842 by adding exact wording from Section 1151—the Declaration of Purpose—of Amendment 851, beginning with the words "(will) assure, through the application of suitable procedures of professional standards review. . . ."

Mr. Chairman, we do want to make it clear that while we consider the basic goals of Amendment 851 sound with respect to approved peer review, we think that administration on the Amendment's terms would be impractical for reasons of fragmentation, administrative costs, staffing requirements, dubious cost-benefit relationships, and other factors.

REPORTING OF UNASSIGNED PAYMENTS FOR MEDICAL SERVICES

Mr. Chairman, the Treasury Department presented testimony Monday for proposed legislation to require reporting to the Internal Revenue Service of health insurers' payments on so-called unassigned claims. Unassigned claims are payments to the patient, rather than to the physician. The legislation would apply to private as well as government business.

Because of the way Blue Shield operates, most of our payments are made directly to physicians. Section 6041 of the Internal Revenue Code of 1954 requires an annual report of these amounts on the IRS Form 1099. Blue Shield Plans are and have been regularly reporting this information and these reports cover the bulk of Blue Shield payments.

The balance of four benefit payments are made directly to subscribers. We have the technical capability also to report information on these data on the IRS Form 1099 as well. However, it will require the development of a new system together with a massive computer program effort. In addition to this sizable outlay, it is estimated that the annual cost to Blue Shield-Blue Cross in additional operating expenses will be $24,000,000 per year. This estimate was developed by a special task force of IRS which included, in addition to their staff, technical experts of Blue Shield, Blue Cross and the commercial insurance companies. The report of that task force indicates that the insurance companies will incur even a greater cost. These additional costs to Blue Cross, Blue Shield and the insurance companies must necessarily be passed on to subcribers since no other source of funds has been indicated.

Mr. Chairman, the report of the task force has been made available to your staff. We urge that it be given careful consideration. In addition to the question of cost, we also believe that a careful reading of that report raises a question over the usefulness of the information supplied relating to payments to someone else other than the taxpayer.

OTHER COMMENTS

Mr. Chairman, I would now like to discuss very briefly other sections of the bill which have some bearing on Blue Shield.

Section 222 of the bill deals with prospective reimbursement, and experiments and demonstration projects to develop incentives for economy in the provision of health services. We feel strongly that no one system of reimbursement has proved to be most effective and most appropriate in all circumstances. We concur with the need for controlled experimentation, and support both the intent and, in general, the language of this Section.

Our own Association is developing experiments in area-wide or community-wide utilization review and medical review, and we welcome the prospect of similar experimentation in government programs. In general, such review is most productive only when there is a mechanism to identify where review should be concentrated. Again in general, the means of identification is available only through the carriers. We feel the bill should require consultation with carriers in the design of such programs, to insure that the best use is made of the data in their possession.

We feel, too, that the administrative costs of experimental programs—to the extent that they exceed normal administrative costs—should be separately identified and funded, and should not constitute a charge against the Trust Funds unless they are offset by specific appropriations.

Section 225 seeks to provide incentives for outpatient care in Title XIX by increasing Federal matching funds for outpatient services in hospitals, clinics, and home health services, and decreasing matching percentages for inpatient care. While we support the intent of the program to use less expensive services, we feel that Section 225 should be changed substantially in two respects. First, the programs should incorporate safeguards against overzealous state administration, so that in the interest of economy patients are not denied necessary services. Secondly, by favoring institutional outpatient services against those services provided in the offices of physicians, the aim of using the least costly services to the maximum may be undermined.

Section 228 would eliminate the requirement that states have comprehensive Medicaid programs by 1977. We are in favor of this Section which would allow states to continue in the program even though they have not yet established comprehensive programs. At the same time, we would urge that Federal-State efforts be made to provide comprehensive benefits to Medicaid patients.

Sections 225, 250, 257 and 258 are all intended to provide safeguards for the elderly from being deprived of benefits under Medicare for technical reasons, and we support these provisions.

EXHIBIT A

STATEMENT OF THE BOARD OF DIRECTORS OF THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS REGARDING PEER REVIEW ORGANIZATIONS

NABSP welcomes an encourages the increasing interest on the part of organized medicine in peer review of utilization, cost, and quality of medical service. Blue Shield recognizes an obligation both to the public and to the profession to assist peer review organizations (PRO's) in establishing realistic goals, and achieving them as effectively and economically as possible.

Blue Shield distinguishes between claims review and peer review. Claims review is the function of the carrier, necessary to the discharge of the carrier's obligation to render benefits in precise compliance with the benefit contract. It requires substantial commitments of personnel and equipment, at costs which must be borne by the subscriber.

Claims review produces, in addition to other information, a large data base for the study of patterns of care, both of the community and of the individual practitioner. To a considerable extent, these data can be analyzed and interpreted by skilled, non-medical members of the carrier's staff. However, the application of such interpretations should always, to the extent possible, utilize the special knowledge and guidance available only through peer review.

This does not imply that peer review organizations should limit themselves to consideration of the carrier's conclusions. In matters of quality, cost, and appropriateness of service, the special expertise of the physician can and should extend the review process considerably. This effort depends for optimum productivity on cooperative relationship between the carrier and the PRO, including necessary access by the PRO to the carrier's data base. It is important to the purposes of economy and efficiency, which are a major segment of the justification for peer review, that this be achieved with an absolute minimum of duplication of effort and expenditure, which must be passed on to the patient-subscriber. While Blue Shield wholeheartedly endorses the concept of peer review, application of the process should be done in the most efficient way.

To encourage the formation of the most effective possible PRO's, and to promote the most productive possible carrier-PRO relationships, the Board of Directors of NABSP requests the cooperation of the American Medical Association in establishing a joint task force to define what information developed by each can be utilized by the PRO and the carrier, and in what format it can best be furnished, and to design a model system for the exchange of such information. NABSP contemplates that the task force would remain in existence indefinitely, to provide systems support for innovations and refinements in the peer review and claims review processes as they are developed.

STATEMENT PRESENTED BY RALPH W. SCHAFFARZICK, M.D., CHIEF MEDICAL ADVISOR, CALIFORNIA BLUE SHIELD, SAN FRANCISCO, CALIF.

Mr. Chairman and Members of the committee, I am Ralph W. Schaffarzick, a practicing internist in San Francisco, a member of the clinical faculty of Stanford University School of Medicine. I served seven years on the peer review committee of the San Francisco County Medical Society and for the past one and one half years have been employed part time as the Chief Medical Advisor of California Blue Shield. I appear today in the latter capacity.

This committee is to be commended for its evident desire to rely most heavily on the medical profession through its peer review activities to control utilization of medical services and facilities, thus influencing both the quality as well as the costs of medical care. We are concerned, however, that the role of carriers and intermediaries not be overlooked as an important segment in any effective system of peer review.

The two purposes of my presentation today are first, to inform the committee of the level of peer review activities carried on directly within California Blue Shield as a carrier for Title XVIII and XIX in California and secondly, to indicate to the committee our concept of an appropriate and effective peer review system which utilizes cooperatively the capabilities of carriers and intermediaries and professional provider organizations.

Within California Blue Shield, peer review is a continuing part of claims review and processing. I will first enumerate the peer review mechanism which we employ and briefly outline how they work in the claims system.

The mechanisms are:

1. Utilization guidelines for claims review established by the Medical Policy Committee of our Board of Trustees.
2. An extensive computer system of peer-group norms of utilization for each medical specialty.
3. A constantly updated record of services received by each beneficiary.
4. One hundred fifty (150) part time medical advisors and consultants from all parts of the state and representing all major specialties.
5. A utilization audit unit which conducts investigations into unusual cases and prepares material for review by committees of the local medical societies.

As a result of these mechanisms within California Blue Shield, an enormous and effective amount of peer review takes place in the handling of claims before going outside the carrier.

In addition to applying the limitations imposed by the program itself, claims examiners and their computer support capability reject outright or select for examination by physician consultants, large numbers of claims on the basis of guidelines established by the Medical Policy Committee of the Blue Shield Board of Trustees. The Medical Policy Committee consists of a hospital administrator, a dentist, and a representative of labor, in addition to a broad spectrum of practicing physicians.

Guidelines are established by this committee on such things as the number of acceptable vists to patients in nursing homes, the acceptable ratio of injections to office vists, payment criteria for multiple surgical procedures, and the acceptability of certain procedures in relation to the patient's diagnosis. Particularly difficult questions are referred to the Scientific Board of the State Medical Association or to medical specialty organizations for their opinions.

The guidelines set down by this committee are implemented in the claims process. They are also continually reviewed and updated by the Medical Policy Committee which works closely with our Medical Advisor System of over 150 practicing physicians who are employed part time by Blue Shield. Dentists, pharmacists, optometrists, and podiatrists also serve in the Medical advisory system.

Some Medical Advisors provide peer review *on site* in each claims processing unit. Others review questionable claims or abnormal patterns of utilization which are identified by claims examiners or by the computer employing a system of peer group norms. Many questionable claims or practice patterns are resolved by peer review and consultation at this level.

As indicated by the exhibits, considerable reductions of charges or disallowances of payment are achieved by the Medical Advisor System of peer review.

Instances of apparent repeated unacceptable practices, abuse or suspected fraud receive in depth investigation and then review by local peer review committees in each county medical society, which may result in a variety of disciplinary or even legal actions.

Additionally, through sub-contract arrangements with foundations and some non-foundation local medical societies, primary claims screening review is carried out at the local level. This activity depends upon the desires and the capabilities of the local medical society. We actively encourage this type of primary local involvement.

The primary objective of this intense and continuous peer review activity in California Blue Shield is to identify and correct inappropriate patterns of practice and to identify those few providers who require disciplinary action. The second important function is the conservation of program dollars so they are not spent for unnecessary or inappropriate services. The savings to the public resulting from this carrier's control activities in Medicare and Medicaid amount to 33 million dollars out of the billed total of 173 million dollars in physicians charges alone. Much of this reduction from billed amounts is due to charge ceilings and the roll backs imposed by the government itself. However, a smaller yet considerable segment is due to peer review conducted directly within the carrier in cooperation with the state and local medical associations.

Mr. Chairman, our purpose in making this presentation is to relate to the committee the very thorough and sophisticated level of computer-enhanced peer review of which carriers are capable when working cooperatively with medical associations and other provider groups. It is hoped that the committee, in its consideration of peer review proposals, will see fit to encourage and enhance this level of peer review which we believe results in benefit to all concerned.

In our opinion, it is not the role of carriers and intermediaries to serve merely as conduits for money. They must also exercise controls in a complex and sophis-

ticated manner which far exceed the data processing and administrative capability of any state or county medical society or any hospital.

In our judgment, the optimal level of peer review can only be achieved by integrating the unique capabilities of carriers and intermediaries with the equally unique judgmental skills of local and state provider organizations.

Mr. Chairman, we appreciate the opportunity to submit this statement and the attached exhibits* for your record.

Senator ANDERSON. Thank you.

Senator Bennett.

Senator BENNETT. Mr. Chairman, from what I can absorb from your oral presentation of your attitude toward the PSRO amendment it is that you do not deny value of some review but you think the proposal suggested is fragmentary and a little premature, et cetera, et cetera.

I would like to repeat that I am presenting it on the theory the doctor authorizes at least 80 percent of the functions which finally result in payment, and I think that there is no better spot on which to place the ultimate responsibility. It is not my concept that we are going to create a rigid organization among the doctors but, rather, that we are going to have a revolving process through which nearly all the doctors in a given area can become part of the review process, and certainly the doctors should not sit in an ivory tower and make their determinations.

I think there should be a very difinite relationship between the PSRO groups and the carriers. But I do not think you can formalize it in a national law because I think it must vary from area to area, and under my concept of this program it should be an integral part, but it should be developed at the local level.

With their data banks of information, the Blue Shield organization or the Blue Cross organization can provide a great and needed amount of information or source to which the doctors can go when they face a problem. But I do not think, because we have not developed the review process to a highly technical stage, that we should hold off and say we cannot operate until it is developed, to a technical state. We have seen what happended during the last 2 or 3 years when there was no review.

One of the interesting experiences I had while I was home in Utah a couple of weeks ago was to follow the complaint of a medicare patient whose charge for services not rendered was submitted, and the answer was, "Well, you signed the slip." But Blue Shield paid the bill without her signature. So maybe occasionally somebody had better look at Blue Shield to see whether they are carrying out their function.

I hope we are not setting up a fragmentized situation where a group or a group of antagonistic organizations are fighting among themselves, either for power or for self-defense or for protection. I hope we are trying to set up a system which can protect the medicare recipient as well as the taxpayers and the Federal Government. If we cannot find that system on a more or less voluntary basis, then eventually you are going to have a nonprofessional, Federal bureacracy imposing a rigid formula on the whole situation.

So I hope your attitude will be one of cooperation and anxiety to see the proposal work, rather than to hold off and say, "Well, it is too new, there are problems and, therefore, don't do it."

Mr. KNEBEL. Senator, I think that we share your same concerns and your some hopes, and it is a matter of the direction that we go.

*The exhibits referred to are made a part of the official files of the committee.

We have spoken, we speak, from a point where we feel the carriers have made substantial progress in utilization review. But that there, eventually, must be much more accomplished than there is today.

Our position that we put forth is that to get the most effective utilization review we must have the proper relationship between the claims review processes and the peer review processes, and we have called upon the American Medical Association to join with us in a task force to try to develop the best relationship between these two processes, as we see them, and to develop a national prototype.

Now, as these developments occur, we would expect that the professional standards review organization, with its own natural capabilities, and the carriers with their own natural capabilities, will be able to work together into an efficient working unit, and that is the objective that we have put forth.

Senator BENNETT. All I am trying to do is to set up some kind of a framework in which that can be carried out, because I am sure you realize there are differences among providers, both in their pattern and in their capabilities, and, certainly, we found that out in our study, and we are anxious to develop the best situation on a regional or local basis, and I am happy to have your assurance that you are trying to do the same.

Dr. SCHAFFARZICK. I would, first of all, like to agree heartily with everything you have said, in what you are attempting to do because we feel very strongly in California that this is certainly the route to be pursued, and we have prepared exhibits for you and for the committee, along with formal testimony which, I hope, you will have an opportunity to review later.

But I would like to emphasize our concern that there be a true orchestration of the efforts of the peer review mechanism beginning within the carrier operation and extending out to the various local communities so that it is not a separate activity but something which begins right in the organization itself and then extends out to the various societies so that they can perform this very important function.

I hope you will have an opportunity to review the California experience in what we are trying to do there, which is truly in harmony with your concept.

Senator BENNETT. I will, of course, review it and so will the staff.

I think, however, you will find a difference in quality of performance among the Blue Shield organizations inside of California.

Dr. SCHAFFARZICK. That is correct.

Senator BENNETT. When you are in the process of trying to solve a problem like this, if you begin by making your proposal as weak and as general as possible you can never strengthen it. But if your initial proposal is tough and tight, then you have an opportunity to loosen it as the need for that is evidenced.

So if my proposal seems to be too tough and tight, it has been done deliberately because I realize that adjustments can be made to loosen it. The very reason we are here is that we started out with a loose program on medicare, and now we are having a difficult time to tighten it.

Dr. SCHAFFARZICK. I am personally very relieved to hear your remarks because, on the first perusal of the written statement, I was afraid this was intended to be a mechanism which would wipe out all

the efforts that have been exerted so far, and that what progress has been made will be replaced. So, as I say, personally, I am very relieved to hear from you how you feel about it. I am gratified.

Senator BENNETT. That is all I have.

Senator ANDERSON. Senator Byrd.

Senator BYRD. Thank you, Mr. Chairman.

Mr. Knebel, as a businessman I have had some experience with group health insurance plans and I have been greatly concerned about the tremendous increase in costs. I wonder if you could furnish for the record, for the record take two separate proposals, one in regard to an individual subscriber and the other a group plan, take 50 or 100, it does not make any difference, and give us what the cost in each case would be for September 1, 1960, say, September 1, 1965, and what would be the cost to date.

In other words, I would like to get a comparison for the record of how these costs to the subscriber, whether he be an individual or a company with a group plan, how those costsh ave changed over the past decade.

Mr. KNEBEL. Of course, I do not have the information here with me today, but I would be happy to supply it for the record.

Senator BYRD. Thank you.

Thank you, Mr. Chairman.

Senator JORDAN. Thank you, Mr. Chairman, I have no questions.

Senator ANDERSON. Thank you very much for a very fine presentation.

(Information submitted by Mr. Knebel follows. Hearing continues on page 1168.)

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS,
Washington, D.C., October, 12, 1970.

Hon. HARRY F. BYRD, Jr.
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: When the National Association of Blue Shield Plans testified before the Senate Finance Committee on September 23, 1970, you asked Mr. James Knebel, Assistant Executive Vice President, NABSP, to furnish certain information for the Record. Specifically, you wanted a comparison of Blue Shield costs for individual and group subscribers for 1960, 1965, and 1970. A comparison of those rates in six selected states is attached.

I am also transmitting a copy of this information to the staff of the Senate Finance Committee.

If we can be of any further assistance to you, please do not hesitate to call upon us.

Sincerely yours,

HUGH E. DEFAZIO, Jr.,
Vice President.

Attachments.

Location: Virginia.
Group name: City of Winchester, Size 81 EE's.
Benefits:
Level: Service with $4,000 Single, $6,000 Family Income Limits.
Surgery: $300 Schedule.
In-Hosp. Med.: 70 Days ($302 Max.).
Diag. X-ray: $100 Per Year.
Obstetrical: $90 Normal Delivery.

RATES (RETROSPECTIVELY RATED)

	EE	EE and 1 minor	Family
1960	1.67	2.50	5.95
1965[1]	2.08	3.12	7.34
1970[2]	3.72	5.52	11.42

[1] 1965: Benefits upgraded to service with $5,000 single, $7,500 family income limits, surgical schedule to $404 adding in-hospital intensive care and prolonged detention care, increased X-ray to $150 per year, and normal delivery to $100.
[2] 1970: Program changed to provide benefits on the basis of usual, customary, and reasonable and broadening of radiological therapy.

Note: The Virginia Plan does make available through the group a choice of lesser programs with service provided where the family income limit is $4,000 and in addition a $6,000 family income limit program.

Location: California.
Group name: Federal Home Loan Bank, Size 1960—35 EE's 1970—83 EE's.
Benefits: (See Note).
Level: Service With $6,000 Income Limit (Family).
Surgery: Schedule "B."
In-hosp. med: 100 Days.
OHXL: $50.
Consultation: When Requested By Attending Physician.
H & O: 2 Visit Deductible.
Obstetrical: $50 Normal Delivery.
Maj. Med.:
$5,000 Max.
$100 Deductible.
80/20 Co-Insurance.
$25 Private Room Limit.
(See Note.)

RATES

	Individual	EE and 1	EE and 2 or more
1960	14.90	27.05	28.40
1965[1]	15.35	28.05	29.70
1970[2]	21.00	39.28	44.57

[1] 1964: Increase surgical/medical benefit 10 percent (schedule "J"). Major medical maximum increase to $10,000, dependent eligibility increase to 14 days to age 19.
[2] 1965: Increase income limit to $7,500 (schedule "D") 4.6 percent increase. 1967: $30 cash deductible on H. & O. 1968: (1) Replace schedule "D" with usual, customary, and reasonable, (2) Dependent eligibility increase to age 23, (3) Major medical maximum increase to $20,000. 1969: Included retired employees.

Note: These rates include a 100-day, 3-bed ward rate hospital program.

Location: Pennsylvania.
Group name: Erdman Anthony and Associates, Size 75 EE's.
Benefits:
Level: Service With $4,000 Single, $6,000 Family Income Limits.
Surgery: $300 Fee Schedule (Plan B).
In-hospital med.: 70 Days.
Consultation: One Per Admission.
Obstetrical: $90 Normal Delivery.
H & O: Max. 21 Visits In Any 12 Months (EE Only).

RATES

	Individual	2 persons	Family
1960	1.45	3.35	4.60
1965	1.88	4.37	6.07
1970[1]	1.88	4.37	6.07

[1] 1966: Increase fee schedule from $300 to $360. 1968: Pay podiatrist (surgery). 1969: (1) Added handicapped dependents (2) Reduced ob waiting period. (3) Expanded oral surgical benefits.

Location: Massachusetts.
Group name: Standard Burner Co., Size 70 EE's.
Benefits:
Level: Service With $5,000 Single, $6,000 2-Person, $7,500 Family, Over Income 80% Of Physician's Charge, Beyond Schedule.
Surgery: $500 Schedule.
In-Hosp. Med.: 120 Days.
Consultation: When Requested By Attending Physician.
H & O.: Post Surgical Care.
Obstetrical: $75 Normal Delivery.
Out of Hosp. X-ray: 50%.

RATES (STANDARD RATING)

	Single	Family
1960[1]	2.08	6.13
1965	2.48	7.58
1970[2]	4.70	11.95

[1] 1960: Rate in effect since 1952.
[2] 1970: Program changed to usual, customary, and reasonable benefits including, full OB, consultation, assistant surgeon, OHXL for preoperative and postoperative benefit.

Location: Kansas.
Group name: Marion County Employees, Size 83 EE's.
Benefits:
Level: Service With $3,000 Single, $4,500 Family Income Limits.
Surgery: $450 Max.
In-hospital med.: 120 Days (1st Day Deductible).
In & out pat. x-ray: Accident Only.
Consultation: When Requested by Attending Phy.
Obstetrical: $90 Normal Delivery.

RATES—MERIT RATED GROUP

	Single	Family
1960	2.05	4.10
1965[1]	3.80	7.60
1970[2]	4.20	10.71

[1] 1965—Added nonaccident in and out, patient X-ray nonlimit.
[2] 1967—Changed to prevailing charge program, paying usual, customary and reasonable fees with normal delivery limited to $100.

Note: 1969 Added major medical, $15,000 maximum, $300 deductible, 80/20 coinsurance.

Location: Illinois.
Group name: Rand McNally Co., Size Approx. 150 EE's.
Benefits:
Level: Indemnity.
Surgery: $200 Max.
In-hosp. med.: 70 Days.
Obstetrical: $60 Normal Delivery.

MERIT RATED GROUP	Single	Family
Rates:		
1960	.92	3.04
1965[1]	1.14	3.64
1970[2]	1.01	3.50

[1] Coverage extended to include services of D.D.S. and podiatrist.
[2] 1966 C.O.B. was added to benefit pattern. 1970—(1) Program upgraded to $300 surgical schedule, 120 in hospital medical, normal delivery $80, with corresponding increases in the balance of covered benefits. (2) Dependent coverage extended from age 19 to 23.

Location: Virginia.

NON-GROUP

Benefits:
Level: Service With A $4,000 Single, $6,000 Family Income Limit.
Surgery: $300 Schedule.
In-Hosp. Med.: 70 Days.
Diag. X-ray: $100 Per Year.
Obstetrical: $90 Normal Delivery.

	Individual	Subscriber and 1 minor	Subscriber and family
Rates:			
1960	2.10	----------	8.54
1965[1]	3.88	----------	8.34
1970[2]	4.05	6.18	10.73

[1] 1965 program upgraded to service with $5,000 single, $7,500 family income limits, surgical schedule to $404 adding in hospital intensive care and prolonged detention, X-ray increased to $150 per year and normal delivery to $100.
[2] 1970 program expanded and changed to provide benefits on the basis of usual, customary and reasonable.,

Note.—The Virginia plan also has available a $2,500 single, $4,000 family income limit program as well as a $4,000 single, $6,000 family income limit program.

Location: California.

NON-GROUP

Benefits:
Level: Service with a $7,200 Family Income Limit.
Surgery: 1960 R.V.S. $5 unit.
In-Hosp. Med.: 31 Days.
Diag. X-ray: $50 Per Year.
Hospital: 31 Days 3 or more bedroom.
Hospital Services: In Full.
In-Hosp. Drugs: 1st $15 and 50%.
Maternity: $50 Normal.

RATES

	Male	Female	2 party	3 party	4 or more	Over 60 (per month)
1960	$7.03	$8.45	$14.34	$16.54	[1] $18.24	$1.00
1965[3]	10.05	12.10	20.60	23.70	[2] 26.20	1.60
1970:[4]						
To 30	12.34	14.63	25.74	30.26	----------	----------
31 to 44	16.81	19.94	35.08	41.23	----------	----------
45 to 54	20.30	24.60	42.32	49.77	----------	----------
55 to 64	22.69	26.80	47.30	55.62	----------	----------

[1] And $1 per month.
[2] And $1.60 per month.
[3] 1965: Physician benefits were increased 14.6 percent with schedule change for surgery and in-hospital medical. Hospital benefits reduced to 31 days, 80 percent of charges, maximum room allowance $20, drugs and maternity no change.
[4] 1966: Hospital benefits increase 31 days 80/20 coinsurance with $50 deductible for all hospital charges, maternity remained at $50. 1967 hospital benefit increased to 100 days. 1967 usual, customary and reasonable fee schedule adopted for physcian coverage. 1969-70 hospital coverage increased to 365 days in-hospital, medical increased to 365 days, out-patient diagnostic X-ray increased to full for injuries ambulance coverage included as well as an accident rider.

Note: Benefits supplied as a package, rates reflect hospital as well as professional services provided.

Location: Pennsylvania

NON-GROUP

Benefits:
Level: Service, $4,000 Single, $6,000 Family Income Limits.
Surgery: $300 Fee Schedule (Plan B).
In-hospital med.: 70 Days.
Consultation: One Per Admission.
Obstetrical: $90 Normal Delivery.

	Individual	2 persons	Family
Rates:			
1960	1.60	3.65	5.15
1965	1.95	4.42	6.11
1970[1]	1.95	4.42	6.11

[1] 1966 increase fee schedule from $300 to $360. 1968 pay podiatrist (surgery). 1969: (1) Added handicapped dependents. (2) Reduced ob waiting period. (3) Expanded oral surgical benefits.

Location: Massachusetts.

NON-GROUP

Benefits:

Level: Service With $5,000 Single, $6,000 2-Person, $7,500 Family.
Surgery: $500 Schedule.
In-hosp. med.: 30 Days (Indiv.), 40 Days (Family).
Consultation: When Requested By Attending Physician.
Out Of Hosp. X-ray: 50%.
Obstetrical: $75 Normal Delivery.

	Single	Family
Rates:		
1960[1]	2.14	5.34
1965	2.14	5.34
1970[2]	2.35	7.42

[1] 1960 rate in effect since 1952.
[2] 1968 increased in-hospital medication to 120 days, added assistant surgeon, intensive care and emergency admission room care.

Location: Kansas.

NON-GROUP

Benefits:

Level Service With $3,000 Single, $4,500 Family Income Limits.
Surgery: $450 Max.
In-hospital med.: 120 Days (1st Day Deductible).
In & out pat. x-ray: No limit.
Intensive care: As Necessary.
Obstetrical: $90 Normal Delivery.

	Single	Family
Rates:		
1960	3.35	6.70
1965	3.55	7.10
1970[1]	4.69	10.60

[1] 1967 program was changed to prevailing charge. Program, paying usual, customary and reasonable fees at 20 percent coinsurance level.

Senator ANDERSON. Mr. Walters.

Mr. Walters is not here.

(The prepared statement of Mr. Walters and a communication from the American Medical Association follows:)

A SUMMARY—STATEMENT BY THOMAS G. WALTERS

The National Association of Retired Civil Employees is a 49-year-old, nonprofit organization with a membership of 141,508 as of July 1970. There are some 1100 chapters in the fifty States, Puerto Rico, Canal Zone, and the Philippines. All NARCE members are former Federal employees and their survivors.

We strongly recommend that this committee seriously consider all of the items in this summary, with a full explanation in the body of the attached statement.

I. AMEND SOCIAL SECURITY AND MEDICARE

A. Support Social Security benefit increase.
B. Include Prescription Drugs under Part B (Medical) of Medicare.
C. Extend full Medicare coverage (Parts A and B) to all Federal retirees.
D. Include dental care, dentures, optical care, eyeglasses, and hearing aids under Part B of Medicare.
E. Approve Medicare as qualified plan under Retired Federal Employees Health Benefits Program.
F. Provide coverage for chiropracter's and optometrists' services.

II. PROVIDE TAX RELIEF FOR ELDERLY

A. Exclude portion of Civil Service annuity from Income Tax.

1. Allow $5,000 exempton for family.
2. Allow $3,600 exemption for single person.

B. Reinstate provision to deduct medical and drug expenses from income tax after age 65.

III. ESTABLISH MINIMUM INCOME FOR ALL RETIREES

A. Allow $100 per month for single Social Security and Civil Service annuitants.
B. Allow $200 per month for family under Social Security and Civil Service retirement.
Attachment.

STATEMENT BY THOMAS G. WALTERS, PRESIDENT OF THE NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES, WEDNESDAY, SEPTEMBER 23, 1970

Dear Mr. Chairman and Members of the Committee, My name is Thomas G. Walters, President of the National Association of Retired Civil Employees. Our organization was formed February 19, 1921 and has been in continuous operation since that date. As of July 1970 we had a membership of 141,508 with more than 1100 chapters in every State in the Union, Puerto Rico, Canal Zone, and the Philippines. Our membership is made up exclusively of retirees from the Federal Government and their survivors, and I appear before this committee on behalf of our membership, plus all other Civil Service annuitants and their dependents in the interest of legislation which relates to the treatment of these people.

We appreciate the privilege, honor, and opportunity of appearing for the second time before this committee in the interest of the members of the National Association of Retired Civil Employees. We extend our thanks to you, Mr. Chairman, and to each member of the committee for the time you are devoting to rewrite and liberalize the tax laws and the Medicare program which affects directly or indirectly every American citizen.

SOCIAL SECURITY AND MEDICARE

The National Associaton of Retired Civil Employees strongly supports the intent of H.R. 17550 but we recommend that the benefit increase be 15% instead of 5% as approved by the House of Representatives. The organization I have the honor to represent, not only supports a 15% increase in Social Security benefits, but we support a graduated increase in all annuities under the Civil Service Retirement System, realizing that increases under the Federal Retirement System come under the legislative scope of the House and Senate Committees on Post Office and Civil Service.

We believe, and our organizaton has passed strong resolutions, that Medicare should be amended to include coverage of prescription drugs for out-of-hospital patients. We receive hundreds and perhaps thousands of letters from annuitants and survivors, especially those receiving less than $3,000 a year, telling us they just don't have enough money to pay for the drugs prescribed for them.

We also believe that retired Federal employees and their survivors at age 65 should be eligible for full Medicare coverage, both Parts A and B. They are now eligible for only Part B which is doctors' benefits. Only those who retired prior to July 1, 1960 and reached age 65 before January 1, 1968 are eligible for Part A,

hospital coverage. We would however support Sec. 202 of the bill, H.R. 17550, which would allow certain Federal retirees, now excluded from the benefits of Part A, to purchase this coverage on an individual basis, as is presently done with Part B.

Some of the health benefits plans under the Federal Employees Health Benefits Program, which became effective July 1, 1960, provide for coverage such as dental and eye care. We feel the time has come for Medicare to be amended to pay at least a reasonable portion of the expense of remedial dental care, dentures, eye care, eyeglasses, and hearing aids.

I am sure you appreciate the fact that such restorative care is often necessary for the elderly person, and many of these people simply cannot afford these necessities, yet are severely handicapped without them. We should, therefore, like to support amending Sec. 1861(s) of the Social Security Act to include such coverage among the benefits of Part B of Medicare.

Our Association also believes that those enrolled under Medicare should have the right to secure the services of an optometrist for the services he is legally authorized and competent to perform. The deletion of an optometrist from the definition of "physician" in the present law often causes undue hardship and nonpayment of an otherwise legitimate claim, especially for the person in a non-urban area. To eliminate this inequity we ask that Sec. 1861(r) of the Social Security Act be amended to provide payment for optometrists' services as proposed in S. 1402 by Senator Ribicoff.

We would further ask that chiropractic services be included for coverage under Part B of Medicare, by eliminating the language of Sec. 263 of H.R. 17550 and substituting the language of S. 1812. Many elderly persons derive much physical relief from chiropractors, whose services are already recognized for coverage in a number of health plans. In view of already available information on the matter we see no need for further study as proposed in Sec. 263 of H.R. 17550.

Our members would be willing to increase their payments to cover costs of such additional benefits. Thousands of our members, especially those on low income annuities, and the same is true for Social Security, just do not have the money to give attention to the items we have enumerated in this proposal and which are so often necessary for the elderly.

TAX RELIEF FOR THE ELDERLY

We realize that H.R. 17550 does not include tax reform legislation but in order to keep this fresh in the minds of this Committee and the Members of Congress, we strongly recommend that all annuitants and survivors be granted some tax relief. As President of NARCE we deeply appreciate the accomplishments of this Committee in the 1969 Tax Reform Bill, but we sincerely believe that our members would appreciate more of an across-the-board tax exemption which could be easily understood. Our Association has long recommended that the first $5,000 of an annuity for a family, and $3,600 for a single person, be excluded from the gross income under Federal income tax.

Until 1967 those of us who were over 65 and retired were eligible to deduct drug and medical expenses and we strongly recommend that this provision be reinstated in future tax reform legislation.

We strongly believe that the time has now arrived when Federal annuitants and survivors and Social Security recipients should have a minimum benefit of not less than $100 a month for a single person or $200 a month for a family. I believe the public would strongly support this type of legislation. There are many bills introduced in the House and in the Senate covering most of the items I have mentioned in this statement, demonstrating the interest of Members of Congress in the older people of this country.

In closing, Mr. Chairman and Members of the Committee, we again desire to express our thanks and appreciation for this opportunity to present some of the views of the members which I have the honor of representing.

SEPTEMBER 22, 1970.

Mr. Chairman and Members of the Committee:

I would like to call your attention to S. 4345, a bill introduced by Senator Williams of New Jersey on September 15, 1970, to update the retirement credit for Government annuitants. We are trying to wholeheartedly endorse S. 4345 and trust that this committee will make this bill a part of their recommendations to the Senate. I would like to call special attention to the fact that the

retirement income credit has not been revised for 8 long years and many of our members are in great need of tax relief.

This bill would raise the present maximum amount for computing income credit from $1,425 to $2,278 and we strongly endorse the provisions of S. 4345.

With your permission, I would like to have the statement made by Senator Williams of New Jersey on pages S15410 and S15411 of the Congressional Record of September 15, 1970 made part of my statement.

To supplement NARCE Statement of September 23, 1970.

THOMAS G. WALTERS,
President.

Attachment.

S. 4345—INTRODUCTION OF A BILL UPDATING THE RETIREMENT INCOME CREDIT

Mr. WILLIAMS of New Jersey. Mr. President, I introduce for appropriate reference a bill to amend the Internal Revenue Code to update the retirement income credit for Government annuitants.

Today, there are many retired teachers, policemen, firemen, Federal annuitants, and others who have little or no social security benefits, but receive retirement income from public or private pension plans. These individuals depend upon the retirement income credit for comparable tax treatment as social security beneficiaries.

Social security benefits are, of course, exempt from Federal income tax. Government annuitants receive substantially equivalent tax treatment by being able to claim a 15-percent credit on their taxable retirement income—pensions, annuities, rents, interests, and dividends.

Under present law, the credit is 15 percent of the following:

First. An individual's retirement income or $1,524—$2,286 for a married couple—whichever is lower.

Second. Minus—

Social security or railroad retirement benefits, and

Certain amounts of earned income, depending upon the retiree's age and the extent of his earnings.

However, the maximum amount for computing the credit has not been updated since 1962.

During this period there have been three badly needed social security increases enacted into law. With the 15-percent raise passed last December, the maximum annual social security benefits are now $2,278 for a single person and $3,417 for a married couple.

Yet, the retirement income credit has not been revised for 8 long years, although many elderly taxpayers are in great need of tax relief.

As a result, the credit no longer provides equivalent tax relief for Government pensioners or retirees forced to live primarily on investment income.

Equity in our tax system presents a very compelling reason to place these taxpayers on a par with recipients of social security benefits.

My bill—which is enthusiastically supported by the National Retired Teachers Association-American Association of Retired Persons and the National Association of Retired Civil Employees—would help to correct this long-standing inequity in our tax structure.

First, the bill would raise the present maximum amount for computing the credit from $1,524 to $2,278, the maximum benefit payable to an individual under the Social Security Act. In enacting the retirement income credit in 1954, it was the intent of Congress "to conform the tax treatment of all individuals to those who now receive tax exempt social security benefits." This clear expression of congressional intent should, I believe, be implemented.

Second, the maximum amount for computing the credit would be adjusted automatically with increases in social security benefits. This is essential to prevent long delays in keeping the credit current for persons living on limited, fixed incomes.

Under existing law, the maximum income credit is $229—$1,524 multiplied by 15 percent. My bill would raise this maximum credit to $342—$2,278 multiplied by 15 percent—an additional tax savings of $113 for the overburdened elderly taxpayer.

For a married couple, my bill would raise the maximum credit from $343—$2,286 × 15 percent to $513—$3,417 × 15 percent—$170 more than is allowed now.

In 1967 about one out of every four returns filed by elderly taxpayers—1,617,000 returns—claimed the retirement income credit. This resulted in a tax savings of nearly $171 million for older Americans.

In my own State of New Jersey, it is estimated that about 64,000 returns filed by senior citizens took the retirement income credit—resulting in about $7 million in tax relief.

But, these individuals—desperately in need of tax relief in many instances—are losing precious tax dollars because the credit has not been updated.

Enactment of this measure will help to restore fairness in our tax law and to place Government annuitants on a substantially equivalent basis with persons receiving social security benefits.

But, there is also an administrative matter that merits immediate attention. This deals with the intricacies in computing the retirement income credit, which requires an entire separate schedule with accompanying instructions on the back page to complete.

It is estimated that perhaps one-third of those eligible for the credit may not be claiming it because of its complexity and numerous form transfers.

Moreover, a recent study of Federal retirees revealed that 75 percent reported their annuities inaccurately. It is quite apparent that most of them were not attempting to cheat the Government, since two-thirds of those reporting inaccurately paid too much in taxes.

The retirement income credit in the Internal Revenue Code is undoubtedly a complicated provision. But, a number of steps could be taken to simplify schedule R and to avoid unnecessary form transfers which completely bewilder many unsuspecting elderly taxpayers and confuse them beyond recognition.

At the Senate Committee on Aging's hearing on "Income Tax Overpayment by the Elderly," several concrete recommendations were offered by tax experts to simplify the computation of the credit.

Recently the Commissioner of Internal Revenue called a meeting with some of these witnesses to discuss these measures and other proposals for providing additional tax assistance for older Americans. This conference was a constructive step forward in seeking solutions for greater simplicity in preparing tax returns. And, it is my sincere hope that this meeting will lead to the adoption of measures to make tax preparation easier for older taxpayers.

Mr. President, I might also add that the Senate Committee on Aging, of which I am chairman, plans to issue a report in the near future to recommend several proposals to simplify the gobbledygook presently required.

Because the Committee's jurisdiction is limited to problems affecting the elderly, the scope of the report will necessarily be confined to the aged. This report, however, will be of importance to all age groups, since tax issues usually apply with equal force to the young as well as the old.

With this two prong approach in my bill and the recommendations from the Commitee on Aging's hearing, we can achieve two crucial objectives:

First, our tax system can be made more equitable for elderly retirees.

Second, we can make tax preparation more readily understandable and workable for the aged and other age groups.

Mr. President, I ask unanimous consent that the text of this bill be printed in the RECORD.

The PRESIDING OFFICER (Mr. CRANSTON). The bill will be received and appropriately referred; and, without objection, the bill will be printed in the RECORD.

The bill (S. 4345) to adjust the amounts of retirement income for which a tax credit is allowable under the Internal Revenue Code of 1954 in order to provide benefits thereunder comparable with tax benefits accorded social security recipients, introduced by Mr. WILLIAMS of New Jersey, was received, read twice by its title, referred to the Committee on Finance, and ordered to be printed in the RECORD, as follows:

S. 4345

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 37 of the Internal Revenue Code of 1954 (relating to retirement income credit) is amended—

(1) by striking out "$1,524" in subsection (d) and inserting in lieu thereof "$2,278",

(2) by striking out "$2,286" in subsection (i) (2) (B) and inserting in lieu thereof "$3,417"; and

(3) by redesignating subsection (j) as (k), and by inserting after subsection (i) the following new subsection:

"(j) Annual Adjustments of Limitations.—

"(1) Certification by Secretary of Health, Education, and Welfare.—Before the beginning of each calendar year (beginning with 1971), the Secretary of Health, Education, and Welfare shall certify to the Secretary or his delegate the largest old-age insurance benefit that could be payable for any month during such year under title II of the Social Security Act to any individual who, in such year, attained age 65 and first became entitled to monthly insurance benefits under such title.

"(2) Substitution of limitations.—for taxable years beginning within the calendar year 1971 and each calendar year thereafter—

"(A) subsection (d) shall be applied by substituting, for the $2,278 amount contained therein, the amount certified under paragraph (1) for such calendar year; and

"(B) subsection (i) (2) (B) shall be applied by substituting, for the $3,417 amount contained therein, one and one-half times the amount certified under paragraph (1) for such calendar year."

(b) The amendments made by subsection (a) shall apply to taxable year beginning after December 31, 1970.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., October 2, 1970.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: On September 21, 1970, in hearings before the Senate Finance Committee, Mr. Meade Whitaker, in behalf of the Treasury Department, requested that H.R. 17550 be amended to provide for an information reporting system on unassigned medical payments. A similar provision was deleted by the Conference Committee at the time the Tax Reform Act of 1969 was considered.

The proposed change in information reporting would require Blue Cross-Blue Shield organizations, Medicare and Medicaid agencies, employers and unions operating health insurance plans and similar payers to report "unassigned payments" made to providers. The report would require the identification of each health care statement for services where the amount in 1972 and 1973 is $100 or more, in 1974 and 1975 is $50 or more, and thereafter where the statement is for the sum of $25 or more. In addition, the proposed system requires that the statements for each separate provider be aggregated for the calendar year.

The Treasury Department testimony includes a further recommendation that assigned payment reporting should similarly be authorized except that such reporting should commence at the $100 level beginning January 1, 1971.

While we recognize the Treasury Department's interest in providing additional means by which it might assess a physician's income, we must object to this amendment sought to be added to H.R. 17550. Among other reasons, it is clear to us that the new requirement would not provide the Internal Revenue Service with helpful and meaningful data.

Many patients have more than one health insurance policy. According to the "23rd Annual Survey of the Health Insurance Council—1969," 13,282,000 persons had duplicate hospitalization coverage as of December 31, 1968; 11,800,000 had duplicate surgical coverage; and 7,147,000 duplicate medical (non-surgical) coverage. In times of illness, these persons may file a claim under each of the policies and will often collect benefit payments in excess of the physician's charges. Under the proposed amendment, it will then appear that the physician is receiving considerably more for the care he rendered than what was actually paid to him by the patient. Understandably, the physician frequently is not aware of such multiple insurance coverage nor is he in a position to control such overpayment of insurance benefits to the patient.

It should also be noted that in spite of the widespread use of voluntary health insurance by patients, some still do not use their insurance proceeds to compensate the physician for the services which he has rendered. This situation would still further distort the income figures provided by an insurance company as to the funds paid indirectly to him through the patient, for medical care.

So as to be satisfactorily responsive to inquiries of the Internal Revenue Service, the proposed amendment will necessitate the physician's setting up additional bookkeeping and record procedures for he will find it necessary to record

separately and in detail each charge to a patient which exceeds $25. Since he will often be unaware as to the source of the funds used to pay him, his records will now have to segregate detailed information on all charges which are at or above the amounts stated in the law.

The proposal of the Treasury Department would place physicians in a unique category under our tax laws. We know of no other provision in the tax laws which singles out one class of individual taxpayers, requiring payers to report to the IRS *individual* payments made to the taxpayer as well as the annual aggregate amount of such separate payments.

We believe, Mr. Chairman, that the proposed Treasury Department amendment is unfair and discriminatory, and would do little to accomplish any goal for an improved reporting system. Instead, as an additional cost burden, it would place further upward pressure on the cost of medical care. Therefore, we urge you not to adopt the amendment for information reporting.

However, we do want to be on record supporting your reference to the AMA during the recent session. You stated the AMA has been "completely forthright and honorable, and sought to shield no one."

That is exactly our position. Your words were well-chosen and your point well-taken.

You further said that we have, in the past, requested that examples of chicanery be reported to us, so that we might take our own action. This, too, is correct. Too often people forget that the AMA was founded as a physicians' group intent upon correcting wrongs.

We feel we have lost none of our original zeal. Quite simply, the dishonest or incompetent physician hurts us just as much as he harms his government.

Sincerely,

ERNEST B. HOWARD, M.D.

Senator ANDERSON. We will adjourn the meeting, subject to the call of the Chair.

Thank you very much.

(Whereupon, at 11:55 a.m., the committee adjourned, to reconvene subject to the call of the Chair.)

APPENDIX A

Communications Received by the Committee Expressing an Interest in H.R. 17550—The Social Security Amendments of 1970

STATEMENT SUBMITTED BY HON. KARL MUNDT, A U.S. SENATOR FROM THE STATE OF SOUTH DAKOTA

Section 225 of H.R. 17550 as passed by the House of Representatives is unwise. In my estimation it should not be approved by the Senate in its present form.

The avowed purpose of this section, which would decrease the Federal medical assistance by one-third in any year after a patient has received care as an inpatient in a skilled nursing home for 90 days, is to reduce the Federal expenditure of funds by encouraging the states to require the use of lower cost methods of providing health services to patients receiving benefits under Title XIX of the Social Security Act, or Medicaid, when more expensive institutional health services are not medically necessary.

This purpose is commendable but I do not believe it is realistic. The result, I am afraid, will be patients who may be seriously ill, forced into less costly and inadequate custodial facilities or the States forced to shoulder too heavy a burden.

My own State of South Dakota has tried hard to control expenditures in the area of nursing care. It has been forced to do so because of budgetary limitations. Should Section 225 be approved in its present form, there will be an additional burden placed on South Dakota and States in similar circumstances, i.e. States with a high percentage of elderly people. The States will have to pick up the balance in many instances. I believe this will be true because this high percentage of older individuals assures the existence of hundreds of people in nursing homes who will continue to need a comparatively high level of care and will never improve so much physically that they can get along with less care. Further, in rural, low population States it would be extremely difficult financially and geographically to develop out-patient clinics in such numbers and capacity as to provide for the elderly now in long term care facilities.

I believe Section 225 should be altered to protect those citizens who truly need long term care without penalizing the States. I would support an amendment that provides that a patient needing skilled nursing home care for a period longer than 90 days could continue to receive that care without any reduction in funds. On the other hand, where it can be shown by the medical review provisions of the law, that a patient in a skilled nursing home can be adequately cared for under a less intensive program of care, the funds applicable to that patient would be reduced as provided in the bill.

U.S. SENATE,
Washington, D.C., August 10, 1970.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate,
Washington, D.C.

MY DEAR MR. CHAIRMAN: The welfare of the people of the State of Washing- is of vital concern to us. Many of the services provided our people have been created and are partially funded by the federal government.

One such program is care for the elderly and chronically ill. Section 225 of H.R. 17550, Amendments to the Social Security Act of 1970, now before your committee, proposes to reduce federal financing for that program.

This section provides for a one-third reduction of federal matching funds for skilled nursing and aged mental health care after ninety days and a lifetime cutoff of funds for aged mental health care after 275 days.

While this reduction in funds is offset by increases in outpatient and home health care, its net impact to our State will result in drastically lowering the quality of care provided our aged and ill people.

The State of Washington has for many years had an effective classification system to insure that each individual receives appropriate care. Passage of Section 225 will destroy our ability to provide such care.

We understand that Elliott Richardson, Secretary of HEW, testifying before your committee recently, admitted that Section 225 was a budget-cutting measure.

There are times when economy measures are necessary, but not at the expense of those who are elderly, ill, or unable to care for themselves.

We are opposed to passage of Section 225 of H.R. 17550 and we hope that you will take whatever action is necessary to eliminate this section from the bill.

Sincerely,

WARREN G. MAGNUSON.
HENRY M. JACKSON.

U.S. SENATE,
Washington, D.C., June 23, 1970.

Hon. RUSSELL LONG,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR MR. CHAIRMAN: One of the provisions in the Social Security Amendments of 1970 (H.R. 17550), recently passed by the House, is causing my State of Michigan a good deal of concern. No doubt other states will share this concern when the probable impact of the provision is made clear to them.

In order that the Finance Committee be made aware of the ramifications of this bill for the State of Michigan, I am submitting a statement for your consideration. If the Committee has need of further information on this matter, I would be most happy to submit it.

With best wishes.

Sincerely,

PHILIP A. HART.

Enclosure

STATEMENT OF HON. PHILIP A. HART, A U.S. SENATOR FROM THE STATE OF MICHIGAN

Mr. Chairman, my statement will be very brief and directed at only one aspect of the Social Security Amendments of 1970 that recently passed the House. I am concerned with a provision contained in Section 225 in Title II of HR 17550. It provides for the establishment of incentives for states to emphasize outpatient care under Medicaid programs. Specifically the bill decreases the Federal Medicaid matching percentages for extended stays in skilled nursing homes, mental hospitals and general hospitals while increasing the matching percentage for outpatient services.

The intent of the provision is no doubt to encourage medical personnel to move patients out of medical care facilities when their condition allows less intensive care. I have no objections whatsoever to more efficient use of medical facilities; in fact, the Antitrust and Monopoly Subcommittee, which I chair, is currently investigating high hospitalization costs. No doubt some of its recommendations will involve more efficient use of hospital facilities, including faster patient turnover.

But the point with Medicaid patients is that generally they are not able to go home after 90 days in a skilled nursing home. They are largely elderly citizens fighting illnesses for which there are no speedy cures. Many simply cannot be transferred to intermediate or out-patient facilities.

The impact of this provision, then, might be to transfer a large part of the cost of the program to the states without improving the efficiency of the health care delivery system.

R. Bernard Houston, Director of the Michigan Department of Social Services, cogently presented this argument to me in a recent letter. He wrote:

"I am deeply concerned about the decreases in the federal Medicaid matching percentages contained in the Social Security Amendments of 1970 and their ramifications for Michigan.

"The changes proposed in that bill (H.R. 17550) now before the Senate will result in a net annual loss of $15.3 million in federal revenue to Michigan.

Skilled nursing home service	—$11,221,200
General hospital services	—182,500
Mental hospital	—4,500,000
Total	—15,903,700
Outpatient, clinic, home health services	+611,000
Net loss	—15,292,700

"While we support the purpose of placing emphasis on outpatient services, the benefits from this emphasis cannot result in any immediate reduction in need for long-term care. The average age of the 18,000 patients in nursing homes in Michigan is over 75. It is unrealistic to assume that they will be rehabilitated within 90 days; it is unconscionable to terminate or reduce assistance in their behalf, but the options available to the state are limited.

"The bill in its present form does not alleviate the major problems in long-term care programs, nor does it reduce the cost of medical care for those needing it. It merely shifts that cost from one level of government to another with less fiscal resources. In its practical application, this can only reduce the medical care available to the needy and elderly in Michigan. Curtailment of other medical services to compensate for the loss of revenue is inevitable."

This concern is by no means limited to Michigan. Doubtless it is felt by all states with extensive Medicaid programs.

The Federal government, particularly during a period of inflation when health costs are skyrocketing, should not cut back on health care for the aged. Nor should it renege on its commitments and impose further financial burdens on the states.

Mr. Chairman, I respectfully urge the Committee to delete this section from the Social Security Amendments of 1970.

(The following communication was forwarded to the committee by Hon. George D. Aiken, a U.S. Senator from the State of Vermont:)

STATE OF VERMONT,
EXECUTIVE CHAMBER,
Montpelier, April 20, 1970.

Hon. GEORGE D. AIKEN,
U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SENATOR AIKEN: Although I am in complete accord with the general concept that steps must be taken to curb rapidly rising costs of medical care, I cannot support H.R. 16264 (Omnibus Bill to Reduce Federal Outlays) regarding Medicaid. (Title XIX).

The bill in question would have a disastrous effect in Vermont and presumably in all the other states. A summary of the impact on Vermont if the bill were enacted follows:

These estimates, computed from available program statistics and information, show the effect upon Vermont's Medicaid program in fiscal year 1970.

(1) *Outpatient hospital and home health agency services* comprise a relatively small percentage of the Vermont Medicaid expenditures. An increase of 25 percent in the federal matching percentage would bring the State an additional $61,000 in federal funds.

(2) *Inpatient hospital care in excess of sixty days* in a fiscal year constitutes approximately 4 percent of the patient days rendered to recipients under age sixty-five. For those aged sixty-five and over, the impact of this proposal can only be roughly estimated because of the complications of Medicare benefits and their relationship to the "benefit period." The reduction in federal matching funds for Vermont would approach $40,000 during the present fiscal year.

(3) Many of the patients, welfare and non-welfare, resident in Vermont's *skilled nursing homes* have been confined for long terms. If the federal matching percentage were reduced by one-third after ninety days of inpatient skilled nursing home care, it is estimated that federal funds for this care would drop from $1,896,832 to $1,466,950 during FY 1970 for a decline of 22 percent.

(4) The most severe impact of the proposals would be upon *the mental institutions* and their inpatients. Title XIX is limited to the sixty-five and over mental patients and these remain the most difficult to rehabilitate to the point of discharge. Application of the reduction in federal matching by one-third for the 91st through the 365th day of care and its entire elimination thereafter would lower federal matching to Vermont from an estimated $764,750 to $90,750.

Vermont Medicaid appropriations for FY 1970 total $12,325,439. Under the present federal matching percentage of 64.96 percent, federal funds will provide $8,006,547 in matching against state funds for the remaining 35.04 percent, or $4,318,802. Had the four provisions listed above been in effect during FY 1970, federal funds would have been reduced by an estimated $1,083,882 (13.5 per-

cent) to a level of $6,022,665. State expenditures would correspondingly increase by this same $1,083,882 to $5,402,684; an increase of 25.1 percent.

Applying the same mathematical approach (that state funds must be increased by 25 percent) to the amount budgeted for Medicaid during FY 1971 reflect that state funds would have to be increased by $1,330,000 to provide the original level of care contemplated in that budget.

In view of the adverse impact that H.R. 16264 would have on Vermont, I urge you to strongly oppose passage of this bill.

With the best personal regards,

Sincerely,

DEANE C. DAVIS, *Governor.*

BALTIMORE, MD., *September 10, 1970.*

Hon. RUSSELL LONG,
Chairman, Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: Please bring to the attention of the public witnesses to be heard on the new Medicare-Medicaid bill, the much greater and more effective form of discrimination against Medicare-Medicaid citizens than race, color, creed and source of origin.

This is Medicare-Medicaid support of the minority hospital "privileged" group of doctors, as the only ones permitted to utilize the tax supported beds and facilities at each hospital instead of the citizen's right to have his own doctor treat him at any hospital the patient and doctor choose. As you well know, Medicare is paid for in part by the patient, who is led to believe that the AMA policy concerning the practice of medicine is in effect as follows:

1. That it is a *basic right* of every citizen to have available to him adequate health care.
2. That is is a *basic right* of *every citizen* to have a *free choice* of *physician* and *institution* in the obtaining of medical care.
3. That the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person.

Any bill regarding Medicare or Medicaid incorporating the preceding as passed by our Baltimore City Medical Society in support of the AMA, should require any intermediary such as Blue Plans, Aetna, etc. to withhold or withdraw contracts with any hospital discriminating on the basis of "privileged" groups or any other form of discrimination except professional qualifications and conduct.

I will be pleased to testify as to further details of this and the effects on cost; and, furnish supporting evidence of how this is done and how it affects the Medicare-Medicaid group.

Please let me know when your committee wishes to check with me as an average representative physician in the practice of medicine, well acquainted with the average patient's needs and points of view.

Awaiting your reply, I am

Sincerely,

M. B. LEVIN, M.D.

WASHINGTON, D.C., *June 17, 1970.*

COMMITTEE ON FINANCE,
U.S. Senate,
Washington, D.C.

DEAR MEMBERS OF THE COMMITTEE: In your consideration of H.R. 17550, the bill dealing with social security benefits, may I ask you also to consider the information contained in this letter?

Inasmuch as the 84th Congress in Public Law 243, effective July 1, 1955, specifically *excluded* D.C. substitute teachers from coverage under the U.S. Civil Service Retirement Act, I find myself now credited with only eight years of Civil Service retirement credit instead of fourteen years which I had every reason to expect when I retired in October 1968. The 84th Congress removed this coverage in 1955 and substituted nothing in its place. Thus, teachers, as substitutes, had Civil Service coverage up to July 1, 1955 and beginning in October 1965 were granted Social Security coverage but Congress has done nothing in the way of coverage for those during the interim period, July 1955 to October 1965.

Losing six years of retirement credit under the Civil Service was a serious financial blow to me for the reason that my husband when he retires two years hence will have acquired only sixteen years of Civil Service retirement credit. If widowed, my retirement would be only 55 percent of what his small retirement would be.

I had tried to provide for such an emergency, widowhood, by entering the D.C. School System in December 1954 as a substitute teacher. I was informed that such a Federal position was covered for retirement under the Federal Civil Service. Following six years as a substitute I became a temporary teacher for eight years. Temporary teachers also were covered by the Civil Service Retirement Act. This service I did receive credit for and it provides a basic annuity to me of $72. Yet I began my service in December 1954 with Civil Service coverage and money deposited with the Civil Service was held by them for fourteen years until I retired. Had Congress not removed my coverage in 1955 my annuity for fourteen years based on $6,960 (5 year high) would be about double what it is at present.

My husband, when he entered government service in May 1954, paid into the Social Security for seven quarters following which he was transferrel to Civil Service coverage. For that reason, especially, it is our wish that government employees be permitted to pay into the Social Security System of Retirement. My husband is 68 years of age and he needs only eight more quarters to qualify for this Social Security protection which we shall surely need. We are not asking for charity, but instead asking for a privilige given to millions of people to provide for a retirement that would have some security in these days of high prices.

Being former residents of Appalachia with low annual incomes of $3,000 to $5,000 and victims of the 1929 Depression when even married women teachers were not permitted to teach, it has been an uphill struggle to provide a realistic retirement for ourselves.

The Civil Service is *not* a retirement system that provides security except for those who obtain *full* retirement after many years of service. Yet my husband has given to government service sixteen of the most productive years of his life and has paid hard earned money into *both* Federal retirement systems. Unless he is given the opportunity to complete the remaining eight quarters for coverage under Social Security all of the money he has paid into the Social Security so far will be lost to us forever. We could face up to this loss if the Civil Service retirement were realistic in his case but it will not be.

Would you, the Members of the Finance Committee, consider giving Federal employees who have paid into the Social Security during their Federal Service the opportunity to complete the requirements for coverage? This is an extremely serious question I am asking of your Committee and a question if answered in the affirmative would give us some retirement security.

We hope this letter will alert the Committee to the *individual* and *urgent* need of some Federal employees to be able to *complete* their coverage under Social Security. Therefore, we plead with you to consider the inequities I have referred to in this letter and hope and pray you will provide legislation that will permit my husband to *complete* his coverage for qualification under Social Security. Such legislation would also benefit me as well as my husband.

Sincerely yours,

(Mrs.) Jean L. Reynolds.

Comments of Illinois Department of Public Aid, Harold O. Swank, Director

Much as Illinois welcomes and endorses the increases in Social Security benefits and other improvements in Social Security—and also many of the improvements in Medicaid and Medicare—contained in HR 17550 as passed by the House of Representatives May 21, 1970, we must vigorously protest to the Committee on Finance and the entire membership of the Senate the proposed attempt to control Medicaid costs by cutting back Federal participation in State expenditures for hospitalization, skilled nursing home care, and care of aged persons in hospitals for mental diseases.

Our protest is directed to those provisions of Section 225 (page 103 et seq., of the Bill in the Senate) which, after December 31, 1970:

(1) reduce Federal participation by ⅓ for inpatient services in a general hospital or tuberculosis institution beyond 60 days (whether or not consecutive) during any calendar year (defined as the four calendar quarters ended with June 30);

(2) likewise (except for the definition of calendar year) reduce Federal participation for inpatient care in a skilled nursing home beyond 90 days; and (3) reduce Federal participation by ⅓ for inpatient care in a hospital for mental diseases beyond 90 days up to a total of an additional 275 days—after which Federal participation terminates.

The foregoing time limits, after which the proposed reductions in Federal participation take effect, are *in addition to* the time limits established for these services for aged persons entitled to have medicare payments made under the Medicare Title XVIII. However, for Medicaid patients not fortunate enough to be covered by Title XVIII, the time limits do not stand on top of the medicare coverage.

Labeled in the Bill as "Incentives for States to Emphasize Outpatient Care under Medicaid Programs", these cutbacks in Federal participation are accompanied by a 25 per cent elevation in Federal participation in outpatient hospital services and clinic services (other than physical therapy services) and in home health care services (other than physical therapy services).

These provisions were included in the Bill by the House Committee on Ways and Means without notice to State Medicaid agencies of the Committee's intent to take this action and without opportunity for the States to register their reactions with the Committee. *Hearings were not held on these issues.* House consideration of the Bill under a closed rule precluded floor amendment in that chamber, although some States, through their representatives, registered protest.

We shall set out later in these Comments those features of the Medicaid and Medicare amendments which we view as program improvements—some excellent as they stand and others requiring revision or clarification. We must, however, accent the negative first because of the false premises upon which the proposed cutback is based; its impact on State finances in any State which feels morally obliged to meet the essential medical needs of the poor; its impact on the condition of the poor and social stability in those States which might choose to match Federal cutbacks with corresponding State cutbacks; and its long range implications for future national or nation-State programs to meet the medical care needs of the population.

THE CUTBACK IN FEDERAL PARTICIPATION IN MEDICAID

With concern mounting at all levels of government—*State and local*, as well as national—over the ever larger and competing demands on the tax dollar to provide the public services required by a growing population in a complex and highly interdependent society, Illinois fully appreciates the Congressional concern obviously underlying the Medicare and Medicaid provisions contained in this Bill. There is no question that these programs must be kept within defensible bounds and that provisions which do not serve program objectives, as they become apparent through experience, must be promptly corrected. However, the attempt here made to control some aspects of the Medicaid program by reducing Federal participation in State obligations for the program is not only violative of the original Federal commitment—which was conductive in many States to the commitment of State and local funds toward the program—but it is obviously based on a misunderstanding of the nature of the Medicaid undertaking and on false premises concerning responsibility for the increasing demands on the Federal dollar to meet the Federal share of the total commitment.

Proposed at this point is a reduction in Federal participation for certain institutional services. On the same premises, the next step might well be to reduce and ultimately terminate the Federal participation in "intermediate care" institutional services (not subject to reduction under the present proposal). Later, there would be nothing to prevent—again on the same premises—Federal participation being reduced, or ultimately eliminated, in outpatient services. And thus would terminate in totality Federal participation in the program.

The nature of the medicaid undertaking

This beginning of a "closed end" approach to the original Federal "open end" commitment to the Medicaid program has arisen, we suspect, because the Congress—until Medicaid Title XIX of the Federal Act took effect in January 1966 and the States began to participate in the Title—was unaware of the extent of the medical needs of the poor and medically indigent throughout the nation. While States such as Illinois had comprehensive programs very similar to those operated today under Medicaid, Federal participation was only minimal

and only sparingly reflected in national statistics for the poor. In other States, the medical needs of the poor and medically indigent—if met at all through public funds—were submerged in operating data for so-called charity or free hospitals, or free public clinics and "charity doctors" and not correlated with any available statistics on public tax dollars spent for medical care through the public assistance programs. The remainder of the need, if met at all, was met through private charitable funds or the personal charity of medical care providers.

This scattered and uneven system was suddenly nationalized and made a public commitment under Title XIX as part of the 1965 amendments to the Federal Act. The need—and to a considerable extent the public expenditure, had that public expenditure actually been countable and counted—was there all along, but it did not become visible until the advent of Medicaid. The situation might be compared to the impact upon the people of the United States had there been no information concerning the enlarged need for subsistence aid created by the Great Depression in the 1930's, until after the first year of Federal and State expenditures in providing unemployment relief. Thus, in the case of Medicaid, it may be said that it was only the size of the tax funding required that made Congress and the people generally aware of the size of the medical needs of the poor and the medically indigent when the Medicaid program came along and made that volume visible in a single set of statistics.

In the hasty attempt made by this Bill to plug one area of cost (institutional services) in the Medicaid program—through the inequitable device of reducing the Federal share of that cost—we see only an ineffective and unwarranted protest against a fiscal obligation which came as a surprise to the Federal Government but for which the Federal Government is equally, if not more, obligated than the States. For Medicaid, as against Medicare, *is a means-tested poverty program.* And, by now, it is well settled that the causes of poverty are not confined to State lines, that a national program of reduction and prevention, supplemented by State effort so as to adapt the basic national program to area differences, offers the only logical approach.

It is therefore vitally important that we keep in mind the essential difference between those public services for which the public, through its government, has made a commitment as desirable for the citizenry in general and those public services which are provided to only that segment of the population able to meet a means test establishing poverty. These latter public services go beyond those which are merely beneficial or conductive to the public welfare in general. They represent instead the necessities of life itself—the means of subsistence, and, after the enactment of Medicaid, the alleviation and prevention of illness. These services are now Federal as well as State commitments. Within the confines of that segment of the population able to meet a means test defining them as poor, *the public commitment for financing the necessary costs must obviously be open end.*

False premises underlying the proposal

On this background of astonishment and concern with the cost of the Medicaid program—leading to the beginning of closing the Federal commitment—the cutbacks proposed in this Bill then proceed to remedy the situation on three false premises:

1. The false premise that only the Federal Government is concerned with Medicaid costs.

In Medicaid, the *State* dollar is also involved and in many States also considerable local dollars.

In Illinois in the fiscal year ending June 30, 1971, we expect to spend some $126.3 million in *State* dollars under Medicaid Title XIX for medical care to the aged, the blind and the disabled and families with dependent children, plus $15 million in State dollars for care of the aged in hospitals for mental diseases who are needy by public aid standards—or a total of $141.3 million in *State* dollars. In addition to this, Illinois will spend $20 million in State dollars for the medically indigent, including families of the working poor, not covered at present by Title XIX, with a local contribution of $4 million toward this program. With the Federal share of this total outlay coming to considerably less than half of the total, surely it cannot be said that Illinois does not have at least equal concern with costs.

2. The false premise that State laxity is primarily responsible for rising Medicaid costs, especially in the more costly segments of hospital and skilled

nursing home care and care of the aged in hospitals for mental diseases. Instead, the facts are

(*a*) In Illinois, the medicaid program is carrying the slack of the health needs of the poor which are not covered at all under the national contributory hospital and medical insurance program—the Medicare program established by Title XVIII—or which are not covered because of the time and other limitations set in that program for Medicare coverage.

In Illinois, at least, the bulk of Medicaid expenditures for institutional services is required to *supplement* the Medicare program for the needy aged and for disabled adults under 65 not as yet covered by Medicare. That is, Illinois' largest outgo for Medicaid is required to pick up where Medicare has left off. Medicaid costs would be reduced dramatically if Medicare were expanded to cover a larger portion of the medical needs of aged and disabled persons now covered under the Federal Act for Social Security benefits. But obviously this would require elevation of the tax on employers and empolyees to support the broadened program. Medicaid represents simply a shift of this non-covered need to general tax revenues. Surely there is no warrant for placing the blame upon the States—and the States alone—for this choice of the source for funding the unmet portion of the medical need Medicare Title XVIII is designed to supply.

In Fiscal 1971, for example, $140.8 million of the total Illinois Medicaid expenditures of $252.6 million—or 55.7 per cent—will go for care of the aged, the blind and the disabled. In addition we will spend $30 million for care of the aged who are needy by public aid standards in hospitals for mental diseases. For institutional care—outside of that provided in hospitals for mental diseases—we will be spending, for the aged, $3.4 million for hospitalization, $4.4 million for skilled nursing home care, and $39.9 million for intermediate care—hardly indicative of overutilization of expensive hospitals and skilled nursing home care. For the blind and disabled we will be spending $44.1 million for hospitalization—as this group is not covered by Medicare—plus $1.3 million for skilled nursing home care and $11.7 for intermediate care.

Thus, for institutional care of the aged supplementary to Medicare Illinois will be spending a total of $47.8 million as against a total of $57.1 million for institutional care for the blind and disabled. Furthermore, under the provisions of this Bill, the time limitations for care of the blind and disabled in hospitals and skilled nursing homes do not stand on top of the Medicare time limits—a double inequity for these needy people, as well as the States, for the choice made not to include them as well as the aged in Medicare Title XVIII.

This discriminatory treatment as between persons covered by Medicare and equally ill persons not covered by Medicare emphasizes, in our judgment, the invalidity of this Bill's arbitrary time-limit approach. If the time limits set for non-Medicare patients have validity, then Medicaid should not meet the hospitalization and nursing care requirements of the aged beyond those covered by Medicare and, further, Medicare coverage of the services at issue should be reduced to the same time limitations proposed in this Bill. Any such action would, of course, deny to the aged *poor* (so determined by Medicaid's means test) those additional necessary medical services other aged persons covered by Medicare are able to purchase from their own resources.

(*b*) Hospitalization and skilled nursing home expenditures under Medicaid are not so much the result of overutilization under Medicaid but are attributable primarily to rises in costs as a result of the hitherto unqualified "reasonable cost" concept of Medicare, as carried over by HEW regulations to apply to Medicaid.

This will be rectified by some of the changes made by this Bill in the Medicare and Medicaid Titles. But it is foolhardy to expect that this long overdue correction—five years after the programs went into effect—can roll back costs to the more reasonable level that would have obtained had heed been given to the protests made at the outset by State welfare administrators to this and other faulty concepts set out in Medicare and then carried over to Medicaid.

3. The false premise that a "closed end" or cut-off approach can be adopted only by the Federal Government—that the States, if care in hospitals or skilled nursing homes, or hospitals for mental diseases is medically necessary beyond the limits set in the proposal, are *necessarily* committed to meet the need irrespective of the Federal cutback.

If a "closed end" approach is valid for the Federal Government, it is valid also for the States. This can mean only that persons for whom care in hospitals,

skilled nursing homes, or hospitals for mental diseases continues to be medically necessary will have their care terminated despite continued need. Thus, they must go uncared for—or they must fall back upon the charity of the providers to continue the care without any public payment.

SPECIAL PROBLEMS IN THE PROPOSED CUTBACK FOR MENTAL DISEASE HOSPITALIZATION

In the proposal for the cutback in Federal participation for care provided under Medicaid to the aged in hospitals for mental diseases, the States are faced with two additional problems:

1. Federal participation is not only reduced after 90 days but it is terminated entirely after an additional 275 days.

2. Where "intermediate care" is all that is required but placement cannot be found in outside facilities, any *public* hospital for mental diseases is discouraged by the concluding paragraph of Section 225 of the Bill (page 107) from establishing a section in the institution to provide intermediate care. Federal aid is prohibited to patients in such a section of a *public* hospital.

Because of the complexities of mental disease and the many as yet unexplored areas of effective treatment—at least treatment reasonably assuring no recurrence—we cannot agree with the "assumption" that necessary treatment for patients over 65 "rarely continues beyond a year". The complexity and uncertainty of the treatment required in mental disease is reflected in the provision contained in the present Section 1902(a)(20) of the present law—and unchanged by this Bill—requiring that States which include in their Medicaid Plans the aged in hospitals for mental diseases provide "assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care". The quoted "assumption" not only contradicts this other provision of law but it could be construed as implying that the aged are, in fact, abandoned as recipients of necessary mental treatment by the factor of age. If this is the reality, it should not be remedied by termination of Medicaid payments. Rather, it should be remedied by insistence that the necessary mental treatment be provided—as is now done by the section of present law herein quoted.

The second difficulty stems from the faulty concepts underlying the "intermediate care" provisions of present law (which we will discuss at the end of these Comments) and what would appear to be the vestigial remains of the attempt made in the original Social Security Act of 1935 to legislate out of existence *public* institutions providing care to the ill or infirm. Intended, we surmise, to bar from Social Security Act coverage care provided the poor in the infamous "almshouses" of the prior era, the prohibition originally was interpreted to bar Federal participation in care provided in *any* public institution—including hospitals or skilled nursing homes operated by State, county or city authorities. These latter bars have now been lifted—but with "intermediate care" placed in Title XI and not in Title XIX, it has been construed as a *non-medical service* and thus, when provided by a public institution, Federal participation is prohibited.

Not only do we see nothing wrong with *public* institutions as against private non-profit and private profit institutions—all are now subject to modern concepts of standards of care and increasingly are open to private pay patients as well as patients whose care is paid for by tax funds—but a special problem is presented by the aged now in State hospitals for mental diseases but no longer requiring hospital care. Prior to the development of the State-Federal public assistance programs in 1935 and thereafter, and more recently the Medicaid program under Title XIX, these State hospitals for mental disease had become dumping grounds for impoverished infirm aged persons—not mentally ill—who had no relatives or whose relatives could not or would not care for them at home—or could not or would not pay for their care in other institutional settings. After years of confinement in these institutions, the condition of these patients has deteriorated to the point that they are particularly hard to place in skilled nursing homes (if that degree of care is required) or in intermediate care facilities (if lesser care is required).

In this transition period of correcting the situation for these victims of past practices, the Medicaid program must have the flexibility to meet the practicalities of a given patient's situation. We see no valid reason why a State hospital for mental disease should not set aside a portion of its plant to provide "intermediate care" for such ex-hospital patients and also for other patients from the community requiring "intermediate care" because of mental infirmities not requiring hospitalization but nonetheless necessitating institutional care. There

is no reason the Federal Government should *not* participate in this type care merely because it is provided by a *public* institution—provided the care is of a standard equal to or better than that provided by other institutions.

COST IMPACT ON ILLINOIS OF THE CUTBACK PROPOSAL

For the first year after these proposals will become effective the net loss to Illinois in Federal participation is estimated to total $3.9 million:—$300,000 for an estimated 21,000 patient days in hospitals for patients for whom continued hospitalization has been certified as medically necessary *under this State's ongoing hospitalization control program* which reviews hospital stays and their necessity *more frequently* than the controls implied by this proposal; $1.4 million for some 2400 patients for whom care in skilled nursing homes has been certified as medically necessary; $4 million for care of the aged in hospitals for mental diseases; and with the foregoing $5.7 million loss moderated by $1.8 million through the 25 per cent proposed increase in matching for care provided through outpatient hospital and clinic services and home health care services.

In the second year after the proposal takes effect, however, Illinois' loss in care for the aged in hospitals for mental diseases would jump from $4 million to $16 million as more and more patients still requiring mental disease hospitalization care exceed the proposed limits. This would result in a total net loss for the second year of $15.9 million—and more, depending upon the extent to which costs for this institutional service increase and the size of the eligible caseload increases.

While these figures on the estimated loss to Illinois of the proposal are relatively small in terms of this State's total outlay of State and Federal funds for the Medicaid program, this proportion is indicative of the extent to which Illinois has already controlled unnecessary utilization of expensive institutional services without the "incentive" of reduced Federal participation.

We must emphasize: those patients for whom these payments are being continued under the Illinois control program *have been determined to be medically in need of the institutional care provided* or in the case of some patients (primarily in the hospitals for mental disease) care is being continued pending an opening for placement in other institutional facilities. All of the patients involved are Medicare patients who are unable themselves to meet their medical needs where Medicare has left off; or they are patients without sufficient funds of their own whom Medicare does not cover. Under the circumstances stated, the positive "incentive" for outpatient care is irrelevant, the negative "incentive" of reduced Federal participation unwarranted.

SUGGESTED ALTERNATIVE TO THE CUTBACK

As indicated on page 98 of the February 1970 report of its staff to the Committee on Finance concerning *Problems, Issues, and Alternatives, in Medicare and Medicaid,* the *needs of the individual* must be the controlling factor in determining what kind of services are paid for under the Medicaid program. Discussing Congressional intent in adding the intermediate care facility provisions to the Federal Act, the staff pointed to the requirement that there be periodic professional evaluation and audit of the care and facilities in terms of their "appropriateness" to the needs of the individual for whom payment is being made. The report went on to say "The references to 'appropriateness' and 'periodic professional review and audit' indicate Congressional expectation that while overall reductions in institutional costs were anticipated, *a lower cost facility was not to be used where the level of care was below that required by the individual recipient.*" (Emphasis supplied.)

We would add still another factor—not specifically mentioned in the Finance Committee Staff Report—and that is the unavailability, as of a given moment, of a placement opening for a given patient in a lower cost facility, that is, for a patient who could be moved medically to a lower cost facility but such facilities are not available, or available in sufficient quantities, or an opening is not at the moment available for a particular patient.

Assuming that the medical necessity of a given service is established, or it is established that a facility or service appropriate to the patient's needs is not available (thus requiring his continued presence in the higher cost facility), then—for a patient whose inability to pay is established by virtue of his meeting the means test for Medicaid—there are only two alternatives:

1. For the State *and Federal* Governments to continue their present joint obligation to meet his necessary medical needs under the actual operating conditions in the State in which the patient lives; or

2. Deny the essential medical care to Medicaid eligibles—through an arbitrary cut off of the Federal *and State* payments, thus compelling

a. the patient's life or health to be impaired because of lack of care; or

b. the patient's needs to be met through private charitable funds or the personal charity of the medical care provider

We see no viability whatever in the second alternative.

We believe that the medical review and utilization controls first inserted in the Medicaid Title by the 1967 legislation adding Sections 1902(a)(26) and 1902(a)(30) to the Medicaid Title—and further strengthened by the utilization control provisions of H.R. 17550—are sufficient to check any unnecessary use of the more costly services which this Bill would seek to control by reducing Federal aid. However, should the Congress wish to express its intent that the time limits set out in Section 225 be applied as guidelines for determining the necessity for continuing Federal *and State* payments for a given patient, we suggest that the provision be reworded so as to terminate any coverage under Title XIX unless there is on file for the patient exceeding the stated time limits a certification by the utilization review committee that

1. Continued care in a given service is medically necessary; or

2. Continued care in a given facility is not medically required but the patient cannot be moved until an opening is available in an appropriate facility (to be specified).

PROVISIONS OF THE PROPOSAL IMPROVING THE MEDICARE AND MEDICAID PROGRAMS

1. *Increased Federal Participation in Non-Institutional Services.*—The proposal to elevate by 25 per cent Federal participation in outpatient hospital, clinic, and home health care services should stimulate the States to develop, with the aid of the medical community, various alternatives for the more costly institutional services. It should stimulate constant thinking and rethinking of the State's organization of the entire spectrum of services needed to meet the health needs of its people—poor and non-poor alike. This positive "incentive" of additional Federal aid may be compared to the incentive given the States in 1962 legislation—through 75 percent Federal participation as against 50 percent for other administrative expenses—to develop those social services in the public assistance programs which would help public assistance recipients escape from the cycle of poverty. In contrast with the approach taken in this Bill, the 1962 "incentive" for preventive Social Services was not accompanied by a "negative" incentive reducing Federal participation in other necessary administrative expenses.

We have, however, one minor criticism to voice on this proposal. It will cover care provided in the home only if the care is provided through the relatively costly "home health services" as defined in Section 1861(m) of Medicare Title XVIII. In some rural areas it is simply not feasible to set up arrangements meeting this definition. In others the cost involved is not warranted for the number of patients who might need that type of service. This suggests that if a patient can be kept in his home with physician and nursing oversight but does not need all of the services specified in the definition of "home health services", recognition should properly be given to such an arrangement through increased Federal participation.

2. *Medicaid Payments Not Higher Than Charges.*—Illinois has protested from the beginning the ridiculous results of present law and regulations which require that Medicaid payments be paid in amounts higher than hospitals and other providers of services charge the general public. This revision—providing for payments on the basis of costs or charges, whichever are lower—is a long overdue reform.

3. *State Determination of Hospital Payment Rates.*—As noted earlier in these comments, the reasonable cost provisions set out in the Medicare Title and then carried over to the Medicaid Title have played a large part in the elevation of total costs of the Medicaid program. The flexibility given in this Bill for the States to develop their own methods and standards for hospital reimbursement—with protection provided so that State action will not require private patients to subsidize Medicaid for the poor—should materially improve the ability of the States to control cost and to develop hospital payment plans satisfactory

both to the hospitals and to the general public paying taxes for the Medicaid program.

4. *Additional Federal Participation in Medical Claims Processing and Information Retrieval Systems.*—Illinois has established such a system and thus will not benefit from the proposed 90 per cent matching stimulus offered to those States which have not already acted in this area. We do, however, welcome the elevation from 50 to 75 per cent in the Federal share of the on-going costs of this system.

5. *Tie-In of Capital Improvements With State Health Facility Planning.*—The proposal that capital improvements, as a factor in institutional costs, be subject to inclusion only if they tie in with a State's health facility planning is in line with the thinking in Illinois for controlling those costs which do not specifically serve the total health needs of the people of the State.

6. *Experiments in Prospective Reimbursements and Other Possible Incentives for Economy.*—This is another long overdue approach to improving the quality of service provided as well as containing costs.

7. *Institutional Budgeting.*—Though proposed as a requirement for participation in the Title XVIII Medicare program only, submission by hospitals, extended care facilities, and home health agencies of annual operating budgets and capital expenditure plans for at least a 3 year period should materially aid State Medicaid agencies in arriving at appropriate bases for Medicaid patient payments and assist the States in rationalizing and planning a coordinated system for delivery of health services.

8. *Presumptive Eligibility for Extended Care and Home Health Coverage Under Medicare.*—The State Medicaid agencies obviously become involved in situations where Medicare denies retroactively payment for care already provided in an extended care facility or through a home health service and the patient, unable to pay the bill given him for the services denied by Medicare, applies and qualifies for Medicaid. In addition to the established financial need factor, the Medicaid agency is in the difficult position of being pressed to pay for a service that Medicare has determined (*after* the service was provided) *not* to be medically necessary. Yet neither the facility nor the patient are at fault. The proposed adjustment makes good sense.

9. *Additional Controls on Utilization.*—The provisions of Section 235 of the Bill (page 130 et seq.) coordinating the hospital and skilled nursing home utilization review requirements of Medicare with the similar requirements for Medicaid utilization of these facilities should strengthen the hand of Medcaid agencies in advancing more effective use of the utilization review process. We note with particular pleasure the amendment made to Medicaid Section 1902 (a) (30) specifying that Medicaid's utilization review includes *but is not limited to* that prescribed for Medicare. As the House Committee noted on page 45 of its Report 91–1096 on the Bill (when disscussing determination of hospital costs), there are "differing characteristics of the two populations served" by Medicare and Medicaid. We might add to this also that welfare agencies now administering the Medicaid program have a much longer experience than Medicare with problems of utilization and other aspects of cost control.

10. *General Comment on Above Reforms.*—To avoid repetition in each of the above comments with respect to improvements made by this Bill, we wish here to commend the inclusion also of payments made under the maternal and child health provisions of Title V of the Federal Act in the controls established by the Bill. On the same principle, the Congress now or at a latter date might well examine into the desirability of coordinating payment criteria for other governmental medical care payment programs, such as Vocational Rehabilitation and private facility purchased care for veterans. This will require review of Federal laws other than the Social Security Act.

PROVISIONS REQUIRING REVIEW OR CLARIFICATION

1. *Prohibition of Reassignment by Physicians, Dentists or Other "Individual Practitioners" of Their Claims for Payment for Services Rendered.*—Applicable both to Medicare and Medicaid, Section 234 of the Bill (page 128 et seq.) prohibiting reassignment of claims to other organizations or groups, including collection agencies, should aid in controlling inflated or fraudulent claims. However, for the Medicaid program, the language should be broadened to cover such providers as druggists, ambulance services, and other services now within the scope of the Medicaid but not the Medicare program.

2. *Limitation on Institutional Costs Covered by Medicare.*—The provisions of Section 223 of the Bill (page 97 et seq.) excluding from Medicare coverage those institutional costs which exceed those "necessary in the efficient delivery of needed health services" or which "flow from the provision of services in excess of or more expensive than generally considered necessary" are in line with the practice followed in Illinois (prior to the advent of Medicare and Medicaid) ruling out from full "cost" reimbursement those hospitals above the third quartile of cost figures for other hospitals with like facilities and services and also restricting public aid payments to "essential" services (thus ruling out expensive accommodations not required by the patient's condition, and like items). However, the Bill's provisions that such excess cost or services not met by Medicare can be charged *to the patient*, provided all patients are so charged and are notified of their liability in advance, will, unless modified, adversely affect the Medicaid program. Demand will obviously be made upon the Medicaid program for payment of these charges for Medicare patients who qualify for Medicaid. The Bill should be amended to provide that the institutions may not levy such excess charges upon patients whose source of payment is the Medicaid program.

3. *Mandatory Three-Month Prior Coverage Under Medicaid.*—Section 251 of the Bill (pages 142 and 143) *requires* the States to cover the cost of health care provided for the three months prior to the Medicaid application to "any individual who has been determined to be eligible for medical assistance under the plan—if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished". Such 3-month prior coverage is now optional with the States.

While this language, if strictly construed, could protect the States in making such investigations as would assure, for example, that the applicant had not within the period divested himself of assets that would have applied to medical costs had application been made immediately, the "simplicity of administration and the best interests of the recipients" provisions of Medicaid Section 1902 (a) (19) might—on the basis of past experience—be interpreted by HEW as precluding the States from questioning eligibility in such situations. There are also such problems as presumed obligation for services more expensive than or not included in the State's Medicaid plan; the death of the presumed eligible and the unavailability of anyone knowledgeable of his circumstance at the time the application is actually made; and the temptation to some providers to submit for Medicaid payment their slow or bad accounts. In our judgment this exercise of prior 3-months' coverage should remain optional with the States—at least until such time as the Congress is satisfied with the Medicaid program to the extent that it no longer attempts to control costs by reducing or withdrawing Federal participation as an "incentive".

NEEDED CORRECTION OF THE INTERMEDIATE CARE PROVISIONS OF THE FEDERAL ACT

In comments Illinois submitted under date of December 1, 1967 to the Congress on HR 12080, (the Social Security Amendments of 1967), as passed by the Senate November 22, 1967, we urged that the provisions for intermediate care facilities—added to the 1967 Bill at the instance of the Senate Finance Committee—be broadened to include the medically indigent under Title XIX as well as persons eligible for cash grants under the public assistance Titles for the aged, the blind, and the permanently and totally disabled.

We said at that time "There is no reason whatsoever for keeping a medically indigent aged, blind or disabled recipient in a more expensive hospital or skilled nursing home care when his needs for care can be met by an intermediate care facility." We might add at this time the further observation that adults and children in the AFDC program who are also covered under Medicaid—whether qualifying for a cash grant plus medical care, or for medical aid only as medically indigent families—might also require and be properly placed in an intermediate care facility, as such facilities are defined in the Federal Act, when they are no longer in need of more costly hospital or skilled nursing home services.

Although the intermediate care provision added by the Finance Committee carefully specified that the patients covered were to be only those who "because of their physical or mental condition (or both), require living accommodations *and care* which, as a practical matter, can be made available to them only through institutional facilities" but "do not have such an illness, disease, injury, or other condition as to require *the degree of care and treatment* which a hospital or skilled nursing home (as that term is employed in title XIX) is designed to provide" (emphasis supplied), the Committee was, for some reason, persuaded

by representatives of HEW or others to place this provision in Title XI of the Act as Section 1121 rather than in Medicaid Title XIX—where we believe the provision properly belongs.

If for no other reason than the interest the Congress now has in establishing controls in both the Medicaid and Medicare program to assure that patients will not be retained in facilities inappropriate to the *degree* of care required by their physical or mental condition, it is imperative that this provision of law now be removed from Title XI and made a part of Title XIX *so as to make intermediate care facilities a part of the total spectrum of medical services utilized by State Medicaid agencies in fitting the services provided to the needs of the patient.*

Whether the motive in the present placement of the provisions outside of Title XIX was to "conceal" intermediate care expenditures from the total outlay for Medicaid (as has sometimes been alleged), or whether the motive was one of semantics reflecting the hesitation of the medical community to classify as a "medical service" any care requiring less than full time physician and professional nurse supervision, program operations in Medicaid make necessary the elimination of all the subterfuges and frequently changing regulations that have ensued as a result of the present wording and placement of the provisions in the Federal Act. For example:

—only cash grant recipients, or those who would be entitled to cash grants if not receiving care in an intermediate care facility, are eligible under the wording of the present provision. But a State *can* cover a medically indigent person by stretching its imagination as to what that patient's expenses would be if he were living outside of the facility. This imagination stretch will become increasingly difficult as Social Security incerases and other efforts to improve the income of the aged and disabled poor rise relative to State standards for public assistance or Medicaid;

—the artificial separation of these intermediate care facilities from the Medicaid provisions establishing standards and other controls is a positive inducement to wholesale reclassification of institutions not meeting the definition of "skilled nursing homes"—a problem gone into in considerable detail in the staff report of the Committee on Finance;

—HEW regulations, bottomed on this curious placement outside Title XIX and on concluding paragraph (A) of Section 1905(a) of Title XIX, discourage establishment of such additional intermediate care facilities as may be needed by such public bodies as county or local governments. In Illinois a substantial number of counties operate county nursing homes—open by law to private pay patients as well as to patients whose care is paid for from public aid funds under the Federal-State programs or the State-local General Assistance and residue Medically Indigent programs. Some of these county nursing institutions meet State standards for skilled nursing homes; others intermediate standards. All are licensed by the State. As a general rule, the care provided by these homes is equal to or superior to that provided by privately operated homes. Yet, because HEW has held that intermediate care is not a "medical service", patients receiving such care in a publicly operated intermediate care facility are considered "inmates of a public institution" and thus are not eligible for Federal participation in costs.

If cost segregation is the sole motive in treating intermediate care separately from other medical services, this can be done in national statistics by listing intermediate care facility payments as a subitem under Medicaid expenditures (for the purpose of evaluating this expenditure in relationship to the total for all other types of Medicaid expenditures). At present, these expenditures are shown in national statistics as an item separate from money payments, medical assistance payments, and emergency assistance payments. For example: in HEW's public assistance statistics for January 1970, Table 1 shows the federally-aided Medicaid program as totaling $402,421,000 for January 1970, with intermediate care payments shown separately in an additional total of $26,714,000—as against no payments at all in this category for January 1968 when the federally-aided Medicaid program totaled $301,967,000.

If the concern behind this curious placement of the provision is to avoid Medicaid payment for care not medically necessary (purely custodial care is eliminated by definition, which excludes care limited to board and room), then the obvious remedy is to revise the language to require medical certification of the need for the care.

Illinois has urged this change upon the Federal Department of Health, Education, and Welfare since enactment of Section 1121. To date we have been unable to overcome the insistence of medical personnel in the Department that intermediate care, in their judgment, is not classifiable as a medical service. We cannot agree with this position, assuming that a qualified professional has certified to the need for care in an intermediate care facility.

If, however, there exist reasons at this time for caution in defining "medical" services, we recommend—*as an interim measure*—

(1) that Section 1121 be revised in its wording to cover intermediate care furnished cash recipients under *all* of the public assistance Titles of the Federal Act and to cover also the medically indigent who may be included under a State plan under Title XIX;

(2) that concluding paragraph (A) of Section 1905(a) of Title XIX be revised to read:

> "(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution *or in an intermediate care facility as defined in Section 1121*)".

We would hope that the alternative suggested in the foregoing paragraph would not be considered a necessary compromise at this point of Federal and State concern in eliminating serious operational and cost control problems in the Medicaid program. The present restricted concept of a "medical care" institution is not only out of date with the needs of patients as we are now experiencing them under present day developments in the public programs for medical care, but it is out of date with professional practice in the medical and nursing professions which increasingly are utilizing subprofessionals to perform those functions which well can be performed by others under professional direction. With the problem actually one of semantics, all that is needed is the updating of the term "medical care" to remove the Federal roadblock that now stands in the way of providing Title XIX recipients with the full range of care the individual patient may require—and stands in the way of the cost management efforts of State Medicaid agencies.

Statement of the Government Employees Council, AFL–CIO, on Optional Social Security for Federal Employees

Mr. Chairman and members of the Committee, the Government Employes Council and its 34 AFL–CIO affiliates representing more than 1 million postal, wage board, and classified employes of the Federal Government applaud the Committee for its care examination of the Social Security Act, with a view towards updating that statute to better meet the needs of millions of citizens affected by it.

Since the AFL–CIO is able to accurately reflect the views of its member unions on necessary changes in the system, our comments will be confined to one aspect of the program. That is the lack of Social Security coverage for the Federal workforce as public employes.

At the outset, we must emphasize our long standing concern over any attempt to consolidate the Civil Service Retirement and Social Security systems.

Each program serves a different and highly important purpose. Social Security is designed to meet the needs of the entire population in old age, and before acquiring eligibility for regular Social Security payments. It is a system of social insurance, which guarantees to the general working population monthly payments to assure a basic income to families when the principal wage earner can no longer work because of retirement, disability, or death.

Civil Service Retirement, with antedates Social Security by 15 years, was entacted to recognibe a career in Federal public service by providing monthly benefits based upon length of service and the highest level of earnings while employed. Over the years, significant improvements, including payments to disabled individuals and their dependents in the event of his death, have been incorporated in the Civil Service statute.

Because of the heavy payroll contributions employes make to this staff retirement plan, and because its benefits are geared to long Civil Service tenure, employes are understandably anxious to preserve it as the principal source of income when they retire.

From time to time, proposals have been advanced for merging the Civil Service and Social Security programs. The fundamental differences in the pur-

poses they are designed to fulfill has caused us to oppose such efforts. Our attitude on this question has not changed

Nevertheless, this position does not preclude the desirability of making Social Security benefits available to Federal workers generally. Periodic analysis of the question by the Council has resulted in the conclusion that Federal employes should be able to voluntarily elect—and make appropriate contributions to—Social Security coverage, without prejudicing their separate entitlement to benefits under the Civil Service Retirement Act.

There are several reasons justifying this posture.

Social Security would make available more realistic survivorship and disability protection to young workers. Those individuals who leave Federal service before retirement would be assured of survivor and disability rights because their government service would be creditable for Social Security purposes. Even those Federal workers with five years or more Federal service would be able to correct the deficiency between the social insurance system and Civil Service retirement because benefit amounts would always be at least at the Social Security level.

Although some Federal employes gain Social Security credits because of other work, these credits are often insufficient to make them insured under Social Security. If optional Social Security coverage is possible, such credits could be added to those acquired from other non Federal work to increase the worker's lifetime entitlement under Social Security, and in those cases where an individual's work is divided between public and private employment, the monthly benefits would be reasonably related to lifetime earnings and contributions.

Thus, Federal employes would be afforded the basic protection offered by Social Security and supplemental benefits gained under their staff retirement system. In many instances, this is now true for other workers covered by staff retirement, private pension, or profit sharing plans.

In most succinct way of stating our request for serious consideration of such an addition to the pending Social Security bill is to quote a brief excerpt from the Council's program on retirement for 1969–70:

"(We) oppose merger of Social Security and Civil Service retirement systems. However, employes should have the right to participate under an optional program of coverage under the Social Security Benefits Act in addition to the Civil Service Retirement Act."

This feature of the GEC's agenda was approved unanimously at the AFL–CIO Convention in Atlantic City, New Jersey, in October, 1969.

We earnestly solicit your sympathetic attention to our proposal.

PROFESSIONAL THERAPEUTIC SERVICE, INC.,
Dayton, Ohio, July 30, 1970.

Hon. RUSSELL B. LONG,
Chairman, U.S. Senate, Committee on Finance, Washington, D.C.

DEAR SENATOR LONG: I am greatly concerned and feel I should bring to your attention some of the discrimination, bias, and unrealistic provisions in the proposed Social Security Amendments of 1970, H.R. 17550.

Among the discriminating aspects of the bill are:

1. Physical Therapy is the only profession in which the customary fee for service is being eliminated.
2. Physical Therapy is the only profession that is not allowed to exercise their professional knowledge and business ingenuity in treating patients and collecting for services on a justified and reasonable basis.
3. Physical Therapy is the only profession that a limit is placed on the number of patients to be treated and the number of treatments to be given regardless of how badly it is needed in and indicated in a case.
4. Physical Therapy is the only profession which a monetary and economic ceiling is placed regardless of how many individuals are involved, or regardless of how many hours or days are spent in treating patients.

This bill is also biased because—

1. It infers that Physical Therapists must be dictated to in a free society.
2. It implies that Physical Therapists should receive only a fixed amount for service regardless of how good the program is or how many people are involved in giving the service.

3. It denies the Physical Therapist the same degree of latitude on treating patients and developing good quality programs as it does other professions.

4. It denies our aged and disabled the quality and quantity of treatment that other citizens enjoy.

The unrealistic inference in this bill includes such factors as:

1. It is contrary to the American system of fair and equal opportunities for both the Physical Therapist and many of the citizens who badly need our services.

2. It limits and denies individuals the same opportunities and privileges in a free and interprising system.

3. It raises questions as to its legal and constitutional validity.

4. It could greatly deny individuals equal rights to a bodyhood both professionally and economically.

It is my feeling that the above points should be considered carefully and positive provisions made to eliminate their inadequancies.

In addition, the enclosed materials show our organization, individuals employed, and the facilities we service. It would be a grave error to deny our aged, ill, and disabled the opportunity to continue to benefit from services of this caliber on a basis less than would be indicated.

We will be happy to appear before your committee for any further discussion or explanation on any points, or to assist in any capacity you might deem necessary.

It is my sincere hope that you and your committee will carefully consider the points mentioned above and that a fair, equal, and beneficial provision for all Americans be implimented.

Sincerely yours,

CHARLES H. HALL, *President.*

PROFESSIONAL THERAPEUTIC SERVICES, INC., DAYTON, OHIO—PERSONNEL LISTING

PROFESSIONAL STAFF

B. V. Clemons L.P.T., 2076 Fountas Drive Apt. 44, Columbus, Ohio 43220; Medicenter/Columbus, Columbus, Ohio.

Hilda Gray L.P.T., 790 Canoby Place, Apt. 2A, Columbus, Ohio; Medicenter/Columbus, Columbus, Ohio.

Walter Gilbert L.P.T., 956 Berkeley, Columbus, Ohio; Madison County Nursing & ECF, London, Ohio.

C. H. Hall L.P.T., 3603 W 3rd Street, Dayton, Ohio 45417; Grandview Hospital, Dayton, Ohio.

James H. Hawkins L.P.T., 1102 Salem Avenue, Dayton, Ohio 45406; Washington Manor North & South, Dayton, Ohio.

Jacqueline H. Steele L.P.T., 617 Foulke Street, Cincinnati, Ohio 45220; Medicenter/Cincinnati, Cincinnati, Ohio.

Glynn L. Washington L.P.T., 849 Olympian Circle, Dayton, Ohio 45427; Grandview Hospital, Dayton, Ohio.

PHYSICAL THERAPISTS UNDER CONTRACT (DATE DUE AND WHERE ASSIGNED)

1. Lynn Allen, University of Illinois Research Hospital, Chicago, Illinois; October 1970, Columbus.
2. Douglas G. Dewey, University of Colorado, Denver, Colo.; September 1970, Dayton.
3. Joel A. Lamore, University of Colorado, Denver, Colo.; September 1970, Columbus.
4. John Orban, University of Pennsylvania, Philadelphia, Pa.; October 1970, Columbus.
5. John Van Horn, University of Colorado, Denver, Colo.; September 1970, Dayton.

SUPPORTIVE STAFF

1. Hattie H. Angel, 144 Cordell Avenue, Columbus, Ohio.
2. Flora Chattman, 107 Oxford Avenue, Dayton, Ohio.
3. Margaret Devlin, 1740 E. Fulton Street, Columbus, Ohio.
4. Ruby Ford, 1589 Kent Street, Columbus, Ohio.
5. Ty Ann Harris, 618 Upland Drive, West Carrollton, Ohio.
6. Marti Ironside, 3380 Valleric Arms Drive, Apt. D, Dayton, Ohio.

7. Billie Johnson, 3920 Cornell Drive, Apt. E, Dayton, Ohio.
8. Mary Johnson, 865 Gettysburg Ave., Apt. E, Dayton, Ohio.
9. Anne H. Levine, 445 Jefferson Avenue, Urbana, Ohio.
10. Rosella McGee, 2672 McCutcheon Road, Columbus, Ohio.
11. Jessie E. Phipps, 1205 Bryden Road, Columbus, Ohio.
12. Herbert A. Riley, 6709 Tussine Road, Reynoldsburg, Ohio.
13. Margaret Smith, 1822 Kent Street, Columbus, Ohio.
14. Judy Tilton, 2425 Pinegrove Drive, Dayton, Ohio.

FACILITIES BEING SERVED

	Bed capacity
Grandview Hospital, Dayton	366
Washington Manor North (ECF), Dayton	130
Washington Manor South (ECF), Dayton	180
Crawford Convalescent Center, Dayton	88
Medicenter/Columbus (ECF), Columbus	141
Medicenter/Cincinnati (ECF), Cincinnati	248
Madison County Nursing and ECF, London	100
Total	1,253

BOARD OF SUPERVISORS,
COUNTY OF LOS ANGELES,
Washington, D.C., July 21, 1970.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Washington, D.C.
New Senate Office Building,

SIR: The Los Angeles County Board of Supervisors has authorized me to inform you of its action on H.R. 17550. The attached resolution, adopted by the Board, indicates the Board's reasons for taking this position on this particular legislation.

The Los Angeles County Board of Supervisors serves as the executive and legislative head of the largest and most complex County government in the entire United States. It is charged with the responsibility of representing over seven million people, a population greater than any other county in the nation and exceeded in population by only seven states.

Vital services provided to citizens by Los Angeles County include law enforcement, judicial administration, property assessment, tax collection, public health protection, public social services, flood control, water conservation, fire prevention, disaster and civil defense, air pollution control, animal control, inquests, military and veterans affairs, schools, roads, libraries, parks, beaches, hospitals, botanical gardens and museums.

In addition to providing vital services to its unincorporated areas, the County offers contract services to its seventy-seven incorporated cities.

Because of the size of its population and the vital functions performed by the County of Los Angeles for its citizens, the Board of Supervisors has asked that you take into consideration its position regarding this legislation.

Very truly yours,

JOSEPH POLLARD,
Legislative Consultant.

MOTION BY SUPERVISOR ERNEST E. DEBS

The Senate Finance Committee is considering H.R. 17550, a bill passed by the House of Representatives, which would amend the Social Security Act.

Provisions in this legislation would change the percentage of Federal medical assistance for in-patient and out-patient care.

The Federal percentage for out-patient care would be increased by 25%, and the Federal percentage for in-patients, after the first sixty days of care, would be decreased by 33⅓%. Current Federal percentages in each case are 50%.

These changes, if enacted, could result in a loss of Federal money to the Los Angeles County Department of Hospitals between $1.5 and $2.0 million annually.

Therefore, I move that the board:

1. Adopt a position in opposition to provisions in H.R. 17550, which would lower the percentage of Federal medical assistance for in-patient care after the first sixty days of care; and

2. Instruct the Chief Administrative Officer to notify the following persons of the Board's position through Mr. Joseph Pollard:

The California Congressional Delegation,
The Senate Committee on Finance.

NATIONAL ASSOCIATION OF
INSURANCE AGENTS, INC.,
Washington, D.C., July 23, 1970.

Senator RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The members of The National Association of Insurance Agents are deeply concerned about the proposal in the captioned bill seeking to repeal the Workmen's Compensation Offset provision enacted in 1965, which placed a maximum of 80% of average wage on combined benefits.

The proposal, as presented, would authorize payment of Social Security disability benefits in addition to Workmen's Compensation up to 100% of an employee's average wage.

In our considered opinion, such a change would not be in the best public interest for these principal reasons:

1. It would result in a disabled employee receiving a higher net income than he did while working. since income and social security taxes would not have to be paid.
2. It would discourage incentive for rehabilitation.
3. It would result in the freeze of Workmen's Compensation benefits in the various states at current levels.
4. It would adversely affect many injured workmen who rely on Workmen's Compensation alone because they are not entitled to Social Security disability benefits.

We sincerely urge the Senate Committee on Finance to eliminate the proposal under consideration and to retain without change the present provision for coordinating Social Security disability benefits with Workmen's Compensation, subject to the ceiling of 80% of an employee's average wage.

Respectfully,

HAROLD EUSTIS,
Chairman, Casualty Committee.

THE HAMILTON COUNTY CHIROPRACTIC ASSOCIATION,
July 21, 1970.

Hon. RUSSELL B. LONG,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: As secretary of the Hamilton County Chiropractice Association I want to ask for your support and cooperation in having the bill amended for the inclusion of chiropractic in medicare that is now in the Senate finance committee. As you probably know we had over 100 congressmen from the various states including three from the great State of Ohio who, at the request of thousands of citizens, were going to introduce such legislation in the house. However a handfull of men kept this needed legislation from even getting to the floor by holding it in committee with a tie vote. We understand however that the senate can amend this legislation and yet include chiropractic.

The issue and concern of federal aid in the health service field for both the indigent and aging, as delinated under title 19 (medicaid) and 18 (medicare) of the Social Security Act as you are aware, has been brought into sharp and commanding focus. Inadequacies have been encountered, abuses has been uncovered and controversies have arisen with intensity. As a result both the needy and the senior citizens are being deprived of the full privileges intended. We of the chiropractic profession stand appaled and in woeful amazement at such events of the immediate past year as:

1. Political medicine, through it's lobby, has evidenced a totalitarianism that would subjugate all deliberations relating to health care to its officious prejudice and arrogant authority.

2. Yet concurrently, contrary to the professed self-styled highmindedness, a large segment of the practicing membership of the medical profession as well as the institutions representing it, have conducted both a deception and a gouge in the exercise of the economic privileges and responsibilities assigned them in the Medicade and Medicare programs. The allied pharmaceutical industries also participated in the excess. As a result, the Federal Government in its medical aid and care programs are facing an ethical and economic crisis.

3. In conduct of covering-up a face saving mechanism, these people are now purporting that inclusion of chiropractic services in the medical aid and medical care programs would stagger the already unimaginable cost. Nothing is much further from the truth and fact. Chiropractic services accomplish as much or more than certain clinical areas as do medical services, but certainly at much less cost. How can this statement be defended, you may ask? The answer is simply because chiropractic fees are lower, medication costs are eliminated and inpatient hospital and clinical services are avoided and the high cost of surgery is not a confrontation. It is a fact that chiropractic services often obtain results in cases which under medical attention would require hospitalization and surgery.

4. The so-called study of chiropractic made by the *ad hoc* committee and its' advisors and the subsequent reports by the past secretaries of H.E.W., was fixed and simply represented the prejudicial opinion of a group, totally medically oriented and aligned. It would appear completely inconsistent with democratic processes to privilege one competitive profession to define the quality and merit of another despite any purported sophistications.

5. If Congress, if the Department of Health, Education, and Welfare, truly desire to serve the people, let an investigation be made at "grass-roots level". Determine to what extent chiropractic services are being utilized; determine whether this form of therapy has evidenced benefit in certain types of ailments; interrogate the senior citizens to determine whether they really do or do not wish to experience the right to select chiropractic services under the medicare privilege. Do not simply take the word of a modicum of their medically affiliated leaders whose attitudes are completely slanted. Let the members of this committee understand and comprehend chiropractic in terms of the role that it should define in the healing arts of the world and then determine whether the chiropractic profession measures up to the role. Why should chiropractic educations always be compared with medical educations? How can the delineated knowledgeabilities of one profession prescribe for another profession? Have we in our American society no more room for the new and evolving? Have we become enslaved to the totalitarianism of "locked-in" educational concepts?

6. Today there are statutes regulating the practice of chiropractic in forty eight states. Only Louisiana and Mississippi have failed to legally acknowledge the status of chiropractic. Are we to assume that the past legislative bodies of these forty eight great states were unwise, incompetent people, who in irresponsible manner permitted licensure status for quackery and clinical deception? Why is it that patients continue to come to doctors of chiropractic, get results even after having received the best of medical care without avail? Is it because chiropractors are such good mesmerists, or is it because they forbodingly practice black magic? Or could it be that within the radii of their clinical disciplines, they render a rather singular and definitely beneficial service? If chiropractors represent dishonesty they should be weeded out; if they portray clinical effectiveness, heritage commands the privilege of fair play.

There are approximately 500 practicing doctors of chiropractic in Ohio. On an average they will receive and treat 25 patients a day, a relative large percentage of whom are approaching or already are of the medicare age. Are they to be denied these services they have by self-decision sought, simply because a medical lobby has declared it unscientific? Medicine, when it seeks to set up legal safe-guards of practice and avoid vulnerabilities of lawsuits, frankly admits that it is not an exact science. We sincerely ask you to deliberate these facts and then act as you see fit.

Be certain of our respect. Be certain of our very good wishes.

Very sincerely,

RICHARD P. BURGUN, D.C.,
Secretary.

SOUTH JERSEY CHAMBER OF COMMERCE,
Pennsauken, N.J., August 5, 1970.

HON. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: The South Jersey Chamber of Commerce, representing the business community of South Jersey, would like to take this opportunity to express its views on H.R. 17550 currently being considered by the Senate Finance Committee.

The Chamber supports the five per cent increase to Social Security recipients effective January 1, 1971.

We also favor the "exempt earnings" provision and would increase exempt earnings from $1,680.00 to $3,600.00 annual. After the $3,600.00 figure is earned, $1.00 in benefits should be withheld for every $2.00 earned.

The organization opposes the automatic cost of living increase. Historically, Congress has legislated Social Security benefits to keep them ahead of inflation and no doubt will continue to do so when the need has been established and the ability to finance the increase is determined.

The proposed methods of financing the automatic benefit increases is astronomically high and devoid of all practical business sense. It is our contention that tax rate increase is not justified now. Any further benefit increases should be financed by increasing the tax rate on a figure as close to $7,800.00 per annum as possible.

The Chamber opposes the Workmen Compensation and Social Security offset.

We sincerely hope the Senate Finance Committee will give consideration to our views on 17550.

Respectively yours,

LEROY S. THOMAS, *President.*

STATEMENT BY TRUMAN D. WELLER, DAYVILLE, CONN.

SUMMARY

Effect of earning additional income upon retirees between 65 up to 72 who are eligible for social security benefits.

Measurement of amounts available should use by *spendable income.*

Reasons for retirees working:

a. To make up loss of diminishing purchasing power of the dollar on the return from fixed income pensions.

b. Opportunity to buy items and services of a non-necessity character which would otherwise be unattainable.

c. Means of mental and physical stimulation.

Current inequities of social security program kill initiative and incentive:

1. Tendency to limit earnings to the amount which is exempt from forfeiture of social security benefits.

2. The inconsistency of a worker obtaining greater total spendable income by earning less.

3. The inequities which arise from the narrow monetary advantages gained by the person who works and forfeits all or part of social security benefits, compared with the individual who only collects the benefits.

4. The part of the retirement or earnings test which limits earnings by salary or wages in a single month unless benefits are forfeited.

5. Restrictions of the retirement test to the self-employed retirees and handicaps to the operation of his own business.

Remedies in addition to correction of the five points listed above:

1. Need of a steady escalation of total spendable income as the result of each increase in earnings.

2. Removal of the repressive features of the retirement or earnings test.

If not by correction of the above, then there are two remedies:

1. Eliminate the restrictions on all benefits after 65, or

2. Reduce the age to 70 or 68 for removal of restrictions,

Among the advantages of eliminating restrictions is the economy through reduction of paper work and the expense of investigative procedures.

Correction of these weaknesses of the social security program are in keeping with the 10th point in the Bill of Rights for Older Americans.

STATEMENT

To the Senate Finance Committee:

This statement has been prepared for you in connection with your consideration of H.R. 17550.

It is submitted by one who loves this land and believes in the basic principles which helped to make this country so great. Our forefathers worked under a system which brought greater rewards in the way of earnings as they created ideas, applied themselves and developed greater productiveness. In the handling of social security, I see procedures which are diametrically opposed to these basic principles.

I am particularly concerned about a minority group of wage earners and self-employed who are over 65 and eligible for social security benefits. Nearly 2.6 million, they are between the ages of 65 and up to 72, yet they are a small part of the 13 million retired workers receiving old age benefits.

My experience in retirement started three years ago when upon reaching the age of 65 I entered the field which has been described as "statutory senility". In the 36 months since mandatory retirement, I have accepted social security benefits in 14 months and I have forfeited the benefits in 22. Earned income during those 3 years has been both through salary and self-employment. The larger share of the income has come through my own initiative in self-employment.

Throughout this time I have had an opportunity to observe at first hand what I feel can be inequities and injustices which a recipient of social security encounters in trying to earn additional income.

One of the fundamentals for judging or comparing the amount available to the retiree is expressed as "spendable income". This is earned income plus the amount received from social security benefits less the total of federal income tax and the social security tax. The remainder is the net amount that is available for whatever use may be determined by the retiree. Spendable income is the crux to the net income problem of the aged, yet I find practically no mention of it in books on retirement or among social security material.

I am convinced that the initiative and incentive to thousands of elderly Americans is being killed as the result of rules and regulations which are badly in need of an overhaul. Recent legislation amending the social security law and the reforms to the Federal income tax are working towards making the problem even more acute. One example is the new low income allowance in the tax reform for 1970 which makes it more desirable for a retiree receiving benefits to earn an income of $4,000 or less.

This raises the question why should an individual over 65 want to work and attain additional income? First, is the constantly diminishing value of the retirees' purchasing power of the dollar. The one way that he can recoup this loss from his fixed pension or return from savings is by capitalizing upon the experience and skills of his earlier years. Second, it is a means of buying some of the "happiness" articles or services beyond the necessities. Finally, is the belief that this is a means of physical and mental stimulation which is recognized by many authorities as important to the aged.

Today there is still a reflection of the attitude which prevailed in the 1935 depression years when social security became law. That is encouraging older people to get out of the job market in order that the younger could be employed.

The tendency to hamper earnings of those over 65 is seen in the rules and regulations which prevail in the administration of the social security law. Many of the procedures are so complicated that it is difficult for people at ages both under and over 65 to comprehend. In the years of mandatory retirement it is frustrating to those who would like to earn additional income, even with jobs available.

An article which I prepared under the title of "Disincentive Plan—The Social Security Law Discourages Retired Folk From Working" was published in the June 8, 1970 issue of Barron's Weekly and was reprinted in the Congressional Record of July 14, 1970 (see pages S11254–S11256). Five points were developed which, in my opinion, cause unfairness and are detrimental to persons between the ages of 65 to 72:

(1) The tendency to limit earnings to the amount which is exempt from forfeiture of social security benefits. As a result, when recipients approach the ceiling, they are inclined to quit work for the remainder of the year. Unfortunately, there is little general knowledge on the part of the majority of social security beneficiaries that they may currently receive half benefits on earnings in the

$1,200 range between $1,680 to $2,880. Little is understood or has been done to disseminate information as to total spendable incomes.

(2) The inconsistency of a worker obtaining greater total spendable income by earning less. Why should a person earning $3,600 annually have more spendable income than an individual making $4,800?

There is nothing more dampening to an individual's spirit or incentive than to find that by working harder and earning more, the recipient will have less spendable income at the higher earnings figure. This year the disparity between the $3,600 bracket and the $4,800 will even be greater because the earner in the lower range will be relieved of the income tax be paid in 1969, as the result of the 1970 low income allowance.

(3) The inequities which arise from the narrow monetary advantage gained by the person who works and forfeits all or part of social security benefits, compared with the individual who only collects the benefits.

It is ironical that the retiree who works at a narrow margin of spendable income at the end of the year compared with the non-earning individual is contributing revenue to the federal government in the way of income and social security taxes. However, the person who lives only on the benefits is entirely a source of expense to the government.

(4) The part of the retirement or earnings test which limits earnings by salary or wages in a single month unless benefits are forfeited. An individual may receive benefits of $180 a month, yet if he earns $140 currently, he forefeits the benefits for that month.

What is the effect upon the retiree? First, he would be short $40 that month on his income. Second, he probably would not know that at the end of the year he would receive an adjustment on the total of his annual benefits.

(5) Restrictions of the retirement test to the self-employed retiree and handicaps to the operation of his own business. The most hampering and restraining regulations fall upon the individual between the ages of 65 up to 72 who wants to develop ones own business. At a period when every bit of time and energy is needed in sparking the new business, one finds themselves restricted by the number of hours they can work without forfeiting benefits.

The rules say that a person who spends more than 45 hours a month in his business is considered as rendering "substantial service". If less than 45 hours, then the service would not be substantial unless one is "performing highly valuable services, such as management of a sizable business, highly skilled work, etc. Less than 15 hours of service in a month is never considered substantial", according to the material issued by the Social Security Administration.

So the recent retiree desiring to start a business of his own finds he risks the loss of social security benefits in addition to the commitment of time and risk of expenses in starting the project. The path of the oldster who has started his own business before retirement is much easier, because of the foundation which has been laid. But recognition must be given to the fact that many under 65 in salaried positions, involving travel and other responsibilities, are not able to carry on the extra effort required to start a new business before retirement.

There is a philosophy that one might work hard one month and make a sizeable amount and collect social security benefits the next three or four months while taking it easy. This from a sound business standpoint is not realistic. Anyone who wants to build a business knows that they have to consistently keep working. Unfortunately, the present method of handling benefits for the self-employed is not geared for steady and consistent building of a business.

Yet the development of small business on the part of retirees has genuine advantages to the retiree's home business community. The money spent for business expense turns into additional sales for the local filling station, the office supply store, the post office, furniture dealer and suppliers of other materials. Likewise, in the service lines this means additional bank deposits, office and store space, work for sign painters, transportation facilities, along with sanitary, promotion, advertising and legal services. Of this I speak from personal experience these past 3 years.

The retirement test for the self-employed is definitely unrealistic. Limitation of time is impractical in business. Can you imagine a salesman stopping in the middle of a sales presentation because his time had run out and he would lose his benefits for that month? That is—if he were to faithfully report that he had gone over the prescribed time. According to the social security representatives, selling time is measured from the time one leaves his place of business until his return. Isn't it possible that the self-employed might meet with unavoidable delays in getting back to the office beyond ones control?

The rules on benefits for the year apply to the first $1,680 being exempt and the next $1,200 is subject to a one dollar deduction for each two dollars earned. The said part is that few retirees are aware of this. They are under the impression, they will lose all of their benefits if they don't quit for the balance of the year.

What are the remedies for the glaring weaknesses which currently exist in the operation of the social security program?

First, is the need of a steady escalation in total spendable income as the result of each increase in earnings. This gives incentive for the worker to go ahead in giving full attention and interest to the work he is doing. It means that as his productivity increases he will reap the reward of this work through greater total income.

The escalation in spendable income is provided by H.R. 17550, as well as the proposal for reforms in the social security system made last fall by President Nixon. This is done by eliminating the ceiling under which there is a one dollar reduction in benefits for every two dollars earned.

Second, is the removal of the repressive features of the retirement or earnings test. This would avoid having to take a possible loss during a month when earnings exceed $140 and benefits over that amount are sacrificed. The measurement of the worker's effort is expressed when it is recalled that $140 represents 87 hours at the minimum wage of $1.60 per hour. This means that the worker limits himself to less than an average of 22 hours per week. At more skilled work the hours of work would be considerably less

Under self-employment the worker is limited to a maximum of 45 hours during the month or on the average of less than 10 hours a week. One who is considered as a skilled worker can be limited to an average of 3½ hours per week.

The worker who exceeds the earnings limitation for a single month or in self-employment works more than the prescribed hours within a month does not necessarily lose all of his benefits. But he does have to give them up for that particular month or for several months. He is penalized because he has tried to earn some income and may have to wait until after the close of the calendar year to have his account analyzed and the proper adjustment made. This is a distinct hardship to the person whose income has been reduced in retirement and who has established a budget based on social security benefits being received monthly.

Up to now the retiree between the ages of 65 up to 72 has received little relief from his frustrating plight. Isn't it about time that this group be recognized? After all there are 2.6 million of them.

If some solution can't be offered otherwise, then a solution can be found by eliminating the earnings and retirement test entirely. Or even lower the age to say 68 or 70 when the total exemption takes place.

These are some of the favorable factors which would result from lowering the restrictive guidelines:

(1) There would be added incentive to earn more income. The artificial impediments to initiative and incentive would be removed.

(2) The federal government would gain additional revenue through added federal income and social security taxes as the result of encouraging more earned income among the elderly.

(3) The present temptation to evade the restrictions of the retirement or earnings test would be eliminated.

(4) The huge amount of paperwork incurred by the Social Security Administration in obtaining annual and monthly reports by those whose status has changed would have been removed.

(5) The burden of investigative work in connection with the tests by the Social Security Administration would be eliminated.

Today's restrictions of the retirement or earnings test and the inequities covered in this statement are a festering sore to those eligible for social security benefits but who wish to make additional income.

The tenth point in the Bill of Rights for Older Americans, under Title 1 of the Older Americans Act passed in 1965 and extended in 1967 calls for "the free exercise of individual initiative in planning and managing one's own life for independence and freedom".

As time goes on and benefits are increased, the pressure will become greater to correct the injustices covered in this statement. I respectfully submit to this committee that now is the time to meet the issue and correct these problems.

Sincerely,

TRUMAN D. WELLER.

SOUTHERN REHABILITATION SERVICES, INC.,
June 9, 1970.

RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SIR: I am a registered Physical Therapist in Oklahoma City, Oklahoma employed by Southern Rehabilitation Services, Inc. The organization I work for provides physical therapy for all certified extended care beds in the Oklahoma City and Norman, Okla. area.

On May 21st, the House of Representatives passed Bill #17550, Social Security Amendments of 1970. There were many changes in the Bill in regards to Medicaid and Medicare as it relates to physical therapy services. It is my opinion that certain interpretations of Section 254 of the Bill could be detrimental to our profession and to our goal of providing physical therapy services for the extended care facilities of the Oklahoma City area.

Mr. Royce Noland, Executive Director of the American Physical Therapy Association, will appear before your committee in the near future. He will outline the views of the practicing physical therapist concerning Bill #17550. I support his views and would appreciate your active voice on this important matter.

Sincerely yours,

LINDA ERDMAN, R.P.T.

NATIONAL ASSOCIATION OF PHYSICAL THERAPISTS, INC.,
Fairlawn, N.J., August 8, 1970.

HON. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: As per your request, I am herewith outlining the views of my Association in regard to Bill HR 17550, relating to its Section 254, "Physical Therapy Services Under Medicare". We do support this Bill which grants physical therapy services by a qualified physical therapist to Medicare patients in their home or in the private office of the State licensed or registered physical therapist.

Our reasons for supporting this Bill are as follows:

1. It removes a bad system in which at present a Medicare patient must be placed in a hospital and if warranted followed in a Convelescence Center in order to receive prescribed physical therapy. This practice raises the cost of treating the Medicare patient with needed physical therapy tenfold.

2. Or, the Outpatient Medicare patient can be referred through present referral agencies. Then there is an added cost factor (to maintain the agency) because of the patient being reviewed by other disciplines within said agencies and for bookkeeping involved. It has always been our opinion that the referring physician's diagnosis and prescription is being evaluated by an ancillary group (of the agency) who cannot be regarded as peers of the referring physicians. Only the physician is capable of writing the diagnosis and treatment and the physical therapist the right to assist the physician with his evaluation and physical therapy treatment. There has never been a need for the expensive and wasteful middleman. The Veterans' Administration has utilized private physical therapists on direct payment for years and never experienced difficulty.

3. At long last, physical therapy and physical therapists will be recognized as the Allied Medical Profession it is, thereby permitting direct payment as other licensed professions under Medicare. At long last, the monopoly of only granting contracts to a chosen few will be eliminated and patients and physicians will choose their private therapist who has served the community so ably through the years. At long last, a system of pyramiding charges in order to receive physical therapy (an important medically prescribed treatment in the care of the geriatric patient) will be removed.

It is our view that if HR 17550, with Section 254, is adopted by Congress, the $100 presently proposed for Physical Therapy, will prove to be a great asset in reducing present total hospital Medicare costs. This $100 should therefore be increased thereby fighting illness outside of the hospital when the case so permits.

To a member this Organization supports Bill HR 17550, with Section 254. We beseech you, as the Honorable Chairman of the Senate Finance Committee, to recommend its passage by the Senate for this Bill outlines quality medical care with greater efficiency which will result in lowered costs.

Sincerely yours,

PATRICK TROTTA, B.S., R.P.T.,
President.

(The following communication was forwarded to the committee by Hon. Hiram L. Fong, a U.S. Senator from the State of Hawaii:)

HAWAII MANUFACTURERS ASSOCIATION,
Honolulu, Hawaii, July 13, 1970.

Hon. HIRAM L. FONG,
Senior Senator From Hawaii,
Washington, D.C.

DEAR SENATOR FONG: Members of the Hawaii Manufacturers Association are concerned over some provisions of H.R. 17550 (Social Security bill) now being considered by the Senate Finance Commitee, and will likely come to the floor soon.

In view of the recent 15% increase in benefits, we do not favor an additional increase at this time. And, we have specific concern over the proposed change in the traditional concept of paying a maximum of 80% of the injured person's average wage while recuperating.

It is unfortunate, but today a growing number of individuals prefer not to work. If the House bill as sent to the Senate is approved, injured workers will receive 100% of their average wage while away from the job. Tax benefits resulting from this type of income make it profitable to remain disabled. It removes the incentive to rehabilitation and recovery. This is just another way in which inflation grows.

Your considerable influence in halting the flood of legislation which not only increases the cost of American production but further removes the incentive for higher productivity, will be greatly appreciated.

Sincerely yours,

ROY J. LIFFINGWELL,
Executive Vice President.

OFFICE OF THE MAYOR,
BOROUGH OF BETHEL PARK,
Bethel Park, Pa., September 11, 1970.

Senator RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: The plight of a majority of our nation's twenty-five (25) million Senior Citizens is rapidly reaching crisis proportions. These men and women, who have contributed so much to our country's progress during their productive years, are seemingly being pressed further away from the affluence which they helped to create. It is indeed a tragic paradox, and one that should cause a great deal more concern than we are now exhibiting, that so many of our people are spending their twilight years in near-poverty conditions.

The answer to this problem is not an easy one. It cannot be solved by stop-gap meeasures, or ministered to by rhetoric. Revisions in the existing Social Security Law must be those changes which will afford its recipients a fuller and more humane treatment under that law. As lawmakers, you and your colleagues must now recognize that action on this matter can no longer delayed by procrastination or worse, by partisan politics.

While the entire spirit and application of Social Security must eventually become subject to total revision, there are a number of areas that deserve immediate concern. They are as follows:

(1) Automatic "cost of living" increases in Social Security benefits, based on raises in the national cost of living index. Such a feature is absolutely necessary, particularly during those periods of inflation which we are now experiencing. It is inconceivable that we should offer so large a segment of our population a rigid, fixed income and then expect it to be sufficient while prices rise. Our Senior Citizens must pay just as much for food and clothing as those who

are employed. As you well know, however, they are not the beneficiaries of any income adjustments. This proposed "escalator clause", one that responds to the national cost of living index, would greatly reduce or eliminate such a disparity.

(2) Our citizens should be permitted to build maximum retirement credits by age 60. Incorporation of this feature would serve two (2) purposes—it would allow those who wish to retire with full benefits the right to do so, enabling many of our people to better enjoy the fruits of their working years while they are able. It would also create greater employment and advancement opportunities for the younger members of our society, by permitting more frequent openings for their skills, by virtue of early retirements. In other words, full Social Security benefits at age 60 would act as a positive inducement to those of that age in the age in the labor force; by expediting their voluntary retirement, a double benefit would insure to both ends of the labor force, those just entering and those about to leave.

(3) Increasing the supplemental earning limit from $1,680.00 annually, to $4,800.00 annually. One of the most unfair features of the existing Social Security law is that which penalizes a man or woman who is capable of augmenting their Social Security income. Such a feature not only deprives the recipient of badly needed money, but it also causes the loss of pride and self-sufficiency at a time when such qualities are needed most. It is most degrading and humiliating for an able bodied man or woman to discover, late in life, that those qualities of hard work, self assurance, and independence are no longer needed by a Society they have served so long and so well.

(4) Increase payments of medicines and other pharmaceuticals from the present level of 80% to 100% of their cost. A majority of those people now receiving Social Security do so because it is their only source of income. They are totally dependent upon that income, as well as all corresponding benefits, for their health and well-being. Would it not seem essential then to assume that total payment of medicines would also be an integral part of those benefits? If a recipient of Social Security must depend upon help under this law, he or she should be afforded the best protection possible—and not merely partial coverage.

(5) Increase the present burial allowance from $255.00 to at least $500.000. This portion of the Social Security law, while it may seem insignificant in terms of total dollar expenditure, presently represents one of its more inhumane features. It is totally inconceivable that anyone would expect burial expenses not to exceed the current allowance of $255.00, while many of our Senior Citizens have made provisions for their funeral and burial expenses, there are nonetheless a great many who can do little more than look to a pauper's grave as their final resting place. Such a dismal prospect should not cloud the final days of so many of our people. The present limit can and must be increased to at least $500.00 if for no other reason than the peace of mind it may afford those who wait.

These are but a few of the defeciencies in the existing Social Security law that must be changed now. There is simply no justification for a nation that possesses so vast an array of technological expertise, to allow its Senior Citizens to spend their remaining years in the shadows of poverty, humiliation, and despair. I urge you to consider these features—they are important to those who have kept faith with our great land—men and women who only ask now that we do not break faith with them. We are not giving them anything—they have earned it.

Sincerely,

P. J. PAGE, *Mayor.*

STATEMENT OF LOUIS STULBERG, PRESIDENT, INTERNATIONAL LADIES' GARMENT WORKERS' UNION (AFL-CIO)

On behalf of the 435,000 members of the International Ladies' Garment Workers' Union in the United States and Puerto Rico I welcome this opportunity to make known to your Committee our views on H.R. 17550. To our members—80 percent women—and their families, this is legislation of major importance. They look to and depend upon the social security-medicare program for health and well being in their retirement years, for income in the event long-term disability precludes gainful employment, for protection of their dependents in event of death and for aid in meeting the skyrocketing costs of medical care.

The Social Security Act has been a major force in bettering the quality of life in our nation for over 30 years. It stands as an accomplishment we can all be proud of. But it must be continually modernized and improved in order to

keep pace with the national needs. Benefit levels are inadequate and need improvement. Inequities that have been exposed in the system must be corrected. The burden of medical costs borne by the elderly needs to be lightened. Existing benefit financing, largely regressive in nature, needs modification.

We are therefore glad to see your Committee undertaking a review of the present Social Security legislation, H.R. 17550, passed by the House on May 21, 1970 and now bfore you, does, of course, contain many worthwhile features. Yet it also has a number of obvious shortcomings. The analysis that follows will review how well H.R. 17550 measures up to the nation's needs.

INCREASE IN BENEFITS

H.R. 17550 calls for a 5 percent increase in old age, survivors and disability benefits effective January 1, 1971. This is a step in the right direction but regrettably an exceedingly small step. Such an adjustment would not even correct the level of benefits for the erosion caused by intervening increases in the prices of goods and services that must be purchased by the system's beneficiaries. Nor would it correct the appalling situation of many beneficiaries whose benefits will remain much too small and force them to live in the direst poverty. No recognition is given to the fact that the nation's ability to provide a better living standard for the beneficiaries is steadily improving.

Social security benefits play a most crucial role in sustaining their recipients. Most of them, as shown by a recent Social Security Administration study, derive very little income from any other source: [1]

> About one-fourth of the beneficiary couples and two-fifths of the nonmarried beneficiaries had no money income but their benefits, or less than $300 per person in 1967. Most of this group that relied so heavily on benefits had less than $150 per person in income other than benefits. . . . Some of those with more in other income had only public assistance payments, receipt of which involves application of a means test.

Thus, in the absence of any other significant income, the level of social security benefits determines the quality of life of the beneficiaries and whether or not they will live in dire poverty. It is unfortunate that existing benefit amounts—even after the 5 percent increase called for by H.R. 17550—fall short in the main of what is needed for a most modest livelihood. This becomes apparent when one considers the level of existing benefits:

$64 a month minimum benefit for a single retired worker or a widow
$96 a month minimum benefit for a retired couple
$112 a month average benefit for a single retired worker
$101 a month average benefit for a widow
$194 a month average benefit for a retired couple

The insufficiency of these benefits, even after allowance for a 5 percent upward adjustment, stands out sorely when these amounts are contrasted with budgetary requirements for retired persons computed by the U.S. Bureau of Labor Statistics [2] or with the "index of poverty" originally devised by the Social Security Administration and subsequently updated by a federal interagency Committee.[3]

The Retired Couple's Budget for a Moderate Living Standard compiled by the Bureau of Labor Statistics provides a sound basis for judging the adequacy of social security benefit levels. It provides a modest but adequate level of living which enables a retired couple to maintain a healthful, self-respecting existence and permits them to participate in the life of their community in accordance with current American standards. Even though it does not represent an "ideal" American way of living, this budget, after adjustment for intervening price increases, would have required an average retired couple to have an annual income of $4,535, i.e. $378 a month, in June 1970. A single retired person on the same basis would have had to have an annual income of $2,490, i.e. $208 a

---

[1] Lenore E. Bixby, "Income of People Aged 65 and Older: An Overview from the 1968 Survey of the Aged", in Social Security Bulletin, April 1970.

[2] U.S. Bureau of Labor Statistics, "Retired Couple's Budget for a Moderate Living Standard, Autumn 1966" (Bulletin 1570-4) and "3 Budgets for a Retired Couple in Urban Areas of the United States, 1967-68" (Bulletin 1570-6).

[3] Mollie Orshansky, "Counting the Poor: Another Look at the Poverty Profile", Social Security Bulletin, January 1965; "Who's Who Among the Poor: A Demographic View of Poverty", ibid., July 1965; "How Poverty Is Measured", Monthly Labor Review, February 1969. Data for 1969 were published in U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 71.

month. The average social security benefit, however, falls shockingly short of providing anywhere near this modest living standard.

The inadequacy is even more glaring when one realizes that current benefit amounts fall short of the level below which the poverty status of individuals is beyond question. At the core of this "index of poverty" devised by federal authorities is the "economy food plan" designed by the Department of Agriculture for emergency use by families temporarily short of funds, one which calls for purchasing and meal planning skills possessed by only a few individuals. Even this rock-bottom budget required an elderly couple to have an annual income, after adjustments for intervening price increases, of $2,323 i.e. $194 a month, as of June 1970. In the case of single persons over 65 the needed income was $1,852 per year, i.e. $154 per month. Thus, the existing benefit levels, even after a 5 percent raise, would still fall far short of the poverty level!

These data clearly demonstrate that far more substantial benefit improvements are in order than those called for by H.R. 17550. It is for this reason that we urge your Committee, and through you the Congress of the United States, to increase existing benefits by not less than 30 percent. This increase should, of course, also apply to beneficiaries aged 72 or over, now in receipt of special payments under the law. At the very most, this increase could be split in two parts, with part of the increase effective January 1, 1971, and the balance a year later. This is the only way we can bring benefits into line with current needs. This is the only way we can hope to reduce the supplemental public assistance payments now being paid out due to the meagerness of existing benefit standards.

To this end, it is also essential to substantially raise the minimum benefit, a matter neglected by H.R. 17550. The proposed 5 percent increase in this minimum—from $64 to $67.20 a month for a retiree aged 65 or over is shocking in its deficiency, particularly in view of the fact that those with the lowest social security benefits have the smallest amount of income from other sources. Since most of those receiving minimum benefit amounts or near such minimums have incomes so far below the levels of poverty as identified by the federal authorities, the matter is one of highest priority. For this reason we urge that minimum benefits be raised to $120 a month for a person retiring at the age of 65 and, in addition, $60 for his over-65 spouse. This adjustment should be accomplished over a period of not more than 2 years.

AUTOMATIC ADJUSTMENT OF BENEFITS

H.R. 17550 provides for an annual readjustment of benefit levels whenever the Consumer Price Index rises by at least 3 percent from the date of the previous benefit adjustment. While we are in agreement that benefits should not be eroded by intervening price increases, we do not believe that the proposed formula is sound. Even after the improvement in benefit standards that we recommended, the benefit structure would not be ideal. But even if benefits were set at a level of complete adequacy, their future correction solely in line with the subsequent price changes would make them lag, within a relatively short period, behind the living levels attained in the United States in the wake of rising income levels due to improved technology and rising productivity. Social Security beneficiaries would thus be increasingly kept out of the mainstream of American life. For this reason, periodic correction made solely on the basis of changes in the Consumer Price Index is not adequate. Adjustment of benefit levels should be based either on changes in the per-capita incomes of the American people or on changes in average wages and salaries in the United States. In the alternative, as an approximation to the above measures, benefit levels could be corrected in line with changes in average taxable payrolls between the first quarters of respective years, as is proposed by H.R. 17550 with respect to the contribution and benefit base and the earnings limit for the retirement test. Still, the Congress should, as a matter of policy, review periodically the benefit structure even if automatic adjustment is provided for in order to assure that whatever inadequacies that may exist or develop are corrected.

WIDOWS' AND WIDOWERS' INSURANCE BENEFITS

We endorse the provision in H.R. 17550 granting widows and widowers who become entitled to benefits after reaching age 65 a benefit equal to 100 percent of the deceased worker's retirement benefit. Similarly we support the proposal to provide widows and widowers retiring between the ages of 62 and 65 a higher percentage of the deceased worker's benefit amount than the present 82.5 percent.

Widows are particularly disadvantaged in our society. "Many of the 5.6 million women beneficiaries without husbands were widows, often past 73," reports the 1968 Survey of the Aged.[4] "Their OASDHI benefits were low, they seldom worked, and they had little retirement income in addition to OASDHI. As a result, half of them had total incomes below $1,300 and only 1 in 10 had as much as $4,000. One in 10 turned to welfare agencies for cash support." These findings are also echoed by the task force study of the Senate Special Committee on Aging, which found that 6 out of every 10 women living alone had incomes that fell below the poverty line.[5]

In this connection, we urge your Committee to recommend that disabled widows, disabled widowers or disabled surviving divorced wives qualify for the receipt of benefits irrespective of their age instead of qualifying only after they reach the age of 50 as is provided under the existing law. It is in the public interest, it seems to us, to do so when individuals are totally disabled and not able to work.

MODERNIZATION OF THE RETIREMENT TEST AND BENEFIT COMPUTATION

H.R. 17550 would enable social security beneficiaries to earn from employment or self-employment as much as $2,000 a year without loss of benefits. Benefits would be reduced by $1 for each $2 earned in excess of $2,000 with a further proviso that benefits would not be reduced in any month in which earnings do not exceed $166.67. The proposed amendments thus update the provisions of the present Act which enable beneficiaries to supplement benefits by working. The provision for a higher amount of earnings permitted before benefits are affected in part or in full, as well as the elimination of the dollar-for-dollar reduction now in the Act, are sound and equitable. The elimination of the latter test is particularly desirable since income from employment is subject to federal, state and local income taxes, social security contributions and other payroll reductions, while benefits are not; consequently, under the existing dollar-for-dollar test, and older worker's income after the various deductions is lower than what he gets in the form of benefits while not working. This anomaly is corrected by H.R. 17550.

H.R. 17550 properly eliminates an inequity in the present law which sometimes lowers the amount of social security benefits a retiree can collect in the year of his 72nd birthday when earnings after the age of 72 reduce benefits payable earlier in the same year. However, the bill fails to make a similar correction for persons under 72 in the year of their retirement when pre-retirement earnings may reduce social security benefits payable later in the same year. This anomaly should be corrected by the Senate.

The House bill also provides automatic bi-annual adjustments in the amount retirees can earn before suffering a reduction in their benefits. This is to be done proportionately to the changes in the first quarter's average taxable earnings, and is a fairly satisfactory approximation to the formula recommended in this statement for adjusting benefit amounts in proportion to changes in average per-capita income of the American people or in average wages and salaries. It deserves Senate approval.

H.R. 17550 wisely eliminates the inequity of the present Act which computes benefit amounts differently for men and women, as a result of which men's benefits are lower than women's even when their past earnings were identical. The bill changes the method of computing benefit amounts and shortens the computation periods for men to the standard now used for women and thus, quite properly, eliminates an inequity for men already retired or those who will retire in the future.

Unfortunately, however, another important flaw in benefit computation remains. The present formula, while disregarding earnings in the 5 lowest years, is affected by years of low earnings in the early years of work experience as well as by those later in life when the worker may be jobless because of ill health or otherwise. A much sounder approach is to gear benefit levels to the earnings in the more representative years in the individual's work history, such as the highest 10 out of the last 15 years immediately preceding retirement.

---

[4] Lenore E. Bixby, op. cit., p. 3.
[5] U.S. Senate, Special Committee on Aging, "Economics of Aging: Toward a Full Share in Abundance", March 1969, p. 14.

DISABILITY BENEFITS AND EARLY RETIREMENT

H.R. 17550 provides a number of welcome improvements in benefits in the case of disabled persons. Childhood benefits would be payable to children becoming totally disabled between the ages of 18 and 22; eligibility for the blind would be liberalized; social security benefits payable to recipients of workmen's compensation would not be reduced unless they exceed the worker's average earnings in the 5 best years of prior consecutive employment; benefits that otherwise could have been collectable by a disabled person prior to his death would be paid to his survivors. These are worthwhile improvements that should be adopted.

There is another problem that deserves attention. A number of workers become too ill to work after they reach the age of 50 but before they attain 65, and find it impossible to obtain any work either because of their age, their health, occupational changes or inability to adapt. Yet at the present time they would not be entitled to receive disability benefits under the Act as long as work that they could perform, in theory if not in fact, can be found "anywhere in the national economy". The test for disability is much too severe and needs to be modified to qualify workers who become disabled after age 50 and who no longer can perform in their usual occupations.

In fact, the functioning of our economic system forces greater numbers to seek early retirement. This is evident from the fact that despite the low level of basic benefits, a large proportion of retirees choose to avail themselves of the early retirement provisions of the Act through this means even lower benefit amounts for them. There is no question that this situation is the aftermath of the great difficulties older workers encounter in obtaining work once they are displaced in the wake of technological changes or other economic developments. Serious consideration must therefore be given to lowering the retirement age to at least 60 and to providing more moderate reductions in the early-retirement benefit rates than exist at the present time, even if these do not fully conform to actuarial standards, in order to meet a real need.

MISCELLANEOUS AMENDMENTS PERTAINING TO RETIREMENT

H.R. 17550 contains a number of additional provisions which we believe the Senate should support. These include improvement in wage credits for persons serving in the Armed Forces for the period of such service; extension of coverage, elimination of benefit cut-backs due to early retirement when individuals qualify for higher benefits after age 65 on the basis of a different entitlement; elimination of the support requirement for divorced wives; guarantee that no family would have its total family benefits decreased as a result of an increase in the insured person's benefit; and imposition of penalties for furnishing false information to obtain social security numbers.

LUMP-SUM DEATH BENEFIT

We hope that in its consideration of H.R. 17550, the Senate will deal with a provision left untouched by the other body.

From its inception, the Act provided for the payment of a lump-sum benefit to cover burial expenses of a deceased worker in the amount of 3 times the deceased's monthly benefit rate. The upper limit on such payments, despite increased funeral costs, remained unchanged since 1954, at $255, even though it was periodically raised prior to that time. We recommend that the maximum limit on funeral expenses be removed and that lump-sum death benefits be computed solely by tripling the amount of the primary benefit rate. Even the highest lump-sum death benefit under this formula would fall short of actual funeral costs that have to be met by the survivors of the deceased person.

MEDICARE AND MEDICAID

The enactment of Medicare for the aged and Medicaid for individuals with low income is an historic and highly beneficial advance in the social insurance field. Nevertheless, serious gaps and problems exist in this field. Costs of hospital and doctor care have been skyrocketing. The amount of deductibles, the premiums and the cost of co-insurance under the Medicare program have increased substantially and may rise even higher. Thus the monthly premium for Medical Insurance has been increased from the initial $3.00 to $5.30 in a short

span of 4 years. Many medical expenses of the aged are not covered, such as prescriptions outside the hospital, dental care, eyeglasses etc. (in fiscal year 1968, the Medicare program covered only 45 percent of the medical costs of the aged; the individuals themselves, or their families, paid for 30 percent of the total and the remaining 25 percent was a drain on other public agencies).[6] The low incomes of the aged simply do not permit them to make the necessary medical care expenditures without causing undue sacrifice.

Coverage under the Medicare provisions of the Act also falls short of the existing needs. No protection is offered for dependents of elderly persons and they have to meet these medical expenses out of their meager incomes. At the same time individuals under age 65 are not covered by Medicare even when they qualify for disability benefits despite the fact that they have to meet medical costs and even though they are in no position to augment their pensions by taking on employment.

The financing of Medicare also leaves much to be desired. Financing of Medical Insurance by voluntary contributions after age 65 places an onerous burden on the aged worker at a time when he is least able to afford it. We therefore hope that the Senate would provide financing of both Hospital Insurance and Medical Insurance by contributions over the working life of potential beneficiaries.

Any new program, no matter how well planned, is likely to permit a number of unforeseen problems to come to the fore. Medicare and Medicaid are no exception. H.R. 17550 seeks to deal with a number of these. Thus, it seeks to eliminate the possible duplication of benefits whenever this might arise, extends time for enrollment or filing claims, permits reimbursement of Medicaid expenses incurred within a limited period of time prior to filing of formal application for benefits, allows use of hospitals outside the United States in special emergencies, enables dentists to make hospital referrals whenever needed for dental treatment, provides the same rules for recovery of overpayments made to a deceased beneficiary under Medicare as now exist under other provisions of the Social Security Act, and extends coverage to persons over 65 who do not otherwise qualify for Medicare Hospital Insurance though unfortunately at a cost many potential beneficiaries would not be able to meet (something that the Senate may hopefully remedy).

The House bill also makes a worthy effort to limit rising medical and hospital costs for services rendered under Medicare by permitting the termination of payments to suppliers guilty of program abuses, by limiting payments to customary charges when these are lower than so-called "reasonable charges", by tightening rules to prevent improper admissions to hospitals, by preventing improper reassignments of claims to benefits, by modernizing the reimbursement formula to the states in case of Medicaid and by subsidizing states for installation and operation of claims processing and information retrieval systems. The Senate, however, will hopefully make certain that limitations on reimbursement of costs to states or individuals should not be utilized to increase the financial burden to the patients. Otherwise, the very intent of the program would be defeated if this were to take place. It is also essential to prevent continued escalation of medical service costs by providing for their rendition on a contractual basis spelling out negotiated fee schedules.

An important improvement in the present Act, easing the burden on older persons, is the provision of H.R. 17550 which enables the federal Hospital Insurance and Supplementary Medical Insurance Trust Funds to pay the insurance premiums to private or public health maintenance organizations for future services to be rendered Medicare beneficiaries under both parts A and B. There is no similar provision under the present Act for part A of Medicare. The proposed amendment, sound in principle, takes advantage of the existence and growth of group prepayment practice and its ability to provide improved hospital and medical care in a more efficient way. Hopefully the proposed amendment would encourage further growth of such plans. To assure that this does take place, it is essential that H.R. 17550 be strengthened by requiring that group prepayments under Medicare be limited to non-profit health maintenance organizations. Such organizations should be guaranteed a payment of at least 95 percent of the cost that would be incurred in providing the particular services by other than the health maintenance organizations. In the case of new group

[6] Dorothy P. Rice and Barbara S. Cooper, "Medical Care Outlays for Aged and Non-aged Persons, 1966–1968" in Social Security Bulletin, September 1969.

plans, in order to stimulate their establishment, the reimbursement should equal 100 percent of such costs over a limited number of years. However, the health maintenance organizations should be required to spend whatever excess income they derive from such premiums over their costs to provide services not now furnished under Medicare. Thus, while the Trust Funds would save money compared to the costs that would have been incurred if health maintenance plans were not utilized, a further extension of health care protection to the elderly would be fostered.

There are a number of provisions in H.R. 17550 which call for substantial modification. The bill would permit the states to impose flat deductibles or co-payments on some items of health care or services presumably because they are provided in large part at the patient's initiative. Even though in some cases such payments might check the utilization of unneeded services, their primary impact would prevent many of the indigent from receiving the care they need because of inability to meet even modest flat costs. The trend should be towards the elimination of deductibles and co-payments in all cases, including services rendered under Medicare, and *not* in the opposite direction. We hope that the Senate will correct this situation. Any cost limitation which forces the patient to go without essential medical services because he cannot afford the deductibles or co-payments is self-defeating. Similarly, if he cannot afford to purchase prescribed medicinal drugs while out of the hospital, the medical services rendered under part B of Medicare are rendered impotent. It is hoped, therefore, that the Senate will, while reviewing H.R. 17550, move towards elimination of all deductibles and co-payments and arrange for Medicare to meet the cost of prescription drugs while patients are out of the hospital. Also, we hope the Senate will take the initiative bypassed by the House of Representatives to extend the protection of Medicare to those on social security rolls who draw disability benefits while under the age of 65. At the same time, federal standards for hospital and medical care should be gradually developed in accordance with a specific mandate to be provided by statute.

Although Section 1903(e) of the Medicaid statute, according to the Report of the Ways and Means Committee of the House of Representatives on H.R. 17550, induced the states to move more rapidly in the direction of expanding Medicaid programs, only 28 states have so far adopted the joint federal-state programs to assist the medically needy. It is shocking, therefore, to find that H.R. 17550 seeks to remove that particular incentive from the Act. If anything, the provisions should be strengthened by additional inducements for all states to improve Medicaid programs to broaden federal standards for the operation of state programs and thus lessen the wide variations that now exist in the participating states. The desirable alternative would have to be a complete federalization of the Medicaid system, uniform everywhere.

In the hope of improving the use of Medicaid services, H.R. 17550 introduced disincentives for long patient stays in hospitals or nursing homes by reducing the amounts by which the federal government matches state outlays, and provided added incentives for out-patient and home health services by increasing the allowances payable to the states for such purposes. However laudable the objective, it would have a most unfortunate impact on persons in need of long-term treatment. Confronted with a reduction in matching grants, states are prone to eliminate some of the unavoidably essential institutional care for long-term patients. Obviously other solutions than those proposed by H.R. 17550 have to be sought to reduce unnecessarily overlong institutional confinements.

H.R. 17550 bars appeals from carriers' decisions in Medical Insurance cases involving under $100. This would unfortunately permit non-governmental agencies to act both as judge and jury in such cases without giving a fair hearing to the claimant. Even if the amounts are small, appellants should not be denied this right and hopefully the Senate will see to it that they are not.

The complexities of the Medicare-Medicaid program and the large number of individuals not now protected by such insurance programs suggest that the time may be at hand to consider the enactment of a system of national health insurance. The outlines of such a program are contained in H.R. 15779 introduced by Hon. Martha W. Griffiths. We commend this bill to your attention.

FINANCING

H.R. 17550 proposes to finance the improved benefits by increasing the contribution base to $9,000 per year to be automatically raised bi-annually proportionately to increases in average first quarter's taxable payrolls, and proposes a

modified schedule of contribution rates for the coming years both for Old Age, Survivors and Disability Insurance and Hospital Insurance.

Unfortunately, the proposed modifications are inadequate inasmuch as they leave a substantial fraction of covered payrolls outside the pale of taxation. At the time social security system was first introduced in 1938, only 3 percent of covered workers earned more than the maximum taxable under the law, the objective being to provide substantially total coverage. At the present time the corresponding coverage of taxable earnings would require the adoption of a contribution base of at least $15,000.[1] The adoption of this amount as the contribution and benefit base would assure the needed funds and would equalize percentagewise the burden currently imposed on lower-paid individuals with that borne by those in the higher income brackets.

In any case, it would bring the ceiling closer into line with current income patterns and assure more adequate protection for persons covered by the social security system. At the same time it would not require the promulgation of increases in contributions currently planned for 1975 and thereafter—the $15,000 contribution base and its bi-annual automatic readjustment would yield the needed additional funds. The federal government, however, should also help to finance the social security system out of general revenue, as is already done in some portions of the program. The amended Act should provide for increased government contribution until it is responsible for one-third of the total cost. Such federal contribution out of general revenue would go a long way towards alleviating the regressive effect of the present financing method and help finance Medical Insurance under Medicare over the working life of covered persons (as is presently done for Hospital Insurance).

IN CONCLUSION

Your Committee has before it a monumental task. The improvement and modernization of the social security system is a vital responsibility. Americans with few other resources look to this program to maintain their health and well-being. H.R. 17550 offers a useful starting point for the necessary updating. We hope that our comments will assist the Committee in the development of sound legislation.

STATEMENT OF NATHAN T. WOLKOMIR, PRESIDENT, NATIONAL FEDERATION OF FEDERAL EMPLOYEES, ON OPTIONAL SOCIAL SECURITY COVERAGE FOR FEDERAL EMPLOYEES

Mr. Chairman and Members of the Committee, My name is Nathan T. Wolkomir, I am President of the National Federation of Federal Employees, which is the first and largest of the independent general organizations of Federal employees with members in virtually all Government departments and agencies world-wide. For over 50 years the NFFE has been promoting the welfare of Federal employes and the public interest.

The Committee is holding hearings on social security legislation including House Bill, H.R. 17550. The National Federation of Federal Employees strongly favors legislation having for its object the granting of optional social security coverage for Federal employees. While H.R. 17550 does not include this provision, during this session and in the past sessions of Congress a number of bills have been introduced providing for such optional coverage. We thank the Committee for affording us the opportunity to submit our views on this matter. Mr. Chairman, we are grateful to you and to the members of the Committee for the interest manifested in this whole subject of social security as evidenced by these hearings.

The Social Security System does not generally cover Government employees although certain state, county and municipal employees are given social security coverage and this is also true of employees working in Federal Reserve Banks and in Federal Credit Unions. Likewise if a member of the uniformed services of the United States performed active duty in 1957 and thereafter his military

---

[1] Social Security Bulletin, October 1968, p. 25, shows that the percentage of covered workers with annual earnings in excess of $15,000 amounted to 2.1 percent of their number in 1966. Between 1966 and 1969, however, total wages and salaries in the private economy rose 27.8 percent, while employment increased 7.6 percent (Survey of Current Business, July 1970, p. 39), indicating a nearly 19 percent rise in per-capita wages and salaries. The likelihood is great therefore that in 1970 the percentage of covered employees' earnings in excess of $15,000 a year is apt to be greater than 3 percent.

service counts toward social security protection for him. Social security credits may be also given under certain circumstances for active duty performed after September 15, 1940 and before 1957. It is discriminatory not to permit all Federal employees to elect social security coverage when the above-mentioned groups of individuals are covered under the Social Security System. In each of the situations mentioned above the individuals also are covered under other pension systems.

In our daily contacts with our members throughout the country, we find a very deep interest in optional social security coverage for Federal employees. Indeed, we know of few employment issues of greater interest to Federal workers and their families than this. They feel that a Federal employees should be allowed to elect social security coverage if he so desires. Federal employees can see no sound reason for denying them such coverage. Employees in the private sector have social security coverage and company pension plans which provide them with retirement benefits. Why not the Federal employee? The Federal employees are the largest group of employees, in fact the only large group, without social security coverage.

Mr. Chairman, in addition to these daily contacts with our members in which their interest in this matter is so manifest, this widespread interest and concern also has revealed itself in very concrete form in resolutions adopted by our Locals and then introduced at our national conventions.

For many years, such resolutions have been introduced in large and growing numbers. For example, at our last national convention, held in St. Louis, Missouri, in September of 1968, there were over 25 resolutions on this one subject alone, all urging optional Social Security coverage for Federal employees.

For the information of the Committee, and for the record, I am attaching to this Testimony, as Exhibit A, the text of the master resolution (No. 180) dealing with this issue which was unanimously adopted by that convention. It will be noted that this resolution cites the rationale and the precedents for such action, proposes joint employee-Government contributions, and recommends that the two systems be maintained separate and distinct throughout.

The NFFE urges the enactment of legislation to provide optional social security coverage for Federal employees separate and apart from the Civil Service Retirement System. We would like to stress this point of keeping the Social Security and Civil Service Retirement Systems separate and apart and without merger or interrelation between the two Systems. Our organization sponsored and secured enactment of the original Sterling-Lehlbach Retirement Law passed in 1920 and has worked unremittingly for improvement in the Civil Service Retirement System since that time.

Under the legislation proposed in various bills Federal employees would be permitted to elect social security coverage. The social security contribution or tax from the Federal employee's salary would not be matched by the Federal Government. The Federal department or agency would simply withhold this contribution or tax from the employee's salary. The coverage would be at no cost to the Government. While the NFFE would go along with such provision we would prefer that the employee and the Federal Government contribute to the coverage. In other words, we would not like to see the employee carry the total load of the contribution or tax.

We have noted that the Social Security Administration has expressed opposition to the proposal to accomplish what we believe would be very significant and progressive broadening and improvement in the law, namely, by providing optional coverage.

The Social Security Administration's chief objections on this can be reduced to a single word: Cost. But we do not believe that is a valid or meaningful objection since we see no reason either in logic or in actuarial factors why the question of cost can not be met quite adequately by a reasonable approach with respect to fair and acceptable payments by employees and Government. We find specious the contention that this very large group of employees should be singled out for exclusion from Social Security coverage because their inclusion would mean very minor adjustments administratively and actuarially.

With respect to the Social Security Administration's contention that the overall program would suffer from so-called "adverse selection" from the Federal employee group, we regard this as setting up a palpable straw man. It is our view, based on many years of intimate contact with the aspirations of career Federal employees, that the overwhelming majority of all of these workers would in practical fact elect the optional coverage. Moreover, the Social Security Ad-

ministration has adduced no hard evidence to dispute this view and simply rests upon that very general statement of curbstone opinion. Our position is based upon direct daily and extensive contacts with Federal employees at the grassroots. There is no doubt whatever, based on this evidence plus the proof afforded by scores of resolutions on the subject adopted by our Locals, State Federations, and National Conventions, that the great bulk of all employees would elect the optional coverage. Adverse selection simply would not be an issue.

Mr. Chairman and Members of the Committee, on behalf of the National Federation of Federal Employees, I wish to express our appreciation for your very active and constructive interest with this and other related matters pertaining to the Social Security System. It is our hope that legislative actions on optional social security coverage for Federal employees will be forthcoming soon. Many Federal retirees not only live on less than subsistence incomes but resort to food-stamp programs to survive. Present Federal employees who will be future retirees should not have to look forward to this kind of an existence. They should be allowed to elect during their working careers optional social security coverage to supplement their civil service annuities.

Again, Mr. Chairman, I express my thanks to you and to the members of the Committee for the opportunity to state the views of the National Federation of Federal Employees.

EXHIBIT A ATTACHED TO TESTIMONY OF NATHAN T. WOLKOMIR, PRESIDENT, NATIONAL FEDERATION OF FEDERAL EMPLOYEES

TEXT OF MASTER RESOLUTION ON OPTIONAL SOCIAL SECURITY COVERAGE FOR FEDERAL EMPLOYEES, ADOPTED UNANIMOUSLY BY NFFE NATIONAL CONVENTION, ST. LOUIS, MISSOURI, SEPTEMBER, 1968

RESOLUTION 180

(Optional Social Security Coverage)

Whereas, Under the Federal Retirement System, most employees upon retirement, or employee survivors, will receive an annuity inadequate for their needs; and

Whereas, Private enterprise retirement programs are in addition to Social Security coverage and many city and state governments have, in addition to their retirement program, made available optionally the benefits of Social Security; and

Whereas, Military personnel enjoy the privilege of joint participation in their retirement system and the Social Security System; therefore be it

Resolved, That the NFFE continue to sponsor legislation to provide Federal employees the option of full coverage under the Social Security System, in addition to and separated from the Federal Retirement system, by joint contributions by employee and the Government.

STATEMENT OF THE AMERICAN RETAIL FEDERATION

The American Retail Federation is a national organization which, through its 50 state and 28 national trade association affiliates, represents more than 800,000 retail establishments across the country.

The American Retail Federation wishes to make four points in connection with amendments to our social security system now being considered:

1. The American Retail Federation supports an increase in the Old Age Survivors and Disability Insurance (OASDI) benefits to the extent that it can be accomplished without increasing social security taxes.

2. The fiscal integrity of the three separate trust funds must be maintained. The proposed bill, H.R. 17550, would accelerate the Hospital Insurance rate by more than 17 years. The Federation submits that vigorous supervision must be given to the Health Insurance system in order to prevent drastic rate acceleration.

3. The American Retail Federation supports the principle of liberalizing the retirement test so as to enable retired workers to earn more than $1,680 a year without being severely penalized by reductions in benefits.

4. The American Retail Federation is opposed to an automatic increase in OASDI benefits or wage base levels, tied to either the cost-of-living index or wage levels, respectively.

BENEFIT INCREASES

The major objective of social security is the prevention of destitution for a substantial majority of the aged. Old age benefits are intended to provide a foundation, on which savings, insurance, or private pensions can be built for retirement. Social Security was never intended as a total substitute for private savings or private pension plans.

The Federation recognizes that due to increases in the cost of living an upward adjustment in benefits is necessary from time to time. The Federation supports an increase in benefits that actuarially can be supported without increasing taxes. We supported the 15% increase enacted into law on December 30 of last year. In doing so Congress provided benefits nearly half again as large as was necessary to make up for increases in the cost of living. Despite this, H.R. 17550 would provide an additional 5 percent benefit increase payable next January 1. This results in combined increases on nearly 21 percent within a 1-year period, which as substantially above the erosion in benefits that has resulted from inflation since the last increase in 1968. The practice of bunching increases of this magnitude back to back will, in the long run, lead to further substantial increases in the tax burdens that must be imposed.

The members of the Federation urge, therefore, that Congress should give serious study to the economic impact of a payroll tax on the economy. These taxes cannot be increased ad infinitum. A payroll tax is not an inexhaustible mine. It has limits beyond which it should not go. And, according to many, the progression in the present law now is close to, or may even exceed that limit.

The Federation is seriously concerned with the remarkably large acceleration in the hospital insurance segment of the tax. The hospital insurance system must be vigorously supervised so that drastic rate increases are no longer necessary.

RETIREMENT TEST

The American Retail Federation supports increasing the retirement test so that a retired worker may earn more than $1,680 a year without being penalized by a reduction in benefits. H.R. 17550 would raise this figure to $2,000.

The retirement test was, originally, intended to keep retired workers out of the labor market. It was born in a depression period with substantial unemployment. Economic conditions have changed since then, and it is socially and economically desirable to keep workers in the labor force, particularly those with advanced skills.

Retailing is particularly interested in this provision, since many retailers have found that retired workers make excellent part-time employees to help take care of the daily and seasonal peaks in business. The difficulty has been that these employees are forced to quit, after a period of employment, in order to avoid benefit reduction.

AUTOMATIC COST OF LIVING INCREASES

The members of the Federation are opposed to AUTOMATIC COST OF LIVING INCREASES. The key word is "automatic." Retailers do not oppose periodic reviews of the benefit structure by the Congress nor do they oppose periodic adjustments to bring benefits up to cost-of-living increases under some circumstances. The objection to the automatic adjustment is based on the fact that an upward adjustment might be made no matter what had caused the increase in the Cost-of-Living Index. For example, drastic increases in medical and hospital costs would not affect retired workers receiving old age benefits as much as if the increase were caused by increases in food prices, since they have the protection of medicare. If the increase in benefits were not automatic, Congress could consider the factors which caused the index to rise, and determine whether an adjustment was necessary or not.

STATEMENT OF ASSOCIATED OREGON INDUSTRIES, INC., SUBMITTED BY KARL FREDERICK, MEMBER RELATIONS DIRECTOR

Gentlemen, Associated Oregon Industries, Inc., is the primary representative of business and industry in the State of Oregon with over 1,300 member firms. We respectfully submit the following written statement in opposition to the proposed amendments to Section 224 of the Social Security Act contained in H.R. 17550.

H.R. 17550 proposes to amend Section 224 of the Social Security Act so as to permit a beneficiary to receive state workmen's compensation simultaneously

with Social Security disability insurance, so long as the combined payments do not exceed 100 percent of his average earnings before he became disabled. In our opinion, it is a serious mistake to liberalize the 80 percent provision. Workmen's compensation and Social Security benefits are not taxable. Accordingly, a claimant receiving state and federal benefits under present law, limited to 80 percent of his former gross wages, is now receiving virtually 100 percent of his former take-home pay. If he is allowed to receive up to 100 percent of gross earnings as proposed in H.R. 17550, he could be making more money off the job than he was taking home while he was working. This clearly diminishes an injured worker's incentive to return to work. It also stifles any incentive he might have for entering a rehabilitation program and rehabilitation is the cornerstone of a sound workmen's compensation system.

Furthermore, it is our opinion that opponents to the continuation of the state ssytem of workmen's compensation are advocating this change in the law. Their goal is to abolish the state programs ultimately in favor of a national program administered under the Social Security system. Since 1936 Congress has slowly broadened the scope of the Social Security Act to embrace areas historically within the field of workmen's compensation. In that year the Act was extended to cover persons over 50 years of age who became permanently disabled, whether on the job or off. In 1960 the 50 year age limit was removed. Subsequently, attempts were made to provide disability benefits for any person who was disabled for more than six months. In 1965 Social Security disability benefits were made payable to any eligible, industrially-disabled worker who is or who can be expected to be totally disabled for a year or more after a six-month waiting period. In that same year, an amendment to the Social Security law was adopted which attempted to assure that state and federal benefits added together did not exceed 80 percent of the employee's usual pay.

The thrust of these changes is most unfortunate, as the workmen's compensation and Social Security systems have different goals and objectives. The underlying philosophy of workmen's compensation is to resolve problems arising out of work-related injury, disease and death. The approach to solving these problems also concerns safety, accident prevention and rehabilitation programs, as well as compensating an injured workman or his beneficiary. The total approach goes far beyond "cash payment" as a panacea to a complex problem. It is important that the states be permitted to retain the administration of these programs and adapt them to local conditions.

On the other hand, the Social Security system is fundamentally designed for non-workers. It is a "cash payment" approach ,touching persons who are no longer in the labor market and have no intention of returning to it. There seems to be little merit in attempting to reform the Social Security system by getting into an area more appropriately handled by the employment-related workmen's compensation system. We feel that passage of H.R. 17550 with the proposed amendments to Section 224 will be a further step away from the basic philosophy of Social Security and a definite threat to the workmen's compensation system.

STATEMENT OF THE COMMERCE AND INDUSTRY ASSOCIATION OF NEW YORK, INC. SUBMITTED BY MAHLON Z. EUBANK, DIRECTOR OF THE INSURANCE DEPARTMENT OF COMMERCE AND INDUSTRY ASSOCIATION OF NEW YORK, INC.

Commerce and Industry is not only the largest business association in New York but also one of the largest in the nation. Among its approximately 3,500 members are many corporations headquartered in New York but engaged in multi-state operations. Through its Committee on Social Security, which includes executives from leading national business organizations specializing in this field and its Social Insurance Department, the Association studies and actively presents management thinking on the federal social security program and significant social insurance issues at both national and state levels.

In December 1969 a 15% across-the-board increase in social security benefits was enacted into law (PL 91–172). Prior to that increase seven across-the-board increases had been enacted since the inception of the program and Congressional actions had increased cash benefits to 191.1% whereas benefit levels would have risen only to 151.9% if increases had been tied to the Consumer Price Index. H.R. 17550 would grant another increase of 5%.

An analysis of H.R. 17550 as passed by the House reveals provisions which are favored and others which are opposed. For the purpose of brevity we are setting out below our principal objections.

A. WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES

1. History

(a) 1956—The Social Security Law was amended to provide disability benefits for those under 65 years of age. As enacted, a disabled person receiving social security disability benefits would have such benefits reduced by workmen's compensation benefits received under a state program.

(b) 1958—Eliminated by an amendment was the provision for offsetting state workmen's compensation benefits against social security disability benefits. By this amendment a beneficiary was able to draw both state workmen's compensation and social security disability benefits for a single injury.

(c) 1965—The law was again amended so that a disabled worker who qualified for both workmen's compensation and social security disability benefits would have social security benefits payable to him and/or his family reduced by the amount, if any, that the total monthly benefits payable under the two programs exceeded 80% of his social security taxable wages.

(d) 1967—The Act was again amended which permitted a beneficiary to recover the larger of 1) the average monthly earnings used for computing his social security benefits, or 2) his average monthly earnings in employment or self-employment covered by social security during the 5 consecutive years of highest covered earnings after 1950, computed without regard to the limitations which specify a maximum amount of earnings creditable and taxable under social security.

2. Amendment made in H.R. 17550, Section 114(a)

Effective after December, 1970, H.R. 17550 amends the Social Security Act to provide that where workmen's compensation is payable, social security disability benefits will be reduced only by the amount by which the combined wrokmen's compensation and social security payments exceed 100 percent of the worker's average current earnings before he became disabled.

3. Reasons for Opposing the Above House Amendment

(a) The proposed House amendment could allow by the payment of both benefits an amount almost the same or in excess of his pre-injury take-home pay because both social security and workmen's compensation benefits are tax exempt. This would be particularly true in New York because state income taxes are quite high and in addition, New York City has an income tax law.

(b) Prevention of injuries and the restoration of those injured to useful occupations as promptly as possible is one of the major objectives of any workmen's compensation system. This is accomplished by present rehabilitation programs which this Association has supported and which the New York State Workmen's Compensation Board has consistently developed. To the extent that a disabled worker could receive in combined benefits as much or more than his pre-injury take-home pay, a strong incentive toward rehabilitation would deteriorate. It should further be noted that the 1965 social security Senate Finance Committee report stated that it was desirable to avoid the payment of excessive benefits. If the amendment were enacted, there could be a wasteful duplication resulting in unnecessary cost.

(c) The enactment of the House amendment could have an adverse effect on state workmen's compensation benefits. The attention of members of this Committee is directed to the fact that prior to the enactment of social security disability benefits maximum benefits for permanent total disability were the same as for temporary total disability. Since then 9 states have provided lower benefits for permanent total disability, the area where duplication of social security and workmen's compensation is likely to occur. These are Alaska (1959), California (1959), Illinois (1965), Iowa (1959), Missouri (1959), New York (1968), Ohio (1967), Oregon (1959), Rhode Island (1959 but difference restored 1969). In New York workmen's compensation benefits for temporary total disability were this year increased to $95 a week but persons suffering from permanent total or partial disability will receive only $80 a week. But many of these individuals are not entitled to social security disability benefits and they lose $15 a week as a result of even the current supplementary provision in the Social Security Act. In addition there would be a temptation on the part of the state to offset workmen's compensation benefits when social security disability benefits are received.

If the House provision is enacted in its present form, it could be a foot in the door for the absorption of workmen's compensation into the social security system. This is a trend that has developed in other countries. Presently there are

117 countries which have a workmen's compensation program but 70 of these are presently integrated under their social security programs. In the last 7 years there have been 14 countries which have made the change from a private insurance program to that of social insurance.

We assert that the overlap of social security into the workmen's compensation program can only be detrimental to the proper development of the latter system. Commerce and Industry Association fears that such an amendment to our program could be fatal to our present workmen's compensation program. If the workmen's compensation program is absorbed into our social security program, it would no longer constitute an exclusive system, and empolyees eventually, as in Great Britain and other countries, would have a right to bring actions at law against their employees on a liability basis. Likewise social security would not provide any incentive for safety. The absorption of workmen's compensation into the social security system would be detrimental to both the employer and employee.

B. AUTOMATIC INCREASES IN BENEFITS IN THE EVENT OF FUTURE INCREASES IN THE COST OF LIVING

An escalator clause in H.R. 17550 provides an automatic increase in benefits every time the Consumer Price Index rises at least 3 percent in the preceding year, starting in 1972.

Commerce and Industry Association opposes the enactment of the above proposal for the following reasons:

1. Automatic increases in cash social security benefits would contribute to inflationary trends that could occur when inflationary pressures are greatest.

2. The additional money coming into the system from automatic financing adjustments could put the social security program in a straitjacket and might prevent Congress from making other improvements in the program called for by future changes in our economic and social conditions.

3. Increases in the cost of social security resulting from automatic increases in cash social security benefits might discourage employers in improving present pension plans.

4. If an automatic escalator for social security cash benefits is enacted into law, we fear it might set a dangerous precedent automatically to increase interest on government bonds, where many social security beneficiaries keep their nest egg, public assistance, etc.

5. Presently Congress is exploring whether to expand the social security and other income and/or welfare maintenance programs. We point out to this Committee that everything proposed in these areas cannot be done at once. Congress in each of these areas should determine short term objectives in relation to long term and make such adjustments from time to time that are called for by change in our financial and economic situation.

Congress in the past has followed the procedure to review every two to four years the necessity of increasing cash social security benefits. Satisfactory changes have resulted by this procedure, and Congress has fulfilled its responsibility that the increases granted are in accordance with the economic and social conditions existing at those times. The Association sees no adequate or good reason why this past procedure should be changed now.

C. RETIREMENT TEST—AUTOMATIC ADJUSTMENT

The Association favors the retirement test proposed in H.R. 17550 *except that part which provides for an automatic upward adjustment of the annual exempt amount in the monthly test.* Our opposition to the automatic escalation clause is essentially the same as stated on Page 5 under the heading "Automatic Increases in Benefits in the Event of Future Increase in the Cost of Living."

D. FINANCING

The taxable wage base would be increased in H.R. 17550 from $7800 per year to $9000, effective January 1, 1971. Beginning in 1973 the maximum would be increased automatically every two years as the general level of wages rose in order to pay for the proposed increases in cash benefits provided by proposed escalation clauses. Assume that average wages in the first quarter of 1972 were up 5 percent from early 1971. Thus, by order of the Secretary of Health, Education and Welfare, the maximum annual earnings on which the tax is imposed

would be raised from the $9000 provided in H.R. 17550 for 1971 to $9600 after "rounding", the rise to take effect in 1973.

This escalating tax proposal, with adjustments determined by the Executive Branch of the government, would seem to set a dangerous precedent in future tax legislation, with Congress losing much of its control to initiate tax reforms and changes.

There is no automatic increase in the rate of the payroll tax as set out in the bill—only in the maximum earnings on which the tax is imposed. Forecasting a consistent rise, the U. S. News and World Report in its June 8 issue, estimates a taxable wage base of $18,000 by 1989. Taxes to pay for all future increases in benefits would be taken wholly from workers and their employers. The maximum tax on each the employee and the employer would rise from $468 next year to $684 in 1977 and reach $1,170 by 1989.

The escalation clauses in respect to financing raise the question at some future date whether the economy would have the ability to support the social security program at that time. It might be an undue burden on the employed members of our society and on employers who pay half the cost. In making the judgment whether an escalation clause should be enacted, consideration should be given to its effect on private pension plans, particularly those integrated with social security cash benefits, and savings. If these are adversely affected, new investment capital to finance growth and productivity would be impaired.

Since 1950 Congress has increased the taxable wage base to help pay for liberalizations in the program, thereby keeping it actuarily sound, and also to keep cash benefits more closely related to an individual's cash earnings at the time of his retirement. The proposal to raise the tax base to $9000 on January 1, 1971 currently meets neither of these objectives. Its purpose, as we see it, is to be a part of the long-range goal to provide the financing of the automatic cycle of increased benefits tied to a cost-of-living escalator.

If Congress follows our suggestion and eliminates the automatic increases in cash benefits, there is no need to increase the tax base in 1971. Undoubtedly Congress will follow the traditional pattern to review again the social security program prior to further enactments. At that time Congress can adjust the taxable wage base if it is necessary in the light of wage levels, economic and cost considerations, and any other pertinent factors.

In 1967 adjustments were made in tax rates and the taxable wage base increased to $7800. As a result of this change the social security trust funds for the fiscal year that ended on June 30, 1969 showed an excess of income over outgo amounting to about $4 billion. It has further been estimated that at the end of the current fiscal year ending June 30, 1970, the excess of income over outgo for the social security trust funds would be between $6 billion and $7 billion. The financing formula in 1967 was unnecessarily high, and we believe that any overall increases in tax rates or the taxable wage is not appropriate at this time. It is necessary this year to make changes in the tax rates applicable to the trust funds in view of the fact that the hospital insurance trust fund has a minus balance of 0.77 percent under the present law and the cash benefit trust funds appear to be over-financed. Congress should review the tax rates applicable to the trust funds and make such changes to see that all are adequately financed.

We recommend that the past practice of Congress to make the necessary changes in the social security program and the financing to keep them actuarily sound, be continued on a short-range basis.

CONCLUSION

"Mankind should slow down its social revolution to a speed that human beings can cope with." That is the recommendation of Arnold J. Toynbee, famous British historian. Man's social nature, he said, has been changing "at an accelerating rate" that alarmed him.

We are alarmed at the number of social measures that Congress has enacted into law during the past few years. It appears to us that it may be difficult for our economy to absorb them. We suggest that to prevent acceleration, Congress and the Government should slow down in enacting new legislation and at the same time make a new evaluation of old programs. If this is not done, it appears that an additional tax burden must be placed on the American public in order to carry out and supplement the purposes that led to the enactment of such legislation.

We appreciate this opportunity to submit a statement to your Committee on H.R. 17550 concerning certain of the proposed amendments to the Social Security Act.

(The following communication was forwarded to the Committee by Hon. Robert W. Packwood, a U.S. Senator from the State of Oregon:)

OREGON ASSOCIATION OF HOSPITALS,
Portland, Oreg., September 14, 1970.

Hon. ROBERT PACKWOOD,
U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR PACKWOOD: It is our understanding that the Senate Finance Committee is now considering Amendment 851 to the Social Security Amendments of 1970.

Hospital administrators are extremely concerned about this amendment and urge you to consider its effects. It would remove quality control and utilization review from the hospital staff and place it in the hands of the county medical society. The Professional Standards Review Organization which would result would have the authority, among other things, to review all physicians' and hospital medical records, and grant approval before any patient can be granted admission, except in an emergency, for all cases in which payment is made under Medicare and Medicaid.

While hospital personnel in Oregon approve of control of quality and utilization of medical care by peer review, it is believed that medical audit and utilization review are medical staff functions within the institution and that they represent physician responsibility as an integral part of management.

The concept of prior authorization for admissions is strongly opposed as a barrier to the delivery of patient care. It is actually a step backward in medical practice to establish averages to which all patients must conform either to enter a hospital or to remain for treatment.

We will sincerely appreciate your continued attention to the Social Security Amendments of 1970.

Sincerely yours,

P. D. FLEISSNER,
Executive Director.

PRELIMINARY STATEMENT BY FRANKLIN S. NUSBAUM, D.D.S.

The goals of health care in this nation should be *quality, equality,* and *economy.* The guidelines used to achieve these ultimate goals should be quality, equality, and economy. The main concern of the finance committee is the economy aspect of health care. And I am sure the committee realizes that the dollars involved in health care have an effect upon the other two, generally.

The health care problem in the United States is not an underprivileged problem, exclusively; it is not an old age problem, exclusively—it is a *citizenry problem.* (Of the first degree, I may add, socially, morally, and medically.)

What concerns me most in this issue is that there are no blueprints forthcoming from responsible individuals, groups, organizations, and associations on the health care scene (and that includes health care professionals and government representatives) that fully encompass the answers needed to remedy the health care delivery "ills" of this society.

I do believe the American public is entitled to this "visionary blueprint". Indeed, I do not know how a finance committee can perform its financial duties on either a short-range or long-range basis, without knowing where the *non-system* of health care is going in this nation. For sure, to continue along these lines that we have taken up to now, budget bankruptcy of the health care bin is assured. More important, the human being in need of health care will be the guaranteed victim.

Medicare and Medicaid can only be looked upon as a natural social response to the needs of people in the overall history of society and medicine in this country. At the same time, it has been a growing pain in the form of a thorn for those who are trying to administer and regulate these programs. The only solace that can be offered at this time of chaos, confusion, and catastrophe in all of health care for all the people is that these are "growing pains," part of the growing-up processof health care delivery in a nation that has *no system.* Accompanying the "no system" is what I personally refer to as a MEDOPOLY. (spelled M-E-D as in medicine, O-P-O-L-Y)--all together spelling, CATASTROPHE.

This nation needs at this time a national overhaul—indeed, the building anew of health care scheme that replaces the medical mess that supposedly is supposed to serve the people of this nation. Until the plans or blueprints for this future health care scheme are known, and until commitments are made to them we can only expect the same of what we have been having—but much more of it as precious time passes.

The Senate Finance Committee can take a leadership role in this challenging phase of society, and medicine. And this challenge of a new society with new medicine is not so much in terms of dollars, as it is in terms of ingenuity and execution. While the Senate Finance Committee is not charged with creating health care concepts, it does have within its power the ability to motivate, change, curb, initiate, etc. health care currents. At this time I beseech you gentlemen to act in those ways that will bring forth a national plan from the responsible sources that are charged with the care and health of the people of this nation.

Having been in the health care profession for over 15 years, having spent the last few years identifying what is going on with various segments of the health care complex (such as hospitals, third party, doctors, patients, universities of the health professions, government etc.) and having recently completed the writing of a book on this vast subject, I do feel it would be in order for me at this time to suggest at least a few points that I believe should be considered in developing a new health scheme for American society:

(1) hospitals be placed, managed and developed within the framework of a *franchise* or *quasi-public corporation concept.*

(2) the education of future doctors be available for qualified individuals on a free or nearly free basis, that such education be structured under a national plan that meets the needs of this nation's care and delivery, and that these doctors render health care within the framework of the national scheme.

(3) national health care insurance be made available to every citizen and the delivery of such care be provided within the national health delivery system.

I wish to thank the prestigious members of this committee for the opportunity of speaking *to* you on behalf of the American public and would further welcome the opportunity of speaking *with* you.

Thank you.

STATEMENT OF LOUISIANA STATE MEDICAL SOCIETY, SUBMITTED BY W. CHARLES MILLER, M.D., PRESIDENT

The Louisiana State Medical Society is vitally interested in all federal legislation which affects the health care of the American public and especially the citizens of the State of Louisiana. The Society also recognizes and agrees with the concern of the Congress and the Nation for an overall reduction in all federal expenditures. In view of this, we believe that certain provisions of HR 17550 not only adversely affect the delivery of good health care, but also will increase the cost for the delivery thereof.

The Society is particularly interested in Title II of the Bill which contains amendments relating to the Medicare, Medicaid and Maternal and Child Health Programs, and generally endorses and supports the provisions contained therein with the exception of the following five (5) sections of the Bill:

A. Section 227—Authority of Secretary to Terminate Payments to Suppliers of Services.
B. Section 224—Limits on Prevailing Charges.
C. Sections 233—Advance Approval for Extended Care and Health Care Coverage under Medicare Program.
D. Section 239—Payment to Health Maintenance Organizations.
E. Section 263—Study of Chiropractic Coverage.

I. SECTION 227—AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

Under this section of the bill, the Secretary of H.E.W. is given authority to appoint one or more "program review teams" in each State to be composed of groups representing consumers of health services, state and local professional societies, intermediaries and carriers utilized in the administration of Title XVIII benefits.

The Society strenuously opposes the establishment of such "program review teams" for the reasons hereinafter set forth.

We fully concur that the Secretary should be given authority to terminate payments made to suppliers of services based upon a false statement or misrepresentation of any material fact used in making application for such payment. Such functions are the responsibility of the intermediaries and carriers in their administration of the program. Also, there are ample federal laws which provide for criminal penalties for any person making false claims in this and all other federal programs.

For many decades, the Louisiana State Medical Society, parish medical societies and hospital medical staffs within the State have established review procedures for settling controversies pertaining to matters such as to the charges, quality and utilization of medical services. The State and parish medical societies have established procedures which provide for the settlement of any differences or disputes between physicians, physicians and their patients, and third parties. In the event such differences cannot be resolved satisfactorily on a one to one basis, the matter is then referred to the local parish medical society with a request for a review of the controversy in question. If the dispute is not resolved to the satisfaction of the parties involved by the local parish medical society, then an appeal for review may be made in writing to the State Medical Society so that the matter might be acted upon by the Board of Councilors. The Board of Councilors is the judicial authority for the State Society and is composed of eight (8) councilors elected by the House of Delegates. The Board of Councilors has the authority to dispose of the case in any appropriate manner, ranging from dismissal of the case to taking of disciplinary action.

Each hospital in the United States, under the Standards of the Joint Commission on the Accreditation of Hospitals, is required to have various committees to review the activities of the medical staff to assure that high professional standards are maintained and that the medical staffs shall participate in the peer review of all matters pertaining to patient care. These committees cover all phases of medical care and, for example, include a "Tissue" Committee which requires that all specimens removed during a surgical procedure shall be properly labeled and sent to the pathologist for microscopic examinations and diagnostic purposes. For example, if a surgeon removes several "healthy appendices", this surgeon is called before the "Tissue" Committee for an explanation thereof, and this committee may direct that henceforth, before the surgeon is allowed to perform further appendectomies, he must call in consultants to assure that the appendix is diseased and its removal is necessary.

As to how these committees operate, the following story will give a much clearer picture. Not long ago, the members of the local bar association were meeting with the medical society to discuss certain civic matters. Prior thereto, the medical society which held joint meetings with the medical staff of the local hospital held its business meeting at which time a report was made by the chairman of the "Tissue" Committee regarding several surgical cases that had been reviewed by the Committee.

The attorneys could not understand the functions of the "Tissue" Committee until it was explained that it would be like a Committee of the local Bar Association being called in to review "last will and testament" which had been prepared by an attorney for his client to determine whether or not he had fulfilled all the statutory requirements which must be incorporated in such a will. The moral of this story is that the medical profession, through its code of ethical standards, maintains a higher degree of peer review over its members than any of the other professions.

We are in sympathy and agreement with the intent of this section to assure that only the highest quality of medical services is provided and only that those medical services which are needed by the patient will be supplied. However, the establishment of such review teams as contemplated by this bill will require the use of a large amount of medical manpower to perform these administrative and fiscal review functions. This Committee is well aware that there already exists a critical shortage of physicians and such review teams will only add thereto by placing further administrative functions on the already overworked doctor.

We fully concur with the comments of the distinguished senior Senator from Utah, Senator Bennett, when he said:

"As a matter of fact, careful and detailed study has indicated that the Federal Government and its agents do not presently have the capacity to properly administer medicare and medicaid—let alone to cope with the health care needs of

millions of additional persons and reorganize the American medical care system." (Congressional Record, 7/1/70, S10509)

The adding of such program review teams to the responsibility of the Federal Government will only further emphasize the inability of the Government to properly administer these programs.

The principal purpose for the establishment of such "program review teams" is to reduce the cost of these programs. We firmly believe that they will not reduce cost, but will increase the same because, by necessity, they will require additional federal expenditures to be made covering the cost of their operation in that it will reqpuire adltional staff and other similar services to provide for ther operation. Such review teams wil greatly add to the large administrative expenses which are now being experienced in the Medicare and Medicaid Programs.

The Society firmly believes that the cost of operation of such teams will not produce savings comparable to the cost thereof. In Louisiana, the carrier for Part "B" of Medicare, under Title XVIII, for the fiscal year July 1, 1969–June 30, 1970, processed 630,754 claims and paid benefits totaling $18,614,370.00. Currently, there are approximately 2500 physicians participating in the Part "B" Program in the State of Louisiana. Of this number of physicians, there are less than 2% whose claims are being closely reviewed by the carrier in order to maintain program integrity. Less than 1% of the participating physicians either submitted claims for processing wherein the carrier thought it necessary to ask for a formal review thereof by the parish medical society, or were listed in the Report of the Staff to the Finance Committee entitled, "Medicare-Medicaid Problems, Issues and Alternatives" as having received payments in excess of $25,000 in 1968.

In listing the ten (10) physicians in the State of Louisiana who had received more than $25,000 in 1968 (Appendix B) in the Medicare-Medicaid Program, the Committee Staff did not make any comment in Chapter 7 of the Report regarding the fact that the physician expends about 35 to 40% of the gross moneys he receives for his services in the operation and maintenance of his office. Also, the Committee Staff made no comment as to whether or not the practice of these physicans consisted primarily of persons over 65 or that their practice was in a low income area. We believe that the Committee Staff was grossly unfair in reporting these physicans as having received "substantial" sums without including any comment as to either the cost of maintaining their offices or their type or area of practice. This report received nationwide publicity and since only the gross amounts received were reported without any of these major factors being included there, it presented an unfavorable image of the profession. Thus, the public was given the impression that "substantial" income of the 4,284 physicians who were reimbursed $25,000 or more in 1968 was unreasonable. (Table 3, Staff Report.) At the same time, the public was not made aware of the many thousands (more than 9,000 as of September 15, 1968) Federal employees in Grades 16, 17 and 18 whose basic annual salaries are $26,547, $30,714 and $35,505 respectively and who have no office expense or overhead.

We urgently request that the provision pertaining to the establishment of peer review teams as provided for in Section 227 be deleted and that the review of physician charges, utilization and quality of services be continued as they have been in the past. No doubt there have been and will continue to be a few providers of services who will attempt to exploit these programs as has been the practice by all groups of human being since the beginning of time. However, in order to reach this very small minority, we urge greater emphasis be given to establishing a closer working relationship on a non-contractual basis between the intermediaries, carriers and the professional organizations representing the various suppliers so that appropriate action can be taken in regard thereto. We firmly believe that the present system is most adequate and through such a close working relationship we can accomplish the same results and with greater savings of federal dollars.

II. AMENDMENT NO. 851 TO H.R. 17550

Senator Bennett, in his Amendment No. 851, proposed that "Professional Standard Review Organizations" be established for the purpose of promoting effective, efficient and economical delivery of health services for which payment may be made under the Social Security Act through application of professional standard review procedures so as to assure that such services are of appropriate quality, are provided only when necessary, and in the most economical fashion consistent with professional recognized health care standards.

For all intents and purposes, Senator Bennett's amendment expands the provisions contained in Section 227 of H.R. 17550 and spells out in greater detail the functions to be performed by the PSRO. Under this amendment, the Secretary would not only have the authority to terminate payments to suppliers of services but would also have the authority to require that practitioners and providers pay monetary penalties for failure to comply with the regulations prescribed for the operation of PSRO in an amount not to exceed $5,000. Also, the Secretary may either temporarily or permanently exclude such practitioner or provider from the program. Thus, this amendment would give the Secretary of Health, Education and Welfare the authority to establish PSRO, contract for the operation thereof, issue the rules and regulations under which the PSRO would operate and then have them to serve as the prosecutor, judge and jury of those providers brought before the PSRO.

The PSRO would review, not only medical services being provided by physicians, but also would include all providers including hospitals, pharmacies, dentists and all other health care providers. In addition to acting as the prosecutor, judge and jury with regard to services rendered by providers, each PSRO shall determine, *in advance*, which elective in-patient admissions or extended, costly out-patient courses of therapy will meet the established criteria for such admissions. The requirements placed upon the members of such PSRO under such legislation would create unreasonable limitations upon physician and would be very detrimental to delivery of good medical and health care to the beneficiaries of those federal programs.

The Louisiana State Medical Society, in a Special Session of its House of Delegates held on September 13, unanimously voiced its opposition to such organizations for the reasons as set forth above and urges that this amendment or any similar one be *not* adopted.

III. SECTION 224—LIMITS ON PREVAILING CHARGE LEVELS

Section 1842(b)(3) of the Social Security Act as enacted on July 30, 1965, provided that

"In determining the *reasonable charge* for services for purposes of this paragraph, there shall be taken into consideration the *customary charges* for similar services generally *made by the physician* or other person furnishing such services, as well as the *prevailing charges in the locality for similar services.*" (Emphasis added)

Section 224 or H.R. 17550 amends this section by adding a new sentence which defines "reasonable". Under this definition, no charge may be determined to be "reasonable" for services rendered after June 30, 1970, and before July 1, 1971, if it exceeds the higher of (i) the prevailing charge recognized by the carrier for the similar services in the same locality on June 30, 1970, or (ii) the prevailing charge level that would cover 75% of the customary charges made for similar services in the same locality during the calendar year 1969. The section further provides that after June 30, 1971, charges recognized as prevailing within the locality may be increased in any fiscal year only to the extent found necessary to cover 75 percent of the customary charges made for similar services in the locality during the last preceding elapsed calendar year beyond the levels described in clause (ii) above on the basis of the appropriate economic index data and that such adjustments are justified for economic changes.

This section of H.R. 17550 is grossly discriminatory in that it singles out one profession and, in effect, establishes price controls over that profession by the Federal Government. It is difficult to understand how the Congress can single out one group of its citizens and enact laws which will freeze, as of June 30, 1970, the customary charges of physicians furnishing services to beneficiaries of these federal programs. In other words, in the first part of this section, physician customary fees are frozen at the level prevailing in the locality on the base date of June 30, 1970.

The second portion of this section will roll back the customary fees prevailing in the locality for the various physcians so that the fees charged in any locality will only cover 75% of the customary charges made for similar services in the same locality for the calendar year 1969. For example, if in a certain locality the charges of the various physicians for an appendectomy are at five different levels, that is to say, 5% of the physicians charge $150, 30% charge $200, 45% charge $250, 15% charge $300 and the remaining 5% charges are in excess of $300, then and in that event the prevailing fee would be limited to $250. Thus, those physicians who by reason of their training, broad experience and who have

during the calendar year of 1969 charged all of their patients $300 or $350 for and appendectomy, this amendment, if enacted, would roll back the customary charges of these physicians to $250.

The Executive Branch arbitrarily made a cut off, in violation to their statutory authority under the 1965 Act, at 83%. Now, by this amendment, the Congress is setting the cut off at 75 percent and is likewise rolling back the customary fees of those physicians who have customarily charged more than 75 percent of their colleagues. Even during the height of World War II, Congress did not attempt to "roll back" the prices of commodities, services or wages beyond those established in the base period. This legislation is the rankest form of discrimination that has been, in our humble opinion, proposed to the Congress of the United States in modern times.

If the Congress, in its wisdom, determines that this Nation should have overall wage and price controls, the medical profession would gladly concur that any increase in customary charges prevailing in a locality should be tied to the cost of living index. However, to single out one profession and tie any increase of charges for services to the cost of living index is very discriminatory and unjust.

We urgently request that this Committee delete Section 224 from HR 17550.

IV. SECTION 233—ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE PROGRAM

Under the present law, post hospital extended care benefits and post hospital home health benefits are limited to Medicare beneficiaries who, while no longer in need of in-patient hospital care, still require skilled nursing home care, or in the case of home health benefits, physical or special therapy. Likewise, a determination of whether a patient requires the level of care which is necessary to qualify for extended care facilities or home health benefits cannot generally be made until sometime after the services have been furnished. We agree that there is an uncertainty about the eligibility for those benefits which under the present law cannot be determined until after the services have been rendered, and, by reason thereof, if benefits are denied retroactively, it could create a burden upon the patient.

Under the provision of Section 233, in attempting to remedy such a situation, it is placing the responsibility upon the physician to certify that, prior to the admission of a patient to such a facility, a plan must be prepared outlining the type and frequency of services that are going to be required.

We agree with the idea behind this section and the efforts to reduce the cost of the program. However, it places an unreasonable burden upon the profession to demand that physicians, before admitting a patient to an extended care facility or prescribing a home health plan, must set forth all of the pertinent facts which can be or may be presumed to be needed or necessary for this patient. The physician must take into consideration the condition and age of the patient, how he will respond to the treatments, and what effect the prescribed treatment will have on him. In other words, it appears that the Congress is attempting to make the physician practice an "exact" science when he is treating a patient whose needs include admission to an extended care facility.

This Committee is fully aware of the problems that are facing the medical profession with its professional liability insurance coverage, and that the problems resulting therefrom are increasing the cost of medical services. To protect oneself, the physician must make many tests, take every precaution to insure that he is not made a defendant in a malpractice action. Since the practice of medicine is not an exact science, no physician can guarantee the results of drugs or treatments he prescribes. However, the Congress now, if this section is enacted, is placing upon the physician a requirement that he make these determinations in advance and that these determinations will produce the desired results.

If the patient does not respond as anticipated and has an adverse effect as a result thereof, the Congress is making a "sure thing" for the patient in his claim for damages against the physician who made the certification required under Section 233 of HR 17550.

We fully agree with the intention of the Congress to save federal dollars in all its programs, however, from the experience of the medical profession, this will increase instead of reducing the cost of the program because any reasonable physician will not stick his neck out by making such a certification. For the reasons stated, we urge that this section of the bill be deleted.

V. SECTION 239—PAYMENTS TO HEALTH MAINTENANCE ORGANIZATION

The payment to such organizations is to be made from the Hospital Insurance Trust Fund and the Federal Supplementary Medical Trust Fund.

It allows payment to organizations of physicians on a prepaid and per capita basis not to exceed 95% of Secretary's estimated cost for such services, and provided that the organization's enrollment includes members at least half of whom consist of individuals under age 65.

There has been no factual evidence that prepaid per capita programs offer any economy in the costs of medical services nor has there been any clear cut evidence that the quality of care is as good as or better than that received through regular channels. In fact, were a group to be paid for medical services for subscribers, and it was noted as time progressed, that there had been some underestimation of what actual costs would be, it is only natural that persons applying later would receive restricted benefits to diminish costs, in order to arrive at a non-crippling balance. The Staff report to the Senate Finance Committee recommended that the scheduled allowances be adjusted downward. This is not conducive to quality care. Further, we feel that a salaried physician working in a group has less incentive to do in depth studies to determine the causse of ailments than in instances where there is a direct patient-physician relationship and the patient is made to feel that he is individually being cared for rather than a number in an assembly line. This lack of incentive clearly explains the statistics frequently seen that show that less surgery and less laboratory procedures are done in such organizations.

We feel that the only documentary work in this regard is just underway and will take five years until concluded. Any assumptions otherwise are premature and inconclusive and need to be relegated to pure guess work.

One of our officers contacted the office of Dr. Paul J. Sanazaro, Director of the National Center of Health Services Research and Development, seeking information concerning the relative effectiveness, including cost effectiveness, of various patterns of delivering health care. We learned that such documentary information is not yet available from any known source.

Although the alleged shortcomings of present day systems indicate that a number of solutions have been proposed and tried, no consistent method has yet been developed and proven to evaluate these proposed solutions.

It was encouraging to learn that the National Center for Health Services Research and Development had contracted with GEOMET, Inc., a well-respected research organization in Rockville, Maryland, to design a measuring stick by which alternative health care delivery systems could be specified and evaluated, also to seek a possible role for bringing industry into the system and to plan the implementation of one or more alternative systems. We have contacted GOMET, Inc. and have had an opportunity to examine the proposal under which they are persuing the above objectives (Contract No. HSM–110–69–86, the Role of Private Industry in Community Personal Health Care Services).

In validating such a measuring stick, we must make sure that it does on some limited small project first, then expand it to a larger segment. Thus far they have identified about fourteen different types of delivery of health care, including private practice, informal partnerships, single specialty partnerships, multi-special partnerships, pre-pair per capita plans, etc. In attempting to quantify various factors relating to the delivery of care by these various patterns, the measuring device as has been designed seems most practical. The measuring device has been designed, has been validated, and is now in the act of being implemented as far as getting the evidence upon which a decision can be made. It will take at least five years of experience, with digestion of the information, before any real hard conclusions can be drawn. Just as physicians have an obligation to assess new treatments and drugs that are utilized for the benefit of their patients, and are not obligated to accept without skepticism the first reports that come out on new drugs, so do medical organizations have a severe obligation to carefully assess different patterns of delivery of care before wide prescription thereof. The failure to make such an assessment is just as severe as a failure as the failure of the physician who uses untried methods on his patient. An appropriate study of this overall problem is most necessary before jumping to conclusions. Up to now, we have had so-called panaceas with all sorts of magic answers that need to be looked at carefully and without haste before delving into unproven mechanisms.

We of the Louisiana State Medical Society are vitally interested in quality care that can be efficiently delivered to the whole mass of people of the United States, and we feel, thus far, that this has been adequately attained.

For these reasons, we urge that legislative action on Section 239 be delayed until more definite information has been developed on which the Congress can determine the proper course of action to be followed in this regard.

VI. SECTION 203—STUDY OF CHIROPRACTICE COVERAGE

Section 263 directs the Secretary of H.E.W. to conduct a study of the coverage performed by chiropractors under State Medicaid plans approved under Title XIX of the Social Security Act to determine whether, and to what extent, chiropractic services should be covered under Part "B" of Title XVIII. The study is to focus on the limitations which should be placed upon such coverage and on the amounts to be paid for whatever services might be provided. The Secretary is to report the results to the Congress within two years together with his findings and recommendations.

Chiropractic has been shown to be a significant health hazard and in authorizing a study which would involve the actual payment for chiropractic services. the intent of Congress could be erroneously interpreted as actually condoning and therefore endorsing chiropractic.

This Society has submitted chiropractic to critical scrutiny for the past fifty years and has demonstrated that chiropractic as taught in approved chiropractic schools and as currently practiced represents an attempt to mimic medical practice. Additionally, it has found that the theory and practice of chiropractic are based upon invalid and dangerous principles. The application of these principlies deprives patients of a timely opportunity to reap the benefits of modern science in matters of health services. Oftentime, the delay occasioned before persons receive the proper medical care has caused serious damages and may delay or totally prevent his recovery.

In addition to many independent studies which uphold the validity of the position taken in this matter by the Louisiana State Medical Society at least three officially appointed bodies have spoken on this matter.

The report in 1968 from the Secretary of HEW entitled *Independent Practitioners Under Medicare* recommended:

"Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, is it recommended that chiropractic services not be covered in the Medicare Program."

The Report of the National Advisory Committee on Health Manpower, Volume II, dated November 1967, published in 1968, observes, "Although chiropractic is not the only existing cult, it is the only one which still *constitutes a significant hazard to the public.*" Also ". . . *the only legal issue regarding chiropractic is how best to protect the public from its dangers.*" Additionally, "The experience of the last half century which attempts to control chiropractic through licensure laws leads to the conclusion that *more effective safeguards are needed.*" (Emphasis added)

The Task Force on Medicaid and Related Programs, DHEW, in June 1970 recommended, "A legislative amendment should be enacted denying Federal financial participation in Medicaid payments to chiropractors and naturopaths."

The Louisiana State Medical Society feels that the Congress should provide for specific exclusion of any chiropractic services under Social Security legislation and urges that Section 263 of HR 17550 be deleted.

We appreciate the opportunity of presenting our views to the Committee on Finance.

STATEMENT OF HERBERT J. WEBER, CHICAGO, ILLINOIS

FULL SOCIAL SECURITY

(Partly contained in the Full Social Security Bill of 1949, S. 2337, 81st Congress)

Summary

This is a proposal to establish full social security—compensation for involuntary unemployment at the rate of 85% of previous earnings, unlimited in duration and amount, accompanied by equivalent disability, retirement, and

survivorship annuities. Where there were no previous earnings the rate would be based on the minimum wage.

This proposal provides that everyone without regard to any means test is eligible for full compensation against economic vicissitudes, unlimited in duration and amount. A democratic society does not classify its people into patricians and plebeians with acceptance of plebeian class status through a means test required for eligibility for income maintenance payments. In a democratic society any income maintenance payments are made available to everyone without the degradation of acceptance of plebeian class status through a means test.

Taxes to pay for income maintenance payments can be based on income. Income, though no factor in eligibility for receipt of payments, is part of the basis of the taxes to pay for the payments under this proposal.

Full social security eliminates the pall of individual economic insecurity. It spreads among the whole people the cost of individual losses of income from vicissitudes. It takes from everyone the continuous present fear of future economic want.

In addition to its basic effect upon individual want in bad times and individual peace of mind in good times, full social security has basic economic effects. It facilitates continuously increasing production and prevents unemployment due to deficient purchasing power or to fear of it.

Realization of world cooperation for collective security can reasonably be expected if with full social security we make it evident to all nations that unemployment and want will never drive us to militarism for reemployment and recoupment.

Dispossessing nobody, full social security is the means to active basic objectives of labor, farmers, and business alike. A means to active basic objectives of labor, farmers, and business is within the limits of political practicability.

Full unemployment compensation prevents unemployment due to deficient purchasing power or to fear of it

There must be cumulative unemployment whenever producers, knowing that layoffs are occurring, dare not produce freely for fear that their customers will lack funds for purchasing their products. The possibility of public enterprises to give reemployment is not enough to allay this fear. With full compensation for involuntary unemployment, however, layoffs do not substantially diminish the purchasing power of the workers laid off. If layoffs do not substantially diminish the purchasing power of the workers laid off, there is nothing about layoffs occurring in one industry to cause producers in other industries to curtail their production. Unemployment cannot cumulate when full compensation for involuntary unemployment is available just as bank failures cannot cumulate when adequate bank deposit insurance is available.

The social security fund would invest in bonds when its revenue was exceeding its compensation payments and would have to sell its bonds to raise money when its compensation payments were exceeding its revenue. Purchase of these bonds by the public would draw in any savings that were idle because of scarcity of safe investments. The savings so drawn in by the social security fund would immediately become purchasing power in the hands of unemployment compensation recipients. The nation's savings would thus be kept invested to the extent needed to maintain its substantially full continuous purchasing power. Idle savings could not remain idle.

There can be no material problem in administering full unemployment compensation

Full unemployment compensation involves registration for work and acceptance of suitable work. With full unemployment compensation entailing nearly full employment, there can be no material administrative problem. No one could sham involuntary unemployment when he was receiving one job opportunity after another and would have to develop a new sham every other day—a hundred eighty-three times in a year.

Taxes for full social security add nothing to the burden of taxes

Eliminating individual economic insecurity, full social security—full unemployment compensation accompanied by equivalent disability, retirement, and survivorship annuities—makes individual savings against vicissitudes unneces-

sary. Taxes for full social security are a substitute for such savings, not an added tax burden.

A 12½% social security tax should be paid by each individual on income after other taxes, from whatever source derived, with exemption of personal earnings equal to the lowest legal minimum wage for regular workers in his industry; by each employer on the part of each employee's pay equal to the lowest minimum wage for regular workers in his industry; and by each corporation on undistributed income after other taxes. Elimination of the cost of relief and charity warrants placing a portion of social security taxes upon incomes from property and business.

The social security tax rate should be studied for adequacy at periodic intervals.

Full unemployment compensation facilitates continuously increasing production

The basic economic objective that we all want to see attained is continuously increasing production of goods and services. To attain this objective we must continuously advance the efficiency of our productive technology and organization. We cannot get continuously advancing efficiency as long as increased efficiency keeps workers hostile to it by carrying the threat of income-less unemployment.

To eliminate hostility of workers to increased efficiency we must eliminate the threat to the worker's income from increased efficiency. To accomplish this we must adopt the principle that the involuntarily unemployed worker is a worker held in reserve, entitled to approximately his full previous earnings for the full duration of his availability for active duty. With the threat from increased efficiency thus eliminated, we attain a national incentive economy under which effective efforts can be concentrated upon increasing efficiency continuously.

With full social security increased efficiency leads to increased production. If any business increases its efficiency without proportionately increasing its production, it lays off some workers and adds the amount of their wages to its profits and to the wages and working conditions of its remaining workers while the workers laid off draw full unemployment compensation. The increased aggregate income is increased purchasing power, in response to which new production normally develops.

Coordinated advances in production and in wages and working conditions

With full social security, incentive programs can operate to make increased efficiency directly profitable to both workers and businesses. One such program could be based upon bipartisan boards in industries giving continuing business and labor majority approval. A board (which would have nothing to do with bargaining between businesses and workers) would have the duty of working continuously with engineers to improve efficiency. Government financing of necessary capital additions would be made available at rates based on risk. After the businesses had had the savings from these improvements available for a year, the labor members of a board would have the right to order advances in wages or working conditions in the industry equal in cost to around 80% of recurrent savings and 50% of temporary savings.

Under such an incentive program wages and working conditions can advance continuously, not out of profits or increased prices but out of increased efficiency.

Partial social security is not a partial substitute for full social security

Partial social security has only slight economic effect. It lessens the effect of layoffs on purchasing power but not on fear of impending deficient purchasing power. It does not end individual economic insecurity or hostility to increased efficiency.

[From the Congressional Record, July 27, 1949]

FULL SOCIAL SECURITY BILL OF 1949

EXTENSION OF REMARKS OF HON. GLEN H. TAYLOR OF IDAHO IN THE SENATE OF THE UNITED STATES WEDNESDAY, JULY 27, 1949

Mr. TAYLOR. Mr. President, I introduce for appropriate reference a bill cited as the Full Social Security Act of 1949, and I ask unanimous consent that the bill, together with a brief statement I have prepared and a short summary prepared by Herbert J. Weber be printed in the Record.

The VICE PRESIDENT. The bill will be received and appropriately referred, and, without objection, the bill, statement, and summary will be printed in the Record.

The statement and summary are as follows:

FULL SOCIAL SECURITY ACT OF 1949
(Statement by Senator Taylor)

I have today introduced a bill setting up a comprehensive system of unemployment and disability benefits and I'd like to make a brief explanation of what the program would do, and why it is needed.

Unemployment, with its resultant loss of income, is one of the greatest threats to our economic system. The prospect of disability or loss of jobs is a constant menace to all workers. It is impossible for them now to have a sense of security. They are confronted continually by the realization that in case of unemployment all that can be expected is a temporary pittance insufficient to meet even minimum needs. If a slump comes, those that lose their jobs will receive a few small payments, after which they must attempt to exist with absolutely no money coming in. This is one of the imperfections of our democracy that must be corrected to provide security for all workers.

Equally important is the disastrous effect such unemployment has on the entire economy. This loss of purchasing power, coming at a time when buying is already dropping off, could be responsible for turning a temporary slump in to a serious depression. Another depression would be catastrophic not only to ourselves, but to the entire world, and we must take every possible step to avert it. Enactment of this legislation would mean a stable purchasing power, providing a guaranteed market for industrial and farm products. The knowledge that demand will not drop off would result in continued high production and high employment, maintaining a prosperous economy. Unemployment would consequently remain at a low level, so that the costs of this unemployment compensation program would not be large.

The provisions of the bill can be stated quite briefly and simply. Every person willing to work but unable to secure employment because of disability or lack of job openings is paid 85 percent of his previous weekly earnings until he secures employment. If he is partially disabled and can be employed only at a lower rate because of the disability, payment is made for the earnings loss suffered because of his disability. Complete safeguards are provided in the bill to insure against abuse of the program by workers who refuse suitable employment.

Here is the way the program will work. First any person who loses his job can draw compensation amounting to 85 percent of his previous weekly earnings by complying with a few necessary requirements. He must register with the Employment Service and agree to accept any suitable employment offered by the Service or an employer. The term "suitable employment" means a job that he is qualified to hold and which will pay the prevailing wage for that vicinity. He is not forced to accept a job that involves strikebreaking, dangerous working conditions, or similar unreasonable requirements, but must accept any position approved by the Service as suitable for him. If he voluntarily quits such a suitable job without valid reasons, he is ineligible for compensation for a period of 4 months. These provisions are designed to prevent abuse of the system by those who have no desire to work, and at the same time give full protection to the unemployed who are out of work through no fault of their own.

Special provision is made for our elder citizens who have reached the age of 60. They will not be required to continue in the labor market and will receive retirement benefits ranging from 40 percent to 70 percent of previous average earnings, according to the number of their dependents. For example, a man 60 years of age with a dependent wife could receive 60 percent of his previous earnings, allowing them to retire in comfort and live decently for the rest of their days.

Thus, full protection is provided for our working population, regardless of injury, unemployment, sickness, or old age. If a worker loses his job, he will continue to receive 85 percent of his normal income, sufficient to take care of his needs until a job is secured. He must accept any reasonable job offer and cannot refuse to work or quit a job without valid reasons. If he becomes ill, or is injured so that he is physically unable to work, he will receive disability compensation amounting to 85 percent of his previous earnings. All that is needed to establish his disability is a doctor's certificate or examination by the United States Public Health Service. This compensation continues until he is able to work and a job is available for him.

If an employee is partially disabled, and cannot handle his previous work because of the disability, a new job that he is qualified to fill will be given him. Loss in earning power because of his partial disability will be made up by disability payments amounting to 90 percent of the difference in pay resulting from his injury.

Opponents of unemployment insurance have always concentrated on two points—the cost of the program and the possibility of men refusing to work. As I have already pointed out, the bill contains strict requirements that unemployed workers accept suitable jobs, and payments are not made to those who voluntarily quit such jobs or refuse to work. Detailed provisions contain guaranties against such abuses.

In a large portion of the population were unemployed or disabled, it is true that the cost would be high. However, with such a program in operation, there could not be much unemployment since the continuation of high purchasing power in the hands of all the people would guarantee a steady demand for both industrial and farm products. Assurance of ready markets would mean continuous high production and full employment, making for a permanently prosperous economy with minimum unemployment.

The bill is the result of years of work, research and study by a prominent Washington, D.C., economist, Herbert J. Weber. It is an important part of a complete economic program that Mr. Weber has developed.

FULL SOCIAL SECURITY

(Summary by Herbert J. Weber)

This paper sets up a proposal for the establishment of full social security—compensation for involuntary unemployment at the rate of 85 percent of previous earnings, unlimited in duration and amount, accompanied by equivalent disability, retirement, and survivorship annuities. It further suggests the establishment of bipartisan industry boards employing engineers with the function of continuously seeking advances in efficiency coupled with equivalent advances in wages and working conditions.

Full social security eliminates the pall of individual economic insecurity. It spreads among the whole people the cost of individual losses of income from vicissitudes. It takes from everyone the continuous present fear of future economic want.

In addition to its basic effect upon individual want in bad times and individual peace of mind in good times, full social security has basic economic effects. It facilitates continuously increasing production and prevents unemployment due to deficient purchasing power or to fear of it.

Realization of world cooperation for collective security can reasonably be expected if with full social security we make it evident to all nations that unemployment and want will never drive us to militarism or reemployment and recoupment.

Dispossessing nobody, full social security is the means to active basic objectives of labor, farmers, and businessmen alike. A means to active basic objectives of labor, farmers, and businessmen is within the limits of political practicability.

FULL UNEMPLOYMENT COMPENSATION PREVENTS UNEMPLOYMENT DUE TO DEFICIENT PURCHASING POWER OR FEAR OF IT

There must be cumulative unemployment whenever producers, knowing that lay-offs are occurring, dare not produce freely for fear that their customers will lack funds for purchasing their products. The possibility of public enterprises to give reemployment is not enough to allay this fear. With full compensation for involuntary unemployment, however, lay-offs do not substantially diminish the purchasing power of the workers laid off. If lay-offs do not substantially diminish the purchasing power of the workers laid off, there is nothing about layoffs occurring in one industry to cause producers in other industries to curtail their production. Unemployment cannot cumulate when full compensation for involuntary unemployment is available just as bank failures cannot cumulate when adequate bank-deposit insurance is available.

Full compensation for involuntary unemployment assures the farmer as the manufacturer of the Nation's substantially full continuous purchasing power for his products.

The social-security fund would invest in bonds when its revenue was exceeding compensation payments and would have to sell its bonds to raise money when its compensation payments were exceeding its revenue. Purchase of these bonds by the public would draw in any savings that were idle because of scarcity of safe investments. The savings so drawn in by the social-security fund would immediately become purchasing power in the hands of unemployment-compensation recipients. The Nation's savings would thus be kept invested to the extent needed to maintain its substantially full continuous purchasing power. Idle savings could not remain idle.

FULL UNEMPLOYMENT COMPENSATION FUNDS CAN SIMULTANEOUSLY BE FULL EMPLOYMENT FUNDS

Social-security funds would be available for financing public enterprises to the extent of such unemployment compensation as was otherwise anticipated. Appropriation and financing of a small percentage more would maintain virtually full employment.

THERE CAN BE NO MATERIAL PROBLEM IN ADMINISTERING FULL UNEMPLOYMENT COMPENSATION

Full unemployment compensation involves registration for work and acceptance of suitable work. With full unemployment compensation entailing nearly full employment, there can be no material administrative problem. No one could sham involuntary unemployment when he was receiving one job opportunity after another and would have to develop a new sham every other day—183 times in a year.

TAXES FOR FULL SOCIAL SECURITY ADD NOTHING TO THE BURDEN OF TAXES

Eliminating individual economic insecurity, full social security—full unemployment compensation accompanied by equivalent disability, retirement, and survivorship annuities—makes individual savings against vicissitudes unnecessary. Taxes for full social security are a substitute for such savings, not an added tax burden.

FULL UNEMPLOYMENT COMPENSATION FACILITATES CONTINUOUSLY INCREASING PRODUCTION

The basic economic objective that we all want to see attained is continuously increasing production of goods and services. To attain this objective we must continuously advance the efficiency of our productive technology and organization. We cannot get continuously advancing efficiency as long as increased efficiency keeps workers hostile to it by carrying the threat of incomeless unemployment.

To eliminate hostility of workers to increased efficiency we must eliminate the threat to the worker's income from the increased efficiency. To accomplish this we must adopt the principle that the involuntarily unemployed worker is a worker held in reserve, entitled to approximately his full previous earnings for the full duration of his availability for active duty. With the threat from increased efficiency thus eliminated, we attain a national incentive economy under which effective efforts can be concentrated upon increasing efficiency continuously.

COORDINATED ADVANCES IN PRODUCTION AND IN WAGES AND WORKING CONDITIONS

With full social security, incentive programs can operate to make increased efficiency directly profitable to both workers and businesses. One such program could be based upon bipartisan boards in industries giving continuing business and labor majority approval. A board (which would have nothing to do with bargaining between businesses and workers) would have the duty of working continuously with engineers to improve the efficiency of its industry. Government financing of necessary capital additions would be made available at rates based upon risk. After the businesses had had the savings from these improvements available for a year, the labor members of a board would have the right to order advances in wages or working conditions in the industry equal in cost to 80 percent of recurrent savings and 50 percent of temporary savings.

Under such an incentive program wages and working conditions can advance continuously, not out of profits or increased prices but out of increased efficiency.

With full social security, increased efficiency leads to increased production. If any business increases its efficiency without proportionately increasing its production, it lays off some workers and adds the amount of their wages to its profits and to the wages and working conditions of its remaining workers while the workers laid off draw full unemployment compensation. The increased aggregate income is increased purchasing power, in response to which new production normally develops.

PARTIAL SOCIAL SECURITY IS NOT A PARTIAL SUBSTITUTE FOR FULL SOCIAL SECURITY

Partial social security has only slight economic effect. It lessens the effect of lay-offs on purchasing power but not on fear of impending deficient purchasing power. It does not end individual economic insecurity or hostility to increased efficiency.

The bill (S. 2337) to provide substantially full compensation for loss of income from involuntary unemployment and from disability, and for other purposes, introduced by Mr. TAYLOR, was read twice by its title, referred to the Committee on Finance, and ordered to be printed in the RECORD, as follows:

SHORT TITLE, FINDINGS, AND DECLARATIONS OF POLICY

SEC. 1. (a) This act may be cited as the "Full Social Security Act of 1940."

(b) The greatest obstructions to the free flow of commerce are economic depression and social unrest. The principal cause of economic depression and social unrest is insecurity of income. Apprehension of diminishing demand for the products of labor instigates construction of industrial activity and consequent unemployment, which in turn reduces purchasing power and further curtails demand. So long as there is insecurity of income economic depression and social unrest are imminent.

(c) It is hereby declared to be the policy of the United States to eliminate the principal cause of economic depression and social unrest, thereby removing the greatest obstructions to the free flow of commerce, by providing security of income through the establishment of substantially full compensation for loss of income from involuntary unemployment and from disability.

TITLE I—UNEMPLOYMENT COMPENSATION

SEC. 101. Thirty days after the effective date of this act, and each week thereafter so long as he continues to be involuntarily unemployed.

(a) Every reserve worker under the age of 60 years shall be entitled to receive and the Treasury of the United States is hereby authorized and directed to pay to such worker unemployment compensation in an amount equal to 85 percent of his previous weekly earnings.

(b) Every reserve worker 60 years of age or over shall be entitled to receive and the Treasury of the United States is hereby authorized and directed to pay to such worker unemployment compensation in an amount equal to (1) 40 percent of his previous weekly earnings if he has no dependent spouse; (2) 60 percent of his previous weekly earnings if he has a dependent spouse; and (3) an additional 10 percent of his previous weekly earnings for each child under the age of 21 years: *Provided*, That in no event shall he be entitled to receive more than 70 percent of his previous weekly earnings.

SEC. 102. Every unemployed person aged 21 years or over and otherwise qualified as provided in title V, section 501, subsection (b) of this act shall become a reserve worker entitled to receive the unemployment compensation provided for in section 101 hereof by registering with the United States Employment service, hereinafter called the Employment Service, and shall continue to be a reserve worker so long as he continues to be so qualified and complies with all of the rules and regulations issued by the Employment Service which promote the purposes of and are in conformity with this act.

SEC. 103. The Employment Service is hereby authorized and directed forthwith to register every unemployed person who applies for such registration and proves to its satisfaction that he is involuntarily unemployed, who agrees to accept suitable employment at fair remuneration offered to him by the Employment Service and to notify the Employment Service in writing immediately upon his acceptance of employment, and who otherwise complies with all rules

and regulations issued by the Employment Service which promote the purposes of and are in conformity with this act. Such registration shall be applied for personally by said unemployed persons except under conditions under which the Employment Service shall provide by regulation for registration by proxy, attorney, or executor.

SEC. 104. In effecting said registration of unemployed persons the Employment Service is hereby authorized and directed to require of each applicant for registration a statement under oath setting forth (a) his name, address, and age; (b) his previous weekly earnings; (c) his trade, occupation, or profession; (d) that he is involuntarily unemployed; and (e) such other information as said Employment Service shall require to perform its functions under this act.

SEC. 105. (a) Every person claiming to be a reserve worker because of disability or illness shall, in addition to registering with the Employment Service, apply for registration with the United States Public Health Service, hereinafter called the Health Service. The Health Service is hereby authorized and directed to register every such person applying to it who proves to its satisfaction that during the period claimed to be a period of involuntary unemployment either that he is unable to work or that abstention from work is essential to the maintenance of his earning capacity, and who otherwise complies with all rules and regulations issued by the Health Service which promote the purposes of and are in conformity this act: *Provided*, That the certificate of any doctor of medicine duly licensed to practice in the State or Territory or Federal district or possession of the United States in which a disabled or sick person resides, or of any qualified official of the United States or any State or Territorial government or the government of any Federal district or possession of the United States, shall constitute prima facie proof of such disability or illness. Such application for registration shall be made by mail by a physician or other qualified person on behalf of the person claiming to be a reserve worker except as the Health Service shall provide by regulation for such applications by other procedures.

(b) The Health Service is hereby authorized and directed forthwith to certify to the Employment Service the degree of disability or illness of every person whom it registers as disabled or ill, and the Employment Service shall accept certification as conclusive proof of disability or illness and prima facie proof of unemployment because of disability or illness.

SEC. 106. In effecting registration of persons claiming to be reserve workers because of disability or illness, the Health Service is hereby authorized and directed to make such examinations as it may deem advisable and is authorized to require of each applicant for registration a statement under oath setting for such information as the Health Service shall require to perform its functions under this title.

SEC. 107. Immediately after completing the registration of any reserve worker, the Employment Service shall certify to the Treasury (1) that such a person is a reserve worker; (2) his previous weekly earnings; and (3) the amount of unemployment compensation to be paid to him under the provisions of this title.

TITLE II—COMPENSATION FOR PARTIAL DISABILITY

SEC. 201. Thirty days after the effective date of this act, and each week thereafter so long as he continues to be partially disabled, every certified partially disabled worker, including reserve workers, shall be entitled to receive and the Treasury of the United States is hereby authorized and directed to pay to such a person disability compensation in an amount equal to his loss of earnings due to partial disability: *Provided*, That if said person is also a reserve worker, said disability compensation shall be paid in addition to and shall not in any manner diminish the unemployment compensation to which said reserve worker is entitled under the provisions of title I of this act.

SEC. 202. Every partially disabled worker shall become a certified partially disabled worker entitled to receive the disability compensation provided for in section 201 hereof when he has been registered by the Health Service and has been certified to be a partially disabled worker by the Health Service to the United States Treasury, and shall continue to be a a certified partially disabled worker so long as he remains a partially disabled worker and complies with all of the rules and regulation issued by the Health Service which promote the purposes of and are in conformity with this act.

SEC. 203. The Health Service is hereby authorized and directed forthwith to register every partially disabled worker who applies for such registration and

proves to the satisfaction of said Health Service that he is a partially disabled worker, who agrees in writing to notify said Health Service in writing of any change in the degree of his disability, and who otherwise complies with all rules and regulations issued by the Health Service which promote the purposes of and are in conformity of this act: *Provided*, That the certificate of any doctor of medicine duly licensed to practice in the State, Territory, Federal district, or possession of the United States in which said partially disabled person resides, or of any qualified official or employee of the United States or of the government of any State, Territory, Federal district, or possession of the United States, shall constitute prima facie proof of partial disability and the degree thereof.

SEC. 204. In effecting said registration of partially disabled workers, the Health Service is hereby authorized and directed to make such examinations as it may deem advisable and to require of each applicant for registration a statement under oath setting forth such information as the Health Service shall require to perform its functions under this title. Such registration shall be applied for personally except under conditions under which the Health Service shall provide by regulation for registration by proxy, attorney, or executor.

SEC. 205. Immediately after completing the registration of any partially disabled worker the Health Service shall certify to the Treasury (1) that such worker is partially disabled; (2) the degree of his disability; and (3) the amount of disability compensation to be paid to him under the provisions of this title.

TITLE III—UNITED STATES EMPLOYMENT SERVICE

SEC. 301. Section 3 of the act of June 6, 1933, as amended (48 Stat. 114), is amended, as follows:

1. In the first line of the first subparagraph, after the word "bureau" insert "—1.".

2. After the subparagraph (a)—1. add the following new subparagraphs:

"—2. To render full, adequate, impartial, and prompt employment placement service to every person and to every prospective employer who complies with all laws affecting labor relations or standards, to assist every reserve worker to find suitable employment as rapidly as possible, and to assist every partially disabled worker to find suitable employment in which the impairment of his earning capacity by his disability will be minimized: *Provided*, That in rendering placement service no preference shall be given in favor of reserve workers and against employed persons seeking new employment.

"—3. To undertake and carry out periodical national surveys to ascertain the facts with respect to employment and unemployment and report the same to the Congress; to plan, encourage, and operate training programs designed to enable reserve workers to acquire new skills to qualify for new types of work required by technological and economic developments; and to accomplish measures designed to facilitate orderly and economic transfer of reserve workers from one geographical area to another as the general welfare may require."

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. Any determination by the Employment Service or the Health Service under any provision of this act may be appealed to the United States Circuit Court of Appeals of the judicial circuit having jurisdiction at the place where the act occurred which was the subject of the determination appealed. Reasonable findings of fact by the Employment Service or Health Service shall be accepted as conclusive by such court of appeals.

SEC. 402. The Secretary of Commerce is hereby authorized and directed to determine and to publish monthly an index of consumer prices which shall be a weighted average of the Department of Labor index of urban consumer prices and the Department of Agriculture index of price of goods bought by farmers for use in living. The weights used in said weighted average shall be proportional to the respective populations represented.

SEC. 403. This act shall take effect 60 days after the date of its enactment and shall be in effect in the continental United States and all Territories and possessions of the United States except Puerto Rico.

SEC. 404. There are hereby authorized to be appropriated such sums as may be determined by the Congress to be necessary to carry out the provision of this act.

SEC. 405. The act of August 10, 1939 (53 Stat. 1387), as amended, is amended as follows (so as to reduce by 80 percent the unemployment taxes thereunder

and to repeal provision therein for disability compensation to persons aged 21 and over):

(a) Under title VI, section 608, delete the words "3 percent" and in lieu thereof insert the words "three-fifths of 1 percent";

(b) Under title VI, section 609, subsection (b), delete the words "2.7 percent" and inlieu thereof insert the words "fifty-four hundredths of 1 percent";

(c) Under title VI, section 611, paragraph (4), insert after the word "compensation" the words "to persons under age 21."

SEC. 406. Section 416 of the act of August 10, 1946 (60 Stat. 991) is hereby amended (so as to repeal provision therein for disability compensation to persons aged 25 and over) by inserting in subsection (a), after the word "individuals", the words "under age 21."

SEC. 407. Paragraphs 4 and 5 of Section 205 in division II of the act of July 31, 1946 (60 Stat. 727) (providing for disability compensation) are hereby repealed.

SEC. 408. Section 2 of the act of June 25, 1938 (52 Stat. 1096), as amended, is hereby amended (so as to repeal provision therein for disability compensation to persons aged 21 and over) by inserting in subsections (a), after the words "Benefits shall be payable to any qualified employee," the words "under the age of 21 years."

SEC. 409. Sections 3 and 3b of the act of August 4, 1939 (53 Stat. 1202), as amended (providing for disability compensation), are hereby repealed.

SEC. 410. Section 5 of the act of May 22, 1920 (41 Stat. 616), as amended (providing for disability compensation), is hereby repealed.

SEC. 411. Section 4 of the act of June 29, 1936 (49 Stat. 2018), as amended (providing for disability compensation), is hereby repealed.

SEC. 412. Section 22 in subchapter B of chapter I of the Internal Revenue Code is hereby amended (so as to provide for the inclusion of unemployment compensation and disability compensation under this act in gross taxable income) by inserting in subsection (a), immediately before the period at the end of the first sentence, a semicolon followed by the words "and also unemployment compensation and disability compensation received under provisions of the full Social Security Act of 1949."

SEC. 413. All acts and parts of acts in conflict with any provision of this act and not specifically cited in sections 405 through 412 of this title, are hereby repealed insofar as such conflict exists.

TITLE V—DEFINITIONS

SEC. 501. When used in this act—

(a) The terms "workingman" and "workingwoman" shall mean a person who during 80 percent of the decade immediately preceding a period of involuntary unemployment (or, if said person is under age 35, during 80 percent of the period between said person's twenty-first birthday and the beginning of a period of involuntary unemployment) has been either employed, involuntarily unemployed, unemployed because of a labor dispute directly or indirectly involving himself, or devoting substantially full time to education.

(b) The term "reserve worker" shall mean an involuntarily unemployed workingman or workingwoman 21 years of age or over who applies or has applied for registration with the Employment Service as provided herein and who for 1 week or more during the 30 days prior to the date of such application had been involuntarily unemployed, either continuously or intermittently.

(c) The term "person" shall mean a natural person.

(d) The term "involuntarily unemployed" includes any person within the continental United States or any Territory or possession of the United States except Puerto Rico, aged 21 years or over, who is involuntarily without remunerative employment and who is not voluntarily unavailable for acceptance of an offer of suitable employment from the Employment Service during its usual hours of business. The term shall not include any person whose unemployment is due to a current labor dispute directly or indirectly involving himself or include any person whose unemployment is due to imprisonment for crime unless such imprisonment was on a charge later dismissed, nolle prossed, or otherwise abandoned or of which said person was acquitted. It shall not include any person who voluntarily fails to attend and satisfy the requirements of an occupational retraining course prescribed by the Employment Service in accordance with the provisions of title II of this act, or who fails to comply with the rules and regulations issued by the Employment Service which promote the purposes of and

are in conformity with this act; nor any person who, within 120 days next preceding the date of his application for registration by the Employment Service, refused to accept suitable employment or voluntarily terminated suitable employment unless (1) at the time of said refusal or termination said person was under the age of 21 years; (2) said termination was a result of a labor dispute no longer in progress; or (3) said termination was for the bona fide purpose of engaging in self-employment or of devoting substantially full time to education. Any person who when involuntarily unemployed shall refuse to accept suitable employment shall thereupon immediately cease to be involuntarily unemployed.

(e) The term "suitable employment" shall mean employment in a trade, occupation, or profession not inconsistent with past training and experience for which fair remuneration is offered: *Provided*, That an offer of employment at an unreasonable distance from the legal residence of a reserve worker shall not constitute suitable employment. No employment shall be construed to be suitable employment which is illegal, or contrary to public policy, or inimical to the national defense, or contrary to bona fide religious convictions professed for more than 2 years by a reserve worker, or at any place of employment at which a labor dispute is in progress, or which in any respect violates any law affecting labor relations or standards, or with respect to which the working conditions are substandard or dangerous, as determined by the Employment Service, or which was avoidably offered by the Employment Service in disregard of a reserve worker's stated desires with respect to labor union affiliation or other working conditions.

(f) The term "fair remuneration" shall mean the prevailing wage scale or salary rate in any given locality for work for which a reserve worker is qualified by training, experience, physical condition, and quality of past performance: *Provided* That such wage scale or salary rate is not less than the minimum rate of wages fixed for workers other than apprentices by Federal or State law: *And provided further*, That the prima facie proof of fair remuneration for any reserve worker shall be that such remuneration is not less than one hundred-eighty-fifths of the unemployment compensation he is receiving plus or minus an amount proportional to fluctuations, since the date of reserve worker's registration with the Employment Service, in the index of consumer prices provided for in section 402 in title IV of this act.

(g) The term "previous weekly earnings" shall mean the average weekly earnings, less overtime compensation and unearned bonuses, received in money, goods, or services by a reserve worker during his last period of 260 days (continuous or intermittent) of suitable employment next preceding the date of his registration with the Employment Service: *Provided*, That if there were no such earnings or such earnings are not ascertainable the term shall mean the minimum rate of wages fixed for workers other than apprentices by Federal law.

(h) The term "voluntarily terminated," as applied to employment, includes (1) termination of employment by resignation or other voluntary act of a person who thereby becomes unemployed: (2) unemployment resulting from wilful refusal or grossly negligent failure to abide by reasonable safety, efficiency, or disciplinary rules generally enforced, or made necessary by special conditions, in the trade, occupation, or profession involved; and (3) unemployment resulting from wilful and unreasonable underutilization of ability to perform the usual duties of the trade, occupation, or profession involved.

(i) The term "refuse to accept," as applied to employment, includes (1) actual refusal to accept suitable employment and (2) refusal or failure to make reasonable effort to obtain suitable employment pursuant to notification by the Employment Service.

(j) The term "degree of disability" shall mean the degree of impairment in earning capacity equal to that set forth in the schedules of ratings of reductions in earning capacity from injuries or combinations of injuries by the Veterans' Administration at the date of enactment of this act.

(k) The term "loss of earnings due to partial disability" shall mean the difference between (1) the amount of earnings or one hundred-eighty-fifths of the amount of unemployment compensation actually obtained by a certified partially disabled worker while partially disabled and (2) 90 percent of the amount which in the opinion of the Health Service would constitute fair remuneration for suitable employment for such worker if he were not partially disabled.

(l) The term "partially disabled worker" shall mean a workingman or workingwoman aged 21 years or over whose earning capacity is impaired for 1 week or longer by physical or mental illness, physical congenital defect, or injury

whose degree of disability is greater than 10 percent; who is employed at the date of his application to the Health Service for registration as a partially disabled worker; and who after such registration is either employed or a reserve worker.

(m) The term "dependent spouse" shall mean a lawful spouse or a divorced spouse awarded alimony, whose income from employment, unemployment compensation, and disability compensation is less than that of the other spouse or the other divorced spouse.

(n) The term "child under the age of 21 years" shall mean a child by blood or adoption or a stepchild under the age of 21 years.

(o) The term "voluntary unavailability for acceptance of an offer of suitable employment" includes voluntary failure to respond to an offer of suitable employment from the Employment Service and voluntary failure to perform such acts as may be reasonably necessary to enable a reserve worker to accept an offer of suitable employment.

(p) The term "employed" shall mean employment for compensation, including periods for which compensation is received but in which no specific work is performed for such compensation, or self-employment.

TITLE VI—SEPARABILITY

SEC. 601. If any provision of this act, or the application of such provision to any person or circumstance, shall be held invalid the remainder of this act, or the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

STATEMENT OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS, BY JOHN P. MEEHAN, CLU, CHAIRMAN, NALU COMMITTEE ON FEDERAL LAW AND LEGISLATION

INTRODUCTORY REMARKS

I am John P. Meehan, CLU, of Boston, Massachusetts, and I am appearing before your Committee today as the Chairman of the Committee on Federal Law & Legislation of The National Association of Life Underwriters and also as Vice President of the Association's Board of Trustees. For your information our organization is a trade association composed of over 950 state and local life underwriter associations representing a membership in excess of 100,000 life insurance agents, general agents and managers residing and doing business in virtually every locality of the United States.

We appreciate this opportunity to present our views with respect to certain of the proposed revisions in the Social Security system.

Prior to making specific comments on the recommendations contained in H.R. 17550, I should like to summarize our basic position with regard to the OASDI program, its objectives and purposes.

NALU's Basic Philosophy Regarding Social Security

We believe that the Old-Age, Survivors, and Disability Insurance program was designed to provide what is commonly referred to as a "basic floor of protection" against economic want and need, financed by earmarked taxes imposed upon employers, employees and self-employed individuals and, to a small extent, by interest earnings on the Social Security trust funds. It was intended that upon this basic floor, each covered person, by individual and employer initiative, would plan and build additional economic security for himself and his family by means of private savings, investments, insurance, pension programs and the like.

As thus originally conceived and designed, the Social Security program is socially and economically desirable; but to assure its continued existence, it is essential that the program be soundly maintained. *Overexpansion* of the program *must* be *avoided*, since such overexpansion would contravene what we believe to be the basic philosophy behind the program, substantially increase the tremendous financial burden already facing present and future Social Security taxpayers, and pose a threat to the safety and continued existence of the program itself.

NALU Conclusion Regarding Major Features of H.R. 17550

NALU believes that the major OASDI features of H.R. 17550 are in keeping with the basic floor of protection concept. Therefore, NALU endorses and supports the provisions of the bill which would increase Social Security benefits 5%, make benefits automatically responsive to the "cost of living" in the future, increase the earnings base to $9,000, empower automatic adjustments to the wage base, and liberalize the earnings test. However, NALU opposes the sections of the bill which would provide larger benefits to men retiring at age 62 and would allow widows and widowers a benefit equal to 100% of the primary insurance amount if the benefit is applied for at age 65 or over. Also, we oppose an OASDI employer-employee withholding tax rate of more than 10%, as is scheduled in the bill for 1980 and after.

Automatic Adjustments of Benefits

The Department of Health, Education, and Welfare witnesses have described the "purchasing power guarantee" section of the bill as the most significant reform effort in the current legislative proposals. We concur in that characterization of that aspect of the measure. It represents a marked departure from past methods of keeping Social Security benefits up to date. While it appears to be far-reaching, we think it is an idea that has great merit.

One need only consult the recent history of Social Security benefits to gain an appreciation for the "cost of living" idea. Hearings on Social Security, both by this Committee and the House Ways and Means Committee, have been held approximately every two years during the past ten years. The dominant theme of the hearings usually revolves around an increase in Social Security benefits necessitated by the erosion of the value of the dollar by inflation. If a means could be found to make Social Security benefits automatically responsive to the cost of living, it seems to our Association such a feature would be highly desirable. Fortunately, H.R. 17550 contains such a provision.

As contemplated by the bill, Social Security benefits would be increased, automatically, whenever the Consumer Price Index was 3% or more above the Consumer Price Index for the last "cost of living computation quarter." Thus, if the cost of living rose, benefits would be increased. If the cost of living remained stable, benefits would remain at their then current level. NALU believes that the automatic adjustment of benefits provision of H.R. 17550 would allow a rapid, precise realignment between any significant increase in the cost of living and cash benefits under Social Security. Therefore, NALU endorses the automatic cost of living provision and would urge that the Congress enact it.

In one further comment on this aspect of the bill I would like to draw the Committees' attention to a point of which it is probably well aware, and that is, that the bill contains no provision for *reducing* benefits if the cost of living goes down. On the off chance that such a downturn should occur, we think that a provision should be added to the bill to make a corresponding change in the benefit amounts.

Automatic adjustment in the wage base

If the concept of automatic benefit increases is valid and we think it is, then it follows that an automatic method of paying for the increase is also valid. There are three methods of financing benefit increases without doing violence to the philosophy of the Social Security system as it exists today, and the way we think it should be maintained in the future. The three methods are increases in Social Security Tax Rates, increases in the Social Security Wage Base, use of any "actuarial surplus" that develops (such as can arise from increases in taxable wages), or a combination thereof.

Given the proper starting point, a mechanism for the automatic adjustment of the wage base to reflect relative changes in the total earned income of covered workers has valid appeal. While the wage base has increased in absolute dollar amounts over the years, it is an historical fact that the wage base has remained nearly constant since 1951 if expressed in terms of a percent of total annual earnings in covered work subject to Social Security contributions. The proposal presently before this Committee seeks to retain the percentage relationship that history and the Congress has found to be highly successful, except that, apparently, this section of the bill lacks a means to reflect a *decrease* in wages. Just as we have suggested under the automatic benefit section, we would urge the committee to add a decreasing feature to this provision of the bill.

By making the "automatics" a part of the system, the workers of the United States can depend upon Social Security benefits keeping pace with the economy and, at the same time, be assured that the financing of those benefits will be handled in a responsible manner. For its part, management will be able to look upon the Social Security program with confidence, knowing at all times what percentage of average earned income of workers reaching retirement will be replaced by Social Security payments, allowing close correlation of private pension and retirement programs with Social Security to provide a greater measure of retirement security to the working public. And finally, the average working individual will know with certinty just how much economic security he must provide for himself if he is to enjoy the full measure of his retirement years.

Increase in wage base to $9,000

The bill before this Committee proposes to increase the Social Security wage base to $9,000, effective January 1971. While NALU endorses the proposal to increase the wage base to $9,000, we oppose the effective date of 1971 and urge that the new wage base become operative one year later, January 1972.

Originally when the Administration proposed changes in the Social Security system, it was contemplated that restructuring would take substantially the same form as is now being considered by this Committee. However, one major difference between the proposal made in the fall of 1969 and the present one was the effective date of the increased wage base. The Administration proposed that the increase take place January 1972 and in that date NALU concurred. Our support was based upon the best estimates supplied by the Social Security Administration indicating that the ratio between total earnings and earnings subject to tax would be sustained substantially as had been maintained in the past. Since 1951 that ratio has been maintained at about 80%. No data has been presented which indicates that the picture has changed. Believing as it does that the 80% ratio should be maintained, NALU supports a wage base increase to $9,000, *but only effective January 1972.*

5% benefit increase

It is a well known fact that among the individuals most affected by the loss of buying power of the dollar resulting from inflation are those maintaining a household by means of a fixed income. There is little that I can add to the public knowledge about inflation. Suffice it to say that a means should be found to alleviate the problem. In the case of Social Security beneficiaries, the preferable way would be to halt inflation. Until that goal is achieved, however, the benefit schedule will require examination.

The Consumer Price Index tells us that the cost of living marches incessantly on. Since the 15% increase in benefits voted by Congress last December became operative, the cost of living has been shrinking the value of the dollar at an annual rate of about 6%. Last fall, NALU testified before the House Ways and Means Committee to the effect that a 10% increase in benefits was necessary to replace the lost purchasing power of Social Security benefits. Most of the portion of the benefit increase that NALU considered excessive last fall (15% instead of 10%) has now been eroded and, frankly, we find it very difficult to argue that Social Security beneficiaries should not have a 5% increase in benefits, effective January 1, 1971. By Jauary 1971 the inflationary spiral will leave, in all probability, a mere 4% difference between the increase in the benefits voted by Congress in the last year plus the increase proposed in the bill as compared with the increase in the cost of living. While strictly speaking NALU supports only cost of living increases in Social Security benefits, we believe that a 5% increase is merited at this time.

Philosophically, NALU maintains that the Social Security program was designed to accomplish the specific goal of providing a basic income for people who are no longer able to earn income for themselves. We believe that the program has, by and large, accomplished that goal. The only requirement that needs to be met on a continuing basis is to retain the relative position of benefits to the economy as a whole. A 5% increase in benefits next January and thereafter automatically adjusting benefits by the means spelled out in H.R. 17550 will accomplish that goal.

Liberalization of retirement test

NALU supports the provision contemplated by H.R. 17550 to increase the amount of earnings that an individual may have without affecting his Social Security benefits. Under the bill, the earnings exemption would be increased to $2,000 from $1,680, allowing an individual beneficiary to earn up to $2,000 per year without affecting his benefits. Earnings above $2,000 would result in a deduction of $1 for every $2 earned. NALU agrees with the principle of reducing Social Security costs wherever possible and, for that reason, we believe that the Retirement Test is needed. However, we believe that reasonable allowances should be made for personal initiative in supplementing retirement income. We support the bill out of a realization that this aspect of the Social Security system should keep pace with the economy just as the benefit structure does in order to stimulate personal initiative rather than stifle it.

Balance of testimony

The balance of NALU's testimony concerns itself with major OASDI sections of H.R. 17550 which we do not endorse. NALU does not favor 1) the increase in the combined employer-employee OASDI tax to 11%, ultimately, 2) the "early" retirement for men, or 3) the provision for providing a widow or widower aged 65 or over at time of claim 100% of a deceased spouse's primary benefit.

Combined employer-employee tax rate

Limiting the ultimate combined OASDI tax rate to 10% produces reasonable controls on benefit levels. It is a result of our desire to restrict the increase in the tax rate that we do not approve of the foregoing three features of H.R. 17550. Presumably, it would be desirable to have benefit expansion if an acceptable means could be found to finance it. But based upon the philosophical underpinnings of Social Security that it should provide only the basic floor of protection, excessive tax rates can and should be avoided.

At many income levels, even OASDI taxes at the 10% rate could exceed federal income taxes. It appears to NALU that the benefit and financing structure of Social Security are in balance and that the Social Security system is now doing the job of providing the "basic floor of protection." Increasing taxes to go beyond the basic floor seems to our organization to strike directly at the philosophical heart of the system.

Age 62 computation point for men

In addition to objecting to a lowering of the retirement benefit calculation point for men on fiscal grounds, NALU disagrees with the philosophical thrust, as well. The bill provides that the ending point of the period that is used to determine insured status for men and the ending point of the period that is used to determine the number of years over which a man's average monthly earnings must be calculated will be the beginning of the year in which he reaches 62, instead of age 65 as under present law, allowing "early" retirement for men with larger benefits than is provided under present law. The rationale behind this proposed change in computation point is that women have been given the age 62 computation point and, therefore, to be fair, men should be afforded the same treatment.

NALU believes that this rationale is suspect at best, since, as you know, two wrongs do not make a right. We believe that this is the type of gradual over-expansion of the program to which we most strenuously object. We cautioned in the past that there was no reason why, outside of disability, early retirement is beneficial. And we urged in the past that if such treatment were extended to women, it would serve as precedent, encouraging like treatment for men. The committee now has before it a proposal which we believe is unnecessary and undesirable. In view of the increased life expectancy and useful economic life of the average American, we believe that to the extent that any further liberalization in benefits for early retirement would operate to induce covered workers to choose, or be forced into, earlier retirement, such a result would tend to be detrimental both the best social and economic interests of the workers themselves and to the economic growth of the nation. Therefore, we respectfully urge that the section of the bill providing an age-62 computation point for men not be adopted.

One-hundred percent benefits for widows or widowers

Like the provision for an age-62 computation point for men, NALU objects to this section of the bill on financial grounds and for that reason alone would suggest that it not be adopted. But further, it has been shown that, under certain fairly common circumstances, the terms of this proposal would permit a widow (or widower) to receive a higher benefit than had been received by the deceased spouse, or that would have been received by the worker if the widow had died first. Clearly, this result is manifestly unfair and should not be tolerated. Therefore, this section should be deleted.

Summary

As you can discern from the testimony, NALU is in favor of the major provisions of H.R. 17550. We hope our testimony will be considered as one more example of NALU's continuing interest in the Social Security program, an interest which requires that we constantly work for the improvement of the system within the bounds of philosophy appropriate for a social insurance system.

Independent review and study of the social security system

In order to define the future role of Social Security and unearth improvements which may help to round out the program, NALU wishes to renew its request to the committee that a high caliber study committee be established to make a comprehensive review of the goals, priorities and costs of the Social Security program. We believe that such a committee should be made up of experts from all sectors of the economic spectrum, both private and public, actually representing the varying segments of the public. We are aware of the existence of an advisory committee that purports to do this but, frankly, we do not agree that the committee actually meets our definitional requirements.

We would hope that appropriate analysis of the role of private retirement benefits would be included as part of any such study. The role of the private sector and its present and future impact on retirement programs should be thoroughly studied prior to an expansion of the public role beyond reasonable boundaries. We hope, therefore, that the Congress will consider the very real relationship between private and public benefits and that it will refuse to accept the views of those who would expand Social Security to such unreasonable limits as to impede the growth of private pension plans and other retirement programs, or even largely destroy them. We further contend that a thorough examination of the Social Security program would serve to properly focus the attention of all citizens on the objectives and purposes of the system and, in so doing, remove inequities.

STATEMENT OF JOHN F. GRINER, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

The American Federation of Government Employees, the largest Federal employee union in the history of the United States, appreciates the opportunity and the privilege granted it to submit the Federation's views on H.R. 17550, a Bill to amend and improve the Social Security Act and system. We are most concerned that this Bill, which passed the House on May 21, 1970, omits a provision enabling Federal employees to participate individually on a wholly voluntary basis through contributions to the Social Security System.

Our union today represents over 650,000 Federal employees in all types of work in every department and agency, at home and abroad, in exclusive recognition units. Our dues-paying membership exceeds 325,000 employees. Thus, we are aware of the problems which concern Federal employees the most.

A major issue which regularly confronts our members is their denial of participation on a voluntary and individual basis in the Social Security System after they begin to contribute to the Federal Civil Service Retirement Fund. Many Federal employees have worked for private employers and for states and municipalities which participated in the Social Security System. Consequently, they have already contributed monies in the form of Social Security tax to the System. They feel that they should not be denied continued participation in the Social Security System solely because they are working for the Federal Government.

To understand the kind of serious discrimination and inequity imposed on Federal employees, *solely because they work for the Federal Government*, I should like to present a simple, hypothetical case. To make the case even more relevant to the purposes of this Hearing, I am assuming that the Federal employee will be 65 years old in December 1971. Thus, the remedy we are requesting in this legislation would apply to this hypothetical case as well as to other cases in the future.

This Federal employee, born in 1906 earned 10 quarters of social security credit in the last nine years. He joined the Federal service in December 1969. He would like to continue to contribute to the Social Security System because of his advanced age.

What is his current situation?

First of all, if he becomes disabled today he will not receive any benefits from Social Security because he must have earned twenty quarters out of the last forty to qualify for disability benefits. Up to December 1969, he has earned nineteen out of the last thirty-six. If he had been able to contribute voluntarily, he could have earned twenty-three out of the last forty. Thus, by rigid operation of the Social Security System, he has been mandatorily precluded from providing basic coverage to himself and his family, *solely because he has been a Federal employee* since December 1969.

Moreover, if he is disabled and is no longer employable, due to this disability, he will then not be able ever to obtain that last quarter he needs to qualify for old-age retirement benefits when he becomes 65 in December 1971. Thus he is exposed to double jeopardy, to double discrimination. *And the sole reason for this double jeopardy is that he is a Federal employee.* If he were self-employed he would be eligible today to participate in the Social Security System to obtain that last quarter. If he were employed by a private employer, he would be eligible. If he were employed by most state and local governments, he would be eligible. But solely by reason of his Federal employment, he suffers discrimination.

And yet, what would be the maximum benefit this man could be receiving *even* if he were eligible. What is the so-called "saving" to the Social Security System for denying this man a basic coverage? Assuming he was paying in the maximum allowable amount during this period, his Social Security old-age pension would be $126.00 per month (five times $7,800.00 equals $39,000 divided by 5/14 equals average of $2,785.71, providing a monthly payment of $126.00).

But the fact is that even this seriously reduced retirement benefit is being denied to him and to other Federal employees today. Federal employees are prevented by law from participating in the Social Security System on a voluntary and individual basis. Consequently, in the case of disability benefits, they can lose the benefits they have already acquired simply because of the elapse of time. In the case of old-age benefits, they can be prevented from achieving minimal qualification for their specific age group. In both instances, they are being punished solely for being Federal employees.

Over the last several years we have testified on many Bills designed to eliminate the inequities which have arisen from the absence of any kind of interchange between the Social Security System and the Civil Service Retirement Fund. We have previously stated that the present existence of a working interrelationship between the Social Security System and the Railroad Retirement Fund should serve as a model for a working relationship between the Social Security System and the Civil Service Retirement System. Such a model would put an end to the present inequities resulting from Federal employees "falling between the two stools" of Social Security and Civil Service retirement and getting nothing from either.

We are, of course, just as much opposed as in the past to any attempt to "consolidate" the Civil Service Retirement and the Social Security Systems. The goals and purposes of the two programs are essentially different. The Social Security System is a social insurance, health and welfare system designed to provide financial income, partially replacing work-related earnings, to the entire population during old age and during such misfortunes within the normal working years as death or injury to the breadwinner.

The Civil Service Retirement System, which incidentally is fifteen years older than the Social Security System, was originally enacted, and has been continued to be amended, so as to provide annuities to Federal employees primarily on the career principle, therefore basing its annuities on length of service and highest level of earnings while in the Federal employ.

We recognize and wish to maintain this distinction between the Social Security and the Civil Service Retirement Systems. Consequently, we are not proposing any kind of consolidation resulting in mandatory participation by Federal employees under the Social Security System.

Nevertheless, our position does not exclude, and in fact is not in conflict with, the desirability of making Social Security benefits also available to Federal workers generally on an individual and voluntary basis. We understand that the Social Security Administration has opposed such "selective" participation on the grounds that only those people would participate who would "profit" from a voluntary participation system and that those Federal employees who would not "profit" would abstain. The Social Security Administration has contended that there would not be present the actuarial conditions necessary to maintain "in balance" the "profit" and the "loss" participants.

We seriously doubt that this fear of the Social Security Administration is well-grounded. There is little actuarial basis or experience for substantiating it. But, even if we were to concede for the sake of argument that there might be some net loss, it appears to us that it would be of marginal importance and should not exceed a few hundred thousand dollars a year. On the other hand, by risking such a small net loss on the part of the Social Security System, the Congress would eliminate very serious inequities to many American citizens who happen to be Federal employees and who suffer real poverty and hardship from the present situation where they are denied participation.

For example, participation in Social Security would extend much more realistic survivorship and disability protection to young workers. Those employees who leave the Federal service before retirement would be assured of survivor and disability rights because their government service would have been credited, under a voluntary and individual status, for Social Security purposes. Even those Federal workers with five years or more Federal service would be able to ameliorate the deficiency between the higher payments under the Social Security System and the lower payments under the Civil Service Retirement System because benefit amounts would always be at least at the level of Social Security, which at the minimum pension level is now $64.00 per month. The level of the annuities of the Civil Service has been as low as $10.00 per month.

In conclusion, I most earnestly petition this Committee to amend H.R. 17550 to provide for participation by Federal employees while in the employment of their government on a voluntary and individual basis in the Social Security System. I wish to thank once again the Chairman of this Committee, Senator Russell Long, and its other members for the opportunity to present this statement and I shall be pleased to answer any questions either here or by submitting supplemental comments for the record.

GILBERT CLINIC, INC.,
Bethany, Okla., September 17, 1970.

Senator RUSSELL B. LONG,
Chairman, Committee on Finance,
New Senate Office Building,
Washington, D.C.

DEAR SIR: As a practicing physician, treating a large number of elderly patients, many of whom are in nursing homes and extended care facilities, I wish to advise that in my opinion there is an urgent need to change one of the provisions of the law as concerns terminal patients.

We are occasionally presented with the dilemma of treating a patient with a terminal disease such as a malignancy and for which further medical treatment is of no avail, leaving the only alternative as good nursing care. However, some of these people die very slowly and their 100 days, as provided for under the present law, expires making it necessary to move these patients from an extended care facility to a nursing home, thus working an extreme hardship upon both the patient's family and the patient.

I believe that in certain specific cases, such as the terminal patient with uremia or the terminal patient with a proved malignancy should be granted an extension upon request by the attending physician and approval by the Utilization Committee of the extended care facility.

Sincerely yours,

LEON N. GILBERT, M.D.

OKLAHOMA CITY, OKLA., *September 16, 1970.*

Senator RUSSELL LONG,
Committee on Finance

SENATOR RUSSELL LONG: I write this statement as per your request by telegram on Sept. 16, 1970 for the committee on finance. My statement and request is for the committee to add an amendment to the medicare, medicaid bill before the committee at this time. My amendment is:

1. All old age patients who are critical or terminal so stated by their doctor that death will soon follow be allowed to die in peace. As the bill now stands any and all patients must be moved to another hospital after 100 days this is the medicare law as it now stands, or the patient must pay day rates in a General hospital of 35.00 to 40.00 a day or pay extended care cost of $1000.00 per month most patients can't afford this cost. Patients may request re-entry after 10 to 30 days but the terminal or comatose patient it is to late many die in moving them a lot die after being moved Gentleman, and most old age patients who are critical ask the nurse please leave them alone and let them die in peace.

2. I ask the amendment to say that the doctor in charge who knows the patients condition best enter on the patient's chart terminal (eminence of death) or comatose. Patient should not be moved. This gives the old age patient dignity and lets him die in and with peace of mind.

3. I request the amendment to say that medicare, medicaid will pay all bills both doctor and hospital for patient until patient expires. Most patients expire within 72 hr or 5 days. Any type of movement could cause death and any type of saving the government may think they save is false saving. It cost more to move them.

Gentleman, I am a male nurse working with these patients for 20 years, I have seen the tears the worry by patients and their family how to pay the bills after the 100 days. I close my request by telling each man on the board if the old age person could tell them, God bless each and ever one of you for we need your help now.

MICHAEL MURRIHY, LPN.

STATEMENT OF PEYTON FORD, ON BEHALF OF THE NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

Mr. Peyton Ford, Washington Counsel for the National Association of Life Companies, which represents medium sized stock companies as well as an appreciable number of casualty companies, has asked me to make this statement on his behalf, since he is preparing for the trial of a protracted case which will last approximately six weeks, with preliminary proceedfings to commence on Friday, September 25 and formal trial scheduled to begin on September 28. Mr. Ford has consulted with Mr. DeWitt Roberts, Executive Secretary of NALC, J. W. Baker, a Director of the Association as well as President of the Continental Service Life and Health Insurance Company, John E. Neff, Jr. of American Founders Life, Austin, Texas, a Director of the Association, and Claude Poindexter of Coastal States Life, Atlanta, Georgia, who is a Director and Treasurer of NALC.

It is the consensus of this group that the joint IRS/Insurance Industry Task Force, in preparing its report on the subject of Information Reporting of Payment to Health Care providers, has performed an extensive study of this subject. We, of course, have had the opportunity to see these studies and, in spite of their extremely technical nature, there are three conclusions which stand out: (1) it will be an extremely difficult and expensive operation as to individual policies; (2) it will be a virtually impossible task or project as to unassigned payments (in this connection, it is impossible to supply social security numbers, thus adding to the burden); (3) it will in all probability cost the Government in excess of $37,500,000.00 in lost taxes from insurance companies. It will, of course, cost the companies approximately the same amount.

The money that will be lost is money that is now being paid by insurance companies in taxes—their loss is money that is now being distributed to stock companies and taxed to them. *Whether this equals or exceeds the amount of taxes which might be collected from a few physicians and dealers in prosthetics who should make fraudulent returns is the most important question.*

To us, the figures arrived at as to standard health policies seem low, and are based on atypical companies with a heavy volume of "group." We accept these figures, however, even though they are on the low side.

We would like at this time to urge the Finance Committee's consideration of the following:

(1) The elimination of individual contracts.

(2) The elimination of unassigned payments, or delay reporting until further and more typical figures can be obtained.

(3) The estimate as to cost vis-a-vis the Internal Revenue Service.

Along with the Chairman and the entire Committee, we would be the first to condemn any fraudulent practices in reporting. It is our sincere belief, however, that through proper and vigorous enforcement any such practices can be remedied without placing the unnecessary burden on the relatively few companies that write individual Accident and Health policies, thereby avoiding the high costs that would be necessary to deal with the relatively few and isolated instances of abuse.

MARTIN RENTS CO.,
Los Angeles, Calif., September 22, 1970.

Re: H.R. 17550.

CONGRESS OF THE UNITED STATES,
Senate Finance Committee.

"With respect to medical services, supplies and equipment that do not vary significantly in quality from one supplier to another, after June 30, 1970, a charge will be deemed to be unreasonable if it exceeds the lowest levels at which such services, supplies and equipment are widely available; in a locality unless an exemption is granted by the Secretary. This section further provides that payment will not be made for items or services furnished to the extent that it would exceed the amount determined by the Secretary to be reasonable."

Question: What are the possible effects of implementation of the above proposal? If the carrier undertakes to hew to the semantic line of this proposal a community could be affected as follows:

ABC Feed & Fuel Company having six feed and fuel stores in an area decides to have a sideline department in crutches, canes and wheelchairs. They buy this equipment from well known suppliers and the quality is good. They base their rates 20% under the rates of three other full line DME dealers in the area. The carrier could well assume that it was a proper exercise to establish this rate as the community rate. You may well ask why not? I will tell you *why not*!

First of all, such reasoning does not take into consideration the number of times the service is rendered. This is an absolute essential in any statistical study which purports to show at what the price level a community's needs are met. Thus, ABC Feed may have only 30 chairs in rental service while the full line companies have 300 . . . in the absence of the full line companies' facilities and resources we submit that ABC could not fill the needs of the community at that price level.

Second: A full line DME dealer provides the following list of facilities and services:

1. Repair and maintenance facilities on premises with skilled mechanics employed to provide service where and when needed.

2. He stocks a full line of equipment; not just equipment which an inexperienced supplier thinks is easy to supply . . . he will have oxygen services, supplied by skilled technicians . . . . traction equipment ranging from the simplest cervical types to the most sophisticated full-bed traction units for involved cases and the know-how to set them up. He will have a full range of wheelchairs designed for the many different handicaps (wheelchairs come in over 1200 different models). He will stock a full line of rehabilitation and self-care devices and he will know how to install them and to instruct the patient in their use.

3. He will have 24-hour service available for emergency needs of his patients.

4. He will have and maintain sanitary premises and facilities for delivery of equipment.

Gentlemen, the professional durable medical equipment dealer is a paramedical service of wide range and ability. I am sure you want the Medicare program supported by this type of supplier. I submit that our industry merits the same consideration given the physicians in determination of their charges. If a 75th percentile is to be used, and weight given to the number of times a service is rendered, ample protection will accrue to *both* the program and the beneficiary. When by means of the proposal that leads this letter, you open a door that could be destructive to this industry, you do yourselves and Medicare no service. This concept of low dollar regardless of any other factor *must* result in damage to the Medicare program. Our industry is an equal mix of *services* and product and low dollar is not a proper measure.

Let me point out that a patient lifter, sold mail order by a non-experienced supplier at low dollar can set the pricing for the community, but the patient can

be dropped in the absence of the full indoctrination provided by the professional DME dealer. Thus, the patient can end up in the hospital for an unrelated injury as a result.

Another serious down side effect of the proposal from HR 17550 is that it would almost certainly lead to abandonment of the assignment procedure by the industry. The cost of claims processing would escalate as a result and you would find the amount to be substantial.

Keep in mind that the home is the lowest cost extension of hospital care available to you under the Medicare program. Great caution should be exercised in making it more difficult for the beneficiary to use that low cost facility successfully in his convalescence.

The special paragraphs for HR 17550 are not necessary. Ample protection to the program exists in the percentile method of cost controls. Adoption of this other proposal would produce endless problems for that segment of the health care delivery system that gives you the lowest cost per day of care . . . THE HOME OF THE BENEFICIARY!

Let me now touch upon the other problems of the durable medical equipment industry as related to Medicare.

We are constantly being confronted by HEW with the phrase "intent of Congress". What then is the intent of Congress re the Medicare beneficiary? It is my understanding that the intent was not to pauperize our senior population by the advent of serious illness or injury. It was my understanding that the intent of Congress was to help provide care with the lowest cost methods *consistent with good medical practice.* It is my understanding that the intent of Congress is to utilize as intensively as possible those areas of care that produce results at the lowest cost. If these are truly the intents of Congress, then there are parts of the Medicare Act in our field which are *self-defeating.*

Most health care experts agree that the lowest cost and often the best results are obtained in home care of the patient. Why then does Congress, through HEW, make it so difficult for the beneficiary to make the home an efficient, safe, rehabilitative *low-cost* extension of hospital care? Where is the logic in policy that separates hygienic procedures from medical care? Where is the logic in policy that courts risk of serious injury or aggravation of an existing condition by making many safety and assistive devices prohibited from payment by Medicare? How much virtue is there in the doctrine of *exhaustion?* First, we prohibit the electric bed in 90% of the cases, which exhausts the aged spouse . . . then the aged spouse no longer able to withstand 24-hour nursing duty puts the patient in the nursing home, which at $400.00 to $800.00 or more, exhausts his money . . . which, in turn, places both of them on Medicaid (or welfare, if you prefer) which exhausts our money . . . at what point do we say to ourselves that this effort to realize short-term low-dollar savings makes us risk long-term, large-dollar costs. *Adequate* home care equipment and lower long-term costs are not mutually exclusive. Congress must be made cognizant of the money psychology of the senior citizens . . . they will not often enough, spend what they should to stay within the range of acceptable risk in the care of the patient . . . thus, if Medicare will not pay a share of the toilet safety devices, the beneficiary will forego the device for the sake of economy . . . how many redone hips at $4,000.00 must we pay for, to realize it's better to spend $20.00 for a safety frame? How many preventable hip fractures during a stroke convalescence do we pay for before we realize that a tub grab bar is a better economy at $22.00?

What about the doctrine of "no comfort or convenience items"? This spartan philosophy has resulted in such items as a raised toilet seat being ruled a comfort or convenience item because it could be used in the absence of an illness or injury. Can you picture yourself sitting on a commode raised 4 to 6 inches as a matter of comfort or convenience? But how about the severely involved arthritic who cannot get up from a low level . . . is it a comfort or convenience, or is it a medical necessity? Suppose there *is* a residual benefit to an attendant in the use of a device . . . have you ever witnessed a 75-year-oldster bending to hand crank a hospital bed for her paralyzed spouse? It's not a pretty picture and if it were *your* parent, you would leap to do the job yourself or pay the less-than-70-cents-per-day difference it costs to have an electric bed! I quote you from a carrier letter in my files. . . .

"We get many requests for electric beds from people who are dying of cancer. We disallow most of these for the reason that the person can roll over from side to side to forestall bed sores, and there is no bed that does this at the present time."

This statement assumes that there is *no other reason* for a dying cancer patient to have an electric bed. The writer has obviously never seen anyone dying of cancer; the pain patterns that are relieved by the changes in position are evident . . . pressure is relieved in some configurations by electric beds and all that notwithstanding, the presence of a manual bed also requires a close attendance of an attendant. Of all the faults in the Durable Medical Equipment section of Medicare, the highly restricted use of the electric bed is the worst. If you are a candidate for a hospital bed, you should have an electric bed in most cases.

I suggest that the Act be changed to read that where illness or injury is present that could reasonably lead to the use of an assistive, retabilitative or safety device, and when ordered by the attending physician in the course of medical management of the *existing* condition, Medicare should participate in the payment subject to the cost safeguards provided in the Act. Many of the more enlightened State Medicaid programs have this feature now.

Your carriers will tell you that assignment is the desirable method of payment for them. The claims are most often properly prepared and the cost of processing claims submitted by suppliers is lower by a wide margin than that of claims sent in by individual beneficiaries. Yet we have problems. You do not say to an orthopedic surgeon, "I will pay you $50.00 per month for your hip prosthesis until your fee of $600.00 is paid, but if the patient dies, I will stop payment or if the leg is subsequently amputated, I will stop payment because then we no longer need the hip procedure." What you say to the durable medical equipment industry is that our services must be paid on a time basis related to the use of the equipment and services. You also say you will pay a carrying charge for this privilege. *If* you could get support for sales assignments, you would be paying more in carrying charges than you could ever conceivably hope to gain by terminating payments due to short-term expiration of medical need. The fact is that assignment *purchase* just doesn't work. Your carriers will inform you that very little assignment purchase is submitted by suppliers. We urge adoption of lump sum payments for durable medical equipment when approved by the attending physician, when approved by the carrier review physician and when decided upon by the beneficiary. The argument given us by some departments of HEW that this is an opportunity for unjust enrichment of the beneficiary is without merit in view of the proposed controls.

Industry efforts to support the assignment *rental* program have yielded us a nearly insupportable burden. The 1969 rate freeze has left us with rates that are grossly inadequate. Our industry has historically avoided annual rate increases. Thus, we withheld increases in many areas of the country as long as we could . . . many companies have rates in effect which prevailed in 1967 . . . when raised in 1969, and then only by a modest amount, we were told by the carriers that these new rates could not be recognized. We were also told that in June of 1970, we could expect some rate relief. This has not been forthcoming. HEW has instructed carriers to withhold rate increases until Congress acts on changes in the Medicare Act. Thus, many of us approach *1971* with rates established in *1967*, or before. I am sure I need not point out the changes in the Bureau of Labor statistics index since then, or bury you under documentary evidence of the number of price increases we have had in every area of our business. This industry will cooperate in any equitable plan to control annual increases, or limit them to the BLS index changes, but what you have done is legislate price control in only one segment of the field, letting steel, manufacturers, labor, taxes, rents and every other overhead expense escalate without control. This is grossly unfair. We seek immediate relief in an instruction to HEW to permit increases not to exceed BLS index percentages for those companies who can demonstrate that they did not raise rates annually prior to 1969.

In closing, our industry contends that your short-term savings are too dearly bought . . . that home care should be intensively utilized and encouraged as the least expensive facility for the care of the patient . . . that modern labor-saving devices not be prohibited because of their marginal benefit to the attendant, that *safety* and *hygienic* equipment for the *already involved* patient is a proper extension of the Medicare program.

WHAT IS THE INTENT OF CONGRESS?

MARTIN FRANK,
Director, California Rental Association.

STATEMENT OF PATRICK J. NILAN, LEGISLATIVE DIRECTOR, UNITED FEDERATION OF POSTAL CLERKS

Mr. Chairman and Members of the Committee, I am Patrick J. Nilan, Legislative Director of the United Federation of Postal Clerks with offices at 817-14th Street, N.W., Washington, D.C.

We appreciate the opportunity to present this statement concerning H.R. 17550 on behalf of the nation's 310,000 postal clerks for whom we are the Exclusive National Representative for labor-management relations and collective bargaining with the Post Office Department. Our membership is entirely within the postal clerk craft and employed in post offices in all 50 states, the District of Columbia, Puerto Rico, Virgin Islands and Guam.

When Public Law 86-382 was enacted in 1959, the United Federation of Postal Clerks Hospital Plan subsequently became a charter underwriter under this "Federal Employees Health Benefits Act." Our plan was approved by the United States Civil Service Commission to participate under the Act and has a continuing contract with the Commission.

Mr. Chairman and Members of the Committee, our organization is concerned only with TITLE II, Part A, Section 201 of H.R. 17550, which has to do with "Coverage Under Medicare Program—PAYMENT UNDER MEDICARE PROGRAM TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM." The United Federation of Postal Clerks and our Hospital Plan are opposed to the provisions of Section 201 and respectfully urge the Committee to delete this section from H.R. 17550.

While we are not completely familiar with all aspects of the Medicare Act or the pending legislation, we are convinced that if the provisions of Section 201 should become law that Federal employees participating in health and hospital plans under Public Law 86-382 will certainly not benefit as we are sure the House of Representatives intended when H.R. 17550 was approved by the other body.

There is no question that Federal employees and their health plans would suddenly become obligated for the payment of millions of dollars in benefits each year which rightfully have been and should continue to be the responsibility of the Medicare Act.

In order to explain the reasons why we are opposed to Section 201 of the pending legislation we would like to refer the Committee to the "Report Of The Committee on Ways and Means on H.R. 17550." Specifically, we refer to pages 24 and 25 of the Report under the heading "General Discussion of Medicare, Medicaid, and Maternal and Child Health Provisions." Under Part 1, which discusses coverage under medicare program, we would like to correct the impression that the Federal Employees Health Benefit program is not voluntary. Participation in the health plans, under Public Law 86-382 is *entirely voluntary*, both for employees and annuitants. In reality, FEHB basically provides supplementary benefits to Medicare, similar to the situation in the private sector where employees who are eligible for Medicare can obtain private insurance such as "Blue Cross—Over 65" and other similar policies as supplemental coverage and pay the additional premium cost.

In paragraphs 4 and 5 of this part of the Report, we would like to point out that the experience of our United Federation of Postal Clerks Hospital Plan indicates that only approximately 33% of our members over 65 are eligible for Medicare, "Part A." The experience of our Plan contradicts the Report which states, "About 50% of retired and active employees age 65 and over are entitled to hospital insurance benefits under medicare."

Mr. Chairman and Members of the Committee, again in paragraph 6 of the Report, we must challenge the statement contained therein, particularly as far as the UFPC Plan is concerned. The UFPC Hospital Plan provides *specific credits* for all Medicare members. Our policy is to credit any savings realized by the UFPC Hospital Plan, resulting from medicare payments on charges which our Plan would normally have paid if there had been no medicare coverage and these credits can be used by the member to receive additional benefits which exceed the normal medical, diagnostic and first-aid maximum benefits applicable under both our Low and High Option Health Plan Coverages. In addition, this credit can be used by a member to pay the $30 deductible and 20% co-insurance not normally allowed under drug coverage, and also to exceed the normal $25 daily allowance for special nursing care in regard to High Option benefit pay-

ments. *These additional benefit credits are over and above the benefits provided for those health plan members who do not have medicare.*

In regard to the final paragraph on page 25 of the Report by the House Committee on Ways and Means, we would like to emphasize that if this provision is enacted into law, the more than 75,000 members of the UFPC Hospital Plan would necessarily have to pay an increased premium resulting from the increased cost of benefits which our plan would be required to make in lieu of present medicare benefits. Such increased premium costs for our 75,000 plus members would actually be discriminatory, since the vast majority of our members are *not* entitled to Medicare benefits, "PART A". Therefore, these members would be paying substantially increased premiums for which they would receive absolutely no additional benefits, *unless* they obtained other employment in the private sector to earn sufficient social security credits to become eligible for Medicare benefits under "PART A".

The Health Benefits Act of 1959, amended July 1960, provides that there be only two Health Plans available to Federal Employees, that is, High Option or Low Option, Self-Only, or Self and Family Coverage. In order for the UFPC Hospital Plan to provide the coverage suggested in TITLE II, PART A, Section 201, (c)(1), of H.R. 17550, existing law would have to be changed to allow a third health plan option. If this should be done, an additional problem is created, for example, a man over 65 is entitled to Medicare "PART A". The member has a wife and children. We ask *what* plan would then be made available to cover the wife and children, in order that they would be given benefits that a member over 65, *who does not have medicare*, with a wife and family, would be entitled to at the same cost.

We feel that the proposed amendment to the Social Security Act, which would apply to hospital plan coverage under the Federal Employees' Health Benefits Program, would be patently unfair as this is discriminatory legislation. This legislation selects only that insurance in the Federal Employees' Health Benefits Program.

The insurance carriers have no control over the modification of the Federal Employees' Health Benefits Program and cannot unilaterally make available a supplemental coverage for members who have Medicare.

One of the major problems, in offering supplemental care, would involve a member who would be eligible for Medicare coverage and a spouse who was considerably younger, with no Medicare eligibility in the near future. As a matter of fact, our Plan has several members in their sixties who have spouses who are less than thirty years old.

We also have members whose age would entitle them to Medicare, who have young children by virtue of recent marriages to wives who are much younger than our members.

It would seem that this legislation, if enacted, would make it mandatory for a hospital plan to charge a lesser premium for a member with Medicare, and who had a younger wife and several small children, than the premium that we would charge a member and spouse with no children. Patently, such a procedure would be unfair.

Mr. Chairman and Members of the Committee, it is our sincere hope that, in view of the position of the United Federation of Postal Clerks and our Hospital Plan as provided in this statement, you will delete Section under TITLE II, from H.R. 17550 in the best interests of the membership which we represent and the health benefits coverage which we provide efficiently and economically within the premium cost structure of our Health Plan. We shall be happy to provide this Committee with any additional information and a further explanation of this statement if requested to do so.

STATEMENT OF THOMAS F. MITCHELL, EXECUTIVE REPRESENTATIVE, GEORGIA-PACIFIC CORPORATION, WASHINGTON, D.C.

My name is Thomas F. Mitchell of Washington, D.C., and I appear here as a representative of Georgia-Pacific Corporation, one of this Nation's major wood products manufacturers. Georgia-Pacific Corporation has long felt an obligation to its employees and to the public to advocate improved state workmen's compensation laws. We appear here today because we believe state workmen's com-

pensation systems would be weakened by a proposed amendment to Section 224 of the Social Security Act, contained in H.R. 17550.

Section 224 of the Social Security Act now permits a beneficiary to receive state workmen's compensation simultaneously with social security disability benefits so long as the combined payments do not exceed 80% of his average earnings before he became disabled. Benefits payable under the Social Security Act are presently offset against state workmen's compensation payments. H.R. 17550 proposes to amend Section 224 to eliminate the social security offset to permit a beneficiary to receive combined state workmen's compensation and social security payments not to exceed 100% of his average earnings before he became disabled without regard to comparative income tax impact. We oppose this amendment as we would oppose any amendment which would allow a person to receive a higher income *for not* working than *for* working. But perhaps there is a more important factor we should consider first.

We have felt for some time that there may be some who would like to abolish state workmen's compensation programs in favor of a national program administered under the Social Security System. Section 224 is amended, as proposed, would be a significant step towards ultimate realization of that goal.

If Section 224 is amended as proposed, incentive for continued upgrading of state workmen's compensation laws will be removed. The states now have the incentive to adequately care for the industrially disabled through state administered workmen's compensation programs. Remove that incentive and a more costly and far less effective "federal" system will be established. In truth, this proposal will encourage the states to *neglect* their workmen's compensation programs and *eventually* welcome a complete Federal workmen's compensation program under the Social Security System.

This would be a tragedy for injured workmen who would become pensioners under the federal government just when state workmen's compensation programs have been moving from the original emphasis on monetary and medical benefits to increasing emphasis on rehabilitation. This new emphasis recognizes that the concept of "buying off" or "paying off" the disabled workman is shortsighted and cruel. This new emphasis on rehabilitation and restortation to work recognizes the need to return a disabled workman to his rightful place as a productive contributor to our system, not to add another name to the pension roles. The proposed amendment to Section 244 would deal a damaging blow to this new conceptual emphasis.

Actually Congress has in other legislative fields encouraged the states to rehabilitate the disabled. Millions of dollars have been voted by Congress under a State-Federal matching fund program to encourage development of *state* physical and vocational rehabilitation programs. It doesn't make sense for Congress on the one hand to encourage the states to rehabilitate the disabled and on the other to approve a proposal which will *insure the failure of the rehabilitation effort.*

Worse yet, weakening state workmen's compensation programs would weaken accident prevention programs. In the long run, the goal of everyone should be eliminating on-the-job injuries. Accident prevention under state merit premium rating systems encourages the employer to be constantly striving to improve the safety record. Since the *employer*, in most states, pays the entire cost of state workmen's compensation, the most effective way to materially reduce his cost is to prevent accidents thereby reducing his insurance premium.

If the benefits are determined and paid by the Federal government, employer interest and incentive is discouraged.

I have tried to show how the proposed amendment will remove incentives—incentives to states to improve their workmen's compensation programs, and incentives to employers to better accident prevention. What about *motivation*, that fragile force needed to spur the *disability workman to make every effort to get off the disability rolls.* We fear the proposed amendment to Section 224 creates a negative force which will *undermine this motivation.* Even the proposed Family Assistance Plan recognizes the motivation problem—it is even more relevant in disability cases where the proposed pension levels would reinforce the natural tendency not to work because of the disability.

The national economy is as strong and vital as its smallest divisable part—the workman upon whose efforts the economy will flourish or will fail. If we encourage the workman to withdraw from the work force by demonstrating to him it is

no longer necessary that he work, who but the strongest willed shall not eventually choose to "retire"? How long will our economy remain strong and viable under a compensation system which encourages the workman once injured to remain disabled? How can anyone justify a proposal which seeks to make an industrial disability a fortuitous financial event?

What of alternatives? Are we locked into programs which must surely lead to the eventual abandonment of state workmen's compensation programs. Should we stand idly by and watch helplessly as state programs are replaced by a Federal workmen's compensation system. We at Georgia-Pacific think not. We think it proper and appropriate that the Federal government release funds to the various states to stimulate the more deficient states to improve existing programs which would attempt (1) to further develop and enforce meaningful accident prevention programs, (2) to further develop and continue support of programs and facilities for "in-state" rehabilitation efforts, and (3) to implement internal study programs in the area of workmen's compensation.

Rather than weakening state programs as the amendment to Section 224 would do, we believe the efforts of Congress should be directed towards realization of goals which will strengthen existing state programs. We urge this committee to reject the amendment to Section 224.

In addition, I would like to express our strong opposition to Section 103 which provides for an automatic benefit increase tied to a cost of living increase. H.R. 17550, as approved by the House, does not provide for a corresponding benefit reduction if the cost of living should decrease.

We believe that the Congress has always acted promptly and responsibly to protect the aged recipients of Social Security against the ravages of inflation. We do not support the theory that benefit increases tied to a fluctuating, mechanical device would be removed from the political arena and thus be preferable to the present system which relies on the considered judgment of Congress.

All of us, employers and employees, are affected by the Social Security program. We believe this program should be responsive to the will of the electorate through their elected representatives.

Georgia-Pacific Corporation, therefore, urges the Committee to reject the proposed automatic benefit escalator because of the inherent unsoundness of the program and the far-ranging impact this automatic escalator would have on other public programs such as Workman's Compensation, Unemployment Compensation and state and local retirement systems which would inevitably have to adopt a similar principle.

Finally, Georgia-Pacific Corporation is also opposed to the proposal which would allow the Secretary of Health, Education and Welfare to increase automatically the taxable wage base in order to finance added costs resulting from operation of the automatic benefit escalator. We feel this option, also, should rest with the Congress rather than be at the sole discretion of the Secretary of Health, Education and Welfare. We also support previous testimony with regard to the obligation of all workers to share in added costs arising from increased benefit payments.

To the Honorable Members of the Senate Finance Committee:

On March 22, 1967, I appeared before the Ways and Means Committee to discuss the subject of Social Security for Federal employees. A copy of my testimony is annexed hereto.[1] In that testimony, I pointed out by facts and figures that all Federal employees in the lower income brackets of 15 years or less duration were being shortchanged by the Government from what they would have obtained as retirement benefits had they been employed by any other employer.

The facts and figures were verified by the Civil Service Commission, whose letter is also annexed. President Johnson submitted to Congress in 1967 legislation designed to correct these inequities. There were two Administration Bills introduced at that time: H.R. 5710, § 116, which would have allowed for a transfer of credit from the Federal Retirement System to the Social Security System for employees who retired, died or became disabled within 5 years of commencing Federal service. These persons presently have no insurance coverage whatsoever. The other bill was H.R. 6784 which would have guaranteed a civil service annuity not less than what would be authorized by Social Security had it been

[1] See House Ways and Means Committee hearings entitled "Social Security Amendments of 1967", pp. 1540–1543.

covering such Government service. The Ways and Means Committee deleted § 116 from the Final Version of the Social Security Act of 1967 but noted that it was aware of the gaps in coverage but was deferring action pending a study of the problem by the Social Security Administration which is to be completed by Jan. 1, 1969. The Finance Committee stated in its report (No. 744), at page 61:

"The committee is aware of the gaps which exist in the protection of the Federal workers who do not have survivorship, disability, or retirement protection based on that employment.

"A particular hardship exists in many instances when an individual dies during the first 5 years of Government service, when he is not yet entitled to survivorship protection under his Federal staff retirement system but he has lost his social security protection. A similar situation occurs when an individual dies shortly after leaving Federal service and before he has worked under social security long enough to be covered for survivorship benefits."

Nevertheless, your Committee concurred in the decision of the Ways and Means Committee to send the entire matter back to the Social Security Administration for further study, although the subject had undergone comprehensive studies over the years by various committees, commissions, advisory bodies, staff reports, etc. On January 17, 1969, the Social Security Administration did submit a lengthy report to both committees wherein it restated its prior recommendation to allow a transfer of credits for employees of less than 5 years duration and to guarantee an annuity which would be equal social security benefits for all other Government employees. The report was completely ignored in the Social Security Bill submitted by the Administration and by the House Committee.

How much longer must this matter wait for its resolution? Almost every group which studied the problem has pointed out the gross injustices and inequities under the existing system, and yet no action is taken.

Just to use my father's case as an example, as I did in my testimony before the Ways and Means Committee, he would be entitled to about $35 more per month if he was under Social Security than he would obtain from the Federal Retirement System and social security based on his earning prior to Government employment combined. Surely, a person who worked for Government as an underpaid postal clerk for 12 years should not wind up with substantially reduced retirement benefits merely because his employer was the United States and not any one else. There is no justification for further delay. The time for action is now. I am sending you a copy of § 116 of H.R. 5710 of 1967 and strongly urge its inclusion into the present bill, although you may choose to make the effective date June 30, 1970 instead of June 30, 1966 to facilitate administrative problems involved in retroactivity.

I plead with all of the members of the committee to take immediate action on this legislation and not postpone again, and again and again as it has been for the past three decades.

Respectfully submitted.

JUDAH DICK,
Attorney at Law.

Attachment.

U.S. CIVIL SERVICE COMMISSION,
BUREAU OF RETIREMENT AND INSURANCE,
Washington, D.C. May 15, 1967

Mr. JUDAH DICK,
Attorney at Law,
New York, N.Y.

Dr. Mr. Dick: This is reference to your letter of May 4, 1967 in support of your proposal to the Committee on Ways and Means that the provision in H.R. 5710 with respect to transfer of credit for Federal service to the social security system be extended to provide for the transfer to be retroactive to 1936 or 1951. You also made this proposal in your testimony at the hearing held by the House Subcommittee on Retirement, Insurance and Health Benefits on H.R. 6784. I notice from your letter to Chairman Mills that you now suggest the transfer be retroactive at the option of the retiring employee.

In most cases under present law a retiring employee eligible for both civil service retirement and social security gets more total retirement income from the two than he would receive had his Federal employment been under social security. A short-term Federal employee (over 5 years) usually does not suffer much reduction in his life-time average computed under social security because

5 years of the non-social security employment is dropped from the computation. The longer he works in Federal service the more his social security life-time average is reduced but the more his civil service annuity increases.

It is only in rare cases, such as your father's, where the employee has short-time and relatively low-income service under social security, or none at all, and also has relatively short-time Federal service that a complete transfer of credit to the social security systems may result in more retirement income. However, this is true only under present law and will be changed if H.R. 6784 and H.R. 5710 are enacted.

It is the purpose of H.R. 6784 to assure Federal employees the basic retirement, disability, and survivor protection which the social security system provides for non-Federal workers. The transfer-of-credit provision is only one part of the two-fold approach to the overall objective. Its purpose is to fill a gap in the protection afforded by the civil service retirement system, i.e., it provides the basic social security protection for employees who are not entitled to a civil service annuity because they do not have enough Federal service or withdraw their withholdings. It puts *these persons* in the same position they would have been in if they had worked in private industry rather than for the Government. It is not intended to do the entire job of providing the floor of basic social security protection.

The transfer-of-credit provision, like any other legislation extending coverage of social security, is prospective in its application. It is retroactive only, and to the extent necessary, to provide survivor protection for present employees who may die before they have worked long enough after the provision becomes effective to have survivor protection through a transfer of credit. The six quarters of coverage between June 30, 1966 and January 1, 1968 will give the currently-insured status necessary for survivor benefits under social security.

The other provision of H.R. 6784, referred to as the "social security minimum" or "guaranteed benefit level" provision, is designed to correct the deficiencies in the civil service retirement system, i.e., the relatively small annuities for short-term (over 5 years) employees. It applies to persons like your father who are or will be entitled to civil service annuity and accomplishes what you propose for the transfer-of-credit provision. It assures that the civil service annuity payable when added to the social security benefit payable is at least at the level that would have been payable if the Federal service had been covered under social security. Admittedly, the guaranteed benefit level for a retired wage earner does not always equal total family income under social security since it does not provide benefits for wives or children as does social security. On the other hand, survivor benefits are greater because they are based on the high-5 average rather than the life-time average as under social security. Nevertheless, we believe the provision for guaranteed benefit levels accomplishes the limited objective of your proposal and provides better overall protection for employees generally.

For an example of how H.R. 6784 will apply, we will take your father's case and your calculations. You are correct, with one exception, as to your father's annuity at age 62. The reduction in annuity to provide a survivor benefit for a spouse is only 2½ percent of the first $3,600. This would reduce your father's annuity to $80 per month, instead of $74. This $80 plus the social security benefits of $85.50 (We presume you arrive at this figure as $56 for your father, $29.50 for his wife) equals retirement income of $165.50 per month, a little short of the $172.80 you compute as the social security benefits that would have been payable if the Federal service had been transferred to social security.

At age 65, however, your father's civil service annuity would be increased to $129, the difference between his social security benefit of $56 and the guaranteed benefit level of $185 which is payable on the basis of an average salary of $6,232 (See Section 1 of H.R. 6784). This $185 plus the social security benefit of $29.50 for his wife would result in total retirement income of $214.50 per month instead of the $172.80 if he had social security benefits only. His wife would have survivor protection from the time she attained age 62 at 82½ percent of his guaranteed benefit level based on his high-5 average salary instead of 82½ percent of his social security PIA.

Assuming your proposal for a voluntary election of transfer of credit retroactive of 1950 were incorporated in H.R. 6784 and H.R. 5710, your father would have a difficult decision to make upon retirement at age 62. The question will be whether he should trade $41.70 per month in additional retirement income at age 65 and thereafter plus better survivor protection for, by electing a transfer, a refund of withholdings in the amount of $1,561 and additional retirement income

of $7.30 per month for three years. We do not think your father would make the trade. In any event, the case illustrates why we consider H.R. 6784 as the most satisfactory remedy for the deficiencies of the civil service retirement system with respect to short-term Federal employees and why we do not believe your proposal would any better serve the interests of these employees.

Sincerely yours,

ANDREW E. RUDDOCK,
Director.

STATEMENT BY THE NATIONAL COUNCIL OF HEALTH CARE SERVICES, BERKELEY V. BENNETT, EXECUTIVE VICE PRESIDENT

ABOUT THE COUNCIL

The National Council of Health Care Services, organized in October 1969, is an association of multi-facility health care companies. Approximately 90 percent of the Council's member companies are publicly held. As a condition of membership, each company in the Council owns and operates at least three nursing home facilities with a minimum of 300 certifiable beds. Members of the National Council of Health Care Services are united in a common objective: to promote and maintain a professionally and economically sound health care program, with emphasis on providing the best possible care for the patient at the lowest possible cost.

Our members recognize that their first obligation is to the patient, and they believe that any health care facility that fails to show proper concern for the patient's welfare does not deserve to stay in business. Council members further believe that there is nothing inherently "immoral" in profit motivating people to provide the best service for the money, consistent with the patient's best interest. Lower cost does not necessarily mean lower quality of patient care. The multi-facility concept of operating nursing homes has brought significant improvement in the quality of medical care available to many Americans. This movement will continue in the years ahead, raising the standards of care available in nursing homes.

The National Council of Health Care Services believes that the existence of healthy competition between voluntary and proprietary nursing facilities will work to improve the quality of care and efficiency of operation of each type of facility.

Members of the National Council of Health Care Services, as health care professionals and as business men, recognize the necessity of creating a more efficient system for the administration and delivery of health care in order to combat the spiralling costs of the American health care system. In the Council's opinion some provisions of HR 17550 do a great deal to promote efficiency of operation while keeping standards of care high. There are, however, some provisions of this bill which will, if enacted, place obstacles in the path of efficient operation of the health care system and will serve to stifle competition.

SECTION 221—LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

This section will require that expenditures of capital funds for improvements, additions, and the building or leasing of new facilities be approved by a planning agency. Reimbursement under Medicare and Medicaid for depreciation, interest on borrowed funds, return on equity capital, and other expenses related to such capital expenditures will be dependent upon such approval.

The stated purpose of this provision is to ensure National development of health care facilities and eliminate unnecessary program costs due to overbuilding. The Staff Report of the Senate Committee on Finance (pg. 48) supports the contention that expenditure of capital funds should be related to comprehensive health planning. The House Committee on Ways and Means in the report accompanying this bill states that it "believes that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made" (pg. 28). The National Council of Health Care Services agrees with the Committee on Ways and Means. Besides controlling health costs, other benefits of such a connection, which the Committee must have had in mind, can be obtained. Optimum use of health dollars can begin to be realized. Assurance can be obtained that health care delivery systems will be distributed so as to achieve optimum population coverage.

The controlling of health costs, optimum use of health dollars, and optimum distribution of health care delivery systems are aims which the Council can and does strongly support.

However, the system established to tie reimbursement to capital expenditure provided for in Section 221 has serious drawbacks at this time. In instances where a expenditure is disallowed by an agency in clause (ii) of subsection (d)(1)(B), the affected party has no further recourse until such time as the Secretary makes a decision in the matter. The McNerney Report in referring to the very comprehensive health planning agencies who will have initial and therefore considerable impact on this decision process, cites their "relative immaturity", and their delicate and still emerging relationships (pg. 85). The National Council of Health Care Services submits that while it agrees in theory with the intent of this section, the "relative immaturity" of many of these agencies which will have so significant an impact on capital expenditure precludes agreement with the substance of the section. The Council further suggests that a formal appeal process be instituted. Such an appeal procedure should offer an injured party an immediate or timely opportunity to present to the next level in the decision-making process, testimony and information to substantiate his proposed expenditures.

SECTION 222—PROSPECTIVE PAYMENT EXPERIMENTS

This section lays out in stronger and more specific language than the 1967 Act, the thoughts and intent of Congress. Where the 1967 Act authorized HEW to conduct experiments, this section states that the Secretary of HEW is required to "conduct experiments and demonstration projects . . ." In addition to obtaining advice from qualified specialists, the Secretary must file reports of the proposed experiments with the House Committee on Ways and Means and the Senate Committee on Finance prior to putting the experiment into operation.

The staff of this Committee, the Committee on Ways and Means, the agencies who supervise the programs, as well as many who render service to Medicare beneficiaries have testified to their unhappiness with the current system of reimbursement. The inadequacies of the present system, which is based on reasonable costs, have been well documented by the staff of the Senate Committee on Finance and others. The incentives for efficiency and economy which this system offers have been, and continue to be, widely heralded as non-existent.

The National Council of Health Care Services strongly endorses the emphasis which the House Committee on Ways and Means has placed on experimental reimbursement programs. We also realize that the Committee on Finance is very much interested in incentive reimbursement, and we commend the Committee Staff on its efforts to develop an incentive reimbursement system.

In view of the widespread dissatisfaction with the present system and the efforts which have been expanded by the staff, we are confident that the Committee on Finance will act favorably on this measure which encourages the Secretary of HEW to expand this effort at determining the relative advantages and disadvantages of various alternative methods of payment.

Since this provision directs the Secretary to report on the results of experimental programs by July 1972, less than two years from now, the Council further recommends that administrative procedures necessary to qualify for participation in experimental programs be simplified and kept to minimum, so that programs can be initiated without further, unnecessary delay.

SECTION 223—LIMITATION OF COSTS RECOGNIZED AS REASONABLE UNDER MEDICARE

This section is an attempt to disallow costs incurred by providers which are the result of (1) excessive or more expensive than necessary costs, and (2) costs resulting from inefficient operation of a facility. Section 223 gives the Secretary of HEW complete authority to decide which and by how much a provider's costs are "unnecessary in the efficient delivery of needed health services."

The National Council of Health Care Services supports any measures which will discourage inefficient operation of health care facilities. Section 223 is designed to discourage inefficiency by placing limits on "reasonable costs" which will be reimbursed by Medicare. The Committee Report issued as a companion to H.R. 17550, however, points out the real obstacle to efficient and economical delivery of health care by providers, stating, "Unfortunately, a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of the objective." (Pg. 32)

The Committee on Ways and Means has acted to remedy the root cause of this situation in another section of this bill, Section 222, which requires the Secretary of HEW to conduct experiments with prospective rate setting and other methods of payment designed to place a premium on efficient operation of health care facilities. The Secretary is directed to report back to the Congress by July 1972 on the results of these experiments.

The National Council of Health Care Services is concerned that Section 223(b) gives the Secretary of HEW unlimited, blanket authority to set the "limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or group of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals" covered by Medicare. The legislation provides no guidelines from which the Secretary shall set these limits. The Committee Report for the bill notes that limits will be established on the basis of available cost data, about which the Report notes, "The data which is available for this purpose will often be less than perfectly reliable . . . The initial ceilings imposed will of necessity be imprecise in defining the actual costs of efficiently delivering needed health care." (Pg. 33) It appears very likely that adoption of this section as it is now written, will result in the same confusion which has surrounded administrative regulations and their subsequent differing interpretations by fiscal intermediaries that has occurred in the past with the Medicare program.

Further, adoption of this section will undoubtedly cause a large and significant increase in the already high administrative costs of the Medicare program. As the House Committee Report notes, "Your Committee is aware of the magnitude of the task this proposal will impose on the Social Security Administration and on the components of the Department of Health, Education, and Welfare that will be involved in implementing the authority it grants. Difficulties will be encountered as a result of deficiencies in the adequacy and timeliness of cost data and as a result of limitations in current methodology for comparing costs necessary to the efficient delivery of health care." (Pg. 33)

Given these drawbacks, Section 223 has little chance of saving the government money or of promoting efficiency on the part of providers. Therefore, the National Council of Health Care Services recommends that Section 223 be deleted from H.R. 17550. If this section is not deleted, the Council respectfully recommends the following changes.

Under Section 223, providers would have "the right to obtain *reconsideration* (emphasis supplied) of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." The National Council of Health Care Services opposes such a retroactive appeals procedure. If Section 223 is adopted, the Council recommends the adoption of legislation guaranteeing the right of providers to a hearing before an impartial body *before* the Secretary is permitted to "classify" providers for "the purpose of cost limits."

In addition, if Section 223 is adopted, the Council recommends that the Secretary be limited to placing limits on a facility's *total* costs. In order to allow the provider some leeway and initiative to develop efficiency in his operation, such a limitation on the Secretary's authority is necessary.

Finally, if Section 223 is adopted, the Council recommends the inclusion into the legislation of specific language which would make clear the Congressional intent behind this section to make any limits on allowable costs ruled on *prospectively*. Providers of health care services have been subjected too often in the past to retroactive determinations of covered costs. The Congressional intent is clear that rulings on cost limits would be on a prospective basis, but the legislation is not.

SECTION 225—ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE OUTPATIENT CARE UNDER MEDICAID PROGRAMS

Subsection 225(a) provides for reductions by ⅓ of Federal matching funds for long term institutional care after fixed time limits for specific types of care have elapsed. The time limit in the instance of skilled nursing homes is 90 days.

The purpose of subsection 225(a), to encourage use of more effective and lower cost patterns of service is sound. The method by which this section proposes to achieve this purpose suffers from serious weaknesses. Medical science has not yet progressed to that state where we may establish a time limit for a level of patient care and still have a reasonable expectation that all the patients affected will recover to a sufficient degree from their illness that they no longer need

constant skilled nursing services. Cancer, arthritis, emphysema, stroke, paralysis, and the names of many other afflictions common to the elderly surface often enough in our daily conversation to suggest that there will be many patients who will need skilled nursing home services long after the 90 day time limit has expired.

What is going to happen to these people after the 90 day time limit? Many state officials, including the National Governors Conference, have stated that to absorb the cost of these required services would work an extreme hardship on their budgets. Therefore, and in all likelihood, the required services will not be rendered.

To render care at levels lower than what a patient's condition requires will only present the opportunity for a relapse of the acute conditions which initially institutionalized him. Should even a small percentage of relapses occur, no program economies would be realized. A more rational approach would dictate that the patient's health be restored as much as possible, and that efforts be made to assist him in maintaining his health.

If economies are to be realized through curbing overutilization and the program intentions of Congress are to be achieved, it would appear that a method other than an arbitrary time limit should be employed. The National Council of Health Care Services believes that both of these goals can be achieved by employing the Utilization Review Committee provided for in Section 235 and in the review procedure of the State Health Agencies under Subsection 238(d). Only by judging the need of the individual patient can Congress be assured of achieving the necessary program economies without unnecessarily penalizing those who have not recovered within the 90 days time limit.

Further, the Staff Report of your Committee, released February 9, 1970, in its discussion of "wholesale transfer of patients" from the skilled nursing home program to intermediate care facilities, note that "This appears COMPLETELY INCONSISTENT WITH THE CONGRESSIONALLY EVALUATED to determine whether his needs can be satisfactorily met in an intermediate care facility . . . Blanket reclassification of patients . . . is not authorized under either the statute or legislative history. It is a subterfuge which distorts what was intended to ENCOURAGE PROPER PLACEMENT OF THE INDIVIDUAL IN A PROPER INSTITUTIONAL SETTING." (Emphasis supplied) (Pg. 100)

If Congressional intent in the Medicaid program was to professionally evaluate an individual's need for a particular type of care, then Section 225(a) flies in the face of the Congressional intent and should be deleted.

SECTION 227—AUTHORITY OF SECRETARY TO TERMINATE TO SUPPLIERS OF SERVICES

This section provides a mechanism through which the Secretary may weed out those providers, professional and institutional, who abuse the Medicaid, Medicare, and maternal and child health care programs. The abuses cited herein are: making false statements in applying for payment, submitting bills in excess of current cost, furnishing services or supplies which are substantially in excess of patient needs, harmful to individuals, or of grossly inferior quality. Any participating provider who is dissatisfied with a determination of the Secretary is entitled to ample notice, a hearing and to judicial review of the Secretary's final decision after such hearing.

In addition, this section would cause HEW to establish in the states programs review teams which will review cases where there is a likelihood of above mentioned abuses and report to HEW the case reviewed along with analyses and recommendations.

The National Council of Health Care Services and each of its members offer our wholehearted support to this measure. The Medicaid and Medicare and maternal and child health programs have been abused by a few practitioners and operators in each segment of the health care delivery system. As a segment of this health system, nursing homes have received more criticism, with regard to abuses, than we can accept. Of course, it is the patient who really suffers the most from these abuses, and on that basis alone, enactment of this measure is more than merely justified. Also hurt by these abuses and the resultant public criticism are those honest, well-intentioned operators or facilities whose reputations are besmirched by the actions of a few.

As a segment of this health system that is seeking more public recognition for the services that it can provide, we cannot afford a tarnished image which unchecked abuses will bestow upon us. We look to the Secretary of Health,

Education, and Welfare, when and if this measure is enacted, to penalize the malefactors and to restore to the honest and well-intentioned operator the public confidence he should have.

SECTION 228—ELIMINATION OF REQUIREMENTS THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS

Section 228 of this bill would repeal section 1903(c) of the Social Security Act and section 2(b) of P.L. 91-56, which requires states to move toward comprehensive care services to all who meet Medicaid eligibility standards.

We who render health care services to the public would like to see the nation maintain its current program commitments in this regard. If this commitment is suspended, even temporarily, can it ever be regained?

The National Council of Health Care Services also believes that no time should be wasted in working toward improvement in the operation of state Medicaid programs. In its report of February 9, 1970, the staff of your Committee cited Federal leadership under a more fully staffed Medical Services Administration as a "key element which is essential if the program is to function as intended." (Pg. 127) If MSA is to be expected to provide the leadership necessary to assist states in improving their Medicaid programs, the Council recommends that they be given the manpower with which to accomplish that task.

SECTION 230—AMOUNT OF PAYMENT WHERE CUSTOMARY CHARGES ARE LESS THAN REASONABLE COSTS

Subsection 230(a) would require payment for Medicare Part A benefits to be the lesser of reasonable costs or customary charges. The House Committee on Ways and Means believes that it is inequitable for these programs to pay more for these services than the provider charges to the general public. (Companion Report, Pg. 45)

The Staff Report of your Committee (February 9, 1970) proposed essentially the same changes in reimbursement provision (Pg. 52) as a means to eliminate abuses associated with high Medicare costs due to low occupancy rates.

Under the present cost reimbursement system, an extended care facility could be reimbursed for all its empty beds as long as it rendered services to at least one Medicare patient. The National Council of Health Care Services believes that this is a serious weakness in the law. The abuses which take place because of this weakness should be eliminated.

The Council believes that the provisions contained in Section 230(a) will eliminate the potential for these abuses. We submit, however, that under a prospective rate systems, such abuses could not occur.

SECTION 231—INSTITUTIONAL PLANNING UNDER MEDICARE PROGRAMS

Section 231 requires institutional providers under the Medicare program to have (1) a written annual operating budget, and (2) a written three-year capital expenditures plan to be prepared under the direction of the provider's governing body.

The National Council of Health Care Services supports the idea that institutional providers be encouraged to participate in health planning on an individual basis, and believes that budgeting is a necessary step toward efficient operation of facilities.

The Companion Report to the House bill states that "The plan would not be reviewed for substance by the Government or any of its agents. The purpose of the provision is to assure that such institutions carry on budgeting and planning on their own. It is not intended that the Government will play any role in that process." The Council recommends that language assuring this intent be incorporated in to this section to prevent possible conflict with Section 1801 of Title XVIII, which states that the government will "not exercise any supervision or control over the practice of medicine or over operation or administration of medical facilities".

The Council further recommends that specific provision be added to this section to prohibit disclosure of such budgets or plans, since public disclosure out of context might be harmful to a providers' plans for financing or operating.

SECTION 232—PAYMENTS TO STATES TO IMPROVE AND MODERNIZE CLAIMS PROCESSING IN MEDICAID

Section 232 provides for the improvement and modernization of states' claims procedures and information retrieval systems. The need for these improvements has been amply documented by the staff of the Committee on Finance. The National Council strongly supports this measure. Yet, we submit that in implementing these programs, the states would be remiss if they did not include in their programming provisions to eradicate another abuse cited as typical by the staff: slow payment to suppliers of health care goods and services. (Pg. 125)

SECTION 233—ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE PROGRAMS

This section sets up procedures for advance approvals of extended care benefits and home health benefits after discharge from a hospital, based on medical condition.

The National Council of Health Care Services strongly supports this section as a partial solution to one of the major problems experienced by extended care facilities and their patients alike—retroactive denial of benefits. Since physicians, in the face of these retroactive denials, have tended to retain patients in high costs hospitals after their need for acute care has passed to assure coverage, this measure may also serve as an economy measure for the Medicare program.

SECTION 235—UTILIZATION REVIEW COMMITTEES UNDER MEDICAID

This section will require that Medicaid cases in hospitals and skilled nursing homes be reviewed by the same utilization review comittee that reviews their Medicare cases. Where such Utilization Review Committees do not exist, a committee that meets the requirements of Title XVIII is to be established. The Staff Report of The Senate Committee on Finance supports the provisions of this section.

It is the understanding of the National Council that under Section 235 utilization review procedures similar to those of Medicare would be required of state Medicaid plans. Utilization Review Committees would review Medicaid patients with the purpose of checking and diminishing unnessary and excessive usage of institutional care and services. These are worthy aims, yet, as presently constituted, this section appears not to contain a provision for reimbursement of costs incurred by providers for the Utilization Review Committees. Should such a provision be included, the National Council could offer its support to this measure.

SECTION 238—USE OF STATE HEALTH AGENCIES TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID

The purpose of this section is to establish at the state level the capacity for supervising the Medicaid program properly. Included in this section are provisions for the establishment and maintenance of health standards for public and private institutions, by the state health agency, for the review of the appropriateness and quality of care and services furnished to Medicaid recipients.

The Senate Committee on Finance Staff Report would appear to lend support to Section 238. Page 133 contains commentary on the need for states to develop the capacity to establish utilization fraud and abuse investigation, and medical audit units. The provision for establishing review of the care and services provided to recipients would appear to supliicate the utilization review provisions of Section 235.

Such apparent duplication is defensible on the basis that it ensures the reliability of both systems. It ensures the accuracy of the facts found by either unit: the URC for the provider of services, the state health agency for the state government.

The measure to eliminate duplication of effort by making the State Health Agency responsible for the establishment and maintenance of standards for public and private health facilities is definitely a worthwhile one. The National Council would like to offer two notes of caution. First, we believe that as these standards are established (the health and other standards referred to in B under Subsection 238(a)) they should apply equally to public and private facilities. Secondly, we believe that in establishing standards, the States should

be guided by Federal recommended minimums, promulgated in the *Federal Register* of June 10, 1970.

The requirement that state health agencies develop the capacity to review the appropriateness and quality of the care and services provided to recipients, on the surface would appear to be a needless duplication of the function of Utilization Review Committees. However, since it will give added reliability to the program, the National Council lends its support to this measure.

SECTION 239—PAYMENT TO HEALTH MAINTENANCE ORGANIZATIONS

This section provides for capitation payments to Inclusive Health Maintenance Organizations to encourage efficiency and economy in health care delivery by making choices available to beneficiaries.

The National Council of Health Care Services strongly supports the provisions made in this section for the establishment and encouragement of alternative methods of health care delivery. We believe that the Health Maintenance Organization offers. a realistic alternative to the skyrocketing costs of fee-for-service health care.

The Council recommends, however, that the requirement that no more than half of the persons served by an individual HMO be over 65 be removed for experimental purposes.

SECTION 251—COVERAGE PRIOR TO APPLICATION FOR MEDICAL ASSISTANCE

This provision would require the states to provide to individuals who have been determined eligible assistance for care and services rendered in or after the third month prior to becoming eligible. Under present law, states may provide this assistance at their own option.

Under Section 251 of this bill, the Committee on Ways and Means has included a provision which will require states to provide to individuals who have been determined eligible assistance for care and services rendered in or after the third month prior to becoming eligible. The National Council of Health Care Services agrees with the Committee on Ways and Means that such coverage is reasonable and desirable. Accordingly, we offer our support to this measure.

TESTIMONY OF THE CALIFORNIA MEDICAL ASSOCIATION PRESENTED BY RALPH W. BURNETT, M.D.

I am Ralph W. Burnett, a physician in the general practice of medicine in Bakersfield, California, where I am a member of a small group, which includes three other physicians. I have practiced medicine in Bakersfield for 25 years. This year, I have the privilege of holding the office of President of the California Medical Association, representing some 26,000 doctors. I am pleased to have this opportunity to present the views of California's physicians on some of the provisions of the Social Security Amendments of 1970 as contained in H.R. 17550.

Permit me, first, to commend the efforts of this committee to take a thorough and objective approach in analyzing ways in which the Medicare and Medicaid legislation can be refined and strengthened to meet the goals for which it was designed. As physicians, the medical profession in California is particularly concerned that the quality of health care provided to patients under these programs is as high as that received by the patient-public at large. As physicians and tax-payers, we are also deeply concerned that this care be provided in the most economical way compatible with quality care. We believe this committee has demonstrated that it shares this dual concern, on which we will base our comments.

I would like to take two of the sections we have selected for comment out of order in view of their importance and because we believe the medical profession has been playing and can continue to play a particularly significant role in strengthening their intent. These are sections 240 and 234.

PROFESSIONAL REVIEW ORGANIZATIONS

Section 240, as modified by Senator Bennett's amendment 851, is of special interest to us in that it attempts to formalize and extend the ongoing efforts of the medical profession in monitoring the cost and quality of medical care.

While we appreciate this recognition of the importance of professional or peer review systems, we believe that no nationwide "blanket" approach will fit our needs in California. We have been developing and implementing increasingly complex systems of peer review over the past two decades, and we have learned that: 1) Any system must be viable enough to allow for local variations—no approach will encompass all aspects of peer review; 2) Any system must be designed to serve the public interest by being geared first to quality and secondarily to economy.

The California Medical Association has been instrumental in initiating and overseeing a multitude of peer review activities; for example, hospital committees such as tissue, medical record and utilization committees, county medical society mediation (grievance) committees, ongoing claims review by insurance and prepayment organizations in concert with the state and local medical societies and finally the state medical association Appeals Committee and Judicial Commission.

This year we expect our CMA Medical Staff Survey Program to increase the number of hospitals evaluated per year to 200. At the same time we are launching a similar statewide program to evaluate extended care facilities.

We believe that states of proven capabilities in the area of peer review, such as California, should be allowed to continue to advance their quality and cost monitoring systems, in concert with fiscal intermediaries and county societies.

If this kind of desirable latitude is not written into whichever peer review legislation is adopted at the national level, then we hope that such legislation will at least allow for significant local variations in the national plan and specify that there should be one designated responsible organization in each state, such as the state medical association. We feel that such a statewide approach is vital to the profession's ability to carry out a cohesive program. In California we are currently exploring with other provider organizations the feasibility of establishing a separate corporation with representation from all vendors which would oversee and coordinate review of all health services.

In short, we urge you to recognize the tremendous amount of ongoing organized effort by the medical profession in the area of peer review and encourage its continuation and refinement. We do not want government, at this late stage in the evolution of peer review in our state, placed in the role of attempting to specify by law how peer review should be done. Instead, we believe that government should allow us to enlarge the scope of existing peer review mechanisms using a variety of local approaches to assure quality care for the public in the most economical ways.

We wish to express particular concern regarding Section 1168 of the Bennett Amendment entitled "Federal Ownership of Files, Records and Materials." This Section says in so many words that everything a peer review organization acquires in the way of knowledge regarding physicians' practices becomes the property of the government. We have opposed this concept in the past and we oppose it vigorously in this current legislative proposal. The medical profession sees no reason for confidential patient records becoming political property.

HEALTH MAINTENANCE ORGANIZATIONS

The other section we wish to take out of order because of its importance is 229, relating to payments to Health Maintenance Organizations. The medical profession in California has serious doubts about the efficacy of this new approach in terms of safeguarding quality. The public interest cannot be best served by a cost approach only.

If it is enacted, however, we hope that every consideration will be given to making it possible for medical society sponsored plans to gain easier entry under this provision. Such a mechanism represents a marked departure for a number of prepayment plans not historically identified with the capitation elements of prepaid group activities. We therefore see all the greater necessity for the provision of technical and administrative assistance to medical society plans so that they may qualify and actively participate as health maintenance organizations if they so desire. We would, however, recommend that the provision relating to the necessity of enrolling members, at least half of whom should be under age 65, be removed, since this provision would not only be a deterrent but would also serve to disqualify medical society sponsored plans (and possibly some group practice plans) which might otherwise be eligible.

I also would like to express CMA's concern that, unless rigid controls and perimeters are instituted, this section might pave the way to the qualification of certain types of plans organized as profit corporations and lacking in the capabilities of assuring the provision of good medical care or in the motivation for professional commitment directed essentially toward the provision of prompt, efficient and comprehensive patient care. The HMO concept as currently stated in H.R. 17550 does not preclude "investor-owned" plans, nor does it rule out profit taking by those laymen who may invest in HMO ownership. We believe that the definition of "health maintenance organizations" should be strengthened in order to exclude or discourage solely profit-oriented organizations from participating and that legislative safeguards should be incorporated to assure the guarantees of conformance with fiscal social and professional responsibilities. The public must be protected against organizations that cannot deliver what they promise in this area. We also urge you to examine the impact of this approach on the Voluntary Health Insurance movement in light of avoiding actions which would undermine this uniquely American innovation in health care financing.

REASONABLE CHARGES

I now would like to return to earlier portions of H.R. 17550 and comment on selected sections. The physicians of California are disquieted over the provision whereby Section 224 would be amended to impose limits on prevailing charge levels (page 81, H.R. 17550) which are even more restrictive than present administrative policy permits. Although the original legislation specified no percentile designation, HEW now specifies that the prevailing limit to determine the reasonable charge is the 83rd percentile of the customary charges of physicans in their respective communities. The proposed revision would reduce this level to the 75th percentile.

We continue to urge that the original intent of the Medicare legislation on this subject be reinstituted and that levels of physician payment under the Social Security Act reflect what we in California term "Usual, Customary or Reasonable." The definition of this concept, as applied by CMA in its peer review activities, is as follows:

> Usual: "The 'usual' fee is that fee usually charged, for a given service, by an individual physician to his private patient (i.e. his own usual fee)."
>
> Customary: "A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)."
>
> Reasonable: "A fee is 'reasonable' when it meets the above two criteria, or in the opinion of the responsible Medical Association's Review Committee, is justifiable, considering the special circumstances of the particular case in question."

We also must take issue with the projected method of updating levels of payment to physicians by attempting to provide for increases in the level of prevailing charges to reflect changes in the operating expenses of physicians and in other adjustments "as justified by economic changes." It is our opinion that such a provision is discriminatory, not only on the basis of a subjective determination as to what constitutes a prevailing level of charges for similar services rendered, but also by the fact that the total *BLS Consumer Price Index* as a basis for adjustment is an insufficient and inadequate instrument on which to base such adjustments.

Although the report of the Committee on Ways and Means (page 36, line 14, *et. al*) states that the increase in the *BLS Consumer Price Index* "would be considered to indicate the justifiable increase in fees to take account of increases in costs . . . ," the fact is that the service component of the *CPI* is woefully inadequate in reflecting the wages of allied health employees (*e.g.*, nurses and other health-related personnel), wages and salaries which have been rising rapidly and which evidence indicates will continue to rise. Nor does it take into account practice overhead costs, such as equipment, rent and malpractice insurance premiums, which can vary widely according to specialty and location of practice. Thus the physician would be penalized in two ways: 1) through an arbitrary reduction in percentile levels; and 2) through the application of an economic index which does not accurately reflect changes in the costs of an individual physician's practice. We strongly urge, therefore, that the 83rd percentile or other arbitrary percentile designations be rejected in favor of "Usual, Customary or Reasonable" charges monitored by Professional Review Organiza-

tions. If a percentile must be established, we request that it be adjusted on a yearly basis using as an index of change the *Medical Care Component* of the *Consumer Price Index*, which is a relatively more accurate reflection of changes in the costs of medical care.

PAYMENT TO TEACHING PHYSICIANS

Although the report of the Committee on Ways and Means discusses in some detail (pages 39–43) some of the administrative problems in payment for services of teaching physicians under Medicare, it is our opinion that Section 226 of the Social Security Act should not be changed to provide reimbursement for teaching physician services from a fee-for-service basis to a cost reimbursement as contained on pages 87–90 of H.R. 17550, merely to resolve administrative problems. Our recommendation is based upon an extensive review of this problem, not only by the California Medical Association but by the Health Review and Program Council of the Department of Health Care Services of the State of California, which administers our Title XIX program. As a result of a series of eight meetings in 1968 and 1969, a special committee appointed to study the problem as it applied to Medicaid (Medi-Cal in California) arrived at recommendations which were subsequently approved by the Health Review and Program Council (Attachment 1). We believe that these recommendations, which provide for alternative methods of reimbursing for services of teaching physicians, would be most appropriate for consideration by the committee in lieu of the provision presently contained in H.R. 17550.

Also appended (Attachment 2) for the information of the committee is a copy of a resolution adopted by the 1970 House of Delegates of the California Association which deals with this subject and establishes a framework of ethics for your consideration. We therefore recommend that Section 226 be modified and offer Attachments 2 and 3 as suggestions for the basis of such revision.

TERMINATION OF PAYMENTS TO PROVIDERS

Section 227, which authorizes the Secretary to terminate payments to suppliers of services, if adopted, would in our opinion not only aggravate a serious problem as it relates to malpractice suits, but would also interfere with professional judgments and represent intervention in the practice of medicine. Intensive professional efforts, both in-hospital and out-patient, are taking place to exercise the surveillance over the costs and quality of care provided. The introduction of vague definitions such as "grossly inferior quality" and determinations by "other professional personnel" (page 91, line 14, H.R. 17550) would dilute the effectiveness of systems of peer review which are constantly being improved. The danger of retroactively applied malpractice suits, which would add to the cost of medical care, would be just one of the major unfortunate outcomes of such a provision. The California Medical Association as well as California Blue Shield and California's Foundations for Medical Care have instituted innovative mechanisms and approaches in systematic appraisals of the cost and quality of medical care. We feel that these mechanisms provide a basis for accomplishing the intent of this section, yet avoid the dangers and pitfalls inherent in Section 227 as now written.

COMPREHENSIVE MEDICAID PROGRAMS

We further express considerable alarm over the provisions of Section 228 which would eliminate the requirement that states move toward comprehensive Medicaid programs. Such a retrogressive step would defeat the objective of providing the indigent population with the components of medical care necessary for health maintenance.

It is the opinion of the California Medical Association that such a proposed retreat from social commitment as contained in Section 228 would also retard the development of other programs which can be expanded to the total population. The proposal of this Association for a Voluntary Universally Available Health Benefits Program (Attachment 3) is evidence of the interest of California's physicians in establishing components and standards of care which would embrace all individuals and families. Approved by the House of Delegates of the California Medical Association in March 1970 and approved in principle by the House of Delegates of the American Medical Association in June 1970, this proposal provides impelling evidence of the profession's interest and concern not

only with the needs of the Medicaid population but also with those of the total American public. It offers an opportunity to embark upon a coherent and integrated approach to the organization and financing of health care for all people. It is designed as a long-range planning proposal whose implementation can be begun now and expanded over the coming years. We deem it worthy of your serious consideration. Since Section 228 would hinder us from attaining such an objective, we therefore recommended that this section be deleted.

I would also, at this time, comment on Section 222 since its provision for experimentation and demonstration projects in prospective reimbursement offers an excellent opportunity to implement in the State of California some of the innovative aspects of our Proposal for a Voluntary Universally Available Health Benefits Program. Through the cooperative efforts of the Secretary, the California Medical Association, other providers and other organization involved in proposal, it would be possible to select California to engage in this broad scale effort, not only for Medicare and Medicaid recipients, but also for the entire State population. The approval by your committee of the concepts embodied in our proposal could stimulate the initiation of an effort by representatives of the public and private sectors to implement the proposal, phasing in its various provisions as they are judged to be feasible of application at various points in time. We therefore strongly urge your support in encouraging such a statewide demonstration effort which could serve as a model for future developments in the country.

CHIROPRACTIC SERVICES

My final remarks relate to Section 203, which would involve a study of chiropractic services furnished under Title XIX to determine whether such services should be covered under Part B of Title XVIII. The *Report to the Congress* of December 28, 1968, by former Secretary of HEW, Wilbur J. Cohen, recommended that "No changes be made in coverage in relation to the services of chiropractors." The *Report* is a product of a detailed study and we believe that its finding is just as applicable today. We therefore, suggest that no further expenditure of public funds is necessary since the evidence does not support such a proposal. It is our belief that it would be a disservice to the American public to include chiropractic services as a part of any medical program, regardless of funding sources.

I wish to thank you for this opportunity to present my views on behalf of the California Medical Association and of the vast majority of the physicians in California who have played a dynamic and progressive role in attempting to provide the highest quality of medical care to the American people and who will continue to do so, given the opportunities to exercise their professional judgments and to participate in the development of programs to enhance the quality of life for the people of these United States.

ATTACHMENT 1

REIMBURSEMENT FOR PHYSICIAN SERVICES TO MEDI-CAL PATIENTS IN TEACHING AND COUNTY HOSPITALS

1. That medical services provided to eligible beneficiaries under Title XIX in a county or teaching hospital, by a salaried physician or a member of an organized faculty of a medical school, be billed to the carrier designated by the Department of Health Care Services on a fee-for-service basis to the same extent that such services would be billable to the Medi-Cal program for private patient care in the particular community where such service is provided. Out of the fees paid for such services, the hospital shall be reimbursed the cost to the hospital of providing such services. The costs of medical care referred to above should include all expenses of the medical staff which are incurred by the hospital.

2. That such paid hospital staffs may be organized into groups for the purpose of appropriate billing of the fee for such care, as well as maintaining an organized and disciplined staff approach to the providing of such care. However, nothing herein contained shall be construed to prevent an individual member of such a hospital staff from entering into an arrangement with the hosiptal, as recommended in 1. above, on his own behalf.

3. That any salaried physician declining to utilize fee income for reimbursing related hospital costs should be precluded from collecting fees under the program for services rendered in the hospital.

4. That provision be made for the waiver of any regulations governing this subject matter to encourage experimentation and demonstration or alternative system for paying for medical care in teaching and county hospitals.

ATTACHMENT 2

HOSPITAL TEACHING SERVICES

Resolution No. 135–70: Committee C.
Introduced by: James O. Farley, M.D.
Representing: Sacramento County Medical Society.

Whereas, California physicians are dedicated to undergraduate and postgraduate medical education and:

1. California physicians and surgeons are active staff members in private, community, district, and county hospitals that have recognized and certified internships and resident training programs; and

2. California physicians and surgeons instructing interns and residents in medical, surgical, psychiatric and laboratory patient services and skills assume professional and legal responsibility for said services; and

3. Certain governmental agencies and private insurance companies have denied payment to California physicians and surgeons for services rendered during the course of discharging their responsibilities to teach interns and residents in the aforementioned skills and services; now, therefore be it

Resolved: That CMA considers a physician on the staff of a recognized teaching service or hospital to be professionally responsible for the services rendered by interns and residents under his personal and direct supervision for a specific patient while in his direct presence; and be it further

Resolved: That the CMA considers it to be an ethical practice for the teaching physician and surgeon to be designated the attending physician or surgeon in any medical or surgical report, consultation, hospital record or other medical record that describes patient services that may have been performed in such teaching hospital or service under his direct supervision and in his presence; and be it further

Resolved: That the CMA considers it an ethical practice for such teaching physician and surgeon, under circumstances described above, to submit a charge to the patient and/or to any private insurance carrier, or governmental agency usually responsible for such charges, when the teaching physician has, in fact, personally performed such services; and be it further

Resolved: That the CMA does not consider it ethical for services performed outside the presence of the teaching physician and surgeon to be charged to the patient and/or the private insurance carriers or governmental agencies.

ACTION: Adopted.

Referred to: ad hoc Committee on Medical Practice.

ATTACHMENT 3

CALIFORNIA MEDICAL ASSOCIATION FOR A VOLUNTARY UNIVERSALLY AVAILABLE HEALTH BENEFITS PROGRAM

All individuals and families, regardless of income, age, or employment status, would be eligible, subject to the conditions and criteria cited below, either for:

A. Coverage of acceptable levels of benefits through the issuance of vouchers, or

B. Tax credits for the purchase of acceptable levels of benefits, as defined below.

1. All individuals and families, regardless of income, would be entitled to additional medical expense tax credits based upon a graduated percentage of such additional expenses but in no case less than 50 percent of such additional expenses.

2. The determination of those individuals and families eligible to receive vouchers for acceptable levels of health benefit coverage would be based on budgets of adequate, but moderate, living costs as estimated by the Bureau of Labor Statistics, Division of Living Conditions Studies, and up-dated on a bi-annual basis for all areas of the country.

3 Where health care benefits are financed in whole or in part by an employer, tax credits to the individual or family would be applicable to supplement coverage to designated acceptable levels of benefits. Such tax credits would constitute the difference between the costs of benefits previously purchased and the health care budget component established by the Bureau of Labor Statistics.

4. Acceptable levels are defined as "low" or "high" options which contain essential and adequate health care provisions but which may be limited in some respects. The attached guidelines reflect the optimal (high) and

acceptable (low) options to be made available; benefit levels and content of coverage may exceed those indicated.

5. Each individual would have a choice of plan or program which qualifies as an acceptable level of coverage.

6. Each individual would have an option of selecting his plan of coverage on an annual basis.

7. In view of the experience of the Bureau of Retirement and Insurance of the United States Civil Service Commission in administering the Federal Employees' Health Benefits Program, the Commission would be the Federal agency responsible for administering the Voluntary Universally Available Health Benefits Program. It would:

a. Serve as a repository for all Federal funds, i.e., Social Security trust fund, general tax revenues, etc.;

b. with the assistance of a National Advisory Medical Council, establish criteria for the definition of acceptable levels of benefit coverage; and

c. establish rules and guidelines for the guidance of State Civil Service Commissions or other similar agencies which would administer the program on State and territorial levels.

8. The foregoing Voluntary Universally Available Health Benefits Program would make it the responsibility of the Federal government to finance benefit coverage for Medicaid recipients, for an acceptable level of such coverage, with the State assuming the responsibility for financing the costs of any necessary supplemental coverage. This program would eliminate the present Medicare program and absorb it within the provisions cited above. Wherever feasible, the program would also absorb all other Federal programs financing health care benefits for other specialized categories of the population.

9. Other components and requirements:

a. In order to be eligible to receive payment, all institutions providing services would have to be accredited.

b. All institutions providing services would have to provide evidence of active utilization review committees.

c. All plans or programs approved to finance or provide services would have to furnish evidence of peer review activities to evaluate (1) the appropriateness of care provided and (2) the reasonableness of the charges made by providers of services.

10. In order to stimulate demonstration and experimental programs in the organization and delivery of health care, including utilization of new types of manpower, the Federal agency would, upon recommendation of its Medical Advisory Committee, provide grants for such purposes. Approval of grant applications by State Comprehensive Health Planning Agencies would be a prerequisite to funding consideration and approval by the Civil Service Commission.

GUIDELINES TO COMPONENTS OF ADEQUATE HEALTH CARE COVERAGE

OPTIMAL LEVEL

I. PROFESSIONAL SERVICES

A. Medical

1. Outpatient Medical Benefits:

(a) Physicians' services, including consultations, for the diagnosis or treatment of illness or injuries.

(b) Psychiatric care. (Minimal benefits would be for acute psychiatric care.)

(c) Professional services for all baby care from birth through the first year of life. This should include provision for "well baby care."

(d) Inoculation and immunization of infants and adults against communicable diseases on a periodic basis, as indicated by good immunological opinion.

(e) Physical examinations on a periodic basis. (Adult and child periodic health surveys should be available.)

(f) Diagnostic X-ray and laboratory.

(g) Radiation therapy.

(h) Physical therapy—performed by, or under the direct supervision of, a physician.

2. In-Hospital Medical Benefits:
(a) X-ray and laboratory services. (Where employed, co-insurance should apply equally to in- and outpatient.)
(b) Radiation therapy.
(c) Consultation.
(d) Physicians' services for the treatment of illness or injuries during a period of necessary hospitalization.
(e) Acute psychiatric care.

B. Surgical

All surgical procedures intended to bring about the care of illness or the repair of injury, in or out of hospital.
1. Assistant Surgeons, as required.
2. Physicians' services for pregnancy, including prenatal, obstetrical and post-partum care.
3. Complications of pregnancy, e.g., ectopic pregnancy, caesarean section, spontaneous abortion.
4. Medically indicated sterilization procedures.

C. Anesthesiology

Anesthesiologists, as required.

II. Hospital benefits

A. Impatient Hospital Benefits required for the treatment of illness or injuries in a licensed hospital as follows:

1. At least 75% of the cost of a hospital's established two-bed rate (includes board and nursing services) for 365 days.
2. Drugs supplied by and used in the hospital, as well as oxygen, blood and plasma.
3. The costs of all other hospital services, excluding charges for personal items expressly provided for the pleasure of the patient (e.g., TV, telephone, etc.).
4. Hospital extras:
(a) This item should not include any professional services.
(b) It should, however, include the use of the surgery or delivery room, recovery rooms, intensive care units, coronary care units, rehabilitation care units, supplies, etc.
5. Hospital care for pregnancy or any of its complications.
6. Psychiatric care, including psychiatric day care.

B. Outpatient Hospital Benefits for services provided by a licensed hospital:

1. The cost of operating, cystoscopic and cast rooms and their supplies.
2. The cost of emergency room and supplies when needed for medical and surgical emergencies.

III. Extended care facilities

A. Following hospitalization, or where medically indicated.
B. The cost of all necessary professional services, excluding personal services (for patient enjoyment).

IV. Home health and outpatient rehabilitation services

Home visits by medical ancillary personnel of a recognized home health agency to provide, under direction of the attending physician, nursing care, treatments, health teaching and rehabilitative instruction necessary with respect to the treatment of illness or injury.

V. Ambulance services

As ordered by physician.

VI. Prosthetic aids

Based upon medical need, as determined or approved by the physician.

VII. Drugs; outpatient

VIII. Dental care

ACCEPTABLE LEVEL

I. Professional Services

A. Medical

1. Outpatient Medical Benefits:
   (a) Physicians' services, including consultations, for the diagnosis or treatment of illness or injuries.
   (b) Acute psychiatric care.
   (c) Diagnostic X-ray and laboratory.
   (d) Radiation therapy.
2. In-Hospital Medical Benefits:
   (a) X-ray and laboratory services. (Where employed, co-insurance should apply equally to in- and outpatient.)
   (b) Consultation.
   (c) Physicians' services for the treatment of illness or injuries during a period of necessary hospitalization.
   (d) Acute psychiatric care.
   (e) Radiation therapy.

B. Surgical

All surgical procedures intended to bring about the cure of illness or the repair of injury, in or out of hospital.

1. Assistant Surgeons, as required.
2. Complications of pregnancy, e.g., ectopic pregnancy, caesarean section, spontaneous abortion.

C. Anesthesiology

Anesthesiologists, as required.

NOTE.—Example of Contract Exclusion: Cosmetic Surgery; other than those procedures related to birth defects and burns and scars due to injuries and illness.

II. HOSPITAL BENEFITS

A. Inpatient Hospital Benefits

Required for the treatment of illness or injuries in a licensed hospital as follows:

1. At least 75% of the cost of a hospital's established two-bed rate (includes board and nursing services) for 90 days.

A. Inpatient Hospital Benefits

2. Drugs supplied by and used in the hospital, as well as oxygen, blood and plasma.
3. The cost of all other hospital services, excluding charges for personal items expressly provided for the pleasure of the patient (TV, telephone, etc.).
4. Hospital Extras
   (a) This item should not include any professional services.
   (b) It should include, however, the use of the surgery or recovery rooms, intensive care units, coronary care units, rehabilitation care units, supplies, etc.
5. Hospital care for complications of pregnancy.
6. Phychiatric care, including psychiatric day care.

B. Outpatient Hospital Benefits for services provided by a licensed hospital

1. The cost of operating, cystoscopic and cast rooms and their supplies.
2. The cost of emergency room and supplies when needed for medical and surgical emergencies.

III. PROSTHETIC AIDS

Prosthetic Aids: Based upon medical need, as determined or approved by the physician.

NOTE.—Example of Contract Exclusion: Cosmetic Surgery; other than those procedures related to birth defects and burns and scars due to injuries and illness.

STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION ON SENATE AMENDMENT NO. 851 TO H.R. 17550, SUBMITTED BY ROY J. HARVEY, D.D.

Mr. Chairman and Members of the committee, the American Osteopathic Association appreciates this opportunity to express its view on pending Senate Amendment 851, proposed by Senator Bennett.

The American Osteopathic Association shares Senator Bennett's concern over the present problems in professional standards review under Medicare and Medicaid. Our Association most recently manifested its recognition of the need for and its support of the concept of an improved system of peer review last July in Atlanta, Georgia, where our Association's House of Delegates, during its annual meeting, adopted a resolution urging that

". . . The American Osteopathic Association . . . establish a Task Force on Peer Review and make a rational effort to convey the concept of Peer Review to all divisional societies and establish a uniform procedure of Peer Review through the leadership of the American Osteopathic Association."

While we are convinced that Senator Bennett is attempting to respond to the need for a more streamlined and uniform system of peer review, which we most strongly endorse, we are not persuaded that the provisions of Senate Amendment 851 provide the most desirable method of solving any of the present shortcomings in peer review. In fact, it appears that the language of the amendment could actually operate in derogation of the concept of peer review as it is now known.

That concept, as it has been applied, entails the review of health care services by professional colleagues who are educationally and professionally experienced in the same field of health care. In short, that every health care delieverer should be subject to professional review by his own kind—his "peers".

Under Senate Amendment 851 the proposed Professional Standards Review Organization would be "a nonprofit professional society . . . which has available professional competence to review health care services of all types and kinds . . ."

We respectfully submit that there is no one organization which would be professionally competent to review the professional standards of all health care professions.

Our physicians are not professionally competent to pass on the quality of care or the necessity of services rendered by a dentist, nor should a doctor of medicine or podiatrist be charged with the responsibility of determining the propriety or quality of treatment rendered by an osteopathic physician. Yet, if Senate Amendment 851 is passed in its present form, one organization of professionals will have the responsibility for ridging the professional standards of *other* health care professions, about which its members may well have no academic or practical knowledge. Such a system cannot be accurately construed as being "peer review".

The implementation of such a system would place a terrible responsibility on the professional organization designated as the Professional Standards Review Organization and would inevitably lead to a failure of professional standards review.

The purpose of peer review is to insure that the consumer of health care services is receiving fair treatment and the highest quality of health care. This objective will most certainly be foiled if those given the responsibility for safeguarding the patient are not professionally equipped to make an enlightened judgment. The patient will only receive the protection he deserves if the professional conduct of his practitioner is judged by another practitioner from the same health profession who has equivalent training and experience.

In summary, while the American Osteopathic Association recognizes the need for effective professional standards review, we believe that the effectiveness of any review organization rests on the principle that each health profession must have the responsibility to scrutinize the professional practices of the membership within its discipline. Accordingly, we respectfully urge that the Professional Standards Review Organization, contemplated in the amendment, be organizations composed of the individual health disciplines in the program rather than under the administration of any of them.

STATEMENT OF THE MEDICARE ADMINISTRATION COMMITTEE OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, SUBMITTED BY PAUL M. HAWKINS, COUNSEL

This statement is presented on behalf of the Medicare Administration Committee of the Health Insurance Association of America. The Committee is composed of representatives of the following insurance companies: Aetna Life & Casualty, Mutual of Omaha Insurance Company, Nationwide Mutual Insurance Company, The Prudential Insurance Company of America, The Travelers Insurance Company, Connecticut General Life Insurance Company, CNA/insurance, Equitable Life Assurance Society of the United States, General American Life Insurance Company, Metropolitan Life Insurance Company, Occidental Life Insurance Company of California, Pan-American Life Insurance Company and Union Mutual Life Insurance Company. Collectively, these thirteen carriers administer Part B (Supplementary Medical Insurance) benefits for approximately eight million beneficiaries including all Railroad Retirement beneficiaries, who are served by The Travelers Insurance Company. The first five companies named also serve as fiscal intermediaries for hospitals, home health agencies, and extended care facilities under Part A (Hospital Insurance Benefits).

On April 14, 1970, Mr. William C. White presented testimony on behalf of the Committee before the Subcommittee on Medicare and Medicaid of the Senate Finance Committee. Certain specific suggestions were made by Mr. White for changes in the law to improve the administration of the Medicare program. To avoid repetition, we would request that the Subcommittee testimony be incorporated by reference as a part of this statement, and urge that the suggestions made be given your serious consideration.

In addition, we would like to direct your attention to three sections of the House-passed bill (H. R. 17550) and suggest changes in them.

Physical therapy services under medicare (Sec. 254)

We are in complete agreement with that portion of this provision which removes restrictions limiting the coverage of physical therapy services by providers to their inpatients. This will permit an inpatient of a particular hospital or ECF to continue to receive physical therapy services under the Supplementary Medical Insurance Program in those cases where the patient had exhausted inpatient benefits or where he is otherwise ineligible for hospital inpatient benefits.

It is our strong feeling that the physical therapy benefit should not be expanded to include services furnished by a licensed physical therapist in his office or in the patient's home for the following reasons:

1. Physical therapy services are already available under the present law and regulations on an outpatient basis *at cost* to the providers rendering the service. The usefulness of the added provision is really quite limited in that the provision would allow therapy in a physical therapist's office which might be closer to the patient's residence.

2. This provision would increase Program costs for the same services *presently* available by making these services payable on a *fee for service* basis from physical therapist rather than a cost basis (salaried employee) from the existing outpatient physical therapy providers.

3. The objective of limiting physical therapy costs to providers to what would have been paid as salary if the services were performed by a provider's employee (contained in this same section of H.R. 17550) would be frustrated. The result would be that physical therapists who had previously worked on a fee for service arrangement with a provider would terminate this arrangement in view of the pending salary type limitation and go into independent practice—thus retaining the fee for service payment with the accompanying excessive costs which H.R. 17550 is attempting to eliminate.

4. The existing shortage of physical therapists available to medical facilities would be increased as a result of the incentives to go into independent practice to secure the fee for service payment. The rationale here would be, why work for a salary when one could go into business for himself and greatly increase his income with Medicare providing a virtual guarantee of a market and payment for services.

5. The additional record keeping involved in keeping track of the $100 in charges each year would be very expensive.

6. Carriers and intermediaries would be vulnerable for duplicate billings since in most areas they are not the same organization.

7. If physical therapists are allowed to treat in their office, will not the speech therapists, occupational therapists, etc., want the same privilege?

Advance Approval of Extended Care and Home Health Coverage Under Medicare Program (Sec. 233)

While the proposed amendment provides some relief for extended care facilities and patients by authorizing administrative procedures that will minimize retroactive denials of Medicare benefits, it does little to promote greater use of these lower-cost facilities in lieu of higher-cost hospital facilities. Benefits are still limited to those patients who require intensive skilled care, thus promoting unnecessary detainment in higher-cost hospitals of those patients who continue to require institutional medical care prior to discharge home but to a less intensive degree than for which coverage is presently provided for confinement in an extended care facility.

Congress has frequently expressed grave concern over the costs of the Medicare Program. If costs are to be controlled, legislation should be enacted which will change the existing benefit structure for confinement in hospitals and extended care facilities.

Throughout the Medicare hearings held during the past year, your Committee and staff expressed deep concern over the spiraling costs of the Medicare Program and solicited recommendations which might reduce these costs. Various individuals, on behalf of various organizations, recommended a restructuring of the benefits payable for care provided by hospitals and extended care facilities. A theme common to many of these recommendations is to establish incentives which will promote more efficient use of both types of facilities; i.e., restructuring the benefits to promote the progressive care concept so that, it the majority of instances, patients will be discharged *home* from lower-cost extended care facilities rather than directly from higher-cost hospitals. The progressive care concept that was envisioned when Medicare was enacted is not working. This fact is one major reason for high Program costs. According to Social Security Administration statistics, since the beginning of the Program, only about 8% of the Medicare patients discharged from hospitals have been admitted to extended care facilities. This would seem to indicate that many beneficiaries were retained in higher cost hospitals until they convalesced to the point of safe discharge to their homes. If the progressive care concept were working as envisioned, a greater percentage of beneficiaries would be leaving the hospital earlier and utilizing the extended care facility benefit.

What might be the potential savings to the Program if the progressive care concept were working? Based on published government reports, Medicare paid approximately 6 million claims for inpatient confinements in short-term hospitals in 1969. The average length of hospital stay for each of these claims was about 13 days. Assuming that some portion of each of the hospital confinements could have been safely and adequately handled by an extended care facility at an average per diem cost $35 to $40 lower than the average hospital per diem, the potential Program savings for 1969 would have been very substantial. However, as previously mentioned, only about 8% of the hospital discharges worked towards this potential savings by transferring to lower-cost extended care facilities.

The Medicare Administration Committee of the Health Insurance Association of America is available to meet with representatives of Congress, your Committee or staff at their convenience for the purpose of redesigning the hospital and extended care benefit structure to include the following changes which we feel are essential to reduction and control of Program costs:

1. Provide an extended care benefit that will accommodate patients who need convalescent medical care in an institutional setting without regard to the level or intensity of such care, i.e., remove the continuous skilled care requirement.

2. Build patient financial incentives into the hospital benefit that will motivate the patient, his family, physician and hospital Administration to utilize lower-cost extended care facilities as soon as medically feasible.

3. Redirect the activities of utilization review committees whereby positive action will be required to retain the patient in the hospital or extended care facility, if medically necessary, rather than requiring positive action for discharge or transfer.

The following suggested change benefit structure is but one example of how what we are proposing might be accomplished:

Hospital confinements.—First 15 days: Medicare pays for all covered services except for the first $52 (deductible). 16th through 90th day: No Medicare payments *unless* patient's physician and hospital's URC certify in writing that continued hospital confinement is required and that patient's medical needs cannot be safely and adequately provided in a certified extended care facility or at home. With such certification for each extension period up to 15 days, Medicare continues to pay for all covered services except for $13 a day. Lifetime reserve: As at present but with same physician and URC certification requirements applicable to the 16th through 90th day.

Extended care facility confinements.—First 20 days: Medicare pays for all covered services. 21st through 60th day: Medicare pays for all covered services, except $6.50 per day, for each extended period of up to 20 days for which the patient's physician and the facility's Utilization Review Committee certify in writing that patient requires convalescent medical care.

A benefit structure such as outlined above has the following advantages:

1. Provide the patient with a reasonable period of full coverage (except for deductible) to accommodate his acute intensive care hospital needs. The period provided, 15 days, is in keeping with the average length of hospital stay experienced by Medicare patients during 1969.
2. Provides the patient an additional 20 days full coverage for convalescent care in a certified extended care facility, thus giving him a total of 35 days continuous free institutional care, except for the initial hospital deductible.
3. Reduction in the number of days coverage in an extended care facility from the present 100 days to 60 days provides reasonable control against prolonged benefit payments for domiciliary or custodial confinements.
4. Provides a financial incentive for the patient to transfer to the lower-cost extended care facility as soon as is medically feasible and yet provides substantial financial assistance to those who require more than 15 days intensive hospital care.
5. Reduces patient and family pressures on the attending physician to keep the patient in the high-cost hospital.
6. Promotes more effective use of URC physicians' time.

Advance approval of extended care and home health coverage under medicare program (sec. 233)

It is our opinion that the requirement that a plan for furnishing services be submitted to the extended care facility prior to the patient's admission will delay the patient anywhere from one to three days in the hospital while the physician completes the necessary paperwork. The result would be the reverse of what is really intended, i.e., getting patient out of the expensive hospital into a less expensive extended care facility. It is recommended that this requirement be dropped.

STATEMENT OF JOHN A. DECELI, PRESIDENT, MEDICENTERS OF AMERICA, INC., MEMPHIS, TENN.

Last week at the Annual American Hospital Association Convention in Houston, Dr. Roger Egeberg, H.E.W. Assistant Secretary for Health and Scientific Affairs, stated that there would be a saving of $500,000,000 to the Medicare Program if the average length of stay in the hospital were reduced by only one day for each Medicare patient. The average length of stay for Medicare patients is currently about thirteen days, almost twice the average for non-Medicare patients, so the potential saving becomes astonishingly evident.

A mechanism already exists whereby such cost saving can be achieved. The Congress was far sighted and innovative in 1965 when it provided for extended care benefits in the Medicare Program. Extended care was intended to be an alternative to continued hospitalization, a substitution of less expensive facilities and services for those patients who are still recuperating but who no longer need all of the services of an acute hospital. It was never intended to be the long-term custodial type of care so often associated with nursing homes. Instead of providing an additional benefit at an additional cost to the Program, extended care was designed to save money for the Program by providing a lower cost alternative for a portion of the normal hospital stay. The concept is so sensible, and yet it is not working as it was intended.

Senator Moss has charged that the extended care portion of the Medicare Program is being "systematically dismantled" by the Department of Health, Education, and Welfare, and many others have repeated this charge. We do not believe that the Program is being deliberately sabotaged by those who administer it, but deliberate or not, the extended care concept is certainly being impeded. You have all heard about retroactive denials, about delays in payment and audits, about clerks overruling physicians' judgment, and about other problems which have plagued the Program. All over the country, the attitude now is to just leave the patient in the hospital where relatively few questions are asked rather than transfer him to an extended care facility where so many problems are encountered with Medicare. Consequently, patients are remaining in the hospital, and the Program is paying full hospital costs for their entire length of stay.

Because the extended care concept is so practical and sound, and has such cost-saving potential, it must be encouraged. There should be a reaffirmation of support by the Congress, and this support should be implemented by changes in the existing law and regulations. H.R. 17550 takes a small step in the right direction by proposing to guarantee a certain number of covered days in an extended care facility. This should help reduce the reluctance to transfer patients to an E.C.F., but it does not go far enough. It does not propose any real incentives to get patients to leave the hospital sooner, and this is vital in our opinion.

On June 2, 1970, I testified before the Special Committee on Medicare and Medicaid and presented specific recommendations to help encourage the transfer of patients from hospital to extended care facility as soon as practical. The most significant of these recommendations had to do with: (1) making it easier to admit and treat a patient up to the normal recovery time for his condition and then becoming more strict in the requirements for continued hospitalization; (2). introducing a financial incentive for patients to leave the hospital earlier by requiring a co-insurance payment after the fourteenth day; and (3) offering a financial incentive to physicians to utilize the lowest-cost type of service which is appropriate. Certainly these recommendations are subject to modification and improvement, but we urge you again to give them serious consideration.

Let me comment briefly on three other provisions of H.R. 17550. We feel that it places too much power in the hands of the Secretary of Health, Education, and Welfare. Certainly he should have the authority to make decisions, but there should also be an avenue of appeal. The absence of an appropriate appeal mechanism is inconsistent with the principles upon which this nation was built.

The provision which limits reimbursement to reasonable cost or current charges, whichever is less, is equitable for a mature institution. For a new facility it is not, and special consideration should be granted in this instance. To say that "Medicare should not put a new facility into business by paying more than it charges" is reasonable only if the facility is permitted to collect its full charges after it becomes established.

Finally, H.R. 17550 proposes different effective dates for the different provisions of the bill, and some of these dates are already past. We would plead on the basis of fair play that none of the dates are made effective retroactively.

Thank you for the opportunity of presenting this additional statement.

STATEMENT BY E. WILLIAM SMOCK, PRESIDENT, SRS CONSULTANTS, INC., BOSTON, MASS., AND MEMPHIS, TENN.

Mr. Chairman, distinguished committee members, the report No. 91–809 of the Committee on Government Operations, United States Senate, made by its Subcommittee on Executive Reorganization and Government Research, published in April, 1970, "Federal Role in Health," strikes a responsive note in our organization. We have developed a realistic solution to a major aspect of the national crisis of spiraling hospital costs, inequality of distributon of medical care and a declining level of health among our citizens as compared with other Western nations. Our approach has been described by experts in the health field as "the single most exicting breakthrough in *free enterprise* health care."

SRS Consultants, Inc., in association, with Tompe, Inc. of New Jersey, have applied managerial and facility planning capabilities to the problem of delivery of a health service program such that a 400 bed facility in the Parsippany-Trop Hills Area will operate at a fifty-five dollar per day bed cost exclusive of drugs.

The project addresses three major components of a health care delivery system: (1) high quality, low cost health care to the patient; (2) development of

trained health care personnel on the professional and para-professional levels; and (3) community participation and control through proprietary management and allocation of voting stock.

(1) The first aspect of the complex will combine advanced management technology with related skills required to develop and manage the Parsippany Medical Complex. Parsippany Medical Complex will combine a 300 bed General Hospital, a 100 bed Extended Care Center, a Medical Arts Building for the medical progression and necessary ancillary functions to support the above operation.

The proposed Parsippany Medical Complex has extended the traditional goal of medical excellence to include efficiency, effectiveness and profitability by the application of the systems approach. The hospital continues as the focal point for health care, yet it is but an element within a total system aiming toward an interface of the latest achievements in medical and management sciences. Similarly, the need to retain the humanness of the hospital through sensitive and responsive medical care is fundamental to our goals.

Guided by these goals, a total information interface program for the medical and administrative data base will provide the physician, the hospital administrator and all functional groups with the ability to analyze information as well as the ability to simply make use of it. Underlying the system, an information matrix will allow each group to effectively set standards and objectives, evaluate progress, measure performance, direct and allocate resources efficiently.

The systems approach, rooted in all the varied facets of electronic data processing equipment—patient monitoring systems, financial budgeting systems—will open new vistas in medical and managerial capabilities.

(2) With the expansion of post secondary education under the Vocational Education Amendment of 1968 (PL 90-576) opportunities are available for combining the medical facility with Junior College and Technical Institute Training Programs. Advantages to the educational institution are:

(*a*) Availability of a student health service paid for by Tompe

(*b*) Reduction of construction cost to the college because Tompe must provide for power, food, laundry, accounting, data process and management needs. Space for these services would not be required in the college complex. Further the cost to the college of these services would be minimal when purchased from Tompe and the overhead of the college would be reduced considerably.

(*c*) Joint appointments of Tompe professional personnel to the college faculty brings a new life stream into the academic campus, e.g. a psychiatrist teaches English using psychoanalytic theory to evaluate literary characterization.

(*d*) Operational departments within Tompe will provide a reality base for the college's offerings in accounting, social studies, nursing, business administration, biology, psychology, physical education, physics, etc.

(*e*) The life style of the college and that of Tompe as service institutions are so compatible that the presence of Tompe on campus represents an appropriate land use.

(*f*) Students would find employment within the health complex involves them in *relevant* social activity dealing with *real* opportunities for working within the system for the betterment of society.

(3) The whole issue of user control of institutions finds particular focus in the health care field. As the report on "Federal Role In Health" points out in its summary and findings:

Specialization had reduced the number of physicians serving the basic health needs of the population. Many turned to hospital emergency rooms as their "Family Doctor", placing heavy and unexpected demands upon these facilities.

Health insurance plans, by generally covering only care administered in hospitals, encouraged the most expensive care possible. In addition, by covering treatment instead of prevention, the plans were paying for sickness more than health.

As for the health services and professions, they had failed, as the National Advisory Commission on Health Manpower pointed out in 1967, to keep pace with advances in medical science and changes in society. They appeared to be organized more for the convenience and concerns of their practitioners and financial security of the patient.

Tompe offers a solution within the free enterprise system, to the problem described above, by providing for a block of stock to be set aside for community allocation. Where community action agencies exist within the community, this stock would be allocated under an appropriate arrangement with the federal Office of Economic Opportunity. The constitution of community action boards under the Greene amendment to the Economic Opportunity Act provides an equitable means of ensuring participation by all segments of the community. Where a community action agency does not exist we would contempalte either urging the Office of Economic Opportunity to create one or would utilize our resources to ensure adequate representation from all elements of the community.

(The following communication was forwarded to the Committee by Hon. John O. Pastore and Hon. Claiborne Pell, U.S. Senators from the State of Rhode Island:)

HOSPITAL ASSOCIATION OF RHODE ISLAND,
Providence, R.I., September 22, 1970.

Hon. JOHN O. PASTORE,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR PASTORE: The Hospital Association of Rhode Island would like to take this opportunity to express its deep concern over Amendment 851—The Bennett Amendment—to the Social Security Amendments of 1970, H.R. 17550, which is presently consideration in the Senate Finance Committee.

As we discussed with you in Washington on August 18, the hospitals of Rhode Island are of the opinion that H.R. 17550 and now Amendment 851 contain provisions that are contrary to the best interest of the people of Rhode Island as beneficiaries of our voluntary system of hospital care. Our specific objections to the Bennett Amendment are detailed in the enclosed addendum to our earlier position statement on H.R. 17550.

We respectfully ask that you request our enclosed addendum be included in the record of the Senate Finance Committee with our original statement, which you previously had inserted in the Committee's record.

Sincerely,

WADE C. JOHNSON,
Executive Director.

ADDENDUM

HOSPITAL ASSOCIATION OF RHODE ISLAND POSITION STATEMENT ON TITLE II OF H.R. 17550 AMENDING THE MEDICARE, MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS UNDER THE SOCIAL SECURITY AMENDMENTS OF 1970

It is the position of the Hospital Association of Rhode Island and its member hospitals that Amendment 851 (The Bennett Amendment) to the Social Security Amendments of 1970, H.R. 17550, is not in the best interest of the people of Rhode Island as beneficiaries of hospital services.

The Bennett Amendment would take the responsibility for health care quality control and utilization review out of the hospital and its medical staff and place it, improperly, with the county medical society. While the present hospital-based programs of quality control and utilization review may not be perfect, they have been developed and improved substantially over the past few years and are continuing to develop. The standards of the Joint Commission on Accreditation of Hospitals (JCAH) and the services of the nonprofit Commission of Professional and Hospital Activities (CPHA) are important resources for this development and are centered around hospitals. *All* of Rhode Island's voluntary acute-care hospitals are accredited by the JCAH and subscribe to the services of the CPHA.

Most important of all, in our view, is that the hospital is the place where the medical staff, management, and trustees, working collectively, can be made accountable for quality of care and effective use of resources. It should be particularly kept in mind that the hospital board of trustees has the legal responsibility for all care rendered by the hospital.

If the responsibility for quality control and utilization review were transferred from the hospital to the county medical society, we fail to see how the resources, the team approved, and the safeguards described above would be

effectively duplicated, and we therefore see a potential danger to the public interest and safety.

In addition, we think there is danger of conflict-of-interest allegations interfering with a program's effectiveness under a program of peer review conducted by a county medical society.

We therefore urge that the Congress reaffirm the existing Federal policy of supporting, encouraging and strengthening utilization review and quality control efforts under present hospital-based auspices, and that Amendment 851 be defeated.

FARMERS UNION,
OFFICE OF THE PRESIDENT,
September 23, 1970.

HON. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I am taking this opportunity to express the position of the National Farmers Union on the OASDI section of HR 17550, the Social Security Amendments of 1970 now pending before your Committee. I respectfully request that this correspondence be made a part of the record of the hearings on the bill.

We strongly support all of the improvements in the OASDI program contained in the House bill. Particularly significant in our view are the provisions for a five percent increase in payments effective January 1, 1971, for automatic benefit increases thereafter, and for the amount a beneficiary under age 72 could earn in a year and still be eligible for OASDI benefits to be raised to $2,000 and then raised biennially to match increases in average taxable wages.

We firmly urge that your Committee take one additional step, and give top priority to increasing the minimum social security payment to $100 per month for individuals. The additional cost of this minimum payment can be financed by an increase in the OASDI wage base, from general revenue, or a combination of these two sources.

Even if the five percent increase in social security benefits contained in the House bill is enacted, the minimum payment for individuals will be only $67.20 per month. An increase to $100 at this time would improve the economic status of more people now stricken by poverty than any other action that this Congress could take. Today about 40 percent of all of the American people over 65 live in rural areas, and our older rural people are poor. Farm families which are headed by persons over 65 had an average income of less than $3,000 in 1966, compared with about $3,700 for non-farm families. Consequently, a substantial portion of the people who would benefit from a $100 floor under social security payments are farm people.

Since Farmers Union elaborated its position on the Medicare and Medicaid programs in oral testimony before your Committee and an accompanying statement on October 23, 1969, we will not reiterate that position at the present time.

Sincerely,

TONY T. DECHANT.

STATEMENT BY GEORGE J. OTLOWSKI, DIRECTOR, BOARD OF CHOSEN FREEHOLDERS, MIDDLESEX COUNTY, AND CHAIRMAN, DEPARTMENT OF HEALTH AND SOCIAL SERVICES

I wish to thank the Committee on Finance for entering my views into the record. I especially want to thank the Committee members for considering my comments on the Social Security Amendments of 1970.

I have serious reservations about these amendments. They would adversely affect the operation of our Roosevelt Hospital, Middlesex County in particular, and hospitals throughout the country in general.

In the first place, these amendments will give the secretary of HEW the authority to cut funds from any part of the Medicare program if he deems this part to be unnecessary in the efficient delivery of medical health care services. There would be no appeal from his ruling. Even the courts recognize the basic right to appeal. I don't think such authority should be above a lawful method of operation. Secondly, the secretary would have the authority to exclude depreciation, interest on borrowed funds or equity capital, or expenses related to such capital expenditures if they were "not in conformance with standards, criteria, or plans." Again there would be no appeal from the final decision of the secretary.

Third, these amendments would prevent each state from developing separate methods and standards for determining reasonable costs under medicaid. This would result in reimbursement limitations by the various states and would produce an administrative snarl for hospitals caring for Medicaid patients from states with different Medicaid reimbursement formulas. I don't have to tell you that we have enough bureaucracy as it is. Instead of complicating our methods, we ought to set out simplifying them.

Fourth, under these amendments, each participating hospital is required to submit, annually, a three year operating capital budget. Implicit in this provision is the possibility of centralized federal review of hospitals' operating budgets. I fail to see the need for this kind of federal intervention. At the Roosevelt Hospital in Middelsex County, for example, only a part of our institution services medicaid patients. A federal review of our entire operating budget goes beyond proper jurisdiction of control and review.

Fifth, this bill eliminates the requirement that states move toward comprehensive Medicaid Programs. This would remove a powerful influence on states that have already shown a growing reluctance to establish Medicaid programs to the extent envisioned and promised the American people. Here is an area where the federal government should step in.

Finally, I understand that, in addition to the provisions of this legislation, the Finance Committee may consider revisions in the tax exempt status of nonprofit hospitals. Hospitals should be granted tax exemption on the basis that they provide a community service.

In a time of rising costs, especially in health care, a denial of tax exemptions to hospitals would be a disaster. It would increase costs to all patients, including Medicare and Medicaid patients by the amounts needed to pay real estate, advalorem, sales and other taxes at state and local levels. How will patients absorb these costs? Denial of tax exemption would increase costs to patients by the amounts previously contributed by donors who would now refuse their assistance because of previously contributed by donors who would now refuse their assistance because of the effect on their tax status.

My particular concern rests with the Roosevelt Hospital in Middlesex County but I believe that all hospitals will suffer if the provisions I've mentioned are favorably considered. Thank you.

WORKING RETIREES OF AMERICA, INC.,
Boston (Brighton), Mass., July 29, 1970.

Hon. RUSSELL B. LONG,
Senate Office Building,
Washington, D.C.

MY DEAR SENATOR LONG: We appreciate the fact that your office must get thousands and thousands of letters on the subject of Social Security, and that it is physically impossible to wade through each one individually. However, the problem is an individual problem because it affects the personal lives of each of the millions of Social Security recipients affected by the inequities of the Social Security Act as now amended.

Our group is interested directly in the limitations on earnings and the retirement test features of the Social Security Act. It is our sincere belief that these two are the most important features for the many millions of workers who are looking forward to retirement in the next few years, and that the disposition of these two features will make the difference between a state of enforced poverty and a state of individual dignity.

We maintain that the limitation on earnings, namely, $1,680, is a serious error because there is no relationship between this amount ($1,680) and previous earnings, or current wage rates, or cost of living, or any other tangible guidepost. It is merely someone's idea of what it should be. The article by *Robert J. Myers in the READER'S DIGEST, April, 1970,* must not be permitted to intimidate Congress. Nor should it be permitted to panic the American people into a status quo situation on Social Security legislation.

The fact that so many Congressmen and Senators file bills annually to liberalize this amount is living testimony to the fact that there is no logical or tangible reason for it. Therefore, the limitation on income should be abolished.

The retirement test, so-called, is a cruel and degrading bit of legislation which should be abolished completely. Perhaps an example will illustrate the rationale for this statement.

Let us take the case of an average retired couple who receive $1,800 per year Social Security benefits. If the man earns $1,680 as the present law prescribes, he will have a disposable income after deduction for Social Security taxes of about $3,400. At $2.25 per hour, it will take him an average of 14½ hours work weekly to earn the $1,680. The retirement test provides for a forfeiture of $1.00 in benefits for each $2.00 of earnings up to $2,880 total per year. If the man in this case earned $2,880, then there would be deducted from his earnings $182.00 for income taxes (3 exemptions) and $138.32 Social Security tax, leaving a balance of $2,560 in his earnings. Then there will be a deduction of $600.00 in accordance with the terms of the retirement test from his benefits, leaving the balance of $1,200 in benefits, which, when added to his balance of earnings, will be $3,760 total disposable income.

It is noteworthy that in the above example the man who earned $2,880 will receive only $280 additional over the amount that he would have received if he had earned by working only $1,680. It is degrading to expect a man to earn $1,200 and realize only $280 net after all deductions.

It seems that the full intent of the retirement test is to force retirees out of the labor market, even though they are able and willing to work in order to meet the requirements of a moderate standard of living, which, as you know, in our area of Metropolitan Boston, is approximately $4,700 per year for a retired couple. It is unthinkable, rather it is unreasonable to any thinking person why any law should prevent a man from attaining a moderate standard of living through this own efforts in the traditional American way.

This man does not require any special Federal programs or training or help of any kind. No law should prevent him from supporting himself and his wife in a moderate standard of living. Therefore, in the words of a prominent Senator, "It is positively sinful to limit the earnings of Social Security retirees." We believe the retirement test should be abolished completely.

We would appreciate your comments.

Sincerely yours,

PHILIP SAPANARO,
Chairman, Committee on Legislation.

STATEMENT OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION, SUBMITTED BY DEL E. CAYWOOD, CHAIRMAN, LIAISON & PUBLIC RELATIONS COMMITTEE, AND E. B. STEVENS, EXECUTIVE DIRECTOR

Mr. Chairman and members of the committee, this written statement concerning H.R. 17550, the Social Security Amendments of 1970, is jointly prepared by Del E. Caywood, for more than seventeen years the administrator of the Smith-Glynn-Callaway Clinic of Springfield, Missouri, a Past President of Medical Group Management Association and presently the Chairman of the Liaison and Public Relations Committee of the Association and Edward B. Stevens, the Executive Director of Medical Group Management Association, who was the administrator of a medical group owned prepayment medical care plan in Tacoma, Washington from 1939 until 1957.

MEDICAL GROUP MANAGEMENT ASSOCIATION

The Medical Group Management Association, with executive offices located at 956 Metropolitan Building, Denver, Colorado is an organization formed in 1926. Members of the Association are the business administrators of medical groups or clinics in the United States. Both fee-for-service and prepayment groups are represented in the Association. Members come from the largest groups, such as the Mayo Clinic or the Kaiser Permanente Groups, down to the small groups of physicans serving the health needs of the small community. Over 800 medical groups are represented in our membership and this constitutes over 75% of the bsuiness administrators of medical groups or clinics in the United States. According to the American Medical Association Survey of 1969, there are, 6,371 groups of three or more physicians in the United States. 4,827 of these groups, according to the survey, consist of five or less physicians. A very few of these groups would employ business administrators. The average size group represented by members in Medical Group Management Association is between 14 and 15 physicians.

The interest of Medical Group Management Association in H.R. 17550 is prompted by the fact that we represent the business administrators of the great majority of fee-for-service and prepayment type groups in the United States and the groups represented by our members will be directly affected by the adoption of this legislation.

H. R. 17550

We are primarily concerned with the provisions of the bill which seek to reduce the cost of health care for medicare and medicaid beneficiaries. We are aware that the cost of health care can become needlessly expensive under the present system. No group of men or women in the country are more cognizant of this fact than the business administrators of medical groups who are engaged in daily dealings with patients and carriers involving the economics of health care.

1. We are convinced that one area of wasteful costs is due to the unnecessary and excessive use of hospital beds. Patients are placed in hospitals unnecessarily for diagnostic procedures such as laboratory tests and x-ray examinations which could be performed outside the hospital in facilities providing an equal quality of care. Major, economies may be secured and enjoyed in this area through changes and improvements in the system of providing health care. The abuses prevalent in this area involve hundreds of millions or perhaps several billions of dollars in the *total* health care bill and stem from the practice long followed by carriers of refusing to pay for this type of service for the patient unless he or she was confined to a hospital bed. This provides a financial incentive to the patient to help perpetuate this long established practice. An example of the abuses may be apparent in the present cost of care for medicare recipients. We have been told that the Bureau of Health Insurance is spending $27.00 per month per recipient for hospital care under the present law. Payments for medical services under Part B of Medicare have not exceeded $10.00 per month per recipient on a capitation basis. The ratio is, therefor, 73% for hospital care and 23% for medical services. Group practice prepayment plans owned and controlled by medical groups or Blue Shield Plans *providing equal benefits in or out of hospital for diagnostic procedures* spend 35–45% of their premium or dues income for hospital care and the total premium rate or cost does not come close to $37.00 per month per subscriber. This differential certainly indicates that there must be some waste in other systems.

2. The provisions in the proposed bill relating to the use of Health Maintenance Organizations is intended to effect alterations in the system of the delivery of health care which will help eliminate this waste. The objective is laudable. *If the proposed bill is enacted as it is now drawn we believe it will not accomplish its purpose for two principal reasons:*

A. There is no incentive for a person eligible for medicare or medicaid to enroll with a Health Maintenance Organization. He will receive exactly the same benefits and pay the same monthly fee as any other medicare or medicaid recipient. If he enrolls with an HMO, he will give up his right to choose his own physicians or hospital. His care will be provided by his HMO and he will be prevented from seeking care in the major referral clinics and specialty centers found in this country. His HMO will not be obligated to nor could they contract to pay for his care in such centers. With these limitations, why would he choose to enroll with an HMO?

B. The bill contains a built-in deterrent which will discourage medical groups, now engaged in fee-for-service practice, from qualifying as a Health Maintenance Organization. The bill provides that the medical group must furnish the same services which are now covered under Medicare or Medicaid. This will include the obligation to provide such unusual and expensive procedures as open heart surgery, organ transplants, kidney dialysis treatments and several others, *none of which are included as covered hazards under the prepayment medical service agreements ordinarily executed by medical groups.* The cost of these procedures, plus the cost of providing prostheses, wheel chairs, home nursing care, nursing home care and other benefits of this type could spell disaster for a group of 20–30 physicians insuring such risks under the law. Nor could the group re-insure these risks at a realistic cost. We could not conscientiously recommend to any group represented in Medical Group Management Association that they become obligated to pay for all the coverages now provided for in Medicare at a premium rate based on 95% of the cost of the provision of such care by the Bureau of Health Insurance. The group would not enjoy a sufficient distribution of risk to justify the hazards insured.

An additional objection to the provisions of the current bill can be based on its possible effect on the large referral clinics in the United States. For instance, the Mayo Clinic could not possibly continue in existence if its patients came only from Olmsted County, Minnesota. If it were to become an HMO, would it be likely to have any subscribers outside of that county? Probably not and if the Mayo Clinics of this country are to continue they must have wide geographical support. If the HMO is to be the future vehicle for the delivery of health care to our patient population, what will become of these large referral centers which contribute so much to the development of medical care? There are many of these centers and their future is uncertain under the proposed bill. Steps should be taken to make certain they are not legislated out of existence causing their facilities to stand empty and their personnel scattered.

SOLUTIONS

We realize that it is easy to find fault and criticize but much more difficult to come up with meaningful alternatives. We sympathize with the objectives of this bill. We want to offer our help to lower the costs of health care, whether the patient be under age 65 or a Medicare recipient. *We believe that the most economy can be secured by keeping the patient out of a hospital bed.* To that end, we suggest that the bill be amended so as to permit the Bureau of Health Insurance to provide by regulation for new and less costly coverages.

1. We suggest that provision be made for *100% payment of first dollar coverage for laboratory and x-ray diagnostic procedures* to be performed in a diagnostic center containing *no hospital beds* or in the offices of a medical group or a physician under the supervision of persons properly trained and equipped to provide such services.

2. We suggest that the provision for the use of Health Maintenance Organizations be modified to permit the Bureau of Health Insurance to contract with such organizations for the type of care which can be offered by an HMO. In order to encourage the Medicare or Medicaid population to subscribe to an HMO we would recommend the inclusion of first dollar coverage in such contracts for all diagnostic procedures, the elimination of the $50.00 deductible payment by the patient and the retention of the present 20% co-insurance provision.

3. To encourage a fee-for-service type existing clinic to qualify as an HMO, we would recommend that the Bureau of Health Insurance retain a portion of the proposed 95% premium and use this money to provide catastrophic coverage for those patients who may need open heart surgery, organ transplants, prostheses, kidney dialysis treatments and other types of care ordinarily excluded in prepayment medical service agreements signed by clinics or medical groups. We also recommend the elimination of the requirement in the bill that 50% of those covered under prepayment service contracts must be less than 65 years of age.

The adoption of proposals such as we have outlined could discourage the use of hospitals by patients who do not need hospitalization but are occupying a bed because of financial advantage to themselves or because it is more convenient for the patient or the physician.

All of these things can be accomplished by regulations with the proper legislative authorization. Once percentages and coverages are written into the law, it takes another law to change them. Properly administered regulations provide more flexibility and can be adapted to meet the exigencies of the situation.

We would add a word of caution—it has taken 40 years of health insurance benefits tied to hospital bed occupancy to build this costly and inefficient system of health care. Abuses of the system will be not cured overnight or by the adoption of half-way measures. The health care delivery system needs improvement. We believe that medical group managers who are involved daily with the problems of the delivery of health care to large numbers of people can be of help to those who are conscientiously attempting to lower the cost of health care. We are prepared as an association to provide that help. Call on us!

STATEMENT OF SOLOMON I. HIRSH, CHICAGO, ILLINOIS

My name is Solomon I. Hirsh. I am an attorney with the firm of Jacobs, Gore, Burns & Sugarman, located in Chicago, Illinois. We represent a number of physical therapists who are qualified and licensed to practice under the laws of Illinois (Ill. Rev. Stat. 1969, ch. 91, Secs. 22.1–22.20). They have been engaged

in their profession for up to 20 years, working in public and private hospitals, extended care facilities and home health agencies, and maintaining their own clinics to treat patients referred by physicians. However, HEW has promulgated regulations under the Medicare Act which threaten to drive them out of their profession simply because they were not members of the American Physical Therapy Association (APTA) prior to January 1, 1966. These physical therapists have asked me to tell you their story in the hope that Congress will take some action to remedy this gross abuse of power by HEW which threatens the livelihood of several thousand physical therapists throughout the United States, and contributes to the continued existence of unnecessarily costly—and chronically inadequate—physical therapy care for Medicare patients.

In October 1967, HEW promulgated regulations establishing conditions of participation for nursing homes and other extended care facilities in the Medicare program. 20 C.F.R. Sec. 405. 1100, et seq. Section 1126(c)(1) thereof provided:

Physical therapy is given or supervised by a therapist who meets one of the following requirements:

(i) He has graduated from a physical therapy curriculum approved by:

(A) The American Physical Therapy Association; or

(B) The Council on Medical Education and Hospitals of the American Medical Association; or

(C) The Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or

(ii) Prior to January 1, 1966—

(A) Has been admitted to membership by the American Physical Therapy Association; or

(B) Has been admitted to registration by the American Registry of Physical Therapists; or

(C) Has graduated from a physical therapy curriculum in a four year college or university approved by a State department of education, is licensed or registered as a physical therapist, and where appropriate, has passed a State examination for licensure as a physical therapist; or

(iii) If trained outside the United States—

(A) Has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and

(B) Is a member of a member organization of the World Confederation for Physical Therapy; and

(C) Has completed one year's experience under the supervision of an active member of the American Physical Therapy Association; and

(D) Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

Analysis of the foregoing section reveals that subparagraph (ii) thereof constitutes a Grandfather Clause which permits persons to provide physical therapy to Medicare patients regardless of their training or experience, provided only that they were members of APTA prior to January 1, 1966. At the same time, the regulation prohibits physical therapists who are duly qualified and licensed under state laws from treating Medicare patients only because they were not members of APTA prior to January 1, 1966. There are approximately 3,000 practicing physical therapists in the United States who are not members of APTA. A number of them are members of other associations of physical therapists.

Under Illinois law, a person can be licensed as a physical therapist if he has met certain specified education requirements in a school approved by the State's Department of Registration and Education and has passed a test administered by that department. If the person was practicing physical therapy on August 31, 1965, the test is waived if he met the educational requirements "or in the judgment of the Department has the equivalent training or experience" (Ill. Rev. Stat. 1969, Ch. 91, Sec. 22. 9(4)).

APTA has admitted to membership both physical therapists who were licensed upon satisfaction of the educational and testing requirements of the Illinois law, and physical therapists who, like our clients, were licensed under the "equivalence" provision therof. Thus, membership in APTA is no greater guarantee of ability, proficiency and skill as a physical therapist than is licensure by the State of Illinois under its law regulating the practice of physical therapy. Despite this fact, and ignoring State licensing requirements, the HEW regulation

draws a distinction based on membership in APTA whereby APTA members could treat Medicare patients, but non-members could not.

As a result of this regulation, a number of physical therapists in Illinois, who were licensed and registered by the State but who were not APTA members, lost their jobs because nursing homes did not want to risk their certification under Medicare by employing "unqualified" physical therapists. One such physical therapist, James J. McCoy, brought suit against HEW to enjoin the enforcement of this discriminatory regulation as to him. On June 25, 1970, Judge J. Sam Perry, of the United States District Court for the Northern District of Illinois, Eastern Division (Chicago), issued a preliminary injunction against HEW enjoining the enforcement of Section 405.1126(c)(1) as to Mr. McCoy, based on his finding and conclusion that the regulation was arbitrary and discriminatory, and therefore unconstitutional. A copy of Judge Perry's findings of fact, conclusions of law, and order, is attached to this statement as Exhibit A. The Government has let the time go by for appealing this injunction, and it remains in effect today.

Two days after the injunction was granted, however, and without prior notice or providing interested persons an opportunity to be heard, HEW promulgated an amendment to Section 405.1126(c)(1). The amendment does not change the favored status conferred on physical therapists who were members of APTA prior to January 1, 1966. Rather, it merely provides a way by which physical therapists who were already licensed under State laws could establish to the satisfaction of HEW that they were also qualified to treat Medicare patients. The amendment of June 27, 1970, provides:

Subparagraph (c)(1) of § 405.1126 is amended by redesignating subdivision (iii) as subdivision (iv) and adding a new subdivision (iii) to such subparagraph to read as follows:

Section 405.1126 Condition of participation—restorative services.

* * * * * * *

(c) Standard; therapy services. * * *

(1) Physical therapy is given or supervised by a therapist who meets one of the following requirements:

* * * * * * *

(iii) If he is currently licensed or registered to practice physical therapy pursuant to State law, he:

(a) Was licensed or registered prior to January 1, 1970, and has achieved a satisfactory grade through the examination conducted by or under the sponsorship of the Public Health Service; or

(b) Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which he rendered services upon the order of and under the direction of attending and referring physicians; or

* * * * * * *

Thus, physical therapists who, prior to January 1, 1966, were not members of APTA will be permitted to treat Medicare patients if they show they were licensed by a State prior to that date and that they had 15 years of full-time experience. And physical therapists who were licensed by a State before January 1, 1970, and who do not have 15 years full-time experience will be permitted to treat Medicare patients if they can pass a test prepared and conducted "by or under the sponsorship of the Public Health Service."

The requirement that practicing physical therapists, who have satisfied the licensing standards such as Illinois imposes, must now prove themselves anew to HEW is insulting to the physical therapists, denigrates Illinois and the many other States that have adopted and enforced licensing requirements, and unfairly discriminates in favor of one of several voluntary associations of physical therapists. HEW has never offered a satisfactory explanation for not accepting Illinois license as satisfacory evidence that a physical therapist is qualified to treat Medicare patients. The sole excuse it has given is that regulations cannot be written to fit the situation in only a few States, but must be applicable throughout the country. That is a patently specious excuse. In the first place, HEW has written Medicare regulations tailored to fit situations in only a few States. Subpart (11)(c) of Section 450.1126(c) was included for the specific purpose of approving physical therapy licenses issued by the State of New York.

Moreover, Section 1395z of the Medicare Act states in relevant part:

In carrying out his functions, relating to determination of conditions of participation by providers of services . . . the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1395dd of this title, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. *Such conditions prescribed under any of such subsections may be varied for different areas* or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States . . . [Emphasis added.]

And in Section 1395aa(a), Congress expressly authorized HEW to do that which it has refused to do here—accept a State license as evidence of qualification. This section provides:

(*a*) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or extended care facility, or whether an agency therein is a home health agency, or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1395x(s) of this title, or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1395x(p)(4) of this title. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, extended care facility, or home health agency (as those terms are defined in section 1395x of this title) may be treated as such by the Secretary.

That HEW does not really find it difficult or impossible to establish and apply different standards for certain health care services to different areas of the nation is evidenced by the various addenda it has made to the Medicare regulations establishing such varying standards. See 20 C.F.R. Sections 405.1222, 1223, 1228 and 1236. See also 20 C.F.R. Section 1310. Thus, it ill behooves HEW to allege in the case of physical therapists that it cannot be done.

In sum, we respectfully request that Congress take immediate steps to require HEW to accept State licensure of physical therapists where, as in the case of Illinois, the State requirements assure that the person licensed has a reasonable level of skill and knowledge. In this way, many physical therapists will be able to continue their profession, and more and cheaper physical therapy care will become available to Medicare patients.

Thank you for affording me this opportunity to appear before you.

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS EASTERN DIVISION

(No. 70 C 630)

EILEEN RASULIS, ETC., ET AL, PLAINTIFFS

v.

ROBERT H. FINCH, AS SECRETARY OF HEALTH, EDUCATION & WELFARE, DEFENDANT

(No. 70 C 631)

JAMES J. MCCOY, PLAINTIFF

v.

ROBERT H. FINCH, AS SECRETARY OF HEALTH, EDUCATION & WELFARE, DEFENDANT

FINDINGS OF FACT—CONCLUSIONS OF LAW

A. FINDINGS OF FACT

1. Plaintiff Eileen Rasulis is president and sole stockholder of plaintiff Illinois Physical Therapy Clinics, Inc. (hereinafter referred to as "the Clinic"). The Clinic is engaged in the business of furnishing physical therapy to Medicare and other patients in extended care facilities (nursing homes). Plaintiff James

J. McCoy has been a practicing physical therapist for twenty years and is licensed under the laws of the State of Illinois (Ill. Rev. Stat. 1969, ch. 91, Sec. 22.1, *et seq.*). Between April 1967 and May 1968 Mr. McCoy owned and operated a physical therapy clinic in which he treated Medicare and other patients in nursing homes. All the plaintiffs are resident of, and do business in Cook County, Illinois, within this judicial district.

2. Defendant, as Secretary of Health, Education and Welfare, is charged with administering Title XVIII of the Social Security Act, commonly known as the Medicare Program or Health Insurance for the Aged (42 U.S.C. Sec. 1395, *et seq.*). He has the power to make, amend, modify and rescind regulations implementing the provisions of that Act, except that under 42 U.S.C. Sec. 1395, he does not have the power "to exercise any supervisions or control . . . over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervisions or control over the administration or operation of any such institution, agency, or person."

3. In June 1967, pursuant to the provisions of the Administration Procedure Act, defendant's predecessor promulgated regulations establishing conditions of participation for hospitals in the Medicare program. 20 C.F.R. Sec. 405.1001, *et seq.*, Section 1031(d)(3) thereof provides:

If physical therapy services are offered, the services are given by or under the supervision of a qualified physical therapist. A qualified physical therapist is a graduate of a program in physical therapy approved by the Council on Medical Education of the American Medical Association (in collaboration with the American Physical Therapy Association) or its equivalent. Additional properly trained and supervised personnel are sufficient to meet the needs of the department.

4. In October 1967, pursuant to the provisions of the Administrative Procedure Act, defendant's predecessor promulgated regulations establishing conditions of participation for nursing homes and other extended care facilities in the Medicare program. 20 C.F.R. Sec. 405.1100, *et seq.*, Section 1126(c)(1) thereof provides:

Physical therapy is given or supervised by a therapist who meets one of the following requirements:

(i) He has graduated from a physical therapy curriculum approved by—

(A) The American Physical Therapy Association; or

(B) The Council on Medical Education and Hospitals of the American Medical Association; or

(C) The Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or

(ii) Prior to January 1, 1966—

(A) Has been admitted to membership by the American Physical Therapy Association; or

(B) Has been admitted to registration by the American Registry of Physical Therapists; or

(C) Has graduated from a physical therapy curriculum in a four year college or university approved by a State department of education, is licensed or registered as a physical therapist, and where appropriate, has passed a State examination for licensure as a physical therapist; or

(iii) If trained outside the United States—

(A) Has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and

(B) Is a member of a member organization of the World Confederation for Physical Therapy; and

(C) Has completed one year's experience under the supervision of an active member of the American Physical Therapy Association; and

(D) Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

4. Under Illinois law, a person can be licensed as a physical therapist if he has met certain specified educational requirements in a school approved by the State's Department of Registration and Education and has passed a test administered by that department; if the person was practicing physical therapy on August 31, 1965, the test is waived if he met the educational requirements "or in the judgment of the Department has the equivalent training or experience" (Ill. Rev. Stat. 1969, Ch. 91, Sec. 22.9 (4)). The waiver provision is known as the "grandfather clause."

5. Plaintiff McCoy does not have the educational training specified in subparagraphs (i) and (ii) of 20 C.F.R. Sec. 405.1126(c)(1), nor did he meet the educational requirements established by the Illinois law regulating the practice of physical therapy. Rather Mr. McCoy received his Illinois license under the "grandfather clause" in said law.

6. Prior to January 1, 1966, Mr. McCoy was not admitted to registration by the American Registry of Physical Therapists. Mr. McCoy has never been admitted to membership in the American Physical Therapy Association (APTA). However, APTA has admitted to membership both physical therapists who were licensed upon satisfaction of the educational and testing requirements of the Illinois law, and physical therapists who, like Mr. McCoy were licensed under the "grandfather clause" thereof.

7. Membership in APTA, or satisfying the educational requirements for membership in APTA, is no greater guarantee or ability, proficiency and skill as a physical therapist than is licensure by the State of Illinois under its law regulating the practice of physical therapy.

8. Between April 1967 and June 30, 1969, Mr. McCoy provided physical therapy to Medicare patients in extended care facilities. As a result of the promulgation and enforcement of Section 1126(c)(1) of the Medicare Regulations, Mr. McCoy became ineligible to provide such services and was obliged to cease treating them on June 30, 1969. Under the regulation, however, physical therapists no better qualified by education or training than Mr. McCoy are permitted to provide physical therapy to Medicare patients in nursing homes solely because they were admitted to membership in APTA prior to January 1, 1966.

9. Although Mr. McCoy is ineligible to treat Medicare patients in nursing homes under the provisions of Section 1126(c)(1) of the Medicare Regulations, he is eligible to treat Medicare patients in hospitals under the provisions of Section 1031(d)(3) of the same regulations, because his training and experience satisfies the equivalence provision thereof. Indeed, all physical therapists licensed under the "grandfather clause" of the Illinois statute regulating the practice of physical therapy are eligible by their training and experience to treat Medicare patients in hospitals under the provisions of Section 1031(d)(3) even though they may not be eligible to treat Medicare patients in nursing homes under the provisions of Section 1126(c)(1).

10. After the promulgation of Section 1126(c)(1), and as a direct result thereof, the Clinic was threatened with cancellation of its contracts with the extended care facilities it was serving because many of the patients therein were covered by Medicare and Mr. McCoy, its chief physical therapist, was ineligible to treat Medicare patients. A nursing home found by agents of HEW to be treating Medicare patients with an ineligible physical therapist would have its certification as a qualifying extended care facility revoked.

11. In order to keep its contracts with the extended care facilities, the Clinic was forced to remove Mr. McCoy as chief physical therapist and to replace him with a member of APTA.

12. There are approximately 900 physical therapists licensed and registered pursuant to the laws of the State of Illinois and eligible to practice therein. However, only about half of these physical therapists qualify under Section 1126(c)(1). There is thus an acute shortage of physical therapists who are eligible to treat Medicare patients in extended care facilities. As a result, in order to secure an eligible physical therapist to replace Mr. McCoy, the Clinic was forced to pay five hundred dollars more per month than it was paying Mr. McCoy, even though the replacement had less ability, experience and skill than Mr. McCoy.

13. The replacement for Mr. McCoy proved very unsatisfactory, and was responsible for a substantial drop in the Clinic's revenues; however, no physical therapist eligible under Section 1126(c)(1) was available to replace him at a wage the Clinic could afford. The replacement's employment was finally terminated on May 29, 1970, and the Clinic was threatened with the loss of all its contracts with nursing homes because none would use the Clinic's services unless the Clinic's physical therapist was eligible to treat the homes' Medicare patients. The Court issued a temporary restraining order on May 28, 1970, suspending enforcement of the regulation as to the Clinic and Mr. McCoy, thus enabling the Clinic to reemploy Mr. McCoy as its physical therapist and continue to serve the nursing homes with which it had contracts.

14. As a further effect of the lack of eligible physical therapists under Section 1126(c)(1), the Clinic was prevented from expanding its business to serve additional nursing homes because it could not obtain physical therapists eligible to treat Medicare patients, although licensed physical therapists are available to treat Medicare patients in hospitals, or to treat patients whose bills are not paid by Medicare. Most extended care facilities have both Medicare and non-Medicare patients, but it is uneconomic and impractical for the facilities to have different personnel treat each group separately. As a result, these facilities seek only personnel who are eligible to serve all patients; in the case of physical therapists, that means those who qualify under Section 1126(c)(1).

16. Neither the Medicare Act nor HEW provides for the certification of individual physical therapists. Hence, there is no way under the Act that Mr. McCoy can obtain administrative and judicial review of Section 1126(c)(1) of the Medicare Regulations. There is no administrative remedy available to him.

17. Similarly, as a practical matter, there is no administrative remedy available to the Clinic and its owner, Miss Rasulis, to obtain review of the requirements of Section 1126(c)(1). For, were the Clinic to hire a physical therapist ineligible to treat Medicare patients in nursing homes, it would lose its nursing home contracts and be forced out of business before its certification could be administratively reviewed by HEW, thus rendering moot any further administrative or judicial proceedings.

18. Unless an injunction issues restraining and enjoining defendant from enforcing 20 C.F.R. Section 405.1126(c)(1) against them, plaintiffs will suffer irreparable harm and injury in that they will be deprived of their rights to engage in their chosen occupation and business of providing physical therapy to patients in extended care facilities.

B. CONCLUSIONS OF LAW

1. The Court has jurisdiction over the parties and the subject matter of the action. 5 U.S.C. Sec. 702–706; and 28 U.S.C. Secs. 1331(a), 1361, 1391(e) and 2201. *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140–141 (1967); *Toilet Goods Association* v. *Gardner*, 360 F. 2d 677, 683, n. 6 (C.A. 2, 1966), aff'd 387 U.S. 167 (1967).

2. The Medicare Act (42 U.S.C. Sec. 1395, *et seq.*) does not preclude judicial review of the challenged regulation in a proceeding such as this. *Rosado* v. *Wyman*, —— U.S. ——, 90 S.Ct. 1207 (1970); *Cappadora* v. *Celebrezze*, 356 F. 2d 1 (C.A. 2, 1966); *Beers* v. *Federal Security Administrator*, 172 F. 2d 34, 36–37 (C.A. 2, 1949). See also *Abbott Laboratories* v. *Gardner*, *supra*; *Toilet Goods Association* v. *Gardner*, *supra*.

3. There is a great likelihood that plaintiffs will prevail in the final disposition of this case. The uncontradicted allegations of fact in the verified complaint and the evidence adduced at the hearing on the motion for preliminary injunction warrant the conclusion that 20 C.F.R. Section 405.1126(c)(1) constitutes an arbitrary and discriminatory distinction between the qualifications of physical therapists eligible to treat Medicare patients in hospitals, and the qualifications of physical therapists eligible to treat Medicare patients inextended care facilities; and between members and non-members of APTA prior to January 1, 1966. As a physical therapist licensed under the laws of the State of Illinois, Mr. McCoy is eligible to treat Medicare patients in hospitals; no rational basis has been shown why he should be declared ineligible to treat Medicare patients in extended care facilities. Such a discriminatory distinction deprives plantiffs of the equal protection of the laws and deprives them of property without due process of law, in violation of the Fifth Amendment to the Constitution of the United States. For, "a statutory discrimination must be based on difference which are reasonably related to the purposes of the Act in which it is found." *Morey* v. *Doud*, 354 U.S. 457, 465 (1957). See *Shapiro* v. *Thompson*, 394 U. S. 618 (1969); *Carrington* v. *Rash*, 380 U.S. 89, 93 (1965); *McLaughlin* v. *Florida*, 379 U.S. 184, 191 (1964). There is no reasonable relationship between the challenged regulation and its purpose of assuring quality care for Medicare patients, in light of the fact that the same requirement is not imposed on hospitals as is imposed on extended care facilities.

C. CONCLUSION

For the foregoing reasons, the Court finds and concludes that a preliminary injunction should issue against defendant in the terms and on the conditions set forth in the order attached to these Findings and Conclusions.

Dated this 25th day of June, 1970.

S/J. SAM PERRY,
United States District Judge.

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

Civil action No. 70 C 630

EILEEN RASULIS, AS PRESIDENT OF THE ILLINOIS PHYSICAL THERAPY CLINICS, INC., AND ILLINOIS PHYSICAL THERAPY CLINICS, INC., PLAINTIFFS

v.

ROBERT H. FINCH, AS SECRETARY OF HEALTH, EDUCATION AND WELFARE, DEFENDANT

Civil action No. 70 C 631

JAMES J. MCCOY, PLAINTIFF

v.

ROBERT H. FINCH, AS SECRETARY OF HEALTH, EDUCATION AND WELFARE, DEFENDANT

PRELIMINARY INJUNCTION

These causes coming on to be heard on plaintiff's motion for preliminary injunction, and the Court being fully advised in the premises and having heard testimony and argument of counsel and having made findings of fact and conclusions.

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that, pending further Order of this Court, the defendant, Robert H. Finch, as Secretary of Health, Education and Welfare, his successors, officers, agents, representatives, employees, attorneys, insurance carriers and all persons acting in concert and participation with him, be and hereby are restrained and enjoined from:

A. Giving any force or effect to 20 C.F.R. Section 405. 1126 (c) insofar as it declares ineligible plaintiffs Eileen Rasulis, as President of the Illinois Physical Therapy Clinics, Inc.; Illinois Physical Therapy Clinics, Inc.; James J. McCoy, and any other physical therapist authorized to engage in that profession under the laws of the State of Illinois and employed by the Clinic from treating patients in extended care facilities under either Part A or Part B of the Medicare Program;

B. Withholding, refusing or failing to remit any funds due and owing to plaintiffs or any physical therapist authorized to engage in that profession under the laws of the State of Illinois as payment for services rendered to patients in extended care facilities under either Part A or Part B of the Medicare Program.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that, this order shall be effective from and after 4:00 p.m., June 23, 1970;

IT IS FURTHERED ORDERED, ADJUDGED AND DECREED that, plaintiffs file their bonds, with each other as surety, to be approved by this Court, in the sum of TEN THOUSAND AND NO/100 DOLLARS ($10,000), conditioned for the payment of such costs and damages as may be incurred or suffered by any party who is found by this Court to have been wrongfully enjoined or restrained.

Enter.

S/J. SAM PERRY,
Judge, U.S. District Court for the Northern District of Illinois, Eastern Division

---

STATEMENT OF THE AMERICAN COLLEGE OF RADIOLOGY

The American College of Radiology appreciates this opportunity to comment on the Social Security Amendments of 1970 (H.R. 17550).

The members of the College are over 7,000 doctors of medicine who specialize in the use of X-rays and radioactive materials in diagnosis and treatment.

We will confine our statement to a few specific items in H.R. 17550 and Amendment 851 offered by Senator Bennett.

The purpose of Section 222 is to provide the Secretary with authority to carry out and determine the results of experiments and demonstration projects in paying for services under Medicare and Medicaid. This Section permits the Secretary of use "alternative methods for classifying providers", "waive compliance with the requirements of Titles XVIII, XIX and V of the Social Security Act insofar as such requirements relate to methods of payment for services", and make a single combined rate of reimbursement for teaching activities and patient care rendered by residents, interns and teaching physicians in graduate medical education programs.

The need for experiments aimed at producing quality care at the least possible expense to the government is recognized. The special medical service reimbursement problems of physicians practicing in teaching institutions are well known.

We request, however, that the report of the Senate Finance Committee plainly state that such experiments and demonstration projects shall *not* be selectively applied to, or in connection with, a single medical specialty, radiology. On the basis of experience since Medicare and Medicaid became effective, we know that there is a tendency within the Social Security Administration to seek to merge Parts A and B of Medicare insofar as payments for radiology services are concerned (eliminate Part B might be a more accurate description). Radiologists seek to retain an ability equal to that of other physicians to adjust and accommodate to changes in medical delivery and financing systems now and in the future. Radiologists have not sought special privileges and resists special disabilities. We ask for the assistance of the Senate Finance Committee in achieving equal treatment under the law and in regulations issued under the law.

Section 226 deals with payment for services of teaching physicians under the Medicare program. As noted earlier, we are sympathetic to the special problems in this area for attending physicians practicing in a teaching setting.

Radiologits are medical consultants, not attending physicians. Radiologists do, however, practice in teaching settings. Because they do, and because Section 226 may be applied to radiologists, we would note that: each radiologic examination is a physician's service to a patient; each is specific and identifiable; each is direct; the purpose of each and the consultative report on the examination is to help the patient. In the practice of radiology, the fact that teaching is involved is incidental because the radiologist-teacher is 100 percent responsible to the patient and provides the patient 100 percent of his time and knowledge in rendering the individual service. This is a full Part B service and we can see no reason to discount this service because a student is being taught in connection with its delivery, or could we see any reason to cover this service as a part of Part A hospital reimbursement.

The American College of Radiology supports the concept of peer review of the necessity, propriety and quality of professional services. The College currently evaluates the quality of radiologic services being rendered in hospital departments of radiology, private offices and clinics by visitation or radiologist-surveyors. Radiologists meeting standards of practice acceptable to experienced and recognized surveyors are accredited. Radiologists welcome peer review by responsible and professionally qualified physicians.

We are not expert in respect to the specific provisions and ramifications of Amendment 851. We believe, however, that the peer review system would be clearer, cleaner and less cluttered if the Secretary contracted with only one organization in each state, preferably the state medical association. The state medical association could then make subsidiary local arrangements for peer review with county medical societies or groups of such societies.

We question extending the concept of review of physicians' services by physicians to the review of all health services by physicians. It is not at all clear that physicians are the best available experts to review all of the facets of hospital service, extended care and nursing home service. Further, given a need for all possible physicians in active practice taking care of patients, it is probably a poor use of scarce resources to require physicians to devote time to act as the sole evaluators of all health care, individual and institutional.

We particularly support peer review of the necessity of performing diagnosis radiologic services on an in-patient basis, rather than on an ambulatory basis. "Diagnostic" admissions have been an expensive curse in medical economics ever since the initial error of insuring diagnostic services only for hospital in-patients

was made in the early 1930s. Indeed, the development of hospitalization insurance well in advance of medical care insurance was historically most unfortunate in terms of results. This helped create a hospital oriented psychology in generations of administrators of health care insurance programs and in the public at large.

The Medicare law has largely rectified this problem in respect to those over 65, but even here we find a residuum of pro-hospital discrimination. In 1967, Congress, to simplify administration of the Medicare law, amended Part B so as to eliminate the application of co-insurance and the deductible to pathology and radiology services provided Medicare *in-patients*. Pathology and radiology services to ambulatory patients remained subject to co-insurance and the deductible. The American College of Radiology at that time testified against creating this imbalance which would lead some patients to seek hospitalization in order to avoid out-of-pocket expenditures.

When an insurance plan does not cover medicine as it is practiced and creates economic incentives to seek services at certain sites and under certain circumstances, logical practice patterns become distorted. Bad insurance drives out good and rational medical practice. We believe that the Senate Finance Committee might well address itself to the matter of restoring good medical practice. This could be accomplished by reimposing appropriate co-insurance and deductible provisions in respect to radiology services provided to Medicare beneficiaries who are hospital in-patients, or by deleting these requirements in respect to all radiology services.

Parenthetically, if distortions of practice are to be written into Medicare, it would be more logical to selectively eliminate payments for services to hospital bed patients and provide them for ambulatory patients. This would, of course, impose burdens on some of those insured, but it would at least have the virtue of saving the insurance fund from paying for a good deal of unnecessary hospitalization.

In conclusion, The American College of Radiology again thanks the Senate Finance Committee for the privilege of offering these comments.

MASSACHUSETTS LEGISLATIVE COUNCIL FOR OLDER AMERICANS,
Boston, Mass., September 22, 1970.

HON. RUSSELL LONG,
Chairman, Senate Finance Committee,
U.S. Senate,
Washington, D.C.

DEAR SENATOR LONG: The purpose of this letter is to urge you to favorably consider a 12% increase in cash social security benefits this year. Previous increases have been largely eroded by the steady advance in the cost of living and the financial status of our retired population is still critical.

In a recent statement, Senator Harrison A. Williams, Jr. declared that since 1968 the number of older Americans living in poverty has actually increased by nearly 200,000. Our retired population are being left far behind as the rest of our society moves steadily toward improving living standards.

Your Committee can do a great service to millions of Older Americans by proposing an increase in social security of at least 12%.

Your consideration of this request will be greatly appreciated.

Sincerely yours,

FRANK J. MANNING, *President.*

STATEMENT OF THE COMMUNITY SERVICE SOCIETY, COMMITTEE ON AGING, SUBMITTED BY ELIHU SCHOTT, VICE CHAIRMAN

The Committee on Aging of the Community Service Society of New York submits this statement to the Senate Finance Committee for its consideration in reviewing the proposed amendments to the Social Security Act in H.R. 17550.

The Community Service Society of New York is a voluntary nonprofit agency dedicated since 1848 to the strengthening of family life and the betterment of community life. The Committee on Aging within the Department of Public Affairs is a citizens' committee concerned particularly about the well-being of the aged.

We have examined H.R. 17550 and the report of the House Committee on Ways and Means in detail together with related materials. We find and note below that several of the provisions of the bill are commendable improvements of the social security and health insurance system. But there are omissions and deficiencies, in our opinion, which we call to your attention.

Our recommendations do not purport to solve totally the problems of income and health maintenance of older men and women, so many of whom are poor and needful. Rather they represent quite modest steps to improve their situations. The additional costs involved can clearly be financed within the nation's current resources.

First, in respect to the social security cash benefits program, we endorse the provisions that would:

Provide an automatic cost-of-living adjustment mechanism beginning in 1972, to keep benefits current with rises in the cost of living. Across-the-board increases in benefits have been made by Congressional action from time to time. Preferable is the proposal for an automatic adjustment in benefits when the Consumer Price Index has increased three per cent, coupled with a comparable increase in the taxable payroll base to keep the OASDI Trust Funds in balance. Approval of this automatic adjustment is predicated on an increase in the minimum benefit to $90 a month and an across-the-board increase of ten per cent effective in 1971, and, in time, an increase in all benefits to more realistic levels.

Liberalize the retirement test by permitting a beneficiary under age 72, beginning in 1971, to receive full benefits each month if his annual earnings do not exceed $2,000, instead of $1,680 as of now; to receive benefits reduced by $1 for each $2 of earnings between $2,000 and $3,200 (instead of the current range of $1,680–$2,880) and for each $1 thereafter. The bill would also increase from $140 to $166.66 the amount of monthly wages allowable without loss of benefits. These changes represent a quite modest updating of the retirement test.

Increase survivors' benefits at age 65 from 82½ per cent to 100 per cent of the deceased spouse's primary insurance amount, the effective date being January 1, 1971. This provision recognizes the economic needs of dependent widows and widowers.

Set age 62 as the computation point for figuring benefits and benefit eligibility for men as it now is for women. There is no logic for the existing differential which can result in lower benefits for a retired man than for a retired woman with the same wages.

We recommend two changes in the provisions of H.R. 17550 that would:

Provide a ten per cent across-the-board increase in monthly cash benefits above the current benefit rather than five per cent, effective January 1971. A ten per cent increase is considered a modest effort that takes into account the escalation in the cost of living and the level of average benefits which is substantially below minimum needs. By this increase the monthly benefit for an average retired single worker would go from $116 to $127.60; for an average retired couple from $196 to $215.60. This is not an adequate level to meet living needs but it is an achievable improvement at this time.

Provide an increase in the minimum monthly benefit to $90, effective January 1971. This increase has been proposed in other bills introduced in the Senate. It is viewed as a step in the right direction and possible of achievement at this time, although still below a minimum standard of subsistence. It is hoped that, in the future, a program based upon social security payments and payments from other sources will result in an adequate minimum. Since a $90 minimum monthly payment is unrelated to the taxes paid by employees and employers and the self-employed into the Trust Fund, the difference between this amount and the amount that would be provided by a ten per cent increase should be financed from general revenues.

Second, in respect to *selected Medicare provisions* where the Committee on Aging is joined by the Committee on Health:

We support the provisions that would:

Remove the existing requirement that a person must enroll in Part B (Supplementary Medical Insurance) of Title XVIII within three years after becoming eligible.

Authorize the Secretary of Health, Education, and Welfare to terminate payment for services rendered by suppliers of health and medical services found to be guilty of program abuses including overcharging, furnishing inferior or

harmful or excessive services, or making a false statement to obtain payment.

Authorize the Secretary of Health, Education, and Welfare to establish specific periods of time after hospitalization during which a patient would be presumed to require nursing home or home health services. This provides protection against retroactive denial by fiscal intermediaries of extended care benefits, which has caused hardships for patients and the suppliers of services.

Extend coverage to include services rendered by a licensed physical therapist in his office, up to a limit of $100 per calendar year.

We support in principle, but question the utility, of a provision that would:

Allow persons ineligible for Part A (Hospital Insurance) of Title XVIII to enroll for coverage for $27 a month, an amount figured to be the full cost of protection currently, and subject to increase as hospital costs rise; and require enrollment in Part B at an additional monthly fee. This is a high cost for the uninsured to pay for coverage, and beyond the means of many persons. Is it possible to blanket the uninsured in for hospital insurance as was done for those who attained age 65 before 1968 even though they were not eligible for cash benefits? if not, can other programs be developed which will provide needed protection and coverage of health costs?

We urge an additional provision that would:

Incorporate an out-of-hospital drug insurance program under Part A of Title XVIII, such a program to include prescription-requiring drugs prescribed by an authorized prescriber, and non-prescription drugs (e.g. insulin) specified by the Secretary of Health, Education, and Welfare and deemed necessary to ensure the goals of the program; to call for copayment of $1 by the beneficiary for each original prescription and refill; to provide for reimbursement to the vendor rather than the beneficiary; to become effective at a date that allows sufficient time to set up adequate administrative machinery for efficient processing and for developing utilization, quality and cost controls; to be paid for by an increase in contributions by employees and employers and the self-employed. In our judgment, the inclusion of an out-of-hospital drug insurance program would be a great step forward, reducing the need for higher-cost kinds of care and alleviating a serious financial burden on the elderly.

Third, in respect to *selected Medicaid provisions* where, again, the Committee on Aging is joined by the Committee on Health.

We support provisions that would:

Provide a 25 per cent increase in the federal matching share for hospital outpatient services, clinic services and home health services. This provides an important incentive encouraging states to develop and use community-based services.

Authorize the Secretary of Health, Education, and Welfare to establish differential rates for skilled nursing homes and intermediate care facilities. Relating reimbursement to the level of care is sound.

Limit increases in physician fees to the 75th percentile of a given area.

Provide federal funding at a 90 per cent level to states to establish mechanized claims processing and information retrieval systems, and at a 75 per cent level for the continued operation of such systems. Desirable is this encouragement of efficient and modern administration of a system that is complicated indeed.

We are strongly opposed to provisions that would:

Reduce the federal matching share for inpatient care in general and tuberculosis hospitals by one-third after 60 days; in skilled nursing homes by one-third after 90 days; and in mental hospitals by one-third after 90 days, with a 275-day life-time limit thereafter. Such arbitrary limits, in our judgment, are unsound and dangerous. We are not persuaded of the reasonableness of these limits as advanced by the House Ways and Means Committee. We believe that the present provisions should be maintained if they cannot be increased and that reimbursement formulas should not provide a leverage for inappropriate transfers to a lower level of care when this is contra-indicated by a medical diagnosis.

Eliminate the requirement that states establish a comprehensive Medicaid program by 1977. The original target date for this requirement was 1975; in 1969 it was advanced to 1977. The goal of a comprehensive program should be constantly emphasized. If practical problems of compliance exist, the date can again be postponed but should not be abandoned.

In sum and in considered conclusion, we urge the Senate Finance Committee to support constructive changes that will alleviate to a degree the burdens imposed on the old and the sick. Amendments to the Social Security Act have far-reaching consequences; should grow out of humane considerations and a balancing of priorities; should meet evident needs in a way that preserves dignity and independence and strengthens family life in these most difficult days.

STATEMENT OF CONCERNED STATES COMMITTEE SUBMITTED BY MR. LAND D. WALL, CHAIRMAN, IN BEHALF OF THE TEXAS, ARKANSAS, LOUISIANA, WISCONSIN, OHIO, KENTUCKY, MICHIGAN, AND INDIANA STATE NURSING HOME ASSOCIATIONS

I am Land D. Wall, owner and administrator of four nursing homes in the State of Texas, one of which is a 136 bed skilled nursing home located in Lubbock, Texas, the other three being smaller intermediate care facilities located in various locations in West Texas. I am also the Director of the West Texas Home Health Agency in Lubbock, Texas, a non-profit organization sponsored by the Missionary Baptist Foundation of America. I have a Master's Degree in Health Care Administration from George Washington University, specializing in Long Term Care. I am President of the Texas Nursing Home Association, a non-profit Corporation which represents some 550 nursing homes involving more than 35,000 beds. At the present time I serve as Chairman of The Concerned States Committee which is an unincorporated, voluntary Committee of certain State nursing home associations including Arkansas, Louisiana, Texas, Wisconsin, Ohio, Kentucky—and there are others.

We voluntarily assembled our respective State asociations because of various individual State problems, primarily with the Medicaid program, and because we found the problems in the programs to be far too massive for a single national association to effectively cope with. Three of our States gave testimony before the Sub-committee on Oversight Legislation on May 27, 1970, and made it clear that we supported the Finance Committee Staff Report on Medicare and Medicaid and enthusiastically endorsed its findings.

In addition to certain recommendations we we would like to bring to your attention regarding H.R. 17550, we are also submitting the attached copies of the above mentioned statement before the Sub-committee as presented by representatives of the Arkansas, Louisiana, and Ohio state nursing home associations. We continue to support that testimony.[1]

SECTION 225 INCENTIVES FOR STATES TO INSTITUTE UTILIZATION CONTROLS

Our Committee is opposed to this section of the House Bill since reducing federal matching funds after 90 days for care in skilled nursing homes will work obvious hardships on infirmed patients institutions who have no voice in their determination of need for medical care--nor can they control such need for medical care. The financial loss to States will serve only to substantially reduce the quality and level of care now being afforded in qualified skilled nursing homes. The financial impact in all States most probably would prove catastrophic during times whe nthe available tax dollar has already been stretched beyond its limit. The intention of Section, however, is not without merit and it is certainly not our purpose to justify continued over-utilization of skilled nursing home beds in State XIX programs. Where States do not exercise appropriate and professional review procedures within their medical care programs, some measure of control must be imposed to insist on appropriate placement of patients in institutions equipped and designed to meet their needs.

We are concerned also with an additional danger found in Section 225. The Secretary of the Department of Health, Education and Welfare under this provision would be authorized to determine what rates are, or should be, as currently paid to skilled nursing homes and intermediate care facilities. The present language of the proposed amendment not only requires the Secretary to make a determination that there is a "*reasonable cost*" differential between the cost of skilled nursing home services and the cost of intermediate care facility services in the States, it further authorizes the Secretary to reduce federal payments in accordance with such provision.

In this regard, the "reasonable cost" differential is determined to be the excess of the average amount paid per inpatient day for skilled nursing home services (by calendar year quarter) over the average amount paid in such State per inpatient day for intermediate care facility services, regardless of the source of payment.

[1] See Committee on Finance hearings entitled "Medicare and Medicaid," pt. 2, Ninety-first Congress.

We offer our objection quite frankly because the Secretary of HEW until now has shown little competency in coping with anything associated with the word 'reasonable'. The beaurocracy administering Medicare has absolutely maligned the term "reasonable cost" from the inception of the Medicare program and it has finally become so notoriously uneconomical and inefficient that no one recognizes anymore what Congress originally intended in assigning its purpose.

Should the terminology 'reasonable' again be assigned to the responsibility of the Department of HEW, we could again expect hundreds and thousands of regulations, policies, etc., seemingly modifying one or more of the other. Such beaurocratic insistence leaves the vast majority of state agency administrators in a complete state of frustration as to what is actually intended or required. It would create more burdensome red tape, cause a tremendous additional expense to both State and Federal Government by virtue of audits, new accounting methods, checks and balances, etc., and in short cause State personnel to become so leary of finding themselves in fiscal jeopardy that the most caustic position available would be taken in setting rates for skilled nursing homes under Title XIX.

This would all come about at a time when the Nation calls for higher standards and more professional care in institutions that are constantly being forced to spend more and more of their time seeking adequate current financing. It would appear that simpler approach and one which appropriately directs the Secretary would be more desirable.

In the context of the proposed amendment, the "cost differential" is inappropriate since the average in some states for both skilled and intermediate care could closely parallel, according to the actual level of services afforded in each of the two kinds of institutions.

The "cost differential" should relate to rates paid to skilled nursing homes and intermediate care facilities on a yearly basis for similar services. In other words, rather than authorize the Secretary to issue regulations and cumbersome guidelines to cause control of a State's ability and flexibility to determine what rates should prevail in the two programs, it would appear simpler and more desirable as well as economical to require the States to furnish information to the Secretary's satisfaction that the differential in level of payments for skilled nursing home services and intermediate care facilities is systematically related to the differential in the level of services provided by the two kinds of institutions. This will allow States to utilize compatible methods of payment which are most consistent with their individual and peculiar programs and at the same time require them to exercise fiscal responsibility in administering both programs.

We are of the opinion, with regard to the reduction in federal matching after 90 days, that Senator Bennett's proposal to establish Professional Standards Review Organization (PSRO) could encompass the necessary controls to accomplish the intent of Section 225, if that intent is truly to curb overutilization.

Although we prefer the deletion of Section 225, if this cannot be done, we would recommend that the provisions be altered to provide the States sufficient time to institute either the provisions of Senator Bennett's amendment or some other appropriate professional review. Failing this, then federal matching should be reduced for a probationary period of time until such effective professional review becomes a matter of fact.

The "reasonable cost differential" paragraph of Section 225 should be rewritten, in any event, to require State agencies administering Title XIX to furnish to the Secretary's satisfaction that the "cost differential" on an annual basis is reasonably and systematically related to the "services differential" between the two kinds of institutions—skilled nursing homes and intermediate care facilities.

AMENDMENT NO. 851 TO H.R. 17550

The Professional Standards Review Organizations provisions of the amendment offered by Senator Bennett will substantially correct the present shortcomings of current methods of utilization review, and we feel confident that for the first time it will lend to the programs a professional concern of responsibility in matters of standards and utilization review. We are equally confident that the amendment will cause to be effected a more realistic placement of patients in institutions according to their realistic medical need, rather than to the synthetic needs of physicians, institutions, or families of patients. We are in enthusiastic support of Senator Bennett's amendment and endorse its adoption.

SECTION 233 ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER THE MEDICARE PROGRAM

Perhaps the most unfortunate circumstances surrounding the Medicare program has been the constant confusion as to just what constitutes extended care services for the purpose of benefits under the Act. Guidelines have been issued and oft completely changed or altered by the Social Security Administration, leading to misunderstandings nationwide—on the part of beneficiaries, families, providers, certifying physicians, government administrators, as well as the concerned taxpaying public.

The result has been to cause fully qualified extended care institutions throughout the country to be forced into a position of apathy with regard to the Medicare program. In many, many instances fiscal intermediaries, acting under guidelines issued by Social Security, have denied benefits sometimes as long as six months after services were provided—in many instances after beneficiaries have expired.

The provision in H.R. 17550 which guarantees a specific number of days upon transfer or discharge from a hospital will substantially correct this inequity and bring back into the active Medicare program many facilities that have recently either withdrawn from participation or who passively ignore Medicare and turn instead to patients who guarantee payment on admission. We support this provision in the House Bill and trust that the Bureau of Health Insurance will act expeditiously in implementing it.

The one suggestion we would make is that not only should guidelines take into consideration the medical condition of beneficiaries in establishing specified numbers of days upon a hospital transfer, but they should also take into account the length of hospital stay prior to an extended care transfer. In this regard, if the section was broadened to add additional ECF days for shorter hospital stays (for certain specific medical conditions), natural incentives would exist to encourage timely transfers when the patients' conditions warrant such transfer. We recommend that section 233 be strengthened in this respect.

ADDITIONAL OBSERVATIONS AND RECOMMENDATIONS

By and large, with the exceptions already noted and others as presented by the American Nursing Home Association in hearings before the Committee, we feel H.R. 17550 to be desirable, corrective legislation with regard to both the Medicare and Medicaid programs. Because of the massive efforts found in the Bill, however, several areas we think could be further strengthened and both programs substantially bolstered. Following are those areas which we recognize as critical and which, if appropriately considered and acted upon, will restore fiscal responsibility to the programs and correct many abuses which currently plague provider, government and beneficiary alike.

UNLICENSED BOARDING HOMES FOR THE ELDERLY

The skilled nursing home amendments of 1967 as introduced by Senator Moss and found to be worthy by this Committee, were the most responsible consideration ever given towards eliminating sub-standard nursing homes in this Country and bringing about a uniform quality level of care in the Nation's nursing homes. There yet exists, however, throughout the country many sub-standard and unlicensed facilities which provide little more than weather shelter and scant meals. Throughout the Country Public Assistance recipients are allowed to be cared for in so-called 'boarding homes' that are neither licensed, regulated or otherwise governed. We think that Congress is concerned with the care of all the Nation's elderly population whose needs necessarily must be met in institutions. The conditions in some such facilities are so bad that one can only compare them to the nursing homes of the "dark ages" some ten or twenty years ago. So that all our aged citizens may expect and receive decent housing, food and some care, we recommend that the Committee consider amending H.R. 17550 to require States with approved Title XIX plans to provide for the licensure and regulation of 'boarding homes for the elderly'. Such nomenclature could include personal care homes, rest homes, domiciliary homes, etc., and could be identified as those facilities which house more than two or three unrelated individuals under the same roof, and whose average population consists of more than ten or twenty percent of such persons above over the age of 65.

As a minimum, such facilities should be required to meet minimum nursing home standards for State licensure in the areas of Fire Safety, environment and dietary services. We urge you to act with dispatch to bring about this year this sorely needed reform in behalf of our Nation's elderly population.

TITLE XIX PAYMENTS TO SKILLED NURSING HOMES

The Social Security Amendments of 1967 wisely included a provision to require State Title XIX programs to provide and assure that payments to providers "are not in excess of *reasonable charges* consistent with efficiency, economy, and quality of care." We have never felt that payments should exceed this criteria, and justly supported the adoption of this measure, which as you know, was a result of this Committee's concern over excessive payments and utilization of services. We felt additionally that the Committee voiced its informed opinion that "reasonable charges" and not "reasonable cost" should be the upper limit in such payments. The Department of HEW, however, in implementing the provisions of Section 237, took the position that "reasonable charges" was in effect intended to be reasonable cost as per the methods and procedures used by Medicare. This had the effect of limiting such 'reasonable charges' or payments to skilled nursing homes by Title XVIII Reasonable Cost Formula, which has proven to be burdensome and costly to administer.

It had the additional effect of limiting State agencies' methods of payments to the extent that any method which considered economy and efficiency incentives (which Medicare does not recognize as a reasonable cost) could not be considered in compliance with Federal regulations. We are sure that this was not your intention and that the Department of HEW has aborted the economic wisdom contemplated by the amendment.

Since implementing the above regulations pursuant to Section 237, the Medical Services Administration, DHEW, has revised its policy somewhat. However, current regulations still require a sophisticated Medicare Reasonable Cost averaging method to limit payments, and we understand further 'guidelines' are under preparation. So that States may develop, implement and maintain economic and efficient methods of payment, unrestricted by the inefficiencies of "reasonable cost", we recommend that Section 237 be amended to make the record clear that "reasonable charges" shall not be identified with, compared with, or otherwise limited to, "reasonable cost" as that term relates to Title XVIII. Whereas it is only just and sensible that "reasonable cost" should be limited by "reasonable charges", it is equally unjust and senseless to apply the reverse order. We do not feel that the Congress of 1967 intended to eliminate methods of payment to skilled nursing homes under Title XIX which contain factors for efficiency and economy, to say nothing of quality of care—especially at a time when quality standards for nursing homes were soon to become required by Federal law.

We urge your consideration of establishing clear-cut intent that State Title XIX programs for skilled nursing homes may be developed on the basis of "reasonable charges" (not reasonable cost) and may include incentive factors, efficiency factors, etc., not otherwise contemplated by present DHEW regulations, and *not*—related to Medicare's costly and inefficient Reasonable Cost formula.

MEDICAL COMPETENCY OF TITLE XIX STATE MEDICAL REVIEW TEAMS

The 1967 Skilled Nursing Homes Standards Amendments included a requirement that State Agencies administering Title XIX provide for a regular program of medical review of each patient's need for skilled nursing home care, and determinations that such care is satisfactorily provided. The medical review teams contemplated to make such determinations, as the Finance Committee Report stated, were to be independent of the institutions providing such care. The "independence" of such Medical Review Teams have been hampered in that the present law allows the paying agency in the States to employ or otherwise contract such personnel to carry out this vital function. The result in many states has been non-professional determinations made by the thousands based on guidelines (state) which concern themselves with placing as many patients as possible in low cost, sometimes low quality, facilities that can not possibly meet the medical needs of patients. We support the fact that patients not in need of skilled care should not be allowed to remain in costlier skilled care facilities; however we are equally insistent, as we are sure you are, that those who require skilled and intensive nursing and medical care should not be forced

to seek care in intermediate care facilities or boarding homes not equipped to meet their needs. To bring about the reform needed and establish true Independent Medical Review, we urge your consideration of amending the current law (Title XIX, Section 1902(a)(26)) to provide that such medical review teams have the medical competency to carry out the requirements of said Section and that the State Agency employing or contracting their services be separate and divorced from the placement and rate-setting agency administering Title XIX. Such action would lend much assistance in re-directing the program towards the appropriate placement of Title XIX patients in facilities designed and equipped to care for their medical needs, and lend equal assurance that ALL facilities would be appropriately utilized.

PAYMENTS TO EXTENDED CARE FACILITIES FOR MEDICARE SERVICES

As we indicated in our testimony before the sub-committee on May 27, 1970, (see Addendum; Mr. JohnWheeler, President of the Ohio Nursing Home Association), the most efficient and economical extended care facility has an apathetic attitude towards Medicare and most other do not admit Medicare beneficiaries or admit them only when circumstances absolutely demand. The bulk of Medicare admissions to ECFs are thus in costly and inefficient Medicare dominated facilities who depend on such admissions and the resultant "cost" financing with all its impossible shortcomings. We recommend that the "casual" provider ECF be treated in payment methods more similarly to the over-all patient population in order that we may again enlist their economical participation in the Medicare program. The Casual Provider, we suggest, is the ECF with an average annual occupancy of 20 percent or less of Medicare patients. Because this type of provider relies upon other than Medicare patients for virtually all of its operating cash flow, its rate structure is more closely attuned to the competitive, free enterprise factors at work in its community and region. We believe that such providers should be compensated for the relatively small numbers of Medicare patients, based on their bona-fide average daily charges to other patients for similar services.

Implicit in this suggestion is our view that the costly and cumbersome record-keeping, and subsequent expensive and time-consuming audit, be eliminated. The staff report on Medicare-Medicaid very aptly refers to this aspect of the current formula and its application as the "audit overkill", a phrase with which we heartily concur.

We believe recognition that there are in fact the unique "casual providers" to be of the utmost importance to the future stability of the Title XVIII program. The Casual Provider does not now account for large numbers of ECF patients, largely because of the complex, costly and unrewarding cost reimbursement formula. Given the opportunity to provide services to Medicare patients at reimbursement levels which have proven competitive and sound in the normal operation of the facility, the role of the Casual provider can be expected to accelerate.

While the more substantial and major providers are now carrying a relatively large number of Medicare patients, the significant savings in cost-finding and record-keeping, and the substantial savings in follow-up audit, will assure rates charged and paid for Medicare patients that are consistent with the rates paid by all other users of the facility.

CONCLUSION

We trust that we have been helpful in bringing to this Committee some added areas of concern in the Medicare-Medicaid programs and hope that we have been able to add additional consensus in your efforts to strengthen them. Thank you for your consideration of our combined State Associations' thoughts and efforts in this regard.

A RESOLUTION URGING THE OHIO HEALTH COMMISSIONERS ASSOCIATION TO OFFICIALLY SUPPORT THE PASSAGE OF THE PROPOSED AMENDMENT NUMBER 714 TO H.R. 17550, IN THE UNITED STATES SENATE

Whereas, H.R. 17550 is an act which amends the Social Security Act to provide much needed improvements in the medicare, medicaid and maternal and child health programs; and

Whereas, current amendment Number 714 to said H.R. 17550 provides for the position of Inspector General for Health Administration and sets forth the functions and authority of said position; and

Whereas, the passage of this Amendment would be of great benefit to the effective administration of the health care programs; and

Whereas, it is imperative and necessary that said Amendment receive the full support of the Ohio Health Commissioners Association, now therefore, be it

Resolved, that the Ohio Health Commissioners Association is hereby urged to officially support Amendment Number 714 to H.R. 17550, in the United States Senate.

Introduced by Dr. Walter M. Greissinger, M.D., M.P.H., at the Ohio Health Commissioners Conference, September 9-11, 1970, Columbus, Ohio.

NATIONAL GRANGE,
Washington, D.C., September 25, 1970.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, Washington, D.C.

Dear Mr. CHAIRMAN: The National Grange represents 7000 local community Granges across the nation, with a total membership of 600,000. It is more than a farm organization. Its purpose is to serve the total interest of the rural community and the nation.

Social Security is a subject which has drawn considerable attention during the last several Annual Sessions of the National Grange, and I would like to use this means of transmitting the thinking of the Grange to you and through you to the Committee.

Without any question, the cost of the Social Security tax falls most heavily on the self-employed. This includes the total of our farm population. In the midst of a continuing cost-price squeeze on American farmers, they are naturally and rightfully concerned about the amount they can earn while collecting Social Security payments.

At the Annual Session of the National Grange in 1969, the delegate body adopted the following resolution:

SOCIAL SECURITY BENEFITS

Whereas, Social Security benefits currently lag far behind the cost of living, and

Whereas, allowable earnings, now limited to $1680 per year, do not raise the total income of many Social Security beneficiaries to even a poverty level, and

Whereas, Social Security taxes, both on employer and employee, have been increased, therefore be it

Resolved, that the National Grange urge Congress to:

(1) Increase Social Security benefits.

(2) Change the period by which benefits are computed to the three (3) highest years of earnings.

(3) Raise allowable earnings to $3,000 per year.

We recognize that when the Social Security law was passed that there were other social factors that were involved, one of them being the high proportion of unemployed in the United States. It would seem obvious to us at the present time, that with this change which we have seen during the last few years when the unemployed employables are at nearly the minimum number possible in a free society, that the social objectives of getting someone to quit work at 65 to make room for younger people is no longer as valid as it was. This is particularly true if the person is self-employed.

Therefore, it seems logical and reasonable to us, that in the present period of high cost of living plus relatively high employment that considerable flexibility should be written into the law to permit elderly retired people to earn a combination of social security benefits plus earn income that would place them at least a couple of steps up the economic ladder above the poverty level.

Thus, the Committee will understand the Grange's concern with the low level of social security which is available to many of our elderly citizens, and which does put them in a rather precarious situation unless they have other income to fall back on. We would, however, hope that you could see fit to consider the increase in the allowable earnings which would not cost the taxpayer any

additional money and which would go a long way toward completely removing the possibility of those who are without additional resources being limited to an unreasonably low earning and total income level during their declining years.

We would also point out that this provision would not affect many of these people very long, but in the case of some self-employed people and some who are not self-employed, it would permit them to extend the time in which they could live with increased decency and dignity—the real objectives of this legislation in the first place.

We appreciate this opportunity to present the views of the National Grange on this important matter, and ask that this letter be made a part of the hearing record.

Sincerely,

JOSEPH E. QUIN,
Legislative Representative.

STATEMENT BY WILLIAM F. ANDREWS, SR., ADMINISTRATOR, WAKE COUNTY HOSPITAL SYSTEM, INC.—ADDITIONAL COMMENTS REGARDING THE "BENNETT" AMENDMENT TO THE 1970 SOCIAL SECURITY AMENDMENTS

Individual patient health needs will be ignored under the proposed amendment. With national and regional "norms of health care services for various illnesses or health conditions" imposed upon the physicians and providers of care (hospitals) it will be impossible for the total health needs of the individual to be considered. (Norms) may be appropriate when dealing with airplanes or automobiles or other "things" however, people are different from "things" and accordingly their total health needs cannot always be fitted into a set of given "norms."

The rights, responsibilities and authorities of the governing boards of the hospitals will be in jeopardy if the Bennett amendment is passed in its present form. The duties and functions of the Professional Standards Review Organization as proposed, will place serious limitations upon the performance of the trustees. How can trustees continue to perform their duties as a body which is legally accountable for the quality of care rendered within the institution when certain of these duties will be taken away from them?

The proposed amendments also interfere wtih the legally constituted authority of the licensing agencies, particularly of hospitals as providers of service, in the several states. The inspection of physical facilities, the examination of pertinent records, and the evaluation of the quality of services are all responsibilities already, by state's statute, assigned to the state licensing authority. (In North Carolina this authority is given to the North Carolina Medical Care Commission and is found in Article 13 (A), Subchapter 131 of the General Statutes of North Carolina.)

At no place in the proposed amendment do we find any indication as to what it would cost to implement this additional program. The citizens of the United States and the Members of Congress have indicated a keen concern over the cost of the Medicare, Medicaid and Maternal and Child Health Programs. Information is not readily available to indicate what portion of the total expenditure is for actual health services compared with the amount of money spent to administer the program. We interpret the Bennett amendment to add substantially to the cost for administration of the program—services which do not relieve the suffering nor do they meet the health needs of the citizens of our country.

In summary, it appears that the Bennett amendment will:

1. Seriously interfere with the individual rights of our citizens in that no longer will the physicians and hospitals be allowed to provide services according to needs, but will be required to treat persons as "things" under a system of "norms."

2. Those public spirited individuals in every community throughout our country who serve on hospital boards of trustees—this is a service without reward or remuneration—will have their responsibilities and authorities removed in that they can no longer act for or assume their total responsibility in the vital role as hospital trustees.

3. The duly appointed public officials, acting under authority granted to them by their respective state governments, will no longer have the authority to implement the laws of the states as they pertain to the licensure of hospitals.

4. All tax paying citizens will have a further erosion of their tax dollar spent for administrative purposes rather than for the actual provision of health care.

UPJOHN HOMEMAKERS, INC.,
Kalamazoo, Mich., September 25, 1970.

The Honorable RUSSELL B. LONG,
Chairman, The Senate Finance Committee,
Washington, D.C.

DEAR SENATOR LONG: Please note Attachment 1. It contains recommended changes to H.R. 17550, "Social Security Amendments of 1970."

Homemakers, Inc., is a wholly owned subsidiary of The Upjohn Company, Kalamazoo, Michigan. Homemakers, Inc., is a temporary help company, similar to Manpower, Kelly Services, etc., except it provides home and health care services to persons in their own home rather than servicing commerce and industry.

Our rates are fully competitive in costs with any organization now providing services under Medicare and Medicaid. To cite an example: in the City and County of San Francisco, we supply Homemakers services to clients receiving aid from Aid to the Blind, Aid for the Totally Disabled, Old Age Assistance, and charge $3.25 per hour. The local Home Health Agency funded through the United Crusade charges $6.47 per hour for Home Health Aide Services, and will not do Homemaker service.

Homemaker services include housecleaning, cooking, shopping, companion, assistance in personal care such as bathing, hair dressing and to perform all these duties courteously, efficiently and promptly.

These services are also provided to families receiving aid under the Aid to Families with Dependent Children program. Under this program, we provide substitute mothers at a cost of $38.00 per 24-hour periods. The local Family Services Agency of the United Crusade charges $47.00 per 24-hour period, but has not been able to retain workers to meet demands.

It is my opinion that the addition of proprietary agencies to the list of authorized Social Security providers would result in lower costs and improve the quality of services provided. I have attached copies of the State of California Welfare and Institutions Code authorizing the inclusion of such agencies under that state's Home Health program.

Addition of proprietary agencies at this time would permit the gathering of statistical data for consideration of the continuance of this provision under the anticipated Health Security Act of 1973 or later.

Very truly yours,

EDWARD J. WILSMANN,
President.

Two attachments.

SUGGESTED AMENDMENTS

Add (8) to Section 1861(m) as follows: (8) Homemaker services are authorized when recommended by the attending physician. These services may be purchased from a proprietary agency under the following conditions:

(A) The cost of the service does not exceed by more than 5 percent the average cost of the service being performed by staff employed by a public agency.

(B) The proprietary agency agrees to train and employ recipients of public assistance or other low-income persons who would qualify for public assistance in the absence of such employment.

Add to Section 1861(o)(1) as follows (additional underlined): (1) is primarily engaged in providing skilled nursing services, *homemaker services,* and other therapeutic services;

Omit under Section 1861(o) after (5) the words: "except that such term shall not include a private organization which is not a non-profit organization exempt from Federal Income taxation under section 501 of the Internal Revenue Code of 1954 (or a sub-division of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations;"

Add in lieu of the above words after (5), Section 1861(o): "except that such term may include proprietary agencies licensed or accepted under State Law and meets those standards and requirements as may be prescribed in regulations;"

CHAPTER 660

An act to amend Section 11172 of, and to add Sections 11171.5 and 13933 to, the Welfare and Institutions Code, and to add Section 32.7 to Chapter 355 of the Statutes of 1969, relating to public assistance, declaring the urgency thereof, to take effect immediately.

[Approved by Governor July 31, 1969. Filed with Secretary of State July 31, 1969.]

The people of the State of California do enact as follows:

SECTION 1. Section 11171.5 is added to the Welfare and Institutions Code, to read:

11171.5. Homemaker services may be purchased from a proprietary agency under the following conditions:

1. The cost of the service does not exceed by more than 5 percent the average cost of the service being performed by staff employed by a public agency.

2. The proprietary agency agrees to train and employ recipients of public assistance or other low-income persons who would qualify for public assistance employment.

3. The cost of the purchase of such service would qualify for federal reimbursement.

The provisions of this section shall not restrict the right of a chartered county from providing a civil service classification for homemakers.

SEC. 2. Section 11172 of the Welfare and Institutions Code is amended to read:

11172. The county welfare department shall file a certificate with the department stating that they have developed a plan pursuant to Section 11171. Notwithstanding the provisions of Section 12152, 12652, or 13700, upon approval of the county plan by the department, except as otherwise provided in this section no further public assistance allowances shall be made by such county to allow recipients to employ homemaker or attendant care services. State funds appropriated to such county pursuant to the provisions of Sections 15201 to 15204, inclusive, for that purpose are hereby allocated to the county as set forth in the Budget Act for the purpose of providing homemaker services pursuant to this article. The state funds appropriated pursuant to the Budget Act shall cover all of the nonfederal costs of providing homemaker services.

The costs of attendant care services provided in lieu of homemaker services through cash payments to recipients during the developmental period of the homemaker service or in circumstances where such homemaker service is impractical shall be subject to participation by the county in accordance with the regular state-county sharing formula applicable to the category of public assistance for which the recipient qualifies.

SEC. 3. Section 13933 is added to the Welfare and Institutions Code, to read:

13933. Recipients of public assistance as described by Section 13900 of this code who require care in a nonmedical protective living arrangement shall be granted aid in accordance with regulations, and rate schedules established by the Secretary of the Human Relations Agency. Such regulations and rates shall be promulgated by the State Department of Social Welfare as an integral part of their regulations issued for use by county welfare departments in the administration of public assistance programs.

Payments to recipients to cover cost of care as set forth in rate schedules made pursuant to this section shall not be considered expenditures under Chapter 3, 4, 5 and 6 of this part and shall be limited to the amounts and control set forth in the Budget Act.

SEC. 4. Section 32.7 is added to Chapter 355 of the Statutes of 1969, to read:

32.7. Funds appropriated under Section 32.5 of this act may be used by the Department of Social Welfare in an amount not exceeding twenty-eight million fifty-nine thousand nine hundred dollars ($28,059,900) except as otherwise provided in this section, for the cost of the state share of homemaker or attendant care services for which federal grants-in-aid are made to the state, as specified in Section 11172 of the Welfare and Institutions Code, and for the cost of the state share of board and care rate allowances granted to recipients of public assistance, as described in Section 13900 of the Welfare and Institutions Code, who require a nonmedical protective living arrangement. Such amount is allocated as follows:

(a) Thirteen million nine hundred fifty-seven thousand one hundred dollars ($13,957,100) for homemaker or attendant care services;

(b) Fourteen million one hundred two thousand eight hundred dollars ($14,102,800) for board and care rate allowance.

If a change in caseload of recipients who require a nonmedical protective living arrangement and receive a board and care allowance, unrelated to any change in rule or regulation adopted during the current year, results in expenditures in excess of the amounts included in subdivision (b), the Director of Finance is authorized to approve sufficient funds for such purpose in augmentation of subdivision (b) within the limits of funds appropriated under Section 32.5.

SEC. 5. This act is an urgency statute necessary for the immediate preservation of the public peace, health or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting such necessity are:

The orderly implementation of the Homemaker Services Act as enacted by the 1969 Legislature requires the gradual case-by-case transfer from attendant care. The twofold purpose of keeping the aged and the disabled in their own homes in preference to institutionalization and giving able-bodied recipients employment opportunities can only be achieved by gradual implementation.

(The following statement was forwarded to the committee by Hon. John O. Pastore and Hon. Claiborne Pell, Senators from the State of Rhode Island:)

HOSPITAL ASSOCIATION OF RHODE ISLAND POSITION STATEMENT

H.R. 17550, the Social Security Amendments of 1970, as passed by the House of Representatives, is presently before the Senate Finance Committee. This statement, relative to portions of that legislation, reflects the opinion of the Hospital Association of Rhode Island and the seventeen voluntary, non-profit, community hospitals throughout Rhode Island which are its members.

It is the position of the Hospital Association of Rhode Island that this legislation contains many provisions deleterious to the interests of hospitals and deleterious to the adequate and efficient delivery of health care to the people of Rhode Island through our voluntary hospitals.

During a period of inflation and rising hospital costs, we believe it would be fiscally irresponsible for the federal government to move to any thing less than meeting the full financial requirements of health care institutions for the delivery of health care to the less fortunate to whom the government has agreed to provide health care. For the federal and/or state governments to pay less than the full reasonable cost to these institutions for the delivery of health care would be a step backwards to the "welfare" era prior to the Medicare legislation, when the federal government thought it should be afforded the option of buying services from the voluntary sector at less than the full cost of that service.

We are also concerned that parts of this legislation attempt to remove the authority and responsibility for the management and operation of our voluntary hospitals from the voluntary boards of trustees, and the professional administrators hired by these boards of trustees, legally entrusted by the community with this responsibility. (We recommend, in light of this, deletion of Section 231.)

Section 229 and Section 230, as written, could lead to the serious underfinancing of hospitals. We recommend their deletion from the bill.

We urge that reimbursement to hospitals meet the total monetary resources that are needed by a hospital to fulfill its role in meeting community health service objectives.

We recommend federal government leadership and incentive in bring about effective prospective rate setting for hospital reimbursement without the overly burdensome reporting called for in Section 222.

Section 221 should be changed to eliminate the possibility of creating unnecessary "super planning agencies" and to provide that states with certification-of-need laws (as Rhode Island) are deemed to meet the requirements of this section.

Limitation on federal payment for capital expenditures disapproved by state or local health facilities plans should be applied only to expenditures related to the replacement and major modernization of buildings or the expansion of plant equipment for new services—as is now true under Rhode Island's certification-of-need statute.

Under this Section, as well as others such as Section 223, the Secretary of HEW is given considerable authority by which to make final decisions relative to matters of reimbursement. There is provided no appeal process from the Secretary's decision. We urge the insertion, in all cases, of a provision providing for an adequate and equitable appeal process from all of the Secretary's decisions.

Section 227 very commendably attempts to eliminate fraud and abuse in the Medicare and Medicaid programs. We believe, however, that the provision therein which permits the Secretary of HEW to declare that care was "excessive, harmful, or of grossly inferior quality" is dangerous and highly questionable as to its application because it would interfere with the authority and responsibility of medical staffs and medical judgment. This part of Section 227 should be eliminated.

We fully support Section 239 and further suggest that the objectives sought under Section 239, namely the provision of comprehensive health care to the aged, might more effectively be achieved through a single broad program combining institutional health care and physicans' services (that is, a combination of Part A and Part B), as well as preventive care, multiphasic screening and an expansion of other ambulatory health services.

(The following communication was forwarded to the committee by Hon. Claiborne Pell.)

HOSPITAL ASSOCIATION OF RHODE ISLAND,
Providence, R.I., September 22, 1970.

Hon. CLAIBORNE PELL,
325 Old Senate Office Building,
Washington, D.C.

DEAR SENATOR PELL: The Hospital Association of Rhode Island would like to take this opportunity to express its deep concern over Amendment 851—The Bennett Amendment—to the Social Security Amendments of 1970, H.R. 17550, which is presently under consideration in the Senate Finance Committee.

As we discussed with you in Washington on August 18, the hospitals of Rhode Island are of the opinion that H.R. 17550 and now Amendment 851 contain provisions that are contrary to the best interest of the people of Rhode Island as beneficiaries of our voluntary system of hospital care. Our specific objectons to the Bennett Amendment are detailed in the enclosed addendum to our earlier position statement on H.R. 17550.

We respectfully ask that you request our enclosed addendum be included in the record of the Senate Finance Committee with our original statement, which you previously had inserted in the Committee's record.

Sincerely,

WADE C. JOHNSON,
Executive Director.

ADDENDUM

HOSPITAL ASSOCIATION OF RHODE ISLAND POSITION STATEMENT ON TITLE II OF H.R. 17550 AMENDING THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS UNDER THE SOCIAL SECURITY AMENDMENTS OF 1970

September 22, 1970

It is the position of the Hospital Association of Rhode Island and its member hospitals that Amendment 851 (The Bennett Amendment) to the Social Security Amendments of 1970, H.R. 17550, is not in the best interest of the people of Rhode Island as beneficiaries of hospital services.

The Bennett Amendment would take the responsibility for health care quality control and utilization review out of the hospital and its medical staff and place it, improperly, with the county medical society. While the present hospital-based programs of quality control and utilization review may not be perfect, they have been developed and improved substantially over the past few years and are continuing to develop. The standards of the Joint Commission on Accreditation of Hospitals (JCAH) and the services of the nonprofit Commission of Professional and Hospital Activities (CPHA) are important resources for this development and are centered around hospitals. All of Rhode Island's voluntary acute-care hospitals are accredited by the JCAH and subscribe to the services of the CPHA.

Most important of all, in our view, is that the hospital is the place where the medical staff, management, and trustees, working collectively, can be made accountable for quality of care and effective use of resources. It should be particularly kept in mind that the hospital board of trustees has the legal responsibility for all care rendered by the hospital.

If the responsibility for quality control and utilization review were transferred from the hospital to the county medical society, we fail to see how the resources, the team approved, and the safeguards described above would be effectively duplicated, and we therefore see a potential danger to the public interest and safety.

In addition, we think there is danger of conflict-of-interest allegations interfering with a program's effectiveness under a program of peer review conducted by a county medical society.

We therefore urge that the Congress reaffirm the existing Federal policy of supporting, encouraging and strengthening utilization review and quality control efforts under present hospital-based auspices, and that Amendment 851 be defeated.

NATIONAL ASSOCIATION OF STATE
MENTAL HEALTH PROGRAM DIRECTORS,
Washington, D.C., October 9, 1970.

Hon. RUSSELL LONG,
Chairman, Senate Finance Committee, Room 2227,
New Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: On September 15, during the hearings, you asked us about federal support for treatment in mental hospitals of medically indigent persons under 65 yrs. of age (and over 21 yrs.).

The Social Security Act now discriminates against this group by denying them the right to federal benefits if they are treated in a specialty hospital.

It is the estimate of the state agencies treating the mentally ill that if you amended Title 19 of the Social Security Act to provide federal benefits for *active treatment* in *accredited* mental hospitals for *eligible* persons *under* 65 yrs. of age (but over 21 yrs.), then the total (Federal-State) annual cost for this improvement in care would be $63.6 million.

The accompanying chart shows state-by-state supporting data for the above figure. Total cost is $63,623,639.

Under Title 19 the Federal Government would pay benefits averaging 52% or $33,084,202.

All of the hard information on the attached chart was telegraphed or phoned to Washington, D.C. Oct. 6-7-8 (1970) from the 50 state capitals, especially for this study for your committee.

We now respectfully request that you reject the soft "projections" made for your committee by H.E.W.,[1] and once again review the issue of support of improved treatment of medically indigent persons under 65 yrs. of age and, at your next executive session on H.R. 17550, adopt the following amendment to the Social Security Act:

In Section 1905(a)(15) of the Social Security Act—strike out all of paragraph (B)

Respectively,

HARRY C. SCHNIBBE,
Executive Director.

---

[1] I have been authorized by HEW aides to re-state their "estimates" for covering persons "under 65" (including the under 21). Their estimate is $220 million (not $500 million) and this figure applied to a program without controls—like: "accreditation", "active treatment", "medical audit", etc.

UNDER 65 (OVER 21 YRS)

State	1970 patients in active treatment in public mental hospitals who are under 65 (but over 21) and who are title 19 eligible	Active treatment period (days)	Cost of treatment per day	Total cost of treatment
California	5,400	13	$23.50	$2,030,400
New York	9,000	50	20.00	9,000,000
Pennsylvania	4,006	42	21.67	3,646,020
Illinois	5,081	34	21.64	3,738,396
Texas	6,185	60	10.20	3,785,220
Ohio	758	25	30.00	568,500
Michigan	2,462	49	21.51	2,594,913
New Jersey	(1)	(1)	(1)	(1)
Florida	1,106	365	10.00	4,036,900
Massachusetts	2,000	90	18.00	3,240,000
North Carolina	2,105	30.5	13.39	845,078
Indiana	1,870	120	13.50	3,029,400
Missouri	3,109	53	17.40	2,867,120
Virginia	1,305	147	$8.14	1,561,537
Georgia	(2)	(2)	(2)	(2)
Wisconsin	(2)	(2)	(2)	(2)
Tennessee	158	30	24.00	113,760
Maryland	1,500	45	13.20	891,000
Louisiana	1,120	60	17.00	1,142,400
Minnesota	770	90	17.89	1,233,757
Alabama	(2)	(2)	(2)	(2)
Washington	816	52	23.29	988,665
Kentucky	1,394	88	15.00	1,840,080
Connecticut	939	22	35.75	738,523
Iowa	(1)	(1)	(1)	(1)
South Carolina	125	160	19.59	391,800
Oklahoma	570	28	17.58	280,577
Mississippi	(2)	(2)	(2)	(2)
Kansas	283	90	25.00	636,750
Colorado	942	18	64.00	681,984
		4.50	30.00	4,725,000
Subtotal				5,406,984
Oregon	731	48	19.57	687,725
Arkansas	272	45	14.50	177,335
West Virginia	(2)	(2)	(2)	(2)
Arizona	370	60	17.00	377,400
Nebraska	365	50	25.00	456,250
Utah	(1)	(1)	(1)	(1)
New Mexico	(2)	(2)	(2)	(2)
Maine	60	45	12.00	32,400
Rhode Island	1,345	46.4	14.42	911,560
Hawaii	190	30	20.00	114,000
Idaho	(2)	(2)	(2)	(2)
New Hampshire	400	90	10.00	360,000
Montana	(2)	(2)	(2)	(2)
South Dakota	633	60	17.00	645,660
North Dakota	(1)	(1)	(1)	(1)
Delaware	325	36.4	16.00	1,892,800
Nevada	270	271	16.82	1,229,256
Vermont	430	51	13.75	301,537
Wyoming	221	460	16.27	1,657,058
Alaska	131	32	41.24	172,878
Total	58,747			63,623,639

[1] Unable to compute response.
[2] No JCAH hospitals.

TESTIMONY OF THE COUNCIL OF MEDICAL STAFFS (AMERICAN ASSOCIATION OF COUNCILS OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC.) PRESENTED BY DR. JOSÉ L. GARCIA OLLER, PRESIDENT

Mr. Chairman, I am Dr. José L. Garcia Oller, Neurological Surgeon, Founder and President of the Council of Medical Staffs (American Association of Councils of Medical Staffs of Private Hospitals, Inc.). With me are: Dr. Kenneth A. Ritter, practicing psychiatrist, Dr. Robert Meade, plastic surgeon, Vice Presidents of CMS; Dr. Edward S. Hyman, internist, Secretary; Dr. Wesley N. Segre, pediatrician, Treasurer of the CMS and also President of the Louisiana Medical Association representing the Black physicians in Louisiana. The CMS was founded in 1968 "to establish and pursue common goals which will benefit patients and improve the practice of medicine, to promote cooperation of the Medical Staffs of Private Hospitals and to determine the consensus of the private practice of medicine, and to take action in connection therewith." CMS chapters are presently operating in Louisiana, Texas, Michigan, Oklahoma, representing about 100 hospital medical staffs, and organizing in Kansas, Mississippi, Missouri and Minnesota. The CMS holds that private practice provides the highest quality of medical care because of personal dedication to the best interests and welfare of the individual patient.

The CMS has requested this hearing because it is time that Congress hears the views of those actually delivering the medical care which Bennett Amendment No. 851 and H.R. 17550 would most severely and adversely affect:

1. The CMS is opposed to the PSRO provisions of Amendment 851 which require the prior approval by a government agency of the hospital admissions. (Sec. 1155)

(a) The CMS feels that such government control of hospital admissions would create RATIONING OF MEDICAL CARE, with interminable waiting lines of patients awaiting a hospital bed.

(b) Deterioration of quality medical care would inevitably result from substituting a cumbersome government committee system to approve hospital admissions instead of the professional judgment of the patient's doctor.

2. The CMS is opposed to the provisions of the Bill H.R. 17550 which establishes FEDERAL WAGE AND PRICE CONTROL over medical care, as discriminatory and unprecedented and unwarranted. As previously testified by Mr. Robert J. Myers, ex-Chief Actuary to S.S.A. the formula contemplated is certain to eventuate in a flat fee schedule at the "prevailing charge" instead of the "usual and customary" as intended in the "Medicare" Law.

3. The CMS attacks the PSRO provisions of the bill which make every physician a ward of the government, and medical societies an agent of the government.

(a) The physician will become a ward of the government since the Secretary of HEW shall have the power to "exclude (permanently or for such period as the Secretary may prescribe) such practitioner or provider from eligibility to provide such services on a reimbursable basis."

(b) Medical Societies become an agent of the goverment since they will undertake contracts with the Secretary of HEW to form PSRO bodies giving the Secretary of HEW final disciplinary control over the Societty membership. This effectively abolishes the role of the medical society as a free association and changes its character to a quasi-governmental agency. (Sec. 1152).

4. The CMS opposes PSRO provisions which expose to the public government agencies the private affairs of our citizens which are recorded in patients hospital charts.

(a) The CMS opposes Sec. 1155(b)(3) which undertakes to review records of any practitioner or provider; also Sec. 1155(a)(4) which provides for profiles of care with respect to each patient. The maintenance of patient records outside of the physician's office or hospital should not be accepted, as confidentiality of personal affairs is the basis on which medicine is founded. Patients will no longer give adequate information to a physician if the government computer is to have the information! Congress should provide safeguards that the confidentiality of office and hospital records must be preserved. Fiscal audits do not require information on the confidential aspects of the patient's chart! Dr. Kenneth A. Ritter, here with us today, is vitally interested in this item of Confidentiality of Records, and will be available for discussion with your Staff if time permits.

5. The CMS is opposed to the Bennett Amendment because it is based on

fundamentally invalid arguments. Senator Bennett states his amendment is in response to a "justifiable concern" of "the American people" "over the tremendous costs of medical care." The CMS proposes to prove that the charges of alleged escalating costs and overutilization requiring these oppressive measures of control, policing and rationing of care, are *not* valid.

The CMS will present evidence that there has been a deception of the American public as to:

1. Alleged high cost of medical care.
2. Inordinate rise in physicians fees.
3. Inefficiency of our medical care system.
4. Overutilization of our hospitals.
5. The "doctor shortage".
6. "U.S. care is second rate because of high Infant Mortality".

Dr. Edward S. Hyman will present some of the material supporting each of the above 6 arguments.

1. ALLEGED HIGH COST OF MEDICAL CARE

Figure 1 (Fortune Magazine, January 1970) shows the typical misleading and faulty comparison usually presented between the cost of medical care and the cost of living with the statement: "The cost of physicians' services and the cost of medical care have risen 50% since 1959 while the cost of living has gone up only 20%." This comparison between medical care and the cost of living is improper because physicians' services and medical care consists essentially of services, not goods, while the consumer price index includes goods and services. *Figure 2* (U.S. News and World Report, August 25, 1969, page 76) demonstrates that when medical services are compared to all other services, they have each risen 50% in the same time interval. Commodities have risen only 20%. In the same 10 year interval retail store sales have risen 78%, the cost of the U.S. Congress has risen 156%, the 3 cent first class postage has doubled to 6 cents, the 1 cent post card became a 5 cent item, the Postal Service is still short of money. *Figure 3* (U.S. News and World Report, Dec. 8, 1969, page 30). Some argue that the cost of medical care has risen more sharply in the past 2 years, with "Medicare". However, the published data refute this information: In two years the cost of medical care rose 12.9%, but meat, poultry, and fish rose 13.6%, meals at restaurants rose 12.7%, men's clothing rose 12.8%, women's clothing rose 12.0%, shoes rose 12.7%, and public transportation rose 13.0%. Two other items rose much more than medical care.

Owning a home rose 18.2%, and insurance and finance costs rose 21.4%. The cost of medical care has not risen in the past two years as much as these common items. Figure 4. (1968 Source Book of Health Insurance Data, the Health Insurance Institute, New York.) Medical care is only 6.7% of the family budget. These other items, the cost of which have risen as much as or more than medical costs, are also larger items in the budget. Food is 22.3%, housing is 14.4%, household operation is 14.2%, transportation is 12.9%, and clothing and accessories are 10.3% of the budget. Why spotlight the medical profession, when these much larger items in the budget have risen higher than medical services? Figure 5. (U.S. News and World Report, February 9, 1970, page 33.) Many of the critics of medicine are economists in colleges and universities. In the same past 11 years expanses of private colleges increased 80%, which is 60% greater than the rise in medical care. The CMS would point out to these arm chair critics of our so called "non-system" of medicine that their argument would have more credibility if they would control their own costs. Figure 6. (Wall Street Journal, January 6, 1970.) According to the Wall Street Journal, personal income has risen 25% in the same two years in which medical care has risen 12.9%. The CMS would note, therefore, that in relation to the rise in personal income the cost of medical care has fallen in the past two years.

2. ALLEGED INORDINATE RISE IN PHYSICIANS FEES.

Figure 7. ("Medicare" by Robert J. Myers, McCahan Foundation, Bryn Mawr, Penn., 1970, page 202.) The alleged inordinate rise in physician's fees is not real. Referring to Mr. Robert Myers. Actuary for Social Security, in the past 14 years physicians fees have risen almost identically with wages in general. There is no change with the onset of Medicare. The CMS believes that considering these facts, there is no basis for the proposals of H.R. 17550 for fixing of fees at 75 percentile with a cost of living clause, for the proposed cut at previous year's level and for the proposed policing by PSRO of physicians' services and fees.

3. THE EFFICIENCY OF OUR MEDICAL CARE SYSTEM

Figure 8. (Derived from data published in "Hospitals," August 1969.) Concerning the efficiency of our private "non-system" versus Federal and State medicine, the CMS calls your attention to the following data. The cost of hospitalization is not the per diem but the per diem times days, just like a hotel bill. In Figure 7 is shown the data of New Orleans hospitals. The private hospitals, the State Charity Hospital and the two Federal Hospitals are shown. Note that in 1968 the private hospitals ranged from $392 to $648 per stay. Note that Charity Hospital, run by the State of Louisiana, was as expensive as the most expensive private hospitals, yet Charity Hospital claims a desperate and perennial deficit. Furthermore, the two Federal Hospitals were 50% more expensive because the length of stay in government run hospitals is that much longer. Although some would point to the prolonged illness cases seen, this is not true in the larger number of cases, where there is simply no demand for their discharge. Even minor cases stay long periods before final treatment or surgery, as is well known by all who have worked in Federal, military or State hospitals. Isn't this Federal "overutilization"? It occurs in the "system" of government hospitals but from the data, not in the "non-system" of private hospitals. The following year shows the same pattern. The cost per stay in the Federal Hospital rose the same percentage as the private hospitals. Clearly the system of Federal Hospitals cannot control costs any better than the so called "non-system" private hospitals. The CMS notes that whenever Federal controls are added to the hospital system, the hospital costs increased and this will certainly result from PSRO bodies created by Senator Bennett's Amendment 851.

4. OVERUTILIZATION OF OUR HOSPITALS

Figure 9. If a patient stays twice as long in a hospital, the census of that hospital is twice as high. If these government hospitals had to discharge patients as quickly as private hospitals discharge patients the census in the Federal Hospitals would be as low as 25% capacity. One could readily combine both Federal Hospitals under one roof and not waste $15 million on the proposed new Public Health Hospital in New Orleans. Clearly the private hospitals are not the sites of "overutilization." *Figure 10.* The CMS presents the following data on hospital utilization by Medicare patients based on our study conducted in the New Orleans area in 1969,[1] which disproves the claim that physicians "overutilize hospitals" since Medicare. In Figure 10 attached, the number of Medicare patients discharged on the vertical axis. The broken line is the nationwide data of fiscal 1966–67 supplied by the Social Security Administration and the solid line is the data for the New Orleans hospitals for 5 months ending in November 1969, obtained by the CMS.

Note that Medicare patients in New Orleans were discharged almost 1 day earlier in 1969 than were the Medicare patients nationwide in 1966–67. Physicians have not overutilized these hospitals.

4(a) CREDIBILITY OF HEW PRESS RELEASES ON UTILIZATION AND NEED FOR CERTIFICATION

Appendix E. On October 13, 1969 there was a press release from HEW which stated that there was an unusual number of discharges of Medicare patients on the 14th and 21st hospital days. The HEW release argued that there was no medical reason for the large number of discharges on those days and the increased number was attributed to the requirement that a physician must certify the need of hospitalization on these days. Thus, the release inferred that patients were lounging in hospitals, running up physicians' fees and hospital bills and that physicians discharged them to avoid certification of the need for continued stay. A regulation was announced, therefore, to move certification from the 14th day to the 12th and from the 21st day to the 18th, and thus sweep these patients out earlier and save money. They gave as an example of savings the fact that should each Medicare patient go home 1 day earlier we would save $400 million per year in the United States. This reasoning appeared in the

[1] We refer to the study "Statement on Certification; February 1970 American Association of Councils of Medical Staffs of Private Hospitals, New Orleans Area Chapter, Inc., Jose L. Garcia Oller, M.D., President, submitted to the Commissioner of Social Security.

October 14 issue of the Federal Register, at which time the change in the regulation concerning certification dates was announced. The public press swiftly announced that this tightening of certification regulations was going to save the Government $400 million per year which was being wasted presumably and by inference, because of physicians' certification practices. The truth of the matter is, the CMS feels certain, that the average physicians' decision to discharge a patient has never been influenced by the requirement to certify the need for continued hospitalization. We further questioned the inferred savings upon which the regulation was based.

We therefore collected the data of discharges of Medicare patients from the New Orleans Hospitals which you have seen compared to the National data collected by the office of Research and Statistics 3 years before. We protested the change in certification regulation, we protested the need for certification at all, and we have since protested the dollar value assigned to the regulation in a news release "non-sequitur". Although our protest was received in Washington within the allowed period of time, our request for a hearing was not granted. In this graph of *Figure 11* there are 2 curves: the upper curve is a plot of number of discharges vs. date of discharge, the same plot that appears in the graph above. The lower, saw tooth curve is essentially the first derivative of the discharge curve. It is the rate of discharge, or the number of patients discharged that day divided by the number of patients that were remaining in the hospital as of that morning. This is the curve that the Social Security Administration published and this is the curve that was approved by the Health Insurance Benefits Advisory Council (HIBAC) of Medicare.

Note that the shoulder on the upper discharge curve becomes a peak on the lower rate of discharge curve because there were fewer patients available for discharge on the 14th day than there were on the 13th day. Note also in the lower curve the peaks at 7 and 28 days, at which times there was no certification. When we received this data from the Social Security Administration by way of Congressman Hale Boggs' office we were disturbed that the 1969 Social Security Administration decision was based upon 1966–67 data, Social Security advised us that this was the latest data available.

Figure 12. We noted that the deviation from a smooth curve for the rate of discharge showed that only 10,868 extra patients were discharged on the 14th day and 6,669 extra patients were discharged on the 21st day, nationwide per year. This is .024% and 0.149% of the total respectively. We were struck that these are not significant increases on the 14th and 21st days. Moreover if the 14th day peak were advanced 2 days to the 12th day and if the 21st day peak were advanced 3 days to the 18th day, there would presumably be a saving of 41,743 patients days annually, nationwide. Then, if one assigns $100 per day, which exceeds the usual medicare allowance, one could theoretically save a little over $4 million. This is considerably less than the $400 million advertised! The whole story struck us as absurd and we could only speculate as to the reason for it. Since the CMS does not believe any physician bases his decision to discharge a patient on the requirement of certification and since by simple arithmetic the proposed change could only conceivably save $4 million nationwide per year, only if the stated reasons were absolutely correct and the added cost of the additional certification were neglected, we could only conclude that the prime reason for this story and for its wide dissemination in the public press, and for the failure of Social Security to correct the misinformation, would be the desire of the Social Security Administration to tell the public that doctors are allowing medicare patients to stay in hospitals until the need to certify and in doing so are wasting $400 million per year.

This deception of the American public by HEW became certain when the CMS was shown by Mr. Robert J. Myers, who was Chief Actuary of Social Security at the time of the HEW press release on certification that he had written 4 separate memoranda to the Commissioner of Social Security between October 1, 1969 and January 30, 1970 telling the Commissioner that this release was deceitful and that the potential savings were at most $5 million dollars. Copies of these 4 letters are appended, with permission from Mr. Myers. (See Appendix A, B, C, D.)

To date this misinformation has not been corrected and the credibility gap widened. The CMS supplies these facts to object to deception being used to temper popular opinion towards the belief that Doctors overutilize and that there is need for extensive policing such as called for in the present proposed legisla-

tion of utilization review teams in HR 17550 and Amendment 851. We do not overutilize, we resent the deception to sell regulations, and there is no need for legislation.

5. THE "DOCTOR SHORTAGE"

Is there a Doctor shortage? This graph is from the Monograph on Infant Mortality (vide infra). You will note that of the 7 countries compared in the study, the population to doctor ratio is lowest in the United States. Where is the doctor shortage?

6. INFANT MORTALITY

Among the propaganda to discredit the best systems of medical care the world has ever known, is the constantly running statement in the press that "U.S. Health Care is second rate because we rank lower than 13 other industrial countries in Infant Mortality." The usual reference is the USPHS Monograph, Number 1000, Series 3, Number 6, International Comparison of Perinatal and Infant Mortality: The United States and Six West European Countries, March 1967." This Monograph spells out marked differences in definition of terms of neonatal death and variations in reliability of collecting of data among the various countries. It contains qualifying remarks such as those which appear in Figures 14 and 15.

There are many reasons why a death in a newborn in one country is not recorded or counted as such in another. Sweden reports the lowest death rate of the newborn. However, in Sweden a birth need not be recorded for five years, and a neonatal death may therefore never be recorded. In many of the foreign countries referred to, the father, not the physician, voluntarily reports births and neonatal deaths, and again some are not reported and not counted. In the U.S. 97% of the babies were born in hospitals where reporting is at its best, where certification of death by physicians is required.

In Sweden abortions are legal. A poor pregnancy or one in which the mother had German measles will be aborted. In the USA a deformed baby goes to term, is delivered and dies. This becomes a neonatal death, and influences the mortality figure. The criteria for a live birth are not the same: In some countries a live birth is any fetus delivered after 20 weeks, in others 28 weeks, in others any at 1,000 grams (2.2 pounds), and in others any who breathes. It is easy to draw a line at 28 weeks and say that any fetus delivered at 27 weeks who dies is a stillborn, while a death at 28 weeks is a neonatal death. There is no way to compare the 27 week fetus in one country to a 1,000 gram fetus in another. Some families have bigger babies than others at the same maturity. However, it is fair to say that the 350 gram (¾ pound) fetus counted as a fatality in Kansas is an awful lot more premature than the foreign fetus at 900 grams who dies and is not counted. Thirty nine states in our prosperous country call the death of anything over 20 weeks neonatal. This has to be more premature than the 28 week criterion in Norway, the number three country, or in the Netherlands, the number two country. In Sweden the criteria is 35 centimeters (13.8 inches) long. How does this compare to ¾ of a pound in a skinny baby or to 20 weeks in a diabetic?

There are even tax considerations. In the United States the father loses a $600 income tax deduction if the fetus is born dead instead of dying a few minutes later.

In other countries the financial tilt may be the other way. The medical decision is often arbitrary. This affects the recording of statistics.

Until there are uniform criteria of reporting, uniform responsibility for reporting, uniform criteria for abortions, uniform tax laws, and above all, uniform integrity of those who are heard, the comparative statistics are worthless.

Figure 16. The USPHS Monograph also points out (pg. 67) that the difference in infant mortality between the economic classes *actually increased after medical care* became free to all classes. Socialization of medicine and the midwife system and the home delivery system go hand in hand, and with it, the infant mortality of the poor has increased relative to the wealthy class.

Even if you could show that the U.S. was genuinely 14th best in the survival of the newborn it would not mean that our Health Care was at all defective. The U.S.A. is a genetic melting pot that cannot be compared to a genetically more homogeneous population like that in Sweden, whose genes allow for good

survival of the newborn. It would be like matching a German Shepherd against a Chihuahua in a fight to the death and then attributing the outcome to dog food used. According to the Metropolitan Life Insurance Company the newborn survival in the U.S.A. matches that of the European countries from which we are largely derived.

The CMS brings the Infant Mortality deception into focus. It cannot be acceptable as a scientific "yardstick" for quality Medical Care, and should be rejected as propaganda when aimed at discrediting U.S. medical care.

Thank you Dr. Hyman for the presentation of the data.

Mr. Chairman the CMS urges the Senate Committee on Finance to hear the voice of those of us dedicated to the actual care of our sick in America and reject SB 851 and the objectionable Sections of H.R. 17550 listed to prevent *irreparable* harm to our patients.

We thank you for this opportunity to appear before your Committee, and stand ready to discuss any aspects of this testimony when requested.

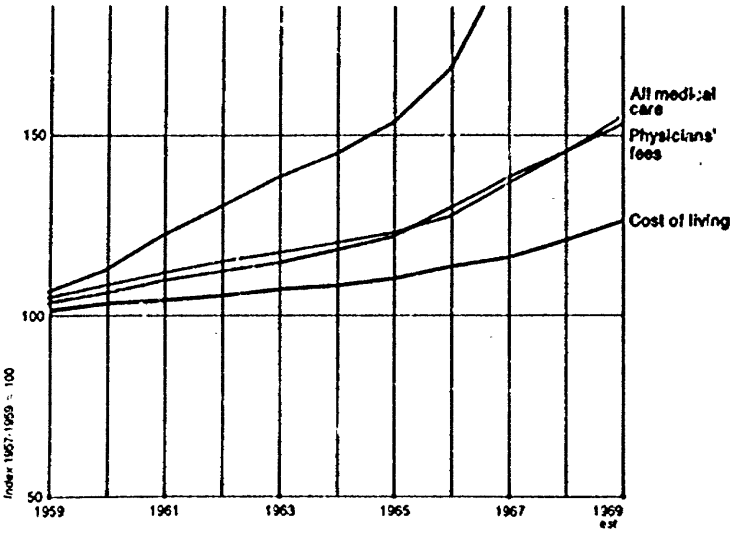


FIGURE 1

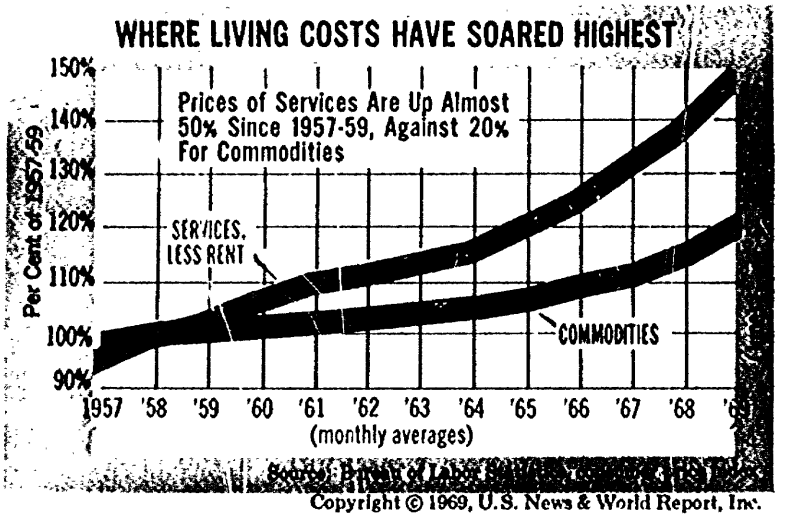


FIGURE 2

Change in average prices across U. S. in the last two years—

Bakery products	Up 4.7%
Meats, poultry, fish	Up 13.6%
Dairy products	Up 6.7%
Fruits and vegetables	Up 7.5%
Meals at restaurants	Up 12.7%
Rents	Up 6.3%
Owning a home	Up 18.2%
Utilities for a home	Up 3.7%
Household furnishings	Up 9.3%
Men's clothing	Up 12.8%
Women's clothing	Up 12.0%
Shoes	Up 12.7%
New cars	Up 3.1%
Gasoline	Up 4.3%
Public transportation	Up 13.0%
Medical care	Up 12.9%
Personal care	Up 9.3%
Recreation	Up 8.7%
Insurance and finance costs	Up 21.4%
Used cars	Down 0.2%

Source: U. S. Dept. of Labor

Dec. 8, 1969
U.S.NEWS & WORLD REPORT

FIGURE 3

PERSONAL CONSUMPTION EXPENDITURES, BY TYPE OF PRODUCT

In the United States, 1967

Type of Product	Personal consumption expenditures (billions of dollars)	Per cent of total
Food (including alcohol)	$109.4	22.3%
Housing	70.9	14.4
Household Operation	69.9	14.2
Transportation	63.5	12.9
Clothing, Accessories, and Jewelry	50.7	10.3
Medical Care*	33.1	6.7
Recreation	30.6	6.2
Personal Business	25.7	5.2
Tobacco	9.2	1.9
Personal Care	8.5	1.7
Religious and Welfare Activities	6.9	1.4
Private Education and Research	7.9	1.6
Foreign Travel and Remittances — Net	4.0	0.8
Death Expenses	1.9	0.4
Total	$492.2	100.0%

*Includes expenses for health insurance.
Source: United States Department of Commerce and Health Insurance Institute.

FIGURE 4

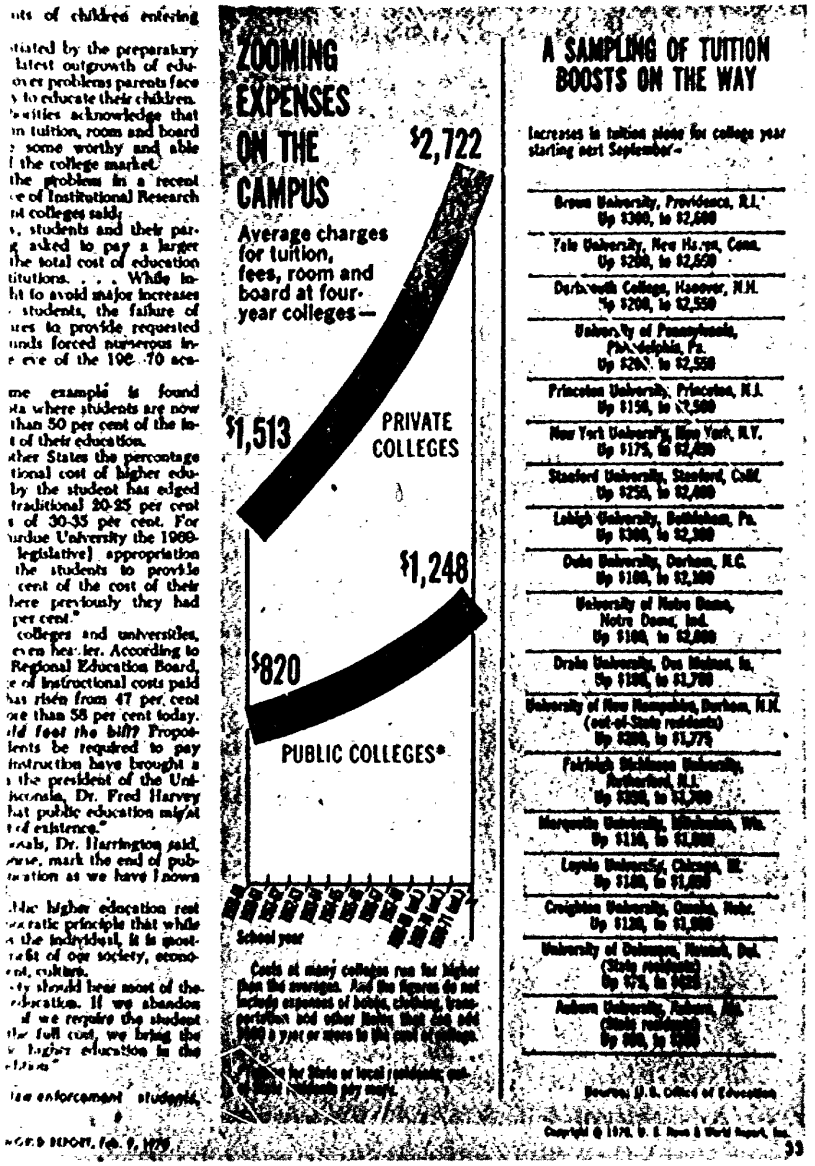
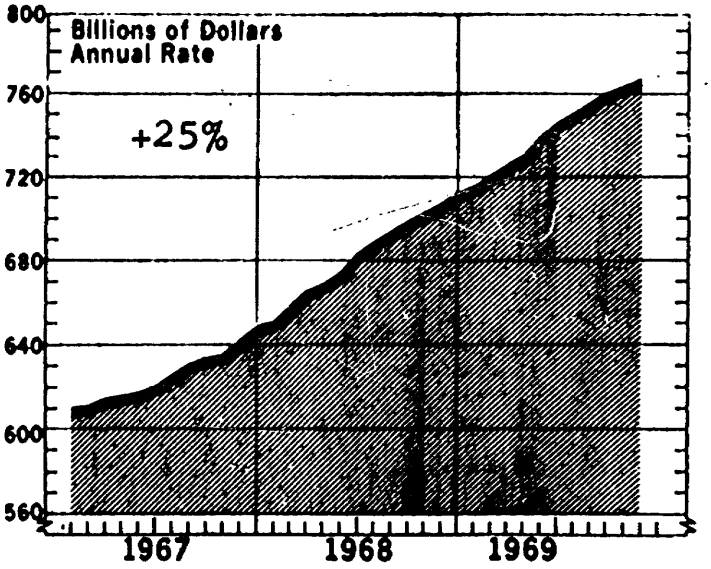


FIGURE 5

JANUARY 6, 1970

Wall Street Journal

Personal Income



PERSONAL INCOME in November rose to a record seasonally adjusted annual rate of $766.9 billion from an upward revised $763.7 billion a month earlier, the Commerce Department reports.

FIGURE 6

Table 10–5. Comparison of Annual Increases in Physician Fees and in Wages

Calendar Year[a]	*Physician Fees*[b]	*Average Wages in Covered Employment*	*Differential Increase of Physician Fees*
1956	3.1%	5.7%	−2.6%
1957	4.4	5.5	−1.1
1958	3.4	3.3	.1
1959	3.9	3.3	.6
1960	1.8	4.3	−2.5
1961	2.6	3.1	− .5
1962	3.1	4.2	− .9
1963	2.2	2.4	− .2
1964	2.3	3.1	− .8
1965	3.3	1.6	1.7
Average, 1956–65	3.0	3.6	− .6
1966	5.9	4.4	1.5
1967	7.3	6.3	1.0
1968	5.5	7.0	−1.5
Average, 1956–68	3.7	4.2	.5

[a] Increase from June of previous year to June of year listed for first column and from first quarter of previous year to first quarter of year listed for last column.

[b] As measured by Consumer Price Index of physician fees.

FIGURE 7

	per diem		days stay		cost per stay
Ochsner	$67.0	x	9.61 days	=	$648
Touro	78.1	x	8.20	=	$640
Hotel Dieu	71.2	x	7.74	=	$552
Flint	49.6	x	10.4	=	$514
Baptist	60.9	x	7.9	=	$480
Mercy	68.0	x	6.86	=	$467
Sara Mayo	64.2	x	6.10	=	$392
Charity	45.3	x	14.1	=	$637
USVAH	49.6	x	22.0	=	$1093
USPHS	52.0	x	17.7	=	$922

FIGURE 8

OCCUPANCY

	PRESENT OCCUPANCY	IF STAY WERE, OCCUPANCY WOULD BE		
		9.6 DAYS (OCHSNER)	8.2 DAYS (TOURO)	6.1 DAYS (SARA MAYO)
CHARITY	72.2%	49.3%	42.0%	31.2%
USVAH	84.5%	36.9%	31.5%	23.4%
USPHS	77.0%	41.8%	36.1%	26.5%

FIGURE 9

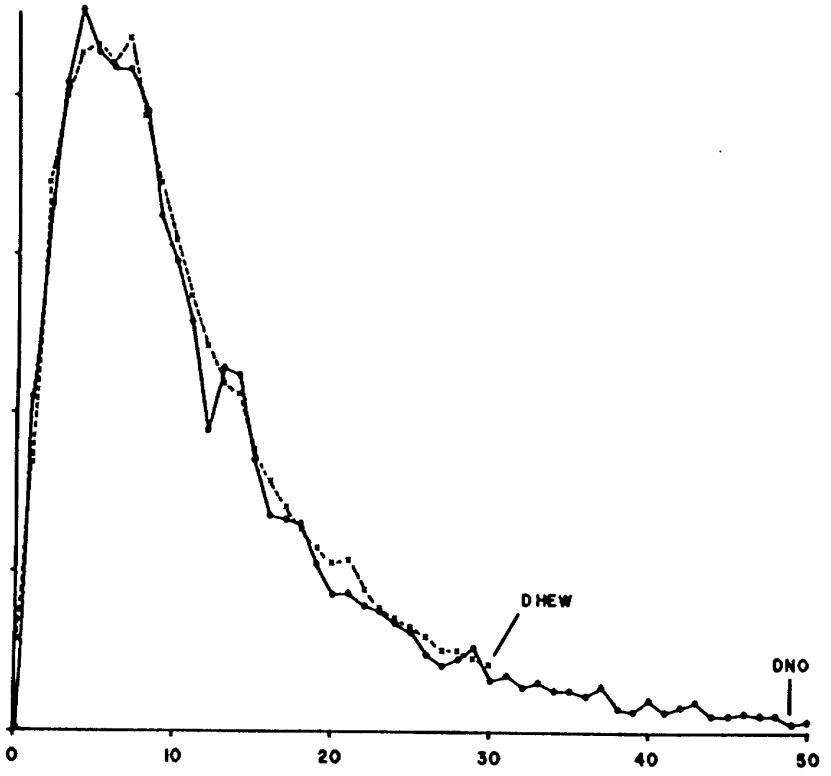


FIGURE 10

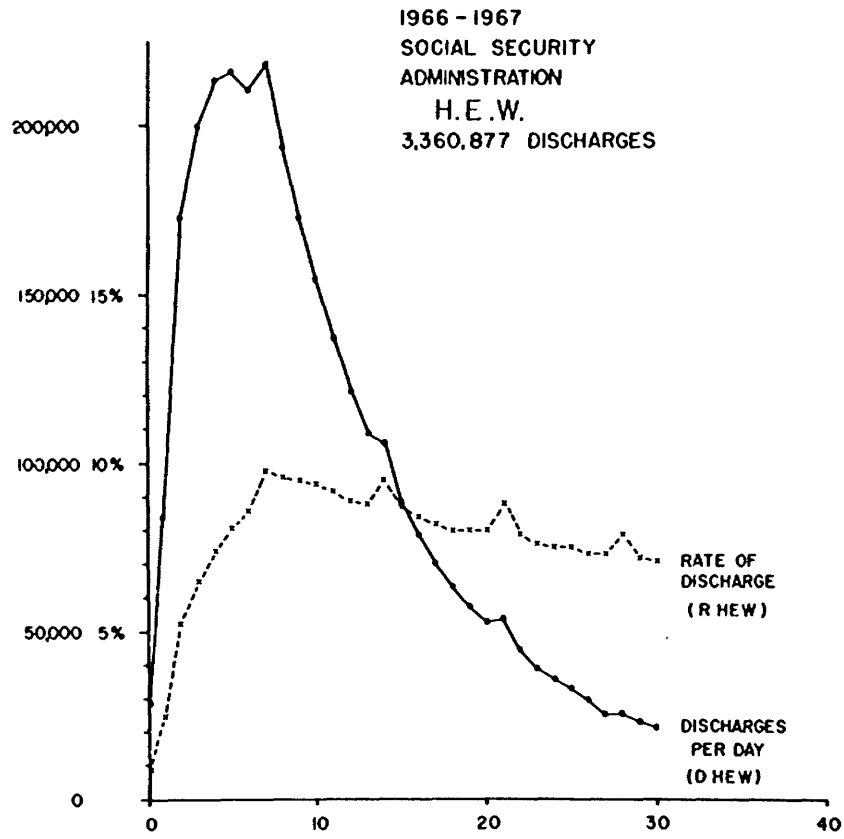

1966 - 1967
SOCIAL SECURITY
ADMINISTRATION
H.E.W.
3,360,877 DISCHARGES
200000
150000 15%
100,000 10%
50,000 5%
0
0
10
20
30
40
RATE OF
DISCHARGE
(R HEW)
DISCHARGES
PER DAY
(D HEW)

FIGURE 11

10,868 PTS. X 2 DAYS = 21,736 PT. DAYS
6,669 PTS. X 3 DAYS = 20,007 PT. DAYS
41,743 PT. DAYS "SAVED"

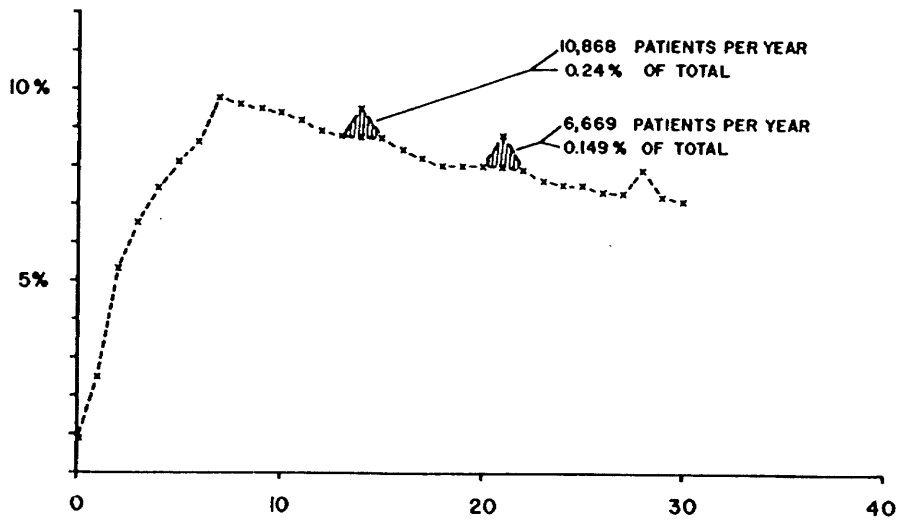


FIGURE 12

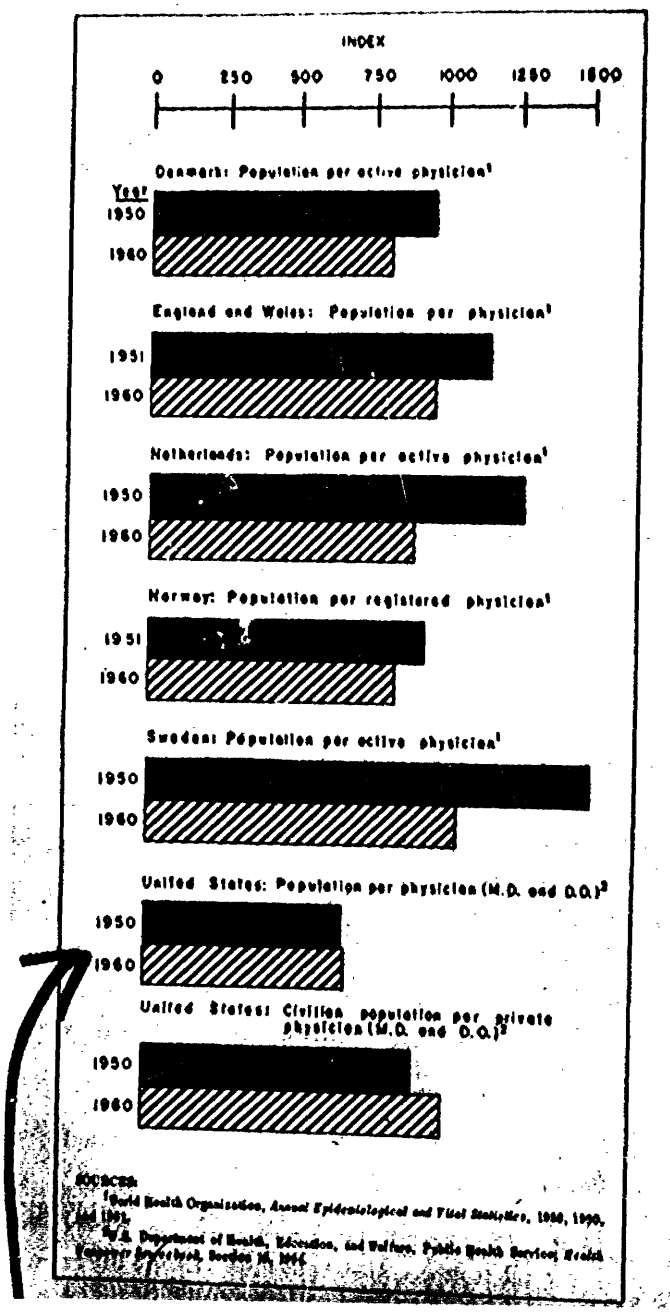

INDEX
0
250
500
750
1000
1250
1500
Denmark: Population per active physician[1]
Year
1950
1960
England and Wales: Population per physician[1]
1951
1960
Netherlands: Population per active physician[1]
1950
1960
Norway: Population per registered physician[1]
1951
1960
Sweden: Population per active physician[1]
1950
1960
United States: Population per physician (M.D. and D.O.)[2]
1950
1960
United States: Civilian population per private physician (M.D. and D.O.)[2]
1950
1960
SOURCES:
[1] World Health Organization, Annual Epidemiological and Vital Statistics, 1950, 1960, Vol. [illegible].
[2] U.S. Department of Health, Education, and Welfare, Public Health Service, Health Manpower Source Book, Section 16, 1964.

FIGURE 13

Answers to these questions will not be found through comparison of disconnected studies with varying study designs. Although a few comparisons may be possible fortuitously, they lack the assurance which is to be derived from a well-designed study planned to give answers to specific questions.

FIGURE 14

Despite the action of the World Health Assembly, changes in the laws of the various countries were not achieved immediately or uniformly. For example, the change in definition of live birth to include "beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles" in addition to "breathing" as evidence of life was not adopted in Sweden until 1959. Even at present, Denmark has no legal definition of "signs of life." Furthermore, changes in law or regulation are not immediately transposed into action. Practices followed by physicians or midwives regarding their understanding, interpretation, and implementation of the law are difficult to assess. European practice continues to prefer "stillbirth" to "fetal death."

FIGURE 15

With the initiation of the National Health Service in Great Britain, a common base of antepartum, partum, and postpartum care became available to the entire childbearing population. Although there were significant declines in infant mortality in each of the social classes in the first half of this century, the relative differences between the classes have not decreased. In fact, the British Perinatal Study suggests that the gap between the classes may have widened even at a time when medical care was readily available to the entire population.[5]

FIGURE 16

JANUARY 14, 1970.

Re Savings from Reducing Time Interval of Physician-Certification Periods Under Hospital Insurance Program (Continued No. 3).

Mr. ROBERT M. BALL,
Commissioner of Social Security.

With further reference to my memorandums of October 14, 29, and 30 on the above subject, I am further dismayed that the misinterpretation that I feared would happen did happen again in an official HEW document.

In *What's New in HEW* for November 1969, the following item appeared:

"An amendment to social security regulations, effective Jan. 1, 1970, is expected to shorten hospital stays and reduce Medicare costs. The regulation, which changes the times a physician must certify the medical necessity of services given to hospitalized Medicare beneficiaries, could cut program costs as much as $400 million a year."

As I brought out previously, the savings for this change—which is most certainly desirable—will probably be only about $5 million per year, not $400 million. Once again, I must state that I think that it is very dismaying that a credibility gap is being created for the present Administration, which could have been readily avoided.

ROBERT J. MYERS,
Chief Actuary.

OCTOBER 14, 1969.

Re Savings from Reducing Time Interval of Physician-Certification Periods under Hospital Insurance Program.

Mr. ROBERT M. BALL,
Commissioner of Social Security.

An HEW press release of October 13 announces that physican certification of the necessity for hospitalization of HI beneficiaries will be required (beginning next January 1) by the 12th day of hospitalization, instead of the 14th day, and the first recertification by the 18th day, instead of the present 21st day.

It is pointed out that data on length of stays in hosptials show that the number of discharges rises significanly on the 14th day and again on the 21st day. Finally, it is stated—as an illustration of the potential cost savings—that a reduction of each hospital stay by an HI beneficiary by one day would reduce program costs by about $400 million in 1970.

It is correct that there is a peak in the discharge rate for the 14th and 21st days, but this amounts to only about 10% more than could be expected by the preceding and subsequent discharge rates (see Report HI-10 issued by ORS). I have made calculations of the effect that would be obtained if this peak in the discharge rate is shifted from the 14th day to the 12th day and from the 21st day to the 18th day. The net effect on the number of days of hospitalization is to reduce the average days of hospitalization per discharge by .014 days, which represents a savings of $5 million per year. It is important to note that the latter figure is far less than the illustrative figure of $400 million, which would result only if the average hospitalization stay were reduced by one day. It is my strong belief that the press release was most misleading—although technically accurate—in quoting this $400 million figure (somewhat facetiously, I might say that it would have been equally accurate, but obviously ridiculous, to have stated if each hospital stay were shortened by 10 days, the program cost would be reduced by about $4 billion per year!).

ROBERT J. MYERS,
Chief Actuary.

OCTOBER 29, 1969.

Re Savings from Reducing Time Interval of Physician-Certification Periods Under Hospital Insurance Program (Continued).

Mr. ROBERT M. BALL,
Commissioner of Social Security.

In my memorandum of October 14 on the above subject (to which I have as yet had no reply). I pointed out that the desirable change that is being made in the conditions for physician certification of the necessity for hospitalization of the beneficiaries is being misleadingly presented to the public by statements that are somewhat along the following lines:

"The potential cost savings can be illustrated by the fact that if each hospital stay is shortened by one day, then Medicare cost will be reduced by about $400 million per year." (Note that "will" is used, rather than "would".)

A statement along these lines has just appeared in the *HEW Field Letter of* October 20. The casual reader could well infer that we expect to save $400 million a year by this change, which is admittedly very desirable regardless of the magnitude of the savings. The same "erroneous" logic could, of course, go on to say that the potential cost savings could be "illustrated" by the fact that, if each stay is shortened by two days, the cost will be reduced by $800 million—or, at the extreme of absurdity, if the average stay were reduced by 14 days, the whole program's cost as to hospital benefits would be eliminated (true, but completely irrelevant and meaningless).

I brought out that the savings for this change will probably be only about $5 million per year. I think that the method of presentation that was followed is most misleading and tends to create a creditability gap for the present Administration that could have readily been avoided. I feel that the present Administration has the basic purpose of avoiding any creditability gap—unlike the previous Administration, which in my opinion, intentionally acted in such manner in a number of instances—and it is unfortunate that the SSA should now have created a problem in this area.

ROBERT J. MYERS,
Chief Actuary.

OCTOBER 30, 1969.

Re Savings from Reducing Time Interval of Physician-Certification Periods Under Hospital Insurance Program (Continued No. 2).

Mr. ROBERT M. BALL,
Commissioner of Social Security.

With further reference to my memorandum of October 29 on the above subject, the misinterpretation that I feared would happen did actually happen.

In *U.S. News and World Report* for October 27 the following statement appeared about the new recertification requirements:

"Under a regulation effective January 1, the average medicare patient is expected to go home from the hospital a day or so earlier than at present."

ROBERT J. MYERS,
Chief Actuary.

[From HEW News, Oct. 13, 1969]

Health, Education, and Welfare Secretary Robert H. Finch today announced an amendment to social security regulations which is expected to shorten hospital stays and thus reduce Medicare costs.

Effective January 1, 1970, the regulation changes the times a physician must certify the medical necessity of services given to hospitalized Medicare beneficiaries.

To illustrate the potential cost savings to the program, Secretary Finch noted that if each hospital stay by a Medicare beneficiary during 1970 is shortened by one day, Medicare costs will be reduced by approximately $400 million.

The new regulation requires that a physician's certification be made by the 12th day of hospitalization instead of the 14th day as required under previous regulations, and that the first recertification be made no later than the 18th day of stay instead of the previously required 21st day.

"Data on length of stays in hospitals under the program show that the number of discharges rises significantly on the 14th day and again on the 21st day," Secretary Finch said. "Since there is no apparent medical reasons why discharges should peak on these days, it seems reasonable to conclude that the requirement for certification and recertification on certain days is in itself a factor contributing to the larger number of discharges on such days. We expect that a reasonable shortening of the certification periods will result in some decrease in the number of unnecessarily prolonged hospital stays."

NATIONAL ASSOCIATION OF MANUFACTURERS,
September 28, 1970.

Hon. RUSSELL B. LONG,
217 Old Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: The National Association of Manufacturers wishes to register its opposition to Amendment No. 929 to H.R. 17550, the Social Security Amendments of 1970.

Briefly, the amendment will appoint a nine member Formulary Committee to compile a listing of drugs eligible for reimbursement under the Medicare and Medicaid programs. The Formulary Committee would be charged with selecting those drugs necessary for proper patient care and with establishing reasonable cost ranges for those listed drugs. The principal change in this amendment from that offered in 1967 is that Amendment 929 increases reimbursement of pharmacies to include reasonable charges or markups.

The National Association of Manufacturers recognizes the need for improving the administrative efficiency and economy of the Medicare and Medicaid programs. However, in our view Amendment 929, while addressing itself to an important issue, would create unnecessary administrative apparatuses for controlling federal drug expenditures.

Further, because the high costs of research and development are reflected in present prescription drug prices, we believe that the adoption of this amendment would jeopardize the development of new drugs. Further, we believe the amendment would inhibit the physician's choice of drug products and would penalize the patient by denying him a drug product that is familiar to him but which may not be on the list for which the government will provide reimbursement.

In addition the amendment would authorize the Secretary of the Department of Health, Education and Welfare to establish and publish a guide showing the "reasonable requisition cost range" of each qualified drug listed in the Formulary. Under this provision the manufacturer, retailer and wholesaler would be faced with fixed ceiling prices. Such a price regulation system would limit prompt and flexible adjustment in prices to take care of changing material, labor costs of other developments. This provision can only be viewed as a price-fixing measure that would discourage competition at the manufacturer and retail levels.

In your introductory statement you estimate that the enactment of this provision will result in a savings of approximately $80 million annually for drugs. However, information as to administrative costs of the amendment, are meager and confusing. In our opinion, it is imperative that administrative costs figures be obtained from the Bureau of the Budget or the Department of Health, Education and Welfare in order to estimate the costs of implementation and adminisration. These costs should enter into deliberations incident to consideration of the proposed amendment.

It is requested that this letter be included as a part of the record of testimony on H.R. 17550.

Sincerely,

LEO V. BODINE.

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS,
Washington, D.C., September 29, 1970.

Re amendment 929 to H.R. 17550.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: As the national organization for the independently owned retail pharmacies of this country, The National Association of Retail Druggists is anxious to bring our views to the attention of you and the other distinguished members of the Senate Finance Committee concerning Amendment No. 929 to H.R. 17550. Our members own some 40,000 retail pharmacies which dispense three of every four prescriptions to the American public.

Historically, our members during the last century have acted responsibly as professionals with compassion for the sick and as small businessmen asking only for a fair opportunity to compete under a free enterprise system. In view of this background you will be pleased to know that our Executive Committee has considered Amendment No. 929 and wishes to commend you for the positive changes you have made in the reimbursement sections of this legislation to accommodate the needs of retail pharmacy which representatives of our association have expressed to you during the evolvement of this proposed legislation.

Listed below is greater particularization expressing the recommendations of our leadership:

1. While we recognize that A. 929 has been modified to allow the small businessman to make "reasonable charges" which reflect his operating expenses and professional services which is not possible under a mandatory fixed fee method, we feel that the words "the lesser of" at the outset of Sec. 1134(a)(1) will seriously obstruct your commendable objective. In other words by simply eliminating "the lesser of" on line 5 page 11, the "reasonable charge" reimbursement method available to our members will meet with our approval as a fair and equitable method and at the same time you will have preserved the controls necessary to prevent excessive charges to the Government.

2. Under Section 1134a(1)(B) at line 18 on Page 11, we recommend addition of the words "and services" between the words "drug" and "to".

3. Under Section 1130(a)(1) at line 19 on Page 2, we recommend that the words "at least-one retail pharmacist to be in active practice" be inserted between words "pharmacy" and "to". Historically all formulary committees have included at least one pharmacist engaged in the type of practice governed by the formulary involved. The "Formulary of the United States" contemplated in this legislation should offer no less protection for the recipients of government medical programs.

4. Discussions have revealed that should this proposal be enacted it is planned for The Department of Health, Education and Welfare to establish an Advisory

Council of practicing retail pharmacists to advise the Department and the Formulary Committee on a wide range of matters related to the distribution of drugs to recipients thru retail pharmacies. It is felt that the protection, which such a council will provide both the government and the profession of pharmacy, can be assured only if the establishment of such a Council is incorporated in the legislation and not left to the discretion of the Secretary.

5. A. 929 in its present form may permit unfair competition for our member stores where small hospitals of any bed capacity could subvert the objectives of this legislation by dispensing many drugs not approved for the Formulary of the United States but approved by a so-called formulary system of such hospital. This circumvention of the intent of A. 929 can be prevented by simply limiting the exception established in Sec. 1132 to teaching hospitals only. Otherwise many dispensing physicians who are invited to dispense by present Medicaid regulations may significantly expand their incomes at government expense and in a manner that could be disastrous for our members.

6. We urge that Amendment 929 be clarified to indicate that retail pharmacies are not required to register. While we understand registration is not intended some doubt has arisen since the application of the words "compounded" or "processed" are uncertain.

7. Since the inception of the Medicare Program, The National Association of Retail Druggists has strongly supported inclusion of home drugs for Medicare patients. We feel this serious omission is creating a great hardship for our older citizens who have coverage for physician services but are denied drug benefits. We join the groups representing the aged in calling for coverage of home drugs in Medicare benefits at the earliest possible date. The long and protracted studies of such coverage have unfairly delayed this vitally needed coverage for Medicare patients.

We respectfully submit that these suggested changes in A. 929 will substantially improve the effectiveness of this legislation and maximize the voluntary participation of retail pharmacists in these government drug programs.

The National Association of Retail Druggists is grateful to the Committee for the opportunity to present its views. We assure you that our officers and staff remain available at the request of the Committee to be of assistance as further consideration is given to Amendment 929.

Sincerely yours,

CHRIS HALESTON, *President.*

Hon. RUSSELL LONG,
Chairman Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: You are to be greatly commended for checking into the problems contributing to the sharp rise in all medical care, whether Blue Cross, Medicare, Medicaid, or entirely privately financed.

Along with many others discussing the question of increasing costs to the public for medical attention; and, also not being on the inside of this highly specialized field, you and they are not to be blamed for (shall we kindly call it) an oversight, pending more thorough investigation, by failing to obtain testimony from an average physician in daily contact with this situation.

In addition to the Federal authorities, who should have urged those in daily contact with the sick public to bring forth their problems; and, to state the facts, if necessary in secret communications where it may endanger the average physician's practice of medicine in hospitals or institutions; and for this reason, keep him from publicizing it. We thereby have state and local groups controlling the practice of medicine; and, these are in a still better position to execute reprisals for stepping out of line.

My own testimony relative to hospital costs, as they affect Blue Cross and Medicare, at our State Insurance Commissioner's hearing might be exemplary for the situation throughout the country.

To begin with, hospital costs even if their major portion goes for personnel cost, include the use of the personnel for purposes other than In-Hospital Medical Care with its immediately related activities. This is the primary purpose of the Blue Cross contract or policy, as well as Medicare attention.

I have pleaded with our state authorities as well as federal, to lop off by clean amputation the attached heavy tail of the welfare and educational activities included under Health, Education and Welfare; and to a noticeable degree, included under Medicare and other hospital costs. In this way we could know approxi-

mately how much In-Hospital Medical Care with its immediately related activities separately, as well as outside medical care, would cost. A copy of my testimony before the last Blue Cross Hearing will bring out some of this (see enclosure).

A list from our State Health Department of only those doctors "privileged" by each hospital in Metropolitan Baltimore to utilize the hospital beds and facilities at each institution, will demonstrate what a small percentage of the physicians in good standing in the community are permitted to use the individual hospital's beds and facilities. This control is so easily facilitated by the individual hospitals, under the guise of maintaining high standards of medical attention at the hospital.

It is very efficiently controlled through the hospital "Application for privilege", which every physician in good standing in the community signs when he applies for privilege, which is his signed advance resignation; and, contains the "red herring" (that he will not split fees), to distract attention from the main issue.

Less than 25% of the physicians in good standing in the State of Maryland are permitted the use of available hospital beds, at even the largest hospital, the Johns Hopkins Hospital with 650 "privileged" doctors, let alone our colored hospital, the Provident Hospital with only 114 physicians permitted to utilize the beds and facilities out of more than 3,000 physicians in good standing in the state. Others are in between these.

In this way, all physicians in good standing in the community cannot utilize the beds and facilities at each institution. These beds and facilities except in emergency, generally furnish nursing home type of attention for the weekend or 1/3 of the week at the extremely high hospital prices, when rotation of physicians to cover the weekend could keep them going under hospital attention throughout the week.

Our doctors do not vote and act at our medical societies by secret ballot, by mail, in order to express their wishes regarding hospitals and general practice, as well as for disciplinary matters.

In our Baltimore City Medical Society, out of approximately 2,500 doctors we have a quorum of 45 required for our meetings; and, twice within the past year, we could not carry on our medical business due to lack of a quorum, when only 23 doctors might be called on to act for the more than 2,500 doctors because of this lack of expression. We cannot vote by proxy or by secret ballot by mail for all matters either in city or state medical societies. Publicized medical actions or medical representatives' statements, might be compared to our City Society actions where the entire membership is not polled, but the small quorum or the majority of the small attendance, whether 23 members or more, supposedly express the sentiment and actions of the entire Society. In our State Society meetings the individual members have no say or vote.

Senator Long, Medicare has chosen in the majority of instances the Blue Cross intermediary; and in others, one or two other insurance companies. These intermediaries, I can show you through their control of physicians' charges, are often responsible for much unsatisfactory experience by both the public and the profession.

Under Medicare A they contribute to the rise of hospital costs for present supposedly In-Hospital Medical Care with its immediately related activities. They often force an unsatisfactory situation in subsequent nursing homes, necessary following hospital attention, in an extremely bad way for both the sick public and the physician. The patient does not have the means to follow up and fight for his rightful recompense; and, the doctor the time, under these conditions, permitting the intermediary to get away with it.

May I here add, that there is an ever present danger of third party regulation of physician charges, of discriminatory, deficient, or inferior attention to Medicare and Medicaid patients on a lower level than in regular private cases.

Furthermore, if the patient i s discriminated against through his physician by this very evident "privileged" discrimination, which has been left out of the list of discriminations pointed out under Medicare; and, which is much more prevalent and effective than race, creed, color or source of origin, as you can see from the hospital "privilege" list.

It might easily be corrected by Congress adding and having the intermediary. withhold or withdraw the contract with any hospital so discriminating, whether under Blue Cross or other insurance groups. This will immediately remove the

fear of reprisal by hospitals against physicians who do not go along with them; and, would allow improvement in medical attention at low cost in hospitals, as well as outside.

I will be pleased to furnish you any additional supportive evidence which I have, to back up my statements, at a mutually agreeable time, as I think you are to be highly commended for investigating not only the high spiralling so-called hospital costs, but improved medical attention as well.

Sincerely,

Dr. M. B. LEVIN.

BALTIMORE CITY MEDICAL SOCIETY, GENERAL MEETING, THURSDAY, MARCH 5, 1970

The meeting was called to order by the President, John N. Classen, M.D. at 8:35 p.m.

The speaker for the evening, Neil Solomon, M.D., was unable to be present due to illness, but Matthew Tayback, Sc.D., Assistant Secretary of Health and Mental Hygiene and Scientific Affairs for the State of Maryland presented a most informative and thought provoking discussion on "A Family Health Assurance Plan." After a question and answer period Dr. Tayback was thanked for his presentation and the business meeting was called to order at 9:40 p.m.

Adoption of minutes.—A motion was made, seconded and carried that the reading of the minutes of the February 5, 1970 meeting be dispensed with and the minutes were adopted as distributed.

Election of new members.—After the following new members were introduced with their sponsors, a motion was made, seconded and adopted that they be elected to membership in the Society:

ACTIVE MEMBERSHIP

Hugh G. Bebee, M.D.
Irving I. Liberman, M.D.
Isidore Mihalakis, M.D.
Consolador C. Palad, Jr., M.D.
Shashi K. Pande, M.D.
Toshio Sasamore, M.D.
Joseph H. Miller, M.D.

ASSOCIATE MEMBERSHIP

Joseph H. Miller, M.D.
Brent C. Sanders, M.D.

Resolution presented by M. B. Levin, M.D.: The Secretary read the following resolution as presented by Dr. M. B. Levin at the February 5, 1970 general meeting of the Society.

Whereas, Our Maryland State Medical Journal, December 1969, page 109, reports the action of our delegates to the AMA House of Delegates, Annual Session, New York City, July 13, through 17, 1969 under Reference Committee B, Medical Care as a right, and;

Whereas, To make its position clear in the long-standing discussion of medical care as a right, the House resolved that it reaffirm its position (1) that it is a basic right of every citizen to have available to him adequate health care; (2) that it is a basic right of every citizen to have a free choice of physician and institution in the obtaining of medical care; and (3) that the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person; and

The resolution was then put to a vote and was adopted by a vote of forty FOR and three OPPOSED.

Investigation of medicare and medicaid cost by U.S. Senate: Dr. Classen stated that the Senate's investigation of the cost of medical care programs to the Federal Government has been much in the news lately. It has been suggested that the onus of responsibility for assisting the government in cutting down these cost should rest with the medical profession. Dr. Classen further stated that he intended to discuss this problem with the Board of Directors at its next meeting with the idea in mind of meeting first with local legislators and then possibly with the U.S. Senators from Maryland to offer the assistance of the Society. Those members present were invited to offer suggestions in this regard which might assist the Board in dealing with this problem.

There being no further business, the meeting was adjourned at 9:55 p.m.

Respectfully submitted,

ROBERT B. GOLDSTEIN, M.D., *Secretary.*

STATE OF MARYLAND DEPARTMENT OF HEALTH,
Baltimore, Md., September 3, 1968.

To Dr. Van Gelder:

The following information is by telephone this date from the respective administrative offices.

Hospital:	*Number of physicians with hospital privileges*
Baltimore Eye, Ear and Throat Hosp	44—44
Bon Secours Hospital	271—271
Church Home and Hospital	368—368
Franklin Square Hospital	251—251
Greater Baltimore Medical Center (merged Woman's Hospital and Presby. Eye, Ear and Throat)	522—522
Johns Hopkins Hospital	650—650
Lutheran Hospital of Maryland	278—278
Maryland General Hospital	362—362
Mercy Hospital, Inc	256—256
North Charles General Hospital	280—280
Provident Hospital	114—114
St. Agnes Hospital	215—215
St. Joseph's Hospital	301—301
Sinai	300—300
South Baltimore General	280—280
Union Memorial Hospital	300—300
University Hospital	414—414

Baltimore City Hospital physicians indicated are those authorized to admit patients. There are none with hospital privileges in the usual accepted meaning.

Professionl staff	49
House Staff	94
Total	143

Dr. WORKMAN.

SENATE OF MARYLAND

No. 539

Senator LAPIDES—Economic Affairs

By the SENATE, February 26, 1970.

Introduced, read first time and referred to the Committee on Economic Affairs

By order, ODEN BOWIE, Secretary.

A BILL ENTITLED

AN ACT to repeal and re-enact, with amendments, Section 560 of Article 43 of the Annotated Code of Maryland (1965 Replacement Volume), title "Health," subtitle "Hospitals and Related Institutions," providing that no hospital receiving State tax monies shall exclude any licensed Maryland physician from the use of its facilities and providing for the non-issuance or removal of a hospital's license for non-compliance therewith

SECTION 1. *Be it enacted by the General Assembly of Maryland*, That Section 560 of Article 43 of the Annotated Code of Maryland (1965 Replacement Volume), title "Health," subtitle "Hospitals and Related Institutions," be and it is hereby repealed and re-enacted, with amendments, to read as follows:

The Board is hereby authorized to issue licenses regardless of type of ownership to open, maintain and operate hospitals or related institutions when the facilities of the hospital or the related institution, after inspection, are found to comply with the provisions of this subtitle and the rules and regulations adopted hereunder by the Board. No license granted shall be assignable or transferable *Every hospital, as defined in this subtitle, which is supported wholly or in part by State tax monies, shall extend to all physicians duly qualified and licensed to*

practice within the State of Maryland by the Board of Medical Examiners, the right to practice medicine, surgery, or any other specialty within it and the right to fully utilize its beds and facilities; the Board shall not issue or continue a license to any such hospital not complying with the aforementioned provisions. The Board may, for cause shown, revoke any license issued by it to a hospital or related institution after giving the licensee a hearing prior to revocation. The hearing shall be held after ten days' notice to a licensee, and he shall have an opportunity to be represented by counsel at the hearing.

SEC. 2. *And be it further enacted*, That this Act shall take effect July 1, 1970.

NOTE.—Italics indicate new matter added to existing law.

BLUE CROSS HEARING—JUNE 5, 1970

Blue Plans was chartered by the Legislature as an insurance company to cover only In-Hospital Medical Care with its immediately related activities. It was and is insurance to cover *hospitalization* costs and not *all hospital* costs. Despite the Blue Plans Ads claiming to sell service of hospital and medical attendants, their policies are insurance policies.

In recent years they have further tried to imitate private insurance companies by eliminating certain selective diseases or conditions from individual polices, once there was any involvement of a certain type in the patient. They have also cut off coverage of all age groups over 65 years ("biggest headache"), which supposedly were of higher cost to the hospitals in raising a higher premium level. When they were cut off, how much did Blue Plans reduce premiums and did this shave costs 15%?

It is generally true that hospitalization attention for the average patient ceases over the weekend; and, only nursing-home attention, except in emergencies, is rendered the patient. From Friday afternoon until Monday morning, patients in noticable numbers at these institutions must occupy bedspace without full and proper medical activities over the weekend, because no arrangements are made by the hospitals for completion of such work. This compels the patient to hang around the hospital for the weekend of 2 to 2½ days without the usual x-rays, laboratory work, operating attention, physiotherapy and other activities, which shut down from Friday P.M. to Monday A.M. In other words, about ⅓ of the 7 days per week's costs are not fully utilized, yet are being charged for at the full hospital, not nursing-home rate, up to $50.00+ per diem, instead of the $12.00 per day which should be the nursing-home charge. (See Chart No. 1) At the high per diem rates, this adds to the overall hospital charges to Blue Plans and directly affects the rates. Without this highly technical professional attention, hospitals are only nursing homes.

The remaining ⅔ of the hospital week are estimated at ⅔ for personnel costs and ⅓ for food, medicines, operating facilities, housekeeping, etc. Granting ⅔ of the 4½ to 5 full hospitalization days per week are for personnel costs, toward what purposes will investigations show their employment?

Blue Plans' policies, by paying for certain attention only inside the hospitals which could be done at lower cost on the outside, force the patient to occupy hospital beds and also contribute to higher rates.

Certainly the number of nurses obtaining increased salary raises in the past three years does not justify the extra charges noted in the hospital increase of costs. As an example, at a prominent hospital with a little over 475 beds, it employs 126 full-time nurses and 140 part-time nurses from 2 to 3 hours daily, which is the equivalent of 47 full-time nurses, making a total of 173 nurses, not counting those in training; or approximately 3 beds per nurse. These 173 nurses are to be raised to an annual salary of $6,000, which would be $1,038 for total nursing. An increase from $4800 to $6000 equals $1200 for each nurse, or a total of $207,600. 475 beds at $4.00 per day increase makes an increase of $1900 daily, times 350 days annually, or $665,200 increase, which is about three times as much as the increase in nursing.

Analysis of hospital costs for only In-Hospital Medical Care and its immediately related activities raised the question, what percentage of personnel costs goes toward the various activities now covered by the overall hospital cost canopy. (See Chart No. 2). How much of the housekeeping costs, for example, go toward In-Hospital Medical Care and its immediately related activities; and, how much toward—

1. Administration; 2. Heating and Lighting; 3. Nursing Attentioon; 4. Food; 5. Nurses' training (½ day cost per bed at least $10.00+); 6. Dispensary Visits (one per each bed at least $10.00+); 7. Operating facilities divided into average number of In-Hospital days of residence of the operated cases; 8. Research Work; 9. Outside Accident Cases (paid?), (unpaid?); 10. Religious Activities and chapel; 11. Social Service and Welfare; 12. Aged Homes; 13. Medical School Activities, etc.

Blue Plans insure two types of cases—

1. Group; 2. Individual.

Why this discrimination as to premiums and coverage, favoring groups as compared to individuals in eliminating certain diseases and conditions? They cut off the 65 year and over age groups, which had supposedly kept Blue Plans premiums high; and, no 65-year+ group cases are now covered. What is the percentage? This should have permitted an immediate reduction in premiums. How much?

Who permitted or authorized Blue Plans to chop off this age group of supposedly highly expensive type?

Who would stop Blue Plans from next cutting off the 30 to 50 year age group, as an example, if in their opinion this proved too expensive?

This same thing could apply to certain types of conditions and diseases; and, by what authority will this be permitted?

This tax-free subsidized corporation of "quasi-public" type with its group-favoring discrimination as compared to the individual (who is usually not in a position to fight this), also favors its participating doctors with discrimination against non-participating doctors of the public, in a large percentage of incidents.

Blue Cross is the collection agency for the hospitals, paying 94% to 96% of the bills presented.

Blue Plans' administrative costs might well be looked into for possible reduction, particularly their expensive sales promotion, the greater expense of delayed processing of claims quite beyond the time-stretch of many private insurance companies, their actual administration costs, and expense fund for building and equipment producing questionable efficiency.

Instead of having reduced the premium rates, when Blue Plans shut off the 65 year and over (higher expense) group, they are higher; and, will spiral to a still higher level if these other activities, not immediately related to In-Hospital Medical Care, are also paid for. Welfare activities may be a community responsibility, or of groups, or individuals and should be channelled and paid for by those whose responsibility they are instead of penalizing the minority segment, the hospital sick or the policy purchasers. As a matter of fact, the public which might have to finance this increase, should decide if it really wants to support any part or all activities not immediately related to In-Hospital Medical Care. Certainly religious, aged home, research, social service, medical school, training of nurses, technicians, etc., indigent programs, outside accident and dispensary work should not be included under Blue Plans costs alone; and, should be considered and evaluated in their respective places and degrees.

Why not try private profit-making insurance companies on a competitive basis for this type of insurance? As a matter of fact, there are private insurance companies that include in competitive costs—major medical, accident and health, life, diagnostic, and weekly wage insurance.

If age groups are to be further restricted, we should definitely consider a Central Insurance Fund Policy for all age groups, with a hospitalization ceiling such as $10,000 and a $10,000 to $20,000 limit for other health and accident costs, as a life time policy, with a tapering off of premiums on the same basis as life insurance policies, and a paid-up policy after a certain number of payments or age. This would take care of all age groups in a better manner and might possibly eliminate supporting or subsidizing the Blue Plans Subcommission of the American Hospital Association, which now acts as a collection agency for the hospitals.

It is true that in order to utilize more fully the hospital beds throughout the week, each hospital might have to turn to professional and technical rotating pools for various types of physicians, technical help, and abolish the present "privileged doctor" system. This would support the AMA House of Delegates

statements that it is the basic right of every citizen to adequate medical care and to have his own physician treat him at the hospital of his choice. We might begin this by applying the AMA principle to the Medicare group.

All doctors in good standing would have the right to the use of available hospital beds and facilities. X-ray, laboratory and other qualified doctors could then rotate services at various hospitals to cover the present deficiencies and improve service and lower the costs, in the public's interest and benefits. This would raise and possibly return general practitioners of medicine inside and outside hospitals to a higher proportion from the present 12 to 16% of physicians.

To properly evaluate In-Hospital costs, we may have to have NIH build and finance an experimental 500 semi-private bed hospital, supervised by the two medical schools and State Medical Society, open to all doctors in good standing to determine after two or three years the cost of In-Hospital attention.

Why should Blue Cross policy holders pay for many of the present and prospective activities not immediately related to In-Hospital Medical Care—not for all *hospital* costs but only for *hospitalization* costs? And, why not uniform rates for the individual as well as group policy holders covering the same illnesses, conditions and benefits whether inside or outside hospitals, to lower costs?

HOSPITAL COST DOLLAR PER DIEM

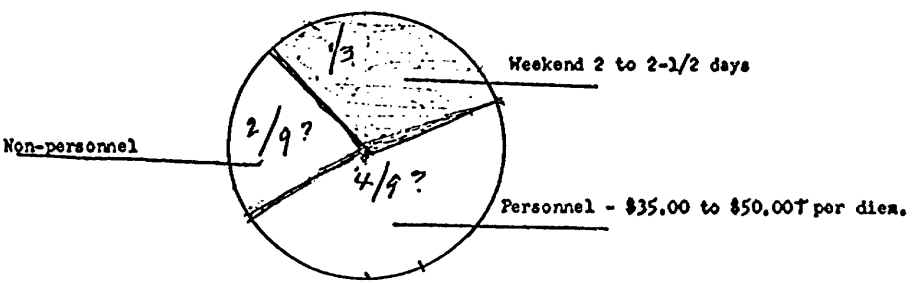


CHART NO. 1

THE HOSPITAL CANOPY OR AREA

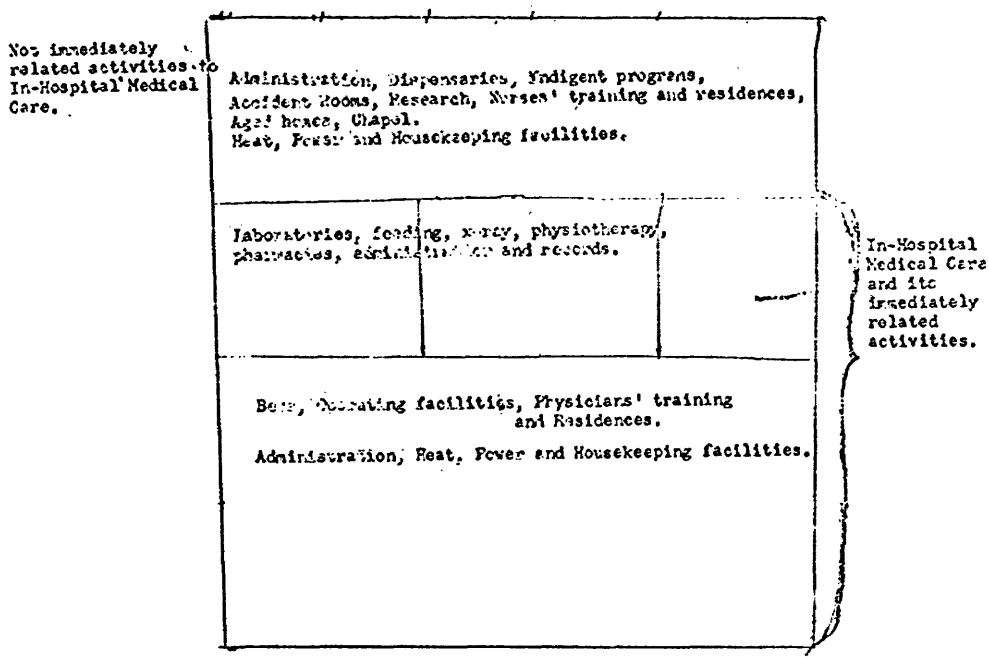


CHART No. 2

FEBRUARY 8, 1968.

Re: House Bill No. 21.

To the Judiciary Committee of the House of Delegates:

The House has been requested by the Medical and Chirurgical Faculty of Maryland, to consider a Commission for disciplining the medical profession in the state of Maryland.

Dr. A. Siwinski, former president of the Baltimore City Medical Society component, after bringing the Disciplining Commission Resolution to the attention of our society, told me that my efforts instigated this action.

Under present state planning, medical matters are in three separate categories.

1. The State Government arm—the State Board of Medical Examiners.
2. The medical profession representative—the Medical and Chirurgical Faculty of Maryland, a private non-profit corporation.

3. Other medically related or associate groups—The Health Department, hospital groups, welfare, nursing homes, medical training, associated professions, etc.

We have no comprehensive group or groups covering all medical and medically related practice and conditions.

There is a definite hiatus wherein none of these subgroups have effective control of medical matters for qualifying and disqualifying doctors, especially in certain divisions. Only the medical profession is properly trained and equipped to practice in contact with the public; and, to know what is best for the public's health and welfare from the medical point of view.

However, we find certain groups and institutions usurping the authority and responsibility that must be reserved to the medical membership—a matter of vital importance to both the doctor and his patient in his fight for life.

The Medical and Chirurgical Faculty in the November 11, 1967 session of the House of Delegates, backed up the AMA House of Delegates, stating that a "physician" is a qualified doctor of medicine or is licensed to practice *unrestricted* Medicine and Surgery. Restrictions are being placed on the doctor of medicine by institutions, which deny him the use of the hospital beds and facilities in behalf of his patient; and, prevent his *unrestricted* practice of Medicine and Surgery.

The proposed Commission on medical discipline does not cover—

(a) Discriminatory restrictions of the physician by the hospitals, involving professional qualifications or conduct, for the use of hospital beds and facilities for the benefit of his patient.

(b) Corporate practice of medicine by an unlicensed doctor, an employee of a hospital, carrying on general practice on the public.

(c) In the private clinic of an eminent institution, after the first visit the patient practically becomes the property of the clinic.

(d) Under the Regional Medical Program, doctors licensed by other states than Maryland will be "blessed" to practice by the Federal Government in the state of Maryland, for private practice without control or qualification by the Maryland Board of Examiners.

(e) There are doctors in private practice who are not members of our component or state societies, but may or may not be members of other medical societies.

(f) Some of our own society members have resigned from our own component and state societies and are not under the control of our present groups.

These are some reasons for my attempts to obtain action by our medical societies on the proper qualifying and disqualifying groups. A comprehensive picture is represented by the following enclosure: The Maryland Board of Medicine.

MARYLAND BOARD OF MEDICINE

1 ↓

LICENSING DIVISION OR
THE STATE BOARD OF MEDICAL EXAMINERS

To grant or cancel licenses to practice unrestricted Medicine, Surgery and Specialties, elected by the entire state membership by secret ballot through the mail.

2 ↓

DISCIPLINING DIVISION

A Joint Board of the Medical Examiners and of the Medical and Chirurgical Faculty of Maryland, in which practicing physicians will equal in number, institutional and other representatives; and, will be elected by the entire membership of the Medical and Chirurgical Faculty of Maryland, by secret ballot through the mail.

3 ↓

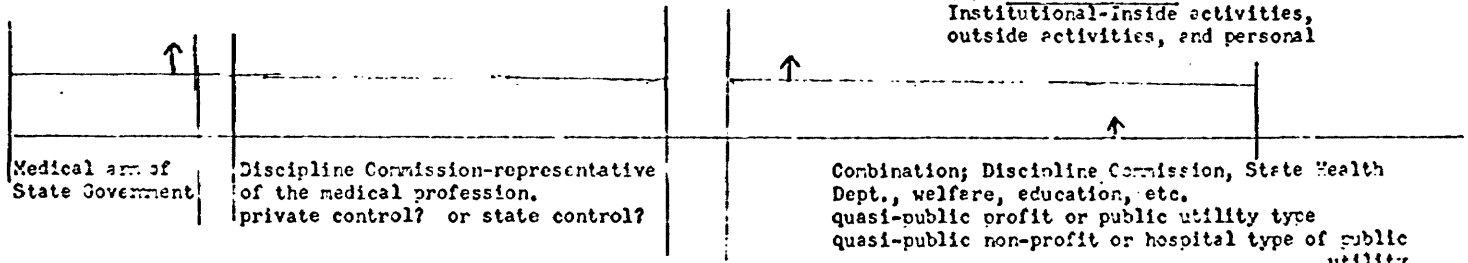
COOPERATIVE (HEALTH DEPARTMENT
(MEDICAL-EDUCATION and
(MEDICAL-WELFARE MATTERS

In each category in joint divisions, practicing physicians will equal in number, institutional and other representatives, elected by the entire membership by secret ballot through the mail.

(A) Health Department
Statewide epidemic conditions;
Institutional checks, including hospitals, mental and other hygiene, etc.
Food standards and conditions;
Pollutions (air
(water (animal and
(land (vegetable life

(B) Medical-Education
Medical Student, graduate and post-graduate studies, Dental, Pharmacy, Nursing and associated workers.

(C) Medical-Welfare
Institutional-inside activities, outside activities, and personal



The proposed Discipline Commission of nine members actually a quorum of seven, empowered by a majority of four votes to remove a physician's license and the livelihood of his dependents, without action by all his peers, is totally unfair. It is not a properly balanced Commission, which should consist of practicing physicians in number equalling the others; and, without the political effect of the Governor's selection of purely practicing physicians.

Any action by this Commission must only be tentative or advisory and must be confirmed by the entire membership of the State Society voting in secret ballot by mail.

All State Society voting must be returned to the entire membership, by secret ballot through the mail, for either confirmation or initiation of matters of statewide concern or of elections.

No one speaks for the Medical Profession, whether of 3,000 members or 3 members, unless so voted or confirmed by such balloting of the entire membership. Otherwise, these people speak only for themselves.

The Legislature must specifically prevent any intervention, denial, interference, qualification or disqualification in the practice of medicine, whether inside or outside of hospitals, by other institutions, groups or individuals throughout the State of Maryland.

The Legislature shall deny to an institution, state tax funds or subsidy in any form, if it discriminates against any member or members practicing medicine, in good standing in the community, in the use of beds and facilities.

When a physician has struggled his way through education, training, experience, and as a member of the medical brotherhood, he is not a juvenile, but a mature individual on equality with his peers. Discrimination or restriction of his practice must be decided by all his fellow members by secret ballot; and, not all nine selected members alone or even four of the quorum of seven votes.

Only the state shall *give* licenses to practice medicine and charters to the Medical and Chirurgical Faculty of Maryland, hospitals and other corporative bodies; and, only the state shall take them away.

Equality being the basis of the parliamentary government of our State Medical Society voting membership, every member shall have the right to his vote in the State Society. One Member—One Vote.

If we are going to change our medical society professional representative and make it an arm of the State Government, we will have State Government control of our profession and destroy the present status of professional control only of our State Society. Before this destruction, the entire membership must vote its decision by secret ballot through the mail.

The vicious application which hospitals request of doctors before granting them or refusing them the privilege, not the right, to practice inside their walls, which permits them to control the doctor's entire practice when using their beds and facilities and which may jeopardize his patient's life, in my opinion is contrary to our Hippocratic Oath. As Dr. Rouse, the AMA president, stated in support of our Hippocratic Oath—"Don't sit back and let the government or anyone else dictate all our policies."

SEPTEMBER 30, 1970.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: Dr. Charles L. Schultze, formerly Budget Bureau Director, told a luncheon meeting of the National Economists' Club, on September 23, that it was generally thought "you ought to have your head examined," if you suggested that Medicare and Medicaid should be examined in terms of "priorities" in relation to other uses of economic resources when they were started. May I submit for your consideration three letters I wrote, two to a newspaper in 1965, and one to him in 1966, before Medicare was initiated. In my May 31, 1966 letter to him, I quote from his testimony before a Joint Economic subcommittee. On the same day he testified, July 22, 1965, my letter in the *Washington Daily News* applied his principles to the Medicare program. We should "analyze the output of a program and compare what we get for what we have to pay" with "a more careful analysis of our objectives throughout the full range of governmental activities," he had told the Joint Economic subcommittee. On the day he said that and also later that year (1965) I put myself in line to "have my head examined" by applying his principles to Medicare. I also pointed out that the first Congressional reports on Medicare "failed to give adequate attention to economic analysis," proposing only actuarial studies. You put yourself in the same line with me, when you said, just before Medicare was passed in the Senate, that it "can

better be judged by an economist than an actuary, better by a social worker than an accountant" (*Congressional Record*, July 9, 1965, page 15582).

The Report of the Task Force on Medicaid and Related Programs, which Mr. Walter J. McNerney, on June 29, 1970, submitted to the H.E.W. Secretary, shows no sign of understanding the distinctions, with which you agree, which Dr. Schultze outlined. I first got involved with this subject because of an assignment in the Social Security Administration to examine another study under Mr. McNerney's direction. I was frustrated when I found I could get nobody in the Social Security Administration to think like an economist. I refer you to the *Report of the Advisory Council on Social Security*, 1965, which guided Congress while initiating Medicare, for evidence of the absence of economic reasoning, in Dr. Schultze's sense.

Note the Chief Actuary's statement that "primary responsibility for the cost estimates for Medicare, except for certain economic assumptions" is considered an actuarial function (Finance Committee Hearings, "Medicare & Medicaid," July 1 & 2, 1969, page 445). This is conceived as excluding responsibility for any determination as to "economic feasibility" (Finance Committee Hearings on "Social Security Amendments of 1967," H.R. 12080, page A208, letter by Chief Actuary).

After hearing an address by Dr. Daniel P. Moynihan, Counsellor to the President, I wrote him a letter suggesting that now, while we are awaiting a new Chief Actuary, certain questions should be raised again. He replied saying my suggestions "will be given serious consideration," and so I ask that my letter to him, as well as the others mentioned above, be put into the record of your current deliberations on Social Security Amendments.

Yours sincerely,

SIDNEY KORETZ.

JUNE 10, 1970.

Dr. DANIEL P. MOYNIHAN,
Counsellor to the President,
Washington, D.C.

DEAR DR. MOYNIHAN: You told the June 2 Annual Dinner guests of the Washington Statistical Society not to neglect "policy" by over-concentration on "program."

You used the National Highway Program as example. Applying your lesson, I asked about the Highway Trust Funds, and then about the Social Security Trust Funds.

The Brookings Institution's *Social Security: Perspectives for Reform* by Joseph A. Pechman, Henry J. Aaron and Michael K. Taussig takes a position different from the one you seemed to favor when you said that the use of Social Security Trust Funds should be decided solely by the "contributers," if you mean by that that payroll taxes should be regarded like insurance premiums.

That "the past is prologue" does not mean that a program of the past should not be changed to fit changing present and future requirements. Therefore, the "fiscalautonomy" legislation in the past no longer fits the requirements of the Social Security Program, according to this study. (See, especially, Chapter IV, "The Objectives of Social Security.")

One thing is wrong with the study. They omitted Medicare. Since Dr. Kermit Gordon, President of Brookings Institution, was the first Chairman of the Health Insurance Benefits Advisory Council which, by law, was supposed to oversee the initiation and workings of Medicare, I asked him why actuaries were being allowed to usurp the role of economists. (The former deal with how much, the latter with how well, money is spent.) My question and his answer may be found on pages 101–2, Joint Economic Committee Hearing, "Twentieth Anniversary of the Employment Act of 1946," February 23, 1966, Eighty-Ninth Congress, Second Session. His answer was, in effect, don't worry, I am an economist.

Now the Chief Actuary, Mr. Robert J. Myers, resigns, not for actuarial reasons, he says, but for policy reasons. According to him, "Principal responsibility for the cost estimates for the Medicare program (except for certain 'economic' assumptions) has always been assigned to me." (Page 445, Senate Finance Committee Hearings on Medicare and Medicaid, July 1 & 2, 1969.) "Cost here also means "benefit." Is that the Chief Actuary's job? Before another one is picked, the questions raised by the Brookings study, extended also to Medicare, should be answered.

I would greatly appreciate your attention to these matters.

Yours sincerely,

SIDNEY KORETZ.

MAY 31, 1966.

Mr. CHARLES L. SCHULTZE,
Director, Budget Bureau,
Washington, D.C.

DEAR MR. SCHULTZE: You stated on July 22, 1965 to the Subcommittee on Fiscal Policy of the Joint Economic Committee that "In order to make intelligent budget decisions we really want to be able to analyze the output of a program and compare what we get for what we have to pay. . . . What we need is a more careful analysis of our objectives throughout the full range of governmental activities, not only in defense, where much work has been done, but also in the poverty program, in transportation, in education, in health, in the conduct of foreign affairs, and, yes, even in the administration of justice."

I wrote a report in the Social Security Administration calling for the application of this principle in the planning for the Medicare program about to go into effect. This was completely ignored. Accordingly, now as an independent citizen I am raising this and other relevant questions. I have had material printed in Committee Hearings of the House and the Senate. I also raised the question in the Economic Symposium of the Joint Economic Committee on celebrating the 20th Anniversary of the Employment Act of 1946.

Immediately after you testified on the above date, I approached you and asked you how Medicare payments would be classified in the national income accounts. One of your assistants present said it would be as transfer payments and indeed it turned out that's what the Budget Bureau did in the Federal Budget. However, the Commerce Department, after considering questions I raised to them, now considers the matter undecided.

Another one of your assistants tells me it makes no difference how this is classified in the national income accounts as far as the program objective of Medicare is concerned (and then inconsistently adds the "transfer payment" classification gives a "better picture"). Do you think it makes no difference?

Mr. Arthur E. Hess, Director of the Bureau of Health Insurance, which will administer the Medicare program, says that "the public will generally react to medicare as a total program . . . he (the beneficiary) is a subscriber of the total health insurance program . . . his program relationship must basically focus on the Social Security Administration."

A new dimension will be introduced into the expenditure of Social Security funds. Till now the Secretary of the Treasury concerned himself with the investment side and the Secretary of H.E.W. with the transfer payments to the beneficiaries. (The Secretary of Labor had nothing to do, though also one of the Trustees.) Who will give an accounting to me (a private citizen) on how well the job of purchasing goods and services to promote health and cure sickness is done?

The Social Security Administration has refused to respond to my questions as an employee with an assignment in this field and now as a private citizen. I would appreciate your cooperation in getting the answers.

Yours sincerely,

SIDNEY KORETZ.

[From the Washington Daily News, July 22, 1965]

ECONOMY RELATES VALUE AND COST

It is just as necessary to reduce costs in providing for health care as it is in providing for national security, both thought of as almost literally priceless. Defense Secretary McNamara has insisted on "program definition" and "cost-effectiveness ratios," claiming we must do "our thinking before we start to bend metal." This applies to health as to defense.

Now a new dimension is to be introduced to the Social Security Trust Funds in that they are to be used to purchase goods and services, when up till now they resulted only in transfer payments. A "dollar's value for a dollar spent" will no longer be automatically assured. We need a reasonable concept of "reasonable cost" to get good results.

Sen. Long said we must seek out "people in the months and the years ahead . . . to see how they are being comforted and being made secure by the bill we are on the verge of approving." This is a far cry from the suggestion the Finance Committee agrees with that "there should be a small continuing actuarial sample (of perhaps 0.1 per cent of all eligible individuals), whose experience can be

followed as promptly and thoroly as if the system related to only about 20,000 persons . . ." This conceives of human beings as if they were beans in a bag or grains of wheat, instead of human beings with whom we must have dialogue and concern.

SIDNEY KORETZ.

[From the Washington Daily News, Sept. 20, 1965]

A BREAKDOWN IN COMMUNICATION

Bruce Biossat reported in his Sept. 7 column that Vice President Humphrey thinks the sort of management analysis Defense Secretary McNamara applied to the Pentagon should be applied to "the huge legislative tonnage dropped on our doorstep." This certainly includes Social Security "medicare."

But Dr. Philip D. Bonnet, President of the American Hospital Association, indicates he will have none of it. He wants less effort devoted to "cost reduction and dollar stretching." The Commissioner of Social Security, Robert M. Ball, in a long speech outlining "Hospitals and Health Insurance for the Aged," before the 67th Annual Meeting of the American Hospital Association in San Francisco on August 30, gave no indication there had been any planning about "program evaluation" and "cost reduction."

Congress failed to give adequate attention to the economic analysis of the subject. There is nothing about "program evaluation" or "cost reduction" in the Senate Finance Committee Report on the 1965 Social Security Amendments. Only Senator Russell Long, just before Senate action, raised the question at all, when he said the program could be "better judged by an economist than an actuary."

SIDNEY KORETZ.

AMERICAN COLLEGE OF APOTHECARIES,
September 22, 1970.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate,
Washington, D.C.

DEAR SENATOR LONG: We have sent you under separate mailing from Milwaukee, Wisconsin, the views of the American College of Apothecaries on the Drug Amendment to H.R. 17550. A copy has been sent also to the members of your Committee. The decision to submit our views was made by our Board of Directors during the 30th Annual Convention just concluded.

Fellows of the American College of Apothecaries fill in excess of 40 million prescriptions each year and provide complete pharmacy service to their patrons. We see in the Amendment the possibility of being placed in the position of where, out of economic necessity, our practitioners will be forced to seriously curtail or eliminate many of the extra services so vital to *complete* quality health care. Included among these services is the keeping of a patient record system designed to protect the patient from possible unfavorable drug interactions and allergic reactions.

The growing numbers of drug interactions and drug reactions has been responsible for greatly increased patient loads in our hospitals, and I need not tell you what that means costwise. The keeping of meaningful family prescription records in the pharmacy can do much to lighten that load. This takes time for which the pharmacist must be reimbursed at a fee commensurate with the time involved, and in keeping with his expertise as a drug expert.

We also see in the bill the distinct possibility that our practitioners may be placed in the position of being required to dispense drug products of questionable quality . . . products which either fail to meet minimum standards or which fall far short of the mark insofar as therapeutic and biological equivalence is concerned.

We are truly concerned with the continued delivery of *quality* health care to the people of the United States, and as members of the health care team, we believe it is our responsibility to address ourselves to this issue. The health care of future generations may well depend on the decisions made by you and your Committee, and we urge you to give careful consideration to the views of the American College of Apothecaries.

Sincerely,

RUSSELL A. BENEDICT, *Executive Secretary.*

AMERICAN CHIROPRACTIC ASSOCIATION,
OFFICE OF THE PRESIDENT,
Augusta, Ga., September 30, 1970.

Hon. RUSSELL B. LONG,
Chairman, Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: May I take this means of expressing to you my sincere appreciation for the opportunity afforded me and my colleague, Dr. William S. Day, President of the International Chiropractic Association, to appear before the Senate Finance Committee and present our case for the inclusion of chiropractice in the Medicare program.

Dr. Day and I are very appreciative of the interest you showed in this matter by asking the pertinent question concerning chiropratic. I sincerely hope that our testimony for your distinguished committee gave you further insight into the advantages of having chiropractic care available to the elderly citizens of this country under the provisions of Title XVIII of the Social Security Act.

Thank you, Senator Long, for your interest in this matter and let me assure you that the chiropractic profession and many, many thousands of elderly citizens will be grateful to you for your support of chiropratic in Medicare.

Yours sincerely,

HOYT B. DUKE, D.C.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES,
Washington, D.C., October 5, 1970.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: The American Federation of Government Employees, as a sponsor for the AFGE Health Benefit Plan, written under the Federal Employees Health Benefit Act and covering approximately 14,000 employees and annuitants request the opportunity to present the attached supplemental statement to be published in the hearings of your Committee pertinent to H.R. 17550.

The testimony which we are presenting deals with Section 201 of the abovementioned Bill, and it is advisable that this information be considered in your mark-up sessions on this Bill.

We regret that this testimony is so untimely in its presentation, but request the consideration of the Committee in its inclusion in your deliberations.

Most sincerely and fraternally,

JOHN F. GRINER, *National President.*

The American Federation of Government Employees as sponsor for the AFGE Health Benefit Plan, an Employee Organization Plan written under the Federal Employees Health Benefits Act, currently covering 13,600 Federal employees and annuitants; and, as the largest organization of Federal employees with a membership exceeding 325,000 persons, most of whom are covered under one of the other Federal Employee Health Benefit Plans, wishes to express its strong opposition to TITLE II, Part A, Section 201 of H.R. 17550 which is before your Committee.

House Report No. 91-1096, the Report of the House Ways and Means Committee on H.R. 17550 on page 25 provides the comment that the purpose of Section 201 of the Bill is "to assure a better coordinated relationship between the FEHB program and Medicare and to assure that Federal employees age 65 and over will eventually have the full value of the protection offered under Medicare and FEHB..."

This is to be accomplished by imposing prime carrier responsibility on the FEHB program as of January 1, 1972 in those cases where the Federal employee or annuitant also has Medicare coverage unless, as stated on page 25 of the Report, "the Secretary of Health, Education, and Welfare certifies that the FEHB program has been so modified as to assure that there is available to each Federal employee or retiree age 65 and over one or more Federal health benefit plans which offer protection supplementing the combined protection of parts A and B of Medicare, and the protection of part B alone and that the Government is making a contribution toward the health insurance of each Federal employee or retiree age 65 and over, which at least equal to the contribution it makes for high option coverage under Government-wide FEHB plans."

Your committee has already received testimony and statements from other sponsors of Federal Employee Health Benefit Plans pointing out the financial losses to the FEHB program and the Federal employee or retiree age 65 and over should the FEHB program be made the prime carrier for benefits with Medicare not duplicating any benefits for services and items covered by the particular FEHB plan involved. Under this method of benefit determination the claim losses under the AFGE Health Benefit Plan would have been increased in excess of $500,000 for the period July 1, 1969 to July 1, 1970, and it would be reasonable to expect that the increased claim losses under the FEHB program would be in excess of $30 million annually. These figures do not include the losses in benefit amounts paid to Federal employees and retirees age 65 and over should the FEHB plans be made the prime carrier and the present system of benefit coordination of benefits between the FEHB plans and Medicare, as established by Civil Service Commission regulations, be abandoned.

This increased claim cost to the FEHB plans, which up to this time has been the legal obligation of Medicare based on the intent of the legislation enacted in 1965 that Medicare would pay its benefits in full without regard to any other benefits that might be payable under an employee health benefits plan, could only result in increased premiums for each of the FEHB plans. Such premium increases would apply to all insured Federal employees regardless of age with the Government paying 40% of the increased premium cost under the legislation recently enacted to increase the Government contribution to FEHB premiums.

It should be noted that employee health benefit plans in private industry would continue to receive the advantage of full benefit payment under Medicare and most of them would continue to coordinate their benefits with Medicare so as to supplement rather than duplicate Medicare benefits in the same manner as that now provided for the FEHB plans under Civil Service Commission regulations. The resulting savings would be passed on to all persons insured under that particular employee benefit plan.

This brings up the question as to why the FEHB plans have been singled out for special treatment under Section 201 of the Bill. It can only be assumed that since the Federal employee has been paying and will continue to pay up to January 1, 1971 approximately 75% of the cost of his health benefit he is more concerned as to how this money is spent and whether he individually receives the full benefit of his own contributions. Since the employee in private industry contributes little, if any, toward the cost of his employee health benefit he is more concerned with the total benefits that he receives from Medicare and his employee health benefit plan than with how these benefits are paid for.

The Federal employee has undoubtedly expressed his concern to his Congressional Representatives with the result that Congress is equally concerned as to whether the present system of benefit coordination between the FEHB plans and Medicare is the best method of providing full health insurance protection for the Federal employee or retiree age 65 and over.

The Civil Service Commission in issuing its regulations on how the FEHB plans would adjust their benefits so that in effect they supplement, rather than duplicate, the benefits provided by Medicare pointed out that there would be no reduction in premium charges under the FEHB plans even though an employee or his spouse, or both are covered by Medicare. They pointed out that, as a class, persons over 65 use between two and three times as much service as younger people, and the true cost of the supplementary coverage under a plan for age 65 and over persons would be roughly the same as they now pay. It was also pointed out that since most low options adequately supplement full Medicare coverage at less cost than the high options, an employee enrolled in the high option who has full Medicare coverage (hospital and medical insurance) for himself and his spouse and has no children who are family members should consider changing to the low option.

Up until the time Medicare became operative on July 1, 1966, the Federal employee and retiree age 65 and over was being subsidized by the younger people insured under the FEHB program. The amount of this subsidy would have gradually increased as more employees and annuitants reached age 65, and had not Medicare entered the picture at this point there would have been considerable agitation from the younger people to the effect that the older age group was not as a class paying their own way. The savings to the FEHB plans under the system of coordinating benefits avoided the possibility that a higher premium rate would have to be applied to the older group of persons insured under the FEHB plans.

We submit therefore that the present system of benefit coordination as established by Civil Service Commission regulations, while not perfect, works to the advantage of all Federal employees and that the Federal employee and retiree age 65 and over, in this manner, has protection that is supplementary to Medicare at a cost to him that is not in excess of what the cost would be for the supplemental plans proposed by Title II, Part A, Section 201(c)(1) of H.R. 17550.

This is not to say that the present system is the best method of supplementing Medicare benefits under the FEHB program, but in our opinion the supplemental plans proposed under Section 201(c)(1) do not accomplish the desired objective and, in fact, would work to the decided disadvantage of many insured Federal employees and retirees who are insured on a family basis under the FEHB program. We refer to the Federal employee and retiree enrolled on a family basis who might be eligible for Part A of Medicare and whose spouse is not, or the reverse situation. Additionally, there are those instances where dependent children are still covered under the FEHB enrollment. While a supplemental plan could readily be designed to supplement the benefits that the Federal employee or retiree himself is entitled to and enrolled for under Medicare, it would be difficult, if not impossible, to design, administer and establish a cost for supplemental or in some cases total coverage for all family members other than the Federal employee or retiree.

We have no quarrel with the intent of Section 201, but strongly object to the solution to the problem as proposed in Section 201(c)(1). We are confident that a workable method of assuring that Federal employees and retirees age 65 and over will have full value of the protection offered under Medicare and the FEHB program can be devised by the responsible parties in the Civil Service Commission and the Social Security Administration in consultation with the insurance carriers under the FEHB program and insurance carriers who have solved this problem for employee health benefit plans in private industry. If it is determined that the present coordination of benefits system is not the most equitable for the Federal employee, an alternate, or alternatives, should be recommended and any requirement for enabling legislation should be referred to the appropriate Committee in Congress.

In conclusion, we wish to record again our strong opposition to Title II, Part A, Section 210 of H.R. 17550 and we urge the members of this Committee to delete this Section from H.R. 17550.

(The balance of the communications were forwarded to the committee by Hon. Robert W. Packwood, a U.S. Senator from the State of Oregon;)

ASHLAND COMMUNITY HOSPITAL,
Ashland, Oreg., October 5, 1970.

ROBERT W. PACKWOOD,
Senate Office Building, Washington, D.C.

DEAR SENATOR PACKWOOD: The medical staff at this hospital has asked me to write to you and explain their views on the Bennett Amendment #851 to the Social Security Amendments of 1970.

We are extremely opposed to this amendment as it would create a chaotic and unworkable situation with regards to admitting patients into the hospital. This amendment stipulates that all Medicare admissions would have to clear through a Utilization Committee of the County Medical Society. We believe that only the attending physician should prescribe what, where and when medical services should be utilized and he, therefore, should have the major role in their control. We feel that medical audit and utilization review are medical staff functions within the institution.

We, therefore, urge your opposition to this amendment.

Sincerely,

PHILIP M. HUNTLEY,
Administrator.

COQUILLE VALLEY HOSPITAL DISTRICT,
Coquille, Oreg., September 15, 1970.

Hon. Senator ROBERT PACKWOOD,
Senate Office Building, Washington, D.C.

DEAR SENATOR: Greetings to you from the Coquille Valley.

Our State Hospital Association has brought the "Bennett Amendment" no. 851, to our attention. It appears to me that this amendment would serve only to muddy the water and increase the confusion relating to utilizaion review, especially for the small over-worked Medical Staffs. It would also handicap the small isolated hospital if it were necessary to obtain permission from a remote body before admission of patients.

I would certainly appreciate your help in at least investigating the results of this amendment and if possible, your support in defeating it, as it is now written.

If your campaign trips ever bring you close to Coquille, it would be a real pleasure to show you what a small community can do to take care of the medical needs of its' people. In our community, this project was spearheaded by your old friend George Ulett, who I'm sure would be happy to conduct you through the building.

Kindest personal regards, and thank you for your consideration of this request.

Yours sincerely,

CHARLES A. EIDE,
Administrator.

MEDICAL STAFF, ST. VINCENT HOSPITAL,
Portland, Oreg., September 21, 1970.

Hon. WALLACE F. BENNETT,
Senate Finance Committee,
Washington, D.C.

DEAR SENATOR BENNETT: As Chief of Staff St. Vincent Hospital, I have been asked to communicate with you our concern about your proposed amendment to the Social Security Amendment of 1970, H.R. 17550.

St. Vincent Hospital is a general 400-bed hospital, serving the community of Portland, Oregon with a regular staff of approximately 350 physicians. We find that we are in considerable agreement with many sections of your proposed amendment, particularly those that have to do with ongoing utilization review and those sections which upgrade the quality of care. However, we find that the section dealing with prior authorization by committee for elective admissions to hospitals is unacceptable in that it would place an unreasonable administrative burden on our already busy medical staff. As you know, physicians make a professional judgment arriving at a decision to admit a patient to the hospital and under Federal programs we must further certify that this is medically necessary. Our staff, through our Utilization Committee, and Admissions Committee, are already carrying out the intent of this objectionable section. We are doing this on a voluntary basis because we feel strongly that professional and peer review should be performed by physicians and that this should be an educational experience, enhancing the quality of care rendered in our institution. We do not feel that quality of care can be achieved by statutory direction.

Sincerely yours,

ERNEST T. LIVINGSTONE, M.D.,
President.

COTTAGE GROVE, OREG., *September 25, 1970.*

Re Bennett amendment, H.R. 17550.

Senator ROBERT PACKWOOD,
Washington, D.C.

DEAR SENATOR PACKWOOD: May I urge you to oppose the Bennett Amendment, now being considered by the Senate Finance Committee.

My reasons for this request are:

(1) It is unnecessary. Current hospital review mechanisms are quite adequate.

(2) It is insulting to have to ask someone else whether I may admit a patient. It is sure to create the patient response of: "If the government doesn't trust this physician, should I?"

(3) County Medical Societies are organizations for collective efforts of a group of physicians to improve their knowledge of their profession. If this organization becomes a policing body, it is likely to deteriorate as an educational organization.

(4) The Bennett Amendment would be very expensive. Review performed by a hospital's own Staff can be done quickly and effectively and demands a small portion of time of the physicians involved. In a set-up as envisioned by Senator Bennett, the clerical work is going to be very extensive and expensive. Physicians certainly cannot be expected to tax themselves to provide the government a service. Therefore, the taxpayer must support an additional, totally useless bureaucracy.

(5) Most important of all, the interposition of a third party, possibly non-medical, into a setting as tense as the decision of whether to go to the hospital, is the greatest invasion of privacy yet proposed. My decision to admit a patient is based on many factors other than simple scientific proof of a specific process. Of necessity, my records concerning a patient often contain intimate details of his business life, domestic life, social life, etc. To make such information available to anyone other than any ethical professional colleague is a violation of privacy as great as invading the confessional booth. Such information is essential to my understanding my patient and his illness. If the patient knew this information might be available to someone else, he would never tell me the entire truth which is very essential in effectively treating his illness. I would be unable to adequately care for this patient under these circumstances.

Gentlemen, may I request that you study this amendment even more carefully than usual. The potential damage to personal freedom and the practice of quality medicine is staggering.

Yours truly,

THOMAS W. PRICE, M.D.

LOWER UMPQUA HOSPITAL,
Reedsport, Oreg., September 28, 1970.

Hon. Senator ROBERT PACKWOOD,
U.S. Senate,
Washington, D.C.

DEAR SENATOR PACKWOOD: By now you have probably received communications from other hospitals in the State of Oregon expressing concern over Amendment 851 to the Social Security Amendment HR 17550. Amendment 851 is known as the "Bennett Amendment" having been introduced by Senator Wallace F. Bennett of Utah.

Both our medical staff and our Board of Directors feel that this Amendment is regressive legislation and feel that it should be removed from a part of the overall Amendments.

We particularly take exception to the part that calls for prior approval for all admissions to the hospital. We feel that there has been much work done in the area of preventative medicine and that this type of requirement would seriously effect preventative measures.

While we do believe in quality control and utilization, we feel that it should be done by our own medical staff and not by an outside group.

Any influence that you may be able to assert on members of the Senate Finance Committee to have this Amendment deleted, in our opinion, will be a great service to the overall medical care of the nation.

Verly truly yours,

R. H. STROWBRIDGE,
Administrator.

WINSTON EMERGENCY HOSPITAL & CLINIC,
OSTEOPATHIC PHYSICIANS AND SURGEONS,
Winston, Oreg., October 5, 1970.

ROBERT PACKWOOD,
Senate Office Building,
Washington, D.C.

DEAR SENATOR: I shall greatly appreciate your voting against Amendment 851 (the Bennett Amendment).

Yours truly,

M. L. FLETCHER, D.O.

DRAIN, OREG., *September 22, 1970.*

Senator ROBERT PACKWOOD,
Washington, D.C.

DEAR SENATOR PACKWOOD: I am writing to request that you vote against Bennett amendment 851; Social Security amendment of 1970, HR. 17550.

I strongly feel that the necessary policing and revenue of the patient care should be, and remain, in the hands of the medical staff of each hospital concerned. I feel that centralization of this activity in each county medical society is wrong, unduly cumbersome, would result in undesirable conflicts between hospital staffs and outside medical personnel. In short, I believe that the amendment would make for poorer utilization of the already overextended medicare dollar. If you have questions or further interest in the possible effects of this amendment, I would be happy to correspond.

Yours very truly,

WILLIAM E. WILTSE, M.D.

APPENDIX B

Reporting of Health Care Payments

(Joint Internal Revenue Service/Insurance industry task force—June 1970)

47-530 O—70—pt. 3——29

July 28, 1970

Mr. William H. Smith
Deputy Commissioner
Internal Revenue Service
1111 Constitution Avenue, N. W.
Washington, D. C. 20224

Dear Mr. Smith:

We are pleased to enclose the report of the Joint IRS/Insurance Industry Task Force pertaining to information reporting of payments to health care providers.

As you may recall, this task force was established in February 1970 to study the problems faced by carriers in reporting to the IRS payments made to health care providers.

This report presents our findings and is divided into two parts:

> First, an identification and examination of the problems requiring action by IRS and/or the insurance industry to facilitate the reporting of assigned payments pursuant to Revenue Ruling 69-595.
>
> Second, an identification and examination of the problems which would be encountered if the reporting requirements were expanded to include unassigned payments.

We appreciate the opportunity to have participated in a joint effort on this very important subject.

Respectfully submitted,

John M. Alexander

Kenneth D. Allen

Otto F. Gaus

John J. Nangle

Bernard Radack

Thomas G. Vitez

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the findings and recommendations of a joint Internal Revenue Service/Insurance Industry task force, based on a study of the problems faced by carriers in reporting to the IRS payments made to health care providers. The study was divided into two parts:

-- An examination of the systems and procedures of the carriers, to identify problems requiring action by IRS and/or the insurance industry to facilitate the reporting of assigned payments; and

-- An identification and examination of the problems which would be encountered if the reporting of unassigned payments were required.

II. DEFINITIONS

A. Carrier

Any organization making health care payments: (1) in exchange for the payment of a premium; (2) in accordance with an employee benefit program; or (3) in connection with a government-sponsored health care program. Included are Blue Cross and Blue Shield Plans, group practice plans, and commercial health, life, casualty and property insurance companies. Also defined as carriers are organizations which administer self-insured health benefit programs for their employees or members.

B. Provider

A person or organization providing personal health care services. In this report, the terms provider, supplier, and health care practitioner are used interchangeably.

C. Assigned Payment

A payment made directly by a carrier to a provider: (1) upon the authorization (assignment) of the person receiving the health care; (2) pursuant to contract provisions; or (3) as required under a government financed health care program. (Some carriers refer to this as a direct payment.)

D. Unassigned Payment

A payment made by a carrier to any person in reimbursement of amounts paid or payable by that person to a provider for health care services. (Some carriers refer to this as an indirect payment.)

III. BACKGROUND

Revenue Ruling 69-595 (Appendix A) requires information returns to be filed with respect to assigned payments aggregating $600 or more annually to certain health care suppliers under health, accident, and sickness insurance plans or medical assistance programs. This ruling applied to payments made on or after January 1, 1969; however, carriers whose accounting systems and procedures were not geared to retrieving and reporting this information for payments made in 1969 were allowed to begin reporting with respect to payments made on or after January 1, 1970.

At the time Revenue Ruling 69-595 was issued, the Congress had under consideration the "Tax Reform Act of 1969" (Public Law 91-172) to which the Senate Finance Committee had added an amendment (Appendix B) designed to broaden the existing statutory information reporting requirements covering health care payments. This provision, which would have required carriers to file information reports not only with respect to assigned payments but also with respect to payments made to insured individuals or other third parties in reimbursement of amounts paid or payable to a provider, was subsequently deleted in the Senate-House Conference.

On December 31, 1969, the IRS issued TIR 1026 (Appendix C) granting a one-year postponement in the application of Revenue Ruling 69-595 with respect to health care payments made by carriers in their regular business. Carriers are now required to report on payments made in their regular business on or after January 1, 1971. The additional year's delay was not extended to payments made under government-sponsored health care programs.

The basis for granting relief was the representation that many carriers could not install a reporting system within the short lead time afforded by the revenue ruling. Moreover, in view of the then prevailing uncertainty as to Congressional action, it was felt that the carriers should not be burdened with the implementation of reporting requirements based upon the provisions of existing law, when it was possible that altogether different reporting requirements would be prescribed within a matter of weeks or months by new legislation. Finally, it was recognized that the revenue ruling left open a number of questions that needed to be clarified or resolved in order to permit an effective system of reporting to be designed and implemented.

Accordingly, the issuance of TIR 1026 envisioned the formation of a join IRS/Insurance Industry task force to study the systemic and procedural aspects of information reporting both under present law and under the Senate Finance Committee amendment. In the interest of promoting ease of communication and meeting an early target date for completion of the study, composition of the task force was limited to six members consisting of two representatives from the IRS and one representative each from the life and health insurance industry, the property and casualty insurance industry, the Blue Shield Plans, and the Blue Cross Plans.

In accordance with this limitation, the task force was composed of the following members:

John M. Alexander
Vice President and Assistant Treasurer
National Association of Blue Shield Plans

Kenneth D. Allen
Assistant Washington Counsel
Health Insurance Association of America
(also representing the American Life Convention and the Life Insurance Association of America)

Otto F. Gaus
Director, External Accounting
Blue Cross Association

John J. Nangle
Washington Counsel
National Association of Independent Insurers
(also representing the American Insurance Association and the American Mutual Insurance Alliance)

Bernard Radack
Systems Development Officer, Systems Development Division
Office of Planning and Research
Internal Revenue Service

Thomas G. Vitez
Tax Research Officer, Research Division, Office of Planning and Research
Internal Revenue Service

The views expressed in this report are those of the individual members of the task force and should not be construed as necessarily reflecting the opinions of the Internal Revenue Service, any carrier association or carrier.

IV. CARRIER VISITS

The task force visited several carriers to consult with key officials and observe claims processing and recordkeeping operations. In selecting these carriers, the task force strove for a representative cross-section, based on company size, extent of centralization, degree of automation, different lines of business, and other considerations. Therefore, it is believed that the problems discussed in this report, although perhaps not all-inclusive, are representative of the major areas of concern.

The carriers visited by the task force were as follows:

(a) Blue Cross and Blue Shield Plans:

Des Moines, Iowa
Indianapolis, Indiana

(b) Life and Health Insurance Companies:

Mutual of Omaha Insurance Co., Omaha, Nebraska
Pan American Life Insurance Co., New Orleans, Louisiana
Metropolitan Life Insurance Co., New York, New York

(c) Property and Casualty Insurance Companies:

Allstate Insurance Co., Northbrook, Illinois

(d) Self-Insured, Self-Administered Plans

Morton International, Inc., Chicago, Illinois

All of these organizations were extremely cooperative and helpful in providing the task force with an understanding of their operations and with insights into the impact of information reporting requirements upon their activities. For this valuable assistance and cooperation, the task force wishes to express its appreciation.

V. SUMMARY OF RECOMMENDATIONS

A. With respect to assigned payments, the task force makes the recommendations listed below. These recommendations are discussed in detail in the succeeding sections of this report. The recommendations are designed to provide additional guidance in the application of Revenue Ruling 69-595 and to promote the accuracy and completeness of the information to be reported.

1. The reporting responsibility for filing information returns on health care payments should be placed on the organization which is identified as the payer on the check or draft; i.e., the Payer of Record.

2. With respect to the first few years of information reporting, carriers, administrators, and third party agents should be given wide latitude to fix by mutual agreement the responsibility for filing information returns.

3. The Income Tax Regulations should be amended to require reporting of payments made directly to professional medical corporations.

4. Payments to hospitals, extended care facilities, home health agencies and other similar facilities should be specifically excluded from information reporting.

5. Payments for drugs, eyeglasses, dentures, prosthetic devices, etc. should be excluded from reporting on the basis that these items are merchandise. However, an exception should be made with respect to merchandise which is included in an assigned payment to a medical practitioner.

6. All joint payment documents, made payable to a beneficiary and a provider, should be treated as assigned payments to a provider for reporting purposes.

7. Carriers need not concern themselves with the question of whether the named payee is, in fact, the taxable person, or is a conduit for another individual provider, clinic, hospital, medical partnership, corporation, etc. The carrier should simply report payments as having been made to the payee named on the check or draft. If and when further distributions occur, it should be the responsibility of the first tier payee to account for the shift in the income.

8. IRS should develop instructions, including appropriate official forms, for use by carriers in requesting provider TIN's. These instructions should illustrate the more common medical practice arrangements and provide guidelines as to which number should be furnished.

9. Carriers should include a field for the provider's TIN on every assignment form or proof of loss form. Since a claim may cover more than one assignee, several fields may be required, with each TIN appropriately linked to the assignee's name and address.

10. If a carrier requires use of a claim form containing a space for the TIN, the carrier should be deemed by the IRS as having requested the payee's number in accordance with Section 6109 of the Internal Revenue Code. A carrier requiring the insertion of a provider's TIN on a check or draft should also be deemed as being in compliance with Section 6109.

11. Professional associations of practitioners and commercial directory-preparers should consider the feasibility and advisability of obtaining taxpayer identifying numbers from health care practitioners and adding such numbers to their published directories.

12. To facilitate the acquisition of taxpayer identifying numbers, the task force recommends that a reference list of practitioners be developed by IRS from its own records, containing names, addresses, and taxpayer identifying numbers, and made available to carriers and self-insured or self-administered plans in either hard copy or magnetic tape form. Distribution should be predicated upon the agreement of a carrier to use the reference list solely in connection with the discharge of its responsibilities under the Internal Revenue Code.

13. As a general rule, the task force recommends that when a multi-line carrier's operations are combined within a single corporation, payments should be aggregated across all lines of business and departments. If, however, the activities are conducted by separate corporations, each corporation should be defined as an individual carrier and file its own set of information documents.

14. The IRS should waive aggregation across service area boundaries, when the likelihood of duplicate reporting is negligible.

15. The IRS should accept reports filed along departmental lines with a reduced reporting floor of $100, when (a) the number of separate sets of reports filed by that carrier does not exceed six, and (b) the reports are furnished in the form of magnetic tape conforming with IRS tape reporting specifications.

16. The task force urges carriers to furnish copies of information documents or similar statements to payees.

17. The task force recommends that for information reporting purposes the date the draft is accepted by the carrier be treated as the payment date. However, exceptions should be granted to carriers whose systems require that reporting of drafts be geared to the date of issuance. When payment is by check, the date of issuance should be deemed the payment date.

VI. CARRIER SYSTEMS

The capturing of the data needed to prepare and submit information reports to the IRS on either assigned or unassigned payments, must be grafted onto the carriers' existing claims processing and payment systems. In this section, the significant features of these systems will be examined as background for a discussion in the succeeding sections of the specific problem areas. Some of these features will vary depending on whether a group insurance or individual insurance policy is involved. A group insurance policy covers a portion of, or all members or employees and their dependents, whereas an individual insurance policy protects the policyholder and his immediate family.

A. Claims Processing

A claimant requesting that a carrier make either an assigned or unassigned payment for health care services, must generally provide an attending physician's report. The report is usually on a printed form prescribed by the carrier. Either included on this form or in an attached statement or bill, is an itemization of the services and charges underlying the claim. When services by several providers are involved, the services rendered and the charges are itemized either on the attending physician's report or on the attached statements or bills.

Insurance companies may set up separate processing systems by lines of business; e.g., group, individual, Medicare, etc. Each may operate as an independent entity with unique procedures and its own data processing system.

B. Provider Identification

Some carriers maintain a master file of providers with whom they normally come in contact. Typically, this procedure is used by Blue Cross and Blue Shield Plans which generally make payments to providers in a specified geographical area. In such cases, each physician, hospital, or other provider has been assigned a provider identification number by the Plan. These numbers must be present on claim forms; if not preprinted by the Plan or entered by the practitioner, they are entered by the Plan during claims processing. Only the provider identification numbers need to be captured for payment purposes. The names and addresses of the providers can be obtained from the master file during payment processing. The master file is also a basis for the maintenance of payment profiles which are used to establish "usual, customary, and reasonable" charges when government-sponsored health care program regulations, or the terms of insurance contracts require that provider bills be reviewed against such norms.

Some large insurance companies maintain a master file for all physicians in private practice and for other providers. However, most commercial carriers do not have any need for, nor do they maintain master files for their regular business. These carriers may occasionally verify provider identification data against reference lists obtained from outside sources, such as the American Medical Association or the American Hospital Association, in connection with claims processing. However, they do not accumulate data by individual

providers, but with respect to policyholders or individuals who are beneficiaries under the policy.

C. Payments

In the case of assigned payments, individual checks or drafts are sent to each provider; hence data relating to individual providers is potentially available from payment records. An unassigned payment is made in the form of a single remittance per claim which is sent to the insured, a beneficiary, or a third party claimant. Therefore, the data required for reporting unassigned payments would have to be extracted from the documentation supporting the original claim, and would necessarily require the capturing of data not now recorded by the carrier. This in turn would cause significant changes in the carrier's processing system. (See Section VIII for a more detailed discussion of this point.)

D. Record Retention

After payment action has been completed, claims documents are placed in folders by the carriers under the names or policy numbers of the insured individual or group, depending on the type of contract involved. After clearance, the checks or drafts are filed in a convenient sequence; for example, by date, by remittance number, by line of business, etc.

E. Variations in Claims Processing

The process previously described generally applies to circumstances when claims are processed and payments made from the central (home) office of the carrier. However, claims processing and payment activities are often decentralized, resulting in variations in the processing. Some typical variations are:

1. The processing of claims and payment functions may be accomplished at carrier field offices. In such cases, the records may either be retained at the field offices or sent to the central (home) office for retention.

2. Claims processing and payment functions may be accomplished by employers, unions, and other organizations who administer their own group health insurance programs, but make payments either on the drafts of the carrier, or on their own checks, with a subsequent reimbursement (in full or in part) by the carrier. In some instances, such functions may be accomplished by an independent general insurance agency employed by the carrier. The procedures relating to these third party cases, and the providing of detailed information to the carrier will vary, depending on the specific contractual arrangements which have been negotiated.

To illustrate the variety and complexity of these arrangements, one carrier visited by the task force has group insurance contracts with the claims processed and drafts issued under these policies by its home office, 14 group offices, 50 general agency offices, and 120 third party administrator offices. Third party arrangements include: (1) group policyholders who pay their own claims, receiving premium credit for performing this function, and (2) third parties who are under contract with the insurance company to perform the claim payment function. Generally, the third party administering arrangements fall into the following categories:

1. Claims are paid by the third party, using the carrier's drafts and worksheets, with notice of the payment to the home office consisting of a copy of the draft and worksheet.

2. Claims are paid by the third party, using the carrier's drafts and worksheets, with notice of payment to the home office consisting of the entire claim file.

3. Claims are paid by the third party using the carrier's drafts (nonstandard) with third party procedures with notice of payment to the home office consisting of a copy of the draft.

4. Claims are paid by the third party using the carrier's drafts (nonstandard) with third party automated procedures with notice of payment to the home office consisting of a punched card.

5. Claims for certain coverages only are paid by the third party using its procedures and the drafts of the carrier, with the remaining coverages paid by the carrier.

6. Claims are paid by the third party using the drafts of the carrier with notice of the payment consisting solely of the draft when accepted by the carrier.

VII. DISCUSSION OF PROBLEMS RELATING TO THE REPORTING OF ASSIGNED PAYMENTS

A. Determination of Reporting Responsibility

The general rule on information reporting is that the payer of the amount to be reported is responsible for submission of the report, although he may delegate this responsibility to an agent. The nature of health care payments and the related processing systems, however, introduce complexities of both an interpretative and systemic nature.

Reporting responsibilities can be fixed in one of three places: (1) on the organization which is identified as the payer on the check or draft (Payer of Record); (2) on the organization which is the ultimate provider of the funds being paid (Source Organization); or (3) on the organization which is processing the claim and preparing the check or draft (Processing Organization). Sometimes these three organizations are one and the same; however, quite frequently two or three different organizations are involved, making it necessary to establish a general rule. Some of the major considerations are:

1. Group insurance contracts often provide that the group policyholder may administer the policy and process the claims. In most instances, the group policyholder uses the checks or drafts of the insurance company on the funds of the insurance company. These self-administered plan arrangements, however, do have a number of variations which pose complications for a definitive placement of the reporting responsibility.

The Payer of Record may actually be receiving complete or partial reimbursement from another party. In this instance, a policyholder under a group insurance contract may be administering its own plan (which is underwritten by an insurance company) and paying benefits to beneficiaries or providers on its own checks or drafts. The insurance company would reimburse the group policyholder in a lump sum payment for claims paid each month.

There are variations in this reimbursement method. For instance, the group policyholder may pay the claims using its own checks or drafts and the insurance company may reimburse it for payments above a specific amount. Alternately, an insurance company may process and pay the claims using the drafts of the group policyholder on the funds of the group policyholder. The insurance company would reimburse the group policyholder for all claims over the above specified amount.

2. The Payer of Record may actually be disbursing funds advanced by another organization. As an illustration, 'carriers and intermediaries' administering the Medicare program make claim payments out of the funds advanced to them by the Federal Government on the basis of letters of credit.

3. The Payer of Record may be reimbursed by another organization after the payment is made. For example, a claimant may file for benefits with two or more carriers. Frequently

the contractual terms require a coordination of the benefits payable. One carrier is usually determined to have primary responsibility and therefore must pay the full amount of benefits under its policy. The remaining, i.e., secondary responsibility carriers, in turn pay additional amounts due on the claim, if any. On occasion, primary and secondary liability determinations are established after a payment has been made to the claimant, resulting in a subsequent monetary adjustment between the carriers.

4. Usually the Source Organization maintains no record of individual payments when it is not also the Processing Organization.

5. As far as the individual provider is concerned, the payments he receives emanate from the Payer of Record on behalf of a specific patient. In many cases, the provider is unaware of the existence or identity of the actual Source Organization.

6. The decision as to where the reporting responsibility is vested has an obvious bearing on the subject of aggregation and the $600 floor for reporting purposes. If the reporting responsibility is delegated to the Processing Organization, effective reporting coverage would be diluted because of the additional number of reporting units.

7. Processing Organizations and Source Organizations are less likely than Payers of Record to have the automated data processing capability which would be useful in accumulating and aggregating payment data and generating reports.

There is no wholly satisfactory solution to these problems. The task force is of the opinion that the most practical approach would be to relate the reporting responsibility to the draft or check itself; i.e., designate the Payer of Record as the party responsible for reporting. The Payer of Record can then arrange for the accumulation of data when its drafts or checks are prepared at locations other than its home office; i.e., by regional or field offices; by subsidiaries, by independent agents or by other third parties. This approach provides consistency, ease of determination, and the possibility of an audit trail between the provider's records, the claims records, and the payment records.

In addition, (1) the Payer of Record is often the Source Organization; (2) since the Payer of Record is the recipient of the "cleared draft" it always has sufficient information for the reporting of assigned payments; (3) the individual provider may only be aware of the Payer of Record and the fact that the payment is on behalf of a specific patient. Therefore, in order to promote ease of reconciliation between the information returns and the

records of the provider, it appears desirable to reflect the Payer of Record as the reporting entity on the Form 1099.

The task force recommends that these principles with respect to the reporting responsibility be applied with flexibility during the first few years of information reporting so as to avoid upheavals in the accounting systems and work flows of the carriers. With this in view, the task force suggests that during this period the contracting parties (carriers, policyholders, and third party agents) be given wide latitude to fix by mutual agreement the responsibility for filing information returns.

B. Payee Coverage

1. Direct Payments to Professional Medical Corporations

Under the present income tax regulations, payments made directly to corporations are not subject to reporting. Many state laws permit physicians and other individual professional medical practitioners to incorporate. Physicians are incorporating in increasing numbers, particularly since the recent change in IRS regulations which recognizes such arrangements for Federal income tax purposes. It appears illogical and inconsistent to require the reporting of payments made directly to an individual practitioner, but not to require reporting of payments made directly to a professional medical corporation for the same services.

Accordingly, the task force recommends that the Income Tax Regulations be amended to require the reporting of payments made directly to professional medical corporations (physicians or other practitioners of the healing arts). This recommendation is dictated not only by the above considerations, but also by the recognition that the reporting problems of carriers will be simplified by the removal of this exemption since carriers often cannot distinguish between incorporated and unincorporated medical practitioners.

2. Hospitals, Home Health Agencies, Extended Care Facilities, Etc.

Under present regulations, payments to these types of organizations are reportable only if unincorporated. An approach might be to include incorporated hospitals, home health agencies, etc. within the scope of information reporting. However, most hospitals, home health agencies, and some extended care facilities are exempt from Federal income taxation, either because they are an integral part of a state or local government or a university, or are incorporated under a state not-for-profit statute and are operated exclusively for charitable purposes. If incorporated hospitals, home health agencies, etc. were included within the information reporting provisions, logic would dictate that an exclusion be carved out for those which qualify as tax exempt organizations. This in turn would pose interpretative problems for carriers in distinguishing between categories of organizations subject to information reporting and those excluded.

Several carriers have tried to distinguish between incorporated and unincorporated facilities and found considerable difficulty in ascertaining the facts. Published directories are incomplete, and attempts by carriers to make the determination by direct contact with hospitals, home health agencies, extended care facilities, etc., have been usually unsuccessful.

A related problem arises from Section 1.6041-3 of the Regulations which excludes from information reporting payments for merchandise, telephone services, and similar charges. Payments made by carriers to hospitals, home health agencies, extended care facilities, etc. may cover a combination of charges, including room and board, drugs, surgical dressings, injections, surgical supplies, and miscellaneous other charges. In order to accurately comply with information reporting requirements, the carrier would have to analyze each provider's bill to determine which charges are reportable and which are not.

The task force believes that the amount of work required to develop the reportable information would be excessive, in view of the fact that the payments in question would represent but a small portion of the gross receipts of these facilities.

Accordingly, it is recommended that payments to hospitals, extended care facilities, nursing homes, home health agencies, and other similar facilities be specifically excluded from information reporting.

It is to be noted that there are instances when a hospital bill will include charges for surgical, radiological, and pathological services in circumstances when the hospital merely acts as a billing and collecting agent on behalf of the physicians rendering the service. Although the payment to the hospital by the carrier would not be reportable under the proposal, the hospital would be required to file Forms 1099 or W-2 with respect to such payments, depending on the relationship between the parties.

3. Payments for Drugs, Eyeglasses, Dentures, Prosthetic Devices, and Other Medical Supplies

As previously indicated, Section 1.6041-3 of the Regulations excludes payments for merchandise from information reporting. The task force views payments for drugs, eyeglasses, dentures, prosthetic devices and other medical supplies as being within the category of merchandise and therefore not reportable. However, an exception should be made with respect to merchandise which is included in an assigned payment to a medical practitioner.

Physicians and dentists often include in their bill charges for injections, drugs, dentures, and other items which could be defined as merchandise; however, the checks or drafts do not identify these items. Since the data for information returns would be derived from these checks or drafts, special procedures would be required to exclude such merchandise from information reporting. There are several practical reasons for not adopting

this course of action: (1) these charges generally represent only a small portion of the total payments to a provider; (2) if these charges were split out for information reporting purposes, without any change in the practice of issuing single checks or drafts to cover both merchandise and other services, there would be inconsistencies between payment reports and practitioner records which would be difficult to reconcile; and (3) if carriers had to issue separate checks for merchandise to facilitate the elimination of such payments from information reporting, their processing costs would be substantially increased.

In view of the above, the task force recommends that when payments to a health care practitioner for services rendered also include charges for merchandise, then the total payment should be reported.

4. Payment to Joint Payees

Carriers may make payments designating the insured individual as joint payee with the physician or other provider of health care services. The payment document is generally mailed to the insured individual although the full payment generally goes to the practitioner.

However, it was pointed out that reporting joint payments as assigned payments to providers is beset with some of the same sort of difficulties discussed with respect to unassigned payments. For example, if the joint check is sent to the insured individual, the physician may not receive any or only a small part of the proceeds. In addition, it often occurs that though a physician may be recognized as a provider in a joint payment instrument, he is only one of many providers (i.e., a hospital, surgeon, anaesthesiologist, etc.) who rendered services in a given case. Accordingly, he may simply endorse a joint payee check and turn the proceeds over to a hospital or others for allocation and distribution. In all such cases, reporting the joint payment as one made to the provider is not accurate.

On the other hand, it appears that more often the provider named on the joint payment document receives the full amount of the payment. The joint payment procedure seems to be a formality designed to place the subscriber on notice that the carrier has made payment under the contract, thus obviating the need for separate notification of the subscriber.

Therefore, on balance the consensus of the task force is that a joint payment should be treated as an assigned payment to a provider, for information reporting purposes.

5. Second Tier Distributions

In numerous instances carriers make payments to providers who either through contractual agreement or informal arrangement transfer the funds to other providers. For example, the carrier may issue a check or draft payable to a physician who is a member of a clinic and who turns all of his fees over to the latter entity. Similarly, payment may be made to a hospital-based physician who is obligated to transmit all of his fees to the hospital.

In these and similar arrangements, the carrier need not concern itself with the nature of the allocations between individual providers, clinics, partnerships, etc., but should simply report the payment as having been made to the payee named on the check or draft.

However, this approach could cause significant discrepancies between income tax return and information return data, and thus generate needless audits of health care practitioners. The self-interest of the Payee of Record necessitates that he establish adequate records to account for these discrepancies.

In a related situation, the practitioner who had actually provided the health care services may direct the carrier, on the assignment form, to make payment to another practitioner.

In such instances the same general rule should apply; the payee named on the check or draft should be assumed to be the provider, for information reporting purposes.

C. Preparation of Information Documents

1. Taxpayer Identifying Numbers

Section 6109 of the Internal Revenue Code requires payers filing information returns to request taxpayer identifying numbers (TIN's) from their payees and record such numbers on information documents filed with IRS. Section 6109 also requires payees to furnish their TIN's to payers upon request. Failure to request the TIN and failure to furnish it when requested subject payer and payee to statutory penalties, where appropriate.

The taxpayer identifying number is the social security number (SSN) for individual health care practitioners. For all other providers, it is the employer identification number (EIN).

IRS regulations relating to taxpayer identifying numbers leave to the discretion of the payer the manner in which payees are to be solicited for their TIN's. Thus, the techniques and procedures for requesting the TIN vary from carrier to carrier.

The task force has found that the response rate in obtaining numbers also varies significantly.

Since most health care practitioners in solo practice have both an SSN and an EIN (the latter being used for payroll tax purposes), the task force has found evidence of considerable confusion among solo practitioners as to which number should be provided. The uncertainty is even greater among practitioners having more complicated arrangements with other individuals, clinics, medical partnerships, and corporations. For example, practitioners may erroneously provide the TIN's of the ultimate recipients of the payments rather than their own TIN's. The problems associated with pinpointing the correct number to be furnished are numerous and complex, in view of the variety of business arrangements under which physicians conduct their professional practices. A sampling by the task force of provider responses to carrier requests for TIN's revealed a high incidence of incorrect numbers.

These findings suggest that the IRS should develop instructions, including appropriate official forms, for use by carriers in requesting provider TIN's. These instructions should illustrate the more common medical practice arrangements and provide guidelines as to which number should be furnished.

A carrier is not required to assume review responsibility or perform a judgmental role with respect to the processing of TIN's supplied by health care practitioners. A carrier will have met its statutory obligations by asking for the numbers and upon receipt recording them accurately in its records, and on Forms 1099 filed with IRS.

Most carriers can potentially make payments to any provider in the country. If these carriers followed the practice of obtaining TIN's in advance, they would each have to correspond with every provider in the nation. This could be extremely burdensome to all concerned. A more feasible approach in these cases would be to capture the TIN during claims processing or as a byproduct of the payment process. If the former, it would obviously be necessary that the TIN be present on the claim form. If the data is to be captured as a byproduct of the payment process, the assignee could be asked to insert his number as part of his endorsement of the instrument.

Accordingly, the task force urges carriers to include a field for the provider's TIN on every assignment form or proof of loss form. (Since a claim may cover more than one assignee, several fields may be required, with each TIN appropriately linked to the assignee's name and address.)

If a carrier requires use of a claim form containing a space for the TIN, the carrier should be deemed by the IRS as having requested the payee's number in accordance with Section 6109 of the Internal Revenue Code. A carrier requiring the insertion of a provider's TIN on a check or draft should also be deemed as being in compliance with Section 6109.

2. Reference List of Providers

Some carriers, particularly those not maintaining master files of providers, would be able to make effective use of a reference list which contains practitioner TIN's. The list could be used to validate the TIN's furnished by practitioners, or as a source of TIN's if not otherwise provided. Such a list would be particularly helpful during the initial years of information reporting.

The availability of a reference list offers another potential advantage to carriers who do not maintain a master file of providers. In its absence, carriers would have to record the practitioner's TIN, and full name and address for each assigned payment. With the reference list, carriers could accumulate data by TIN and name only, and pick up the address information from the list at the end of the year. Under this arrangement, special research would be required only in the limited number

of cases in which the provider was not included in the reference list. Accordingly, a reference list would have a continuing utility to many carriers.

Although a comprehensive listing of all health care practitioners covered by the proposed reporting system (physicians, dentists, nurses, therapists, clinics, paramedical personnel, etc.) would be difficult, if not impossible, to assemble, a good starting point can be made with self-employed physicians and dentists -- believed to be the largest single group. Directories of these professional persons are already compiled by commercial and professional sources (minus the TIN), and the logical long range solution appears to be for these organizations to obtain TIN's and add these numbers to their directories. Professional associations of practitioners and commercial directory preparers should consider the feasibility and advisability of obtaining taxpayer identifying numbers from health care practitioners and adding such numbers to their published directories.

To facilitate the acquisition of taxpayer identifying numbers, the task force recommends that a reference list of practitioners be developed by IRS from its own records, containing names, addresses, and taxpayer identifying numbers, and made available to carriers and self-insured or self-administered plans in either hard copy

or magnetic tape form. The list would be similar to the one distributed by the Social Security Administration to 'fiscal intermediaries' and 'carriers' administering the Medicare program. The task force believes that the availability of the reference list would be most helpful to carriers in posting missing numbers and in validating the accuracy of provider TIN's furnished on claim forms or payment documents.

Widespread dissemination of physician directories could conceivably be open to misuse. Accordingly, it is suggested that distribution be predicated upon the agreement of a carrier to use the reference list solely in connection with the discharge of its responsibilities under the Internal Revenue Code. It is to be noted that commercial directories of practitioners (without SSN but with considerably more relevant educational and professional data) are already on the market and available to all interested users.

3. Aggregation

Revenue Ruling 69-595 requires aggregation of payments for the purpose of applying information reporting requirements. Aggregation has two purposes: (1) to insure that returns are filed with respect to payees receiving small payments, which in total exceed $600; and (2) to reduce to a minimum the physical volume of documents filed with the IRS.

Questions have been raised as to the extent of aggregation required across a carrier's different lines of business (e.g., life insurance, health and accident insurance, property and casualty insurance) and across different departments within the same line of business (individual policies, group contracts, Medicare, Medicaid, etc.).

There do not appear to be any fundamental technological obstacles to aggregation. However, there are numerous practical difficulties for carriers in meeting this requirement.

For example, one large carrier visited by the task force has autonomous divisions within its home office to process claims: (1) a division which processes all claims from individual insurance policyholders; (2) a division which processes only claims from small group insurance policyholders (covering up to 24 employees); (3) a division which processes claims from certain large group insurance policyholders; (4) several group insurance policyholders are large enough to require the establishment of separate claims operations for those specific policyholders; i.e., a claims division for Company A, a separate claims division for Company B, etc.; and (5) a claims division which processes only the claims incurred under the carrier's own group insurance policy covering its employees.

To aggregate payments made by all such functions might require extensive changes in the current procedures of the carriers, both in their manual and automated data processing

systems. In addition, if payments are aggregated, carriers may have to establish separate records to ascertain administrative expenses by lines of business.

If the likelihood of provider duplication is nonexistent or slight, for example when payment operations are decentralized geographically, no real purpose would be served by company-wide aggregation. In this case, the individual segments could simply be assembled by the carrier and furnished to the IRS under a single transmittal.

Even when there is no geographic segmentation, several carriers indicated that they would prefer to reduce the $600 ceiling in preference to aggregating across lines of business and departments. This could provide reasonable assurance of coverage, but would lay the burden of final aggregation on IRS. The task force believes, however, that as long as the number of such segments is reasonably small, and the information provided is in machinable form, the additional processing burden would be nominal.

The task force recommends the general rule that when a multi-line carrier's operations are combined within a single corporation, payments should be aggregated across all lines of business and departments. However, if the activities are conducted by separate corporations, each corporation should be

defined as an individual carrier and file its own set of information documents.

It is expected that aggregation will be accomplished on the basis of taxpayer identifying numbers, but when the TIN is missing, the aggregation and filing would be on the basis of name and address of the provider.

Payments emanating from two or more departments within the same line of business should be aggregated for the purpose of information reporting. Thus, if a carrier makes health care payments to a practitioner based on claims processed by its (1) individual insurance division; (2) group insurance division; and (3) division processing claims only from company beneficiaries, the carrier should file only one Form 1099 with respect to that practitioner and the return should reflect the combined total of payments emanating from all three divisions.

The task force recognizes that this general rule will work a hardship against carriers whose accounting systems are compartmentalized. Difficulties will also be encountered by those carriers whose various departments are mechanized or automated in different degrees or utilize incompatible equipment. For carriers who find it impractical to comply with the general rule on aggregation, the task force recommends that the following exceptions be provided:

(1) The IRS should waive aggregation across service area boundaries, when the likelihood of duplicate reporting is negligible. For example, a carrier with two accounting centers, one processing all claims associated with states west of the Mississippi River, and the other processing all claims associated with states east of the Mississippi River, could submit two groups of information returns, each with a $600 reporting floor per provider, under one covering Form 1096.

(2) The IRS should accept reports filed along departmental lines with a reduced reporting floor of $100, when (a) the number of separate sets of reports filed by that carrier does not exceed six, and (b) the reports are furnished in the form of magnetic tape conforming with IRS tape reporting specifications.

4. Maintenance of Supporting Records

Carriers should have the capability for providing, upon request by IRS or the provider, itemized backup detail in support of the aggregate amount being reported. The IRS prescribes no explicit schedules for the retention of records and requires simply that they be retained as long as they may be material in the administration of the income tax laws. It is the best judgment of the task force that carriers need not retain backup records beyond three years after the close of the payment year.

The task force anticipates that IRS will request carriers for additional information concerning an information return only in a small number of cases. Providers may request detail when there is a discrepancy between the Form 1099 and the providers' records. Carriers currently filing returns with IRS covering health payments report that the volume of requests from providers for detail has not been high. Based on these considerations, the task force believes that the capability to reconstruct payment detail need not be an elaborate or fully automated procedure. Relatively modest techniques should suffice, for example a system whereby checks or drafts could be listed in provider number sequence, with cross-reference thereon to the original claim associated with the remittance. Frequently the carrier will be able to answer inquiries based on the payment documents, i.e., when the inquiries relate only to the check numbers, dates of payment and amounts paid to a provider. When more detailed information is needed, reference will have to be made to individual claims folders, which will increase the cost and complexity of the retrieval process.

5. Statements to Payees

Although present law does not require carriers to furnish health care providers with copies of information returns or similar statements, the task force recognizes that many payers

do in fact furnish payees with such copies. Although this will undoubtedly increase the cost of the form and the volume of inquiries and requests for reconciliation of amounts reported, the task force believes that voluntary compliance in the reporting of health care payments would be stimulated by the furnishing of such a copy of statement. Also, from a public relations viewpoint, it seems desirable to advise the provider that payments to him have been reported to the IRS. Accordingly, the task force urges carriers to furnish copies of information documents or similar statements to payees.

6. Reporting Year

Interpretative problems may arise with respect to the determination of the payment year for reporting purposes. This is particularly true when payment documents are issued by carriers toward the end of a year.

The task force found that some carriers make payments only by check while others utilize a draft system of payment. There are also carriers which use both types of instruments for their payments. The problem was initially approached by focusing upon the distinction between a check and a draft as to the time of payment. Specifically, a check is payable upon demand; however, a draft is not considered "paid" until it has been presented to the bank and accepted by the carrier upon whom it has been drawn.

Based on this determination, the date of issuance for a check and the date of acceptance of a draft would appear to be the logical time of payment for information reporting purposes. The problem is compounded, however, by the fact that carriers have varying systems and accounting procedures which may restrict their ability to capture payment data in accordance with the above guidelines.

For example, some carriers do not record any data on draft payments until the date of acceptance of the instrument, as that is the date on which the draft payment is charged to their account. Because of their decentralized payment process and self-administered plans, they are unable to capture information on the date the draft is issued. Thus, a draft which is issued in December may not be accepted and charged to the accounts of the carrier until February or March when it is too late to report it for the year in which the draft was issued.

On the other hand, there are carriers whose systems and accounting procedures dictate that they capture the information at the time a payment instrument is issued, regardless of whether it is a check or a draft. For carriers which utilize both check

and drafts in their payment processes, an attempt to distinguish between the two instruments would result in their having to establish one reporting system for checks (date of issuance) and another system for drafts (date of acceptance).

The task force recognizes that both as a matter of law and in the interest of sound tax administration, a uniform rule should apply to the reportability of payments by drafts. However, such uniformity, irrespective of whether keyed to date of issuance or date of acceptance, would impose a heavy cost burden on many of the carriers, and would not materially increase the accuracy of the reports.

It is recommended that as a general rule reporting be keyed to the date of acceptance of the draft but that exceptions be granted to carriers whose systems require that reporting of drafts be geared to the date of issuance.

When checks or drafts are issued near the end of the year, there will be discrepancies between the year in which the carrier reports the payment and the year in which the provider reports the income. However, these discrepancies are also found in other information reporting areas and are unavoidable.

VIII. DISCUSSION OF THE REPORTING OF UNASSIGNED PAYMENTS

A. Background

1. General

As previously stated in this report, Revenue Ruling 69-595 requires a carrier to file an information return with the Internal Revenue Service when assigned payments to a provider total $600 or more in a calendar year. The Senate Finance Committee has proposed that carriers should not limit reporting to assigned payments but should also file information reports with respect to unassigned payments; i.e., payments made to insured individuals or other third parties, in reimbursement of amounts paid or payable to a provider or supplier of medical and health care services or goods. */ In other words, a carrier would have to identify all providers whose bills for health services entered into the unassigned payment determination; ascertain the amount of every unassigned payment attributable to each provider; record and store this information, and annually provide reports in each case where the aggregate amount of assigned and unassigned payments for a provider exceeds $600.

In conjunction with its study of the implications of filing information reports on assigned payments, the task

---

*/ Senate Report No. 91-552. See Appendix D.

force was requested to also identify and discuss the problems which would be encountered if legislation prescribing the reporting of unassigned payments were enacted. The analysis of the task force was not directed specifically to the provisions of the Senate Finance Committee proposal, but rather to the general concept of reporting unassigned payments.

Virtually all of the problems inherent in assigned payment reporting, and hence the recommendations covered in the previous section also apply to unassigned payments and will not be repeated in this section of the report.

2. Origins of Unassigned Payments

As previously defined, an unassigned payment is a payment by a carrier to any person in reimbursement of amounts paid or payable by that person to a provider for health care services. Basically, unassigned payments are made to either (1) subscribers or policyholders; (2) beneficiaries of insured persons; or (3) third-party claimants. The term "claimant" will be used hereafter to refer to any person entitled to receive such unassigned payments.

Under most types of health insurance policies or contracts, unassigned payments consist solely of reimbursement for health care expenses incurred by claimants. However,

under automobile, homeowner's and other liability insurance policies, the unassigned payment may include reimbursement not only for health care expenses, but property and other losses as well. The unique problems involved in an information reporting system encompassing these types of payments are discussed in subsection F.

In order to properly evaluate the impact of an information reporting requirement relative to unassigned payments, it was necessary for the task force to examine the systems and procedures utilized by carriers for the processing of this type of claim. The proof of a claim generally consists of a statement from the claimant, a report of an attending physician and the bills or itemized statements of each provider rendering services. Frequently, under major medical policies and contracts, an insured individual may accumulate bills over a period of time and make a single consolidated submission to the carrier.

The carrier must review the claim to determine which services were performed, which of these services were covered by the specific policy or contract, and the amount of benefits allowed for those services. Some contracts or policies specify that benefits may only be paid to the provider or his assignee. Most of the policies of commercial insurance

companies provide that payments are to be made to the named insured; however, companies will honor and accept an assignment to pay the provider. Therefore, the carrier must process each claim to determine whether such assignments have been made, and calculate the amount payable under the contract or policy to the claimant or the assignee, if any.

For example, a carrier may receive a claim which contains the bills of five different providers and make a single payment to the claimant covering the entire claim. In some instances, one or more of these providers may be entitled to an assigned payment. A check or draft would be issued by the carrier to each provider to whom assignment has been made, in the amount payable for his services. This constitutes an assigned payment. The remaining amount payable on that claim would be paid in a check or draft to the claimant, and constitutes an unassigned payment.

B. Taxpayer Identification

1. Taxpayer Identifying Number Requests

The difference between an assigned payment and an unassigned payment has important consequences with respect to the methods the carrier can employ in securing the taxpayer identifying number (TIN) of the provider. Since,

unlike in the assigned payment situation, a direct contact between the carrier and the provider is lacking, the carrier cannot obtain the TIN as a by product of the payment process. As a result, there is a serious question whether recommendation number 10 (see page 8), that the presence of a field for the TIN on an assignment form or proof of loss form constitutes a request for the number, could be made to apply to unassigned payments. The only person in a position to request the provider's TIN would be the claimant who has no legal obligation to do so. Moreover, it would be impractical to impose this responsibility upon him.

If the TIN's are not provided with the claim, the carriers would have to either: (1) initiate special requests to practitioners, and possibly maintain suspense records while awaiting responses; or (2) obtain the TIN's of providers from their previously established records or from reference lists which may be provided by the IRS or through commercial directory sources (see recommendations 11 and 12, page 9).

One of the primary considerations of carriers is that the method to obtain provider TIN's must avoid either a delay in the benefit payment to the claimant or any disruption in the claims processing flow. A method which requires the carrier to request the TIN could delay claims processing. It could

also result in a multiplicity of correspondence between carriers and providers. In addition, it would probably be ineffective because of the lack of direct involvement between the provider and the carrier.

As a result, carriers should not be required to request TIN's from providers in connection with unassigned payments. The most feasible alternative appears to be for carriers to extract provider TIN's from their own previously established records or from reference lists which may be provided by the IRS or other commercial directory sources that might be readily available.

2. Unknown Provider

Sometimes payment is made to a claimant in reimbursement of medical expenses even though the carrier is not given information as to the identity of the specific health care practitioner who rendered the service. For example, this can occur with respect to complementary or supplementary Medicare coverages provided by the carriers for the medical expenses not paid by Medicare. In these instances, evidence of the claim is the submission of an Explanation of Benefits Form which has been given the insured by the Medicare "intermediary" or "carrier" and is the basis upon which the carrier

makes payment to the insured. This form contains an itemization of the services, the charges, and the payment made by that intermediary or carrier for health care benefits covered by Medicare but may not include the identity of the provider.

There are occasions when a bill will be submitted to a carrier which emanates from a group of practitioners, which does not identify the actual provider who has been or will be reimbursed by the policyholder. Without special correspondence and considerable disruption in operating procedures, there would be no mechanism by which a carrier could obtain the actual provider's identification for reporting purposes. This problem could be mitigated by the fact that the group of practitioners may be a partnership or corporation and will have been assigned an EIN, which is ascertainable by the carrier.

When the amount involved is small, a property and casualty insurance company may attempt to settle a case by telephone, without requiring the claimant to submit medical bills or identify the provider. One large carrier estimated that seventy percent of its claims, representing over forty percent of its medical payments and third party liability disbursements, were handled in this manner.

Another example of the unknown provider situation is in the payment up to the limit of a medical payment or third party liability policy. If it is obvious to the carrier that a claim will exceed the limits of the policy, it may make payment without requiring the claimant to identify any providers.

The question is whether the carrier, in such cases, must require that claimants identify the practitioners. Obviously, this would impose burdens on both parties.

The task force is of the opinion that if in its normal course of business a carrier does not require the specific identity of the health care provider who rendered the service, the carrier should not be obliged to file information returns with respect to such payments.

C. Determination of Reportable Amount

1. Reimbursement Method

The reporting of unassigned payments could be accomplished by some formula of allocation or proration of the amount paid to the insured, based upon the different provider bills covered by that payment. This is the approach taken in the Senate Finance Committee proposal, and will be termed the "reimbursement method" in this report. This "reimbursement method" would require an intricate and complex procedure

not only because of the potential number of providers reflected in the payment, but also because of the existence of deductibles, coinsurance, maximum schedules of payment, fee schedules, and the corridors between basic and major medical expense policies.

The following examples will illustrate the difficulties involved:

Example 1 -- Provider bills submitted to a carrier on a particular claim total $500 and cover the services of five physicians whose respective charges are $200, $150, $80, $50, and $20. Assuming a $100 deductible and a 20 percent coinsurance feature, the carrier will pay the insured $320. How should this be allocated among the five service providers?

Example 2 -- Provider bills submitted to the carrier total $1,500 and relate to several physicians. However, the maximum liability under the policy for the service provided is $500, which is the amount paid to the policyholder. How should the $500 be treated for information reporting purposes?

Example 3 -- Under an automobile insurance policy the medical payments coverage has a $1,000 limit. A claimant involved in the car in a serious accident may very well incur several provider bills (within

the year's limitation) totaling $1,800. Also, a hospital bill may be submitted for $800. The carrier will forthwith issue a draft for $1,000. The difficulty of any logical allocation is obvious.

Example 4 -- A policyholder or subscriber who has major medical coverage (with a $100 deductible and an 80 percent - 20 percent coinsurance factor) undergoes surgery and submits a major medical claim with the following provider bills attached -- hospital: $1,000; surgeon: $500; anesthesiologist: $75; drugs: $30; private duty nurses: $200.

How is the $100 deductible allocated among the various providers for reporting purposes? Is it based on the dollar amount of the bills or the number of providers? Assuming it is based on the number of providers, a $20 deductible would be applied to each of the five providers. On an 80 percent payment to the policyholder or subscriber, this would amount to -- hospital: $784; surgeon: $384; anesthesiologist: $44; drugs: $4; and private duty nurses: $144.

Example 5 -- The insurance coverage provided in the following example is termed "Corridor Major Medical." This means certain specified charges are reimbursed

on a fee schedule basis with the remaining charges being subject to a deductible and coinsurance.

Provider bills submitted to the carrier total $1,500 and relate to several physicians, hospitals, ambulances, and pharmacies. The maximum basic plan liability is $1,000 which relates only to one physician's charge and the hospital charge. The unpaid portions of these physician and hospital charges and remaining charges are subject to a deductible and coinsurance for a further payment of $320.

Should the total payment of $1,320 be allocated separately to each provider or should it be allocated according to the percentage allocated of the deductible to the remaining charges after basic benefits have been considered?

Based on these illustrations, it is apparent that any allocation formula devised, based on the carrier reimbursement, would necessarily be arbitrary, and could create wide discrepancies between the actual receipts of providers and amounts reported on information returns.

2. Billed Amount Method

An alternative might be to key the unassigned payment reporting system to billed amounts (i.e., the charges appearing on the bills of providers which are submitted to a carrier

by a claimant) rather than an allocation of the reimbursement amounts. From an operational standpoint, this would have the advantage of reducing the costs and difficulties carriers would incur in capturing unassigned payment information.

This method, however, would require a departure from the present concept of information reporting from a system which is based on an actual payment to a reporting of the data utilized in determining a payment.

There is no currently available data as to whether the billed amount method or the reimbursement amount method is more likely to yield payment information approximating the actual income of a provider. There are many occasions in which a claimant may pay the full amount of the provider's bill and then seek reimbursement from a carrier, in which case the billed amount would have validity and would be the more accurate amount to report to the IRS.

On the other hand, a carrier administering a usual, customary, and reasonable charge program, such as Medicare, may determine that the billed amount is beyond the customary charge of that provider for that service and issue a payment to the claimant based on a lower amount. The claimant may then seek and possibly receive a reduction in the original charge of the provider. In this case, the reimbursement amount would be the more accurate amount to report.

Finally, the claimant may not pay the provider even though the bill has been reimbursed by the carrier, or he may pay only a portion of the billed charges.

In the absence of data, it would appear logical to use whichever of these two methods is simpler for the carrier to implement. This appears to be the billed amount method. However, no reporting should be required under this method in any case where the carrier denies the claim or for any other reason does not make payment to the claimant.

3. Multiple Coverage

Duplicate or multiple coverage of insured individuals has been a matter of concern for a number of years to the insurance industry because it can produce a greater aggregate benefit amount than the actual medical expenses paid or incurred by insureds. The existence of multiple coverage is a matter of concern with respect to unassigned payment reporting because it tends to inflate reported income.

These multiple coverages can result from a number of circumstances, including the following:

a. Employment of both husband and wife with each being covered under a group insurance contract that includes the other spouse as a dependent.

b. Coverages brought about by other forms of dual circumstances, such as:

(1) Group coverage at place of employment and also through a professional organization.

(2) A covered dependent insured at school or camp.

c. Employment of one person by more than one employer having a group insurance program.

d. A desire to supplement with additional coverage an already existing group coverage or previously owned individual policy.

e. Medical payments coverage under automobile and home-owners policies which duplicate other health insurance coverages.

It has been estimated that 31.1 million persons enrolled in private health insurance programs carry multiple or duplicatory coverages for surgical services; 12.2 million for inhospital visits; 6.6 million for X-ray and laboratory examinations, and 4.1 million for office and home visits. */

Many group policies and contracts provide for a coordination of benefits under which payment of full benefits under the policy is made by the carrier whose policy is

---

*/ Derived from "Private Health Insurance, 1968; Enrollment, Coverage, and Financial Experience." Social Security Bulletin, December 1969, Vol. 32, No. 12.

determined as providing primary coverage and the secondary carrier pays the balance of any other covered medical expenses incurred but not covered under the primary carriers policy.

Under the reimbursement method, when primary and secondary coverage situations are in effect, both carriers would have to capture data relating to such payments. Under a billed amount system it would appear that only the primary carrier need capture the amount of the charge of the provider for reporting purposes. In those cases where carriers cannot ascertain who is primary or secondary and in those group cases where there is no coordination of benefits provision, and in the case of individual policies where there is never a coordination of benefits provision, the reporting will always be duplicative.

When there is a clear indication that a claimant has been reimbursed by another carrier, the data need not be captured by the secondary carrier for reporting purposes.

Therefore, the existence of multiple coverage would inevitably result in frequent duplication in the reporting of unassigned payments, regardless of the reporting system utilized. It would be difficult for the carrier, the provider, or the IRS to detect or reconstruct the resulting discrepancies in the reported information.

4. Determination of Reportable Year

Another factor affecting the accuracy of unassigned reporting is the time lapse between the date of the payment by the carrier to the claimant and the date of the payment to the provider. An even greater span of time can elapse between the date the claimant may pay the provider and the date he submits his claim for reimbursement to the carrier. Many claimants will accumulate medical bills for extended periods of time, even years in some instances, beyond the date on which initial medical services were rendered. Because of this telescoping feature, the reimbursement by the carrier and the actual payment to the provider by the insured may occur in different taxable years. This is compounded by the fact that many individuals, even though they have been reimbursed in full by a carrier, will pay their provider on the basis of time payments which could span taxable years.

Since there does not appear to be any possibility of keying information reporting of unassigned payments to the year the provider actually received the income, the reporting of unassigned payments will inevitably cause discrepancies between information returns and tax returns, regardless of whether reporting is based on the date of billing, the date of the claim, or the date of payment by the carrier. Therefore, it would appear that the matter should be resolved on the basis of practicability, gearing reporting to the date of payment by the carrier.

D. Systemic Implications

For purposes of reporting either assigned or unassigned payments, carriers would have to extract and retain information derived from their records, both for the purpose of developing annual information reports to the IRS, and to substantiate such reports in the event of inquiry from the IRS or providers. Assigned payment reports can generally be derived from payment records retained by carriers for other purposes; however, unassigned payment reporting would necessitate the establishment of records and files not now required by the carriers in their regular business operations. In effect, the data relating to each provider involved in an unassigned claim would have to be treated as though that provider had received an assigned payment.

Thus, the additional record-keeping responsibility would have several dimensions:

1. A new file would have to be established and maintained.
2. Several unassigned payment transaction records would have to be generated for each unassigned payment because on the average, there are several providers involved in an unassigned claim.
3. Because it can be anticipated that TIN's would be available less frequently, more voluminous information might have to be captured and stored than would otherwise be required.

4. If copies of unassigned payment reports are sent to providers, it can be anticipated that these would generate a high volume of inquiries from providers unable to reconcile the reported amount with their own records. To forestall this, carriers could provide a detailed listing with each report, identifying each of the claimants involved, the dates the claims were processed, etc. However, this would increase the cost and complexity of reporting. Even so, the discrepancies between the unassigned payment reports and provider records (whether based on the billed amount method or the reimbursement amount method) would be difficult to reconcile.

Since assigned payment reporting is based on actual payments, the capturing of data for reporting purposes would be a by-product of other processes. However, the capturing of data for reporting unassigned payments would require that technically qualified personnel review each claim to capture the necessary data. This process poses a further dilemma for the carriers. While it would be more expeditious from a reporting standpoint to capture such information during the claims process, this would run the risk of imposing delays in the payment process.

Expeditious claim processing and payment is a contractual matter, and is generally a competitive aspect of carrier services, as well as being required as a matter of public policy by the States. Hence, it is likely that carriers would have to resort to the less attractive alternative of capturing unassigned data for reporting purposes after the fact.

E. Aggregation and Reporting

Although the storage, processing, and aggregation of unassigned payment data and assigned payment data would be essentially similar, the disparities in the two types of information suggest that they should not be combined into a single aggregated amount on an information return. The maintenance of two files would not in itself pose an operational problem, but the need to coordinate them to determine whether the reporting floor had been met or exceeded might introduce systemic complexities, especially in the light of the possible incompatibilities in the manner in which the two kinds of files would be maintained and the exceptions to aggregation proposed in Section VII.

Also, to be considered is the dissimilarity between the two amounts. Assigned payment reports represent amounts actually paid to providers, whereas unassigned payment reports are at best an indication of amounts paid or payable to providers.

These systemic and interpretative difficulties would be avoided if no attempts were made to aggregate assigned and unassigned payments, even for purposes of determining whether the reporting floor were met. Accordingly, it is suggested that the reporting floor be determined independently for assigned and unassigned payment reporting.

Although the two types of payments should be separately aggregated, there would appear to be systemic advantages in reflecting them on a single return, whenever both types of payments are reportable with respect to the same service.

F. Unique Problems Relating to Third Party Liability Payments

Conceptually a reporting system would cover not only health care payments paid under health insurance contracts, but health care payments made under property and casualty contracts as well. Potentially subject to reporting are three types of payments: (1) workmen's compensation; (2) medical payments under an automobile or homeowner insurance policy; and (3) third-party liability payments disbursed as an integral part of a tort claim against an insured. The first type of payment is generally assigned; thus, the reporting problems have been covered in Section VII. The second type is usually unassigned but has been covered in prior sections. The third type, also unassigned, has unique problems which merit special consideration.

It is an adjuster's responsibility to collect all of the facts which surround an accident, to form the basis of a sound judgment as to whether or not the insured was the negligent party. Based upon his investigation, the adjuster comes to one of three conclusions:

1. The insured was clearly negligent and the insurance company owes the claimant a monetary recovery.
2. The insured was clearly not negligent and the insurance company owes the claimant nothing.
3. The facts to this point do not paint a clear picture as to liability and the claim is one of doubtful or dubious liability.

In the case of 2. and 3., if the claimant feels the adjuster is in error, he may hire an attorney to pursue the case by suit or compromise. With respect to 1. the claimant has this course open to him if he feels the company is unrealistic in its assessment of his damages. Usually, the attorney's fee is a specified portion of the final settlement.

In either of the several possibilities, the next step is the determination by the carrier of "special" and general damages. "Special" or "out-of-pocket" or known expenses of claimants include bills from providers, bills for prosthetic devices and drugs, damage to the claimant's automobile, and the loss of wages due to the accident. The "general" or unspecific portion

of the claim includes "pain and suffering," loss of consortium and possible disfigurement or disability.

On large bodily injury claims, much emphasis is placed upon the nature and extent of the injuries claimed. The carrier will generally require full medical reports from all of the health care practitioners who have treated the injured party, copies of hospital and medical bills, and other statements necessary to the completion of the claim. The carrier does not inquire into (nor does it bear on the efficient and accurate processing of the claim) whether the bills received have been or will be paid by another carrier or whether the health care provider will eventually receive any payment from the insured. The only concern of the carrier is whether the claimant did incur such injuries. In many instances, in fact, medical bills are accepted as evidence which are clearly marked "paid" by another carrier.

At this point, the carrier will enter into negotiations with the claimant or his representative starting with the base of the "special" damages to reach a settlement figure. The final dollar figure is reached either by negotiated settlement or by jury award, and one draft is issued in full and final payment for all damages, without any specific determination of the amounts with respect to general or special damages. The draft is made out to the claimant or jointly to the claimant and his attorney.

In many instances the case is one of doubtful liability. A claimant may have "specials" (medical bills, etc.,) of $2,500, and were liability unquestioned, would be entitled to settlement of perhaps $4,500. However, because of doubtful liability the parties may agree to settle for lesser amounts (for example, $2,000), to cover all special and general damages. Thus, the problems of determining the health care payments would be compounded.

Interpretative and procedural difficulties will be encountered therefore, irrespective of whether the billed amount method or the reimbursement method is used as a basis for capturing information needed for reporting.

Third party liability payments are so different in kind from other types of health care payments and pose such vexing problems of interpretation and implementation that their exclusion from reporting would appear to be justified.

IX. ESTIMATED VOLUMES AND COSTS

Industry representatives have provided selected statistics relating to the information reporting of health care payments which are presented in Table 1. These estimates are based on a reporting system which follows the findings and recommendations contained in the previous sections of this report. The data were derived from published sources where available, and otherwise from surveys of carriers considered by the industry associations to be representative of the respective industries. Due to limitations of time, the task force did not secure data relating to health care payments by self-insured, self-administered plans and by group practice plans.

TABLE 1

Estimated Annual Health Care Payment Amounts, Work Volumes, and Reporting Costs by Type of Carrier (all data in millions)

Payment Information	Annual Health Care Payments					
	Blue Cross and Blue Shield Contracts (b)		Property and Casualty Insurance Policies (f)		Health Insurance Policies (e)	
	Assigned	Unassigned	Assigned	Unassigned	Assigned	Unassigned
1. Number of claims to be recorded for information reporting purposes	39.0	41.0	0.1	2.5	19.0	55.0
2. Amount of health care payments	$ 6,813.5	$ 830.6	$10.0	$105.0	$900.0	$1,500.0
3. Amount reportable on information returns	$ 2,500.0	$ 600.0	$ 1.0	$ 10.0	(d)	(d)
4. First year costs	$ 5.0(a)	$ 24.5(c)	$ 0.25(g)	$ 13.8(c)(g)	$ 17.6	$ 33.0(c)
5. Subsequent year costs	$ 5.0	$ 24.0(c)	$ 0.25	$ 13.8(c)	$ 4.7	$ 27.5(c)

Sources: Data for Blue Cross and Blue Shield supplied by Blue Cross Association and National Association of Blue Shield Plans; data for Property and Casualty Insurance supplied by National Association of Independent Insurers; data for Health Insurance supplied by Health Insurance Association of America.

Footnotes

(a) Information returns are already being filed; thus, no start-up costs would be incurred.
(b) In view of recommendation 4 (see page 7), these estimates exclude payments made under Medicare (Title XVIII), Medicaid (Title XIX), and CHAMPUS programs to hospitals, extended care facilities, and home health agencies.
(c) Reflects an expected increase in difficulty in capturing and reporting unassigned versus assigned payments, due to difficulties in securing provider TIN's, determining reportable amounts, etc. Also assumes reporting of unassigned payments separately from assigned payments. Data unavailable as to frequency with which unassigned and assigned reports would be made with respect to same provider by same carrier.
(d) Data unavailable on which to base estimate of reportable amounts; i.e., amounts above reporting floor.
(e) Data somewhat understated because of inclusion of only surgical and medical benefit payments; and also because some of the carriers surveyed as basis for projections participate in Medicare and Medicaid but did not include in their reports data pertaining to these programs.
(f) The data presented applies only to medical payments in connection with automobile insurance policies.
(g) Start-up costs unavailable.

Technical Information Release

APPENDIX A

Internal Revenue Service
Washington, DC 20224
Tel. (202) WO 4-4021

For Release: Immediate
November 13, 1969

TIR-1023

The Internal Revenue Service today announced that the following Revenue Ruling will be published in the Internal Revenue Bulletin No. 1969-48, dated December 1, 1969.

SECTION 6041.--INFORMATION AT SOURCE

26 CFR 1.6041: Return of information as to payments of $600 or more. Rev. Ruling 69-595

Advice has been requested whether payments made to suppliers of services under health, accident, and sickness insurance plans or medical assistance programs are required to be reported on information returns, Forms 1099 and 1096, under the provisions of Section 6041 of the Internal Revenue Code of 1954 and the regulations thereunder.

Those making payments include insurance companies (including those participating in Medicare), Blue Cross-Blue Shield organizations, State agencies participating in the Medicaid program (Title XIX of the Social Security Act), and unions and employers having self-insured or self-administered plans.

Medicaid is a State-administered assistance program providing medical care for the needy, under which payments are generally made by a single State agency administering the program or its fiscal agent directly to the supplier.

Generally, health, accident, and sickness insurance policies provide that the amounts payable thereunder are payable to the insured unless the insured assigns his rights to receive payments to those persons who supplied the medical services. In many cases the insured assigns his rights to receive payment to the doctor and payment is made directly to the doctor.

Section 6041(a) of the Code provides, in part, that all persons engaged in a trade or business and making payment in the course of such trade or business to another person, of rent, salaries, wages, premiums, annuities, compensations, remunerations, emoluments, or other fixed or determinable gains, profits, and income, of $600 or more in any taxable year, shall render a true and accurate return to the Secretary of the Treasury or his delegate, under such regulations and in such form and manner and to such extent as may be prescribed by the Secretary or his delegate, setting forth the amount of such gains, profits, and income, and the name and address of the recipient of such payment.

Section 1.6041-1(a) of the Income Tax Regulations provides that the return required by section 6041(a) must be made on Forms 1099 and 1096, and a separate Form 1099 shall be furnished for each person to whom such payments of $600 or more are made. Section 1.6041-1(b) of the regulations provides that the term "all persons engaged in a trade or business," as used in section 6041(a) includes not only those so engaged for gain or profit, but also organizations the activities of which are not for the purpose of gain or profit. See also Rev. Rul. 56-176, C.B. 1956-1, 560.

Section 1.6041-3 of the regulations provides that returns of information are not required with respect to payments of any type made to corporations.

Payments of fees under the plans, programs, or policies here considered to doctors or other suppliers of health care services are made in the course of the trade or business of the persons making the payment. Accordingly, it is held that such persons are required to file Forms 1099 with respect to such payments made directly to doctors or other suppliers. A separate Form 1099 must be furnished by each payer for each doctor or other supplier to whom it makes payments aggregating $600 or more during any calendar year. Pursuant to section 1.6041-3 of the regulations payments to corporations are excepted from the information reporting requirements of section 6041 of the Code.

Under the authority of Section 7805(b) of the Code, this ruling will be applied only to payments made in calendar years beginning on and after January 1, 1969. Since most of 1969 has passed, the Service recognizes that some payers will have problems in establishing accounting systems or procedures for retrieving and reporting information with respect to amounts paid during 1969. Payers whose accounting systems and procedures are not geared to retrieving and reporting this information for 1969 will not be required to file information returns for 1969 provided they file such returns with respect to payments made on and after January 1, 1970.

The Service would prefer that the returns required by this Revenue Ruling be filed in magnetic tape form. The procedural requirements and specifications for magnetic tape reporting are set forth in Rev. Proc. 69-16, I.R.B. 1969-34, 25. Whether filed on paper, Form 1099, or on magnetic tape, the returns should be forwarded on or before the due date (for example, March 2, 1970 with respect to calendar year 1969 returns) for filing to any of the following addresses:

Southeast Region, P. O. Box 47-421, Doraville, Ga., 30340
Midwest Region, P. O. Box 5321, Kansas City, Mo., 64131
Central Region, P. O. Box 267, Covington, Ky., 41012
Southwest Region, P. O. Box 934, Austin, Texas 78767
North-Atlantic Region, P. O. Box 311, Andover, Mass., 01810
Mid-Atlantic Region, P. O. Box 279, Cornwells Heights, Pa., 19020
Western Region, P. O. Box 388, Ogden, Utah, 84401

# # #

~~The amendment made by subsection (b) shall apply with respect to deposits the time for making of which is after December 31, 1969.~~

SEC. 911. REPORTING OF MEDICAL PAYMENTS.

(a) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with other persons) is amended by adding after section 6050 (as added by section 121(c)) the following new section:

"SEC. 6050A. RETURNS REGARDING PAYMENTS TO SUPPLIERS OF MEDICAL AND HEALTH CARE SERVICES AND GOODS.

"(a) REQUIREMENT OF REPORTING.—Every person who during any calendar year—

"(1) makes any payment to a supplier of medical and health care services or goods for medical and health care services or goods rendered, furnished, or dispensed to an individual by such supplier or by another such supplier, or

"(2) makes any payment to any person in reimbursement for amounts paid or payable to a supplier of medical and health care services or goods for medical and health care services or goods rendered, furnished, or dispensed to an individual by such supplier or by another such supplier,

shall, if the aggregate amount of the payments described in paragraph (1) or (2) made during the calendar year to, or in reimbursement of amounts paid or payable to, such supplier is $600 or more, make a return according to the forms or regulations prescribed by the Secretary or his delegate, setting forth the total amount of the payments described in paragraph (1) made to such supplier during the calendar year, and the total amount of the payments described in paragraph (2) made during the calendar year in reimbursement for amounts paid or payable to such supplier, and the name and address of such supplier.

"(b) EXCEPTIONS.—Subsection (a) shall not apply to—

"(1) any payment by an individual for medical and health care services or goods rendered, furnished, or dispensed to himself or any other individual (other than any such payment made in the course of a trade or business),

"(2) any payment of wages (as defined in section 3401(a)) with respect to which a statement is made under section 6051,

"(3) any payment to an organization—

"(A) which is described in section 501(c)(3) and is exempt from taxation under section 501(a), or

"(B) which is an agency or instrumentality of

the United States or of any State or political subdivision thereof,

"(4) any payment for goods or services dispensed or supplied by a noninstitutional pharmacy,

"(5) any payment to an individual by his attorney or agent made with respect to medical and health care services or goods, rendered, furnished, or dispensed to such individual or any other individual, or

"(6) any payment made by any person with respect to which a return is made by any other person.

In the case of any payment in settlement of a claim which includes reimbursement for amounts paid or payable to a supplier of medical and health care services or goods, subsection (a)(2) shall apply to such payment only to the extent that such amounts paid or payable have been separately identified to the person making such payment.

"(c) TREATMENT OF CERTAIN DEDUCTIBLE AMOUNTS.—For purposes of subsection (a)(2), if—

"(1) a single payment is made to any person in reimbursement for amounts paid or payable to two or more suppliers of medical and health care services or goods,

"(2) such payment is less than the amounts paid or payable to such suppliers by such person, and

"(3) such payment does not separately state the amount paid in reimbursement of the amount paid or payable to each such supplier,

such payment shall be treated, under regulations prescribed by the Secretary or his delegate, as made proportionately in reimbursement for the amount paid or payable to each such supplier.

"(d) RETURNS BY GOVERNMENT OFFICERS.—Any return required under subsection (a) with respect to payments made by the United States, any State or political subdivision thereof, or any agency or instrumentality of the foregoing, shall be made by the officers or employees having information as to such payments.

"(e) DEFINITIONS.—For purposes of this section.—

"(1) MEDICAL AND HEALTH CARE SERVICES AND GOODS.—The term 'medical and health care services or goods' means—

"(A) services and goods described in paragraphs (1) through (9) of section 1861(s) of the Social Security Act, or in paragraphs (1) through (15) of section 1905(a) of such Act,

"(B) dentist's services and dental prosthetic devices, and

"(C) such other services and goods (similar

or related to the services and goods described in subparagraphs (A) and (B)) as the Secretary or his delegate may prescribe by regulations.

"(2) SUPPLIER OF MEDICAL AND HEALTH CARE SERVICES OR GOODS.—The term 'supplier of medical and health care services or goods' means any person who—

"(A) renders or furnishes to individuals any medical and health care services described in paragraph (1), or

"(B) furnishes, dispenses, sells, or leases to individuals any medical and health care goods described in paragraph (1).

"(f) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS FURNISHED.—Every person making a return under subsection (a) shall furnish to each person whose name is set forth in such return a written statement showing—

"(1) the name and address of the person making such return, and

"(2) the total amount of payments described in subsection (a)(1) to the person as shown on such return, and the total amount of payments described in subsection

(a)(2) in reimbursement of amounts paid or payable to the person as shown on such return.

The written statement required under the preceding sentence shall be furnished to the person on or before January 31 of the year following the calendar year for which the return under subsection (a) was made.

"(g) RETENTION OF RECORDS.—Every person making a return under subsection (a) shall—

"(1) retain the records and other documents relating to the payments with respect to which such return is made for such time as the Secretary or his delegate prescribes by regulations, and

"(2) make such records and documents available to the Secretary or his delegate whenever in the judgment of the Secretary or his delegate such records and documents are necessary to the determination of the tax imposed on any person under subtitle A."

(b) CLERICAL AND CONFORMING AMENDMENTS.—

(1) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end thereof the following new item:

"Sec. 6041A. Returns regarding payments to suppliers of medical and health care services and goods."

(2) Section 6041(a) (relating to information at source) is amended by striking out "or 6019(a)(1)"

and inserting in lieu thereof "6049(a)(1), or 6050A (a)".

(3) Section 6652(a) (relating to failure to file certain information returns) is amended--

(A) by striking out "or" at the end of paragraph (2);

(B) by inserting "or" at the end of paragraph (3);

(C) by inserting after paragraph (3) the following new paragraph:

"(4) to make a return required by section 6050A(a) (relating to reporting payments made to suppliers of medical and health care services and goods) with respect to payments to, and in reimbursement of amounts paid or payable to, a supplier of medical and health care services and goods,"; and

(D) by striking out "(2) or (3)" and inserting in lieu thereof "(2), (3), or (4)".

(4) Section 6678 (relating to failure to furnish certain statements) is amended—

(A) by inserting "6050A(f)," before "or 6052 (b)"; and

(B) by inserting "6050A(a)," before "or 6052 (a)".

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a) and (b) shall apply with respect to payments made on or after January 1, 1970.

(2) CALENDAR YEAR 1969.—Section 6050A of the Internal Revenue Code of 1954 (as added by subsection (a)) shall apply to payments made during the calendar year 1969 under titles V, XVIII, XIX of the Social Security Act.

(3) TIME FOR RETURNS.—In the case of payments made during calendar year 1969 to which such section 6050A applies, the time for filing returns required under subsection (a) of such section and for furnishing statements under subsection (f) of such section shall be the last day of the fourth month which begins after the date of the enactment of this Act.

(4) EXISTING AUTHORITY.—The amendments made by this section shall not be construed to affect the authority of the Secretary of the Treasury or his delegate under section 6041 of the Internal Revenue Code of 1954 with respect to payments to suppliers of medical and health care services or goods made during any period before the provisions of section 6050A of such Code (as added by subsection (a)) become applicable to

such payments under paragraphs (1) and (2) of this subsection.

(d) AMENDMENT TO SOCIAL SECURITY ACT.—

(1) KEEPING OF RECORDS REGARDING MEDICARE AND MEDICAID PAYMENTS.—Title XI of the Social Security Act is amended by adding after section 1121 the following new section:

"RECORDS WITH RESPECT TO MEDICAL AND HEALTH CARE ITEMS AND SERVICES

"SEC. 1122. (a) It shall be the duty of the Secretary to compile, keep, and maintain, such records as may be necessary accurately to indicate—

"(1) the identity (by name, address, medical or health care specialty, and such other identifying criteria as may be appropriate) of each person who, during the calendar year, furnishes medical or health care items or services to any individual and the number of individuals to whom such items or services were furnished by such person during such year, if all or any part of the cost or charge attributable to the provision of such items or services is payable under a program established by title XVIII or under any program or project under or established pursuant to this title, title V, or title XIX; and

"(2) with respect to each person referred to in paragraph (1), the aggregate of the amounts of the costs or

charges attributable, under each program or project referred to in such paragraph, to medical or health care items or services furnished, during the calendar year, by such person to individuals under such programs and projects (including, in the aggregate amount of costs or charges so attributable, the amounts paid to individuals by reason or on account of the furnishing by such person of such items or services to such individuals).

"(b)(1) In order to carry out the provisions of subsection (a), the Secretary shall require persons, agencies, or agents (including carriers and intermediaries utilized under title XVIII and fiscal agents and insurers utilized under any program established under or pursuant to title V or XIX) administering, or assisting in the administration of, any program or project referred to in subsection (a)(1) to collect, and submit to the Secretary at such time or times as the Secretary may require, such data and information as the Secretary may deem necessary or appropriate. Such persons, agents, carriers, intermediaries, fiscal agents, and insurers shall utilize, in supplying the data and information provided for in the preceding sentence, the identifying numbers required under paragraph (2) as the basic means of identifying persons referred to in subsection (a)(1).

"(2) The Secretary shall require, for purposes of identifying the persons referred to in subsection (a)(1), the cu-

ployment of the identifying numbers utilized on returns required with respect to payments to such persons pursuant to section 6050A of the Internal Revenue Code of 1954.

"(c)(1) The Secretary shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to each calendar year, beginning with the calendar year ending December 31, 1969, a report indicating the name, address, and medical or health care specialty of each person who, during such year, furnished medical or health care items or services to individuals the costs of or charges for which give rise to payments under one or more of the programs or projects referred to in subsection (a)(1) of $25,000 or more. Such report shall indicate the amount of payments under each of such programs or projects attributable to such items or services furnished during such year by each such person and the number of individuals to whom such items or services were furnished by such person during such year.

"(2) Such report for the calendar year ending December 31, 1969, shall be submitted not later than June 30, 1970, and such report for each succeeding calendar year shall be submittal not later than June 30 of the following calendar year."

(2) EFFECTIVE DATE.—The amendment made by

paragraph (1) shall be effective with respect to calendar years beginning after December 31, 1968.

Technical Information Release

APPENDIX C

Internal Revenue Service
Washington, DC 20224
Tel. (202) WO 4-4021

For Release: Immediate
Dec. 31, 1969

TIR-1026

The Internal Revenue Service today announced that, except for payments made under the Medicare and Medicaid programs, the provisions of Revenue Ruling 69-595, I.R.B. 1969-48, 11, relating to information returns, will not be applied with respect to payments made prior to January 1, 1971.

The IRS said that this action is being taken to provide further time for the joint consideration by the IRS and the insurance industry of systems and procedures for retrieving and reporting information necessary to the preparation of these information returns.

# # #

APPENDIX D

EXCERPT FROM SENATE REPORT NO. 91-552 RE SECTION 944

4. REPORTING OF MEDICAL PAYMENTS (SEC. 944 OF THE BILL, SEC. 6050A OF THE CODE, AND SEC. 1122 OF TITLE XI OF THE SOCIAL SECURITY ACT)

Present law.—Under present law every person making payments in the course of his trade or business to another person of rent, salaries, and a variety of other fixed or determinable gains, profits, and income amounting to $600 or more in a calendar year must file an information return showing the amount paid and the name and address and identification number of the recipient.

Under Internal Revenue Service procedures in effect when the bill was ordered reported, information returns were not required of insurance companies (including those participating in Medicare), Blue Cross-Blue Shield organizations, State agencies participating in the Medicaid program, and employers and unions having self-insured or self-administered plans, when they made payments to doctors, dentists, and other suppliers of medical and health care services and goods on behalf of individuals. These organizations are now required by the Internal Revenue Service to make information returns with respect to payments to doctors and other suppliers.

General reasons for change.—Although these organizations are now required by the Internal Revenue Service to make information returns with respect to direct payments to doctors and other suppliers, there is no authority under existing law to require reporting by those organizations of payments made to the patients for services or goods furnished by the suppliers even though in normal circumstances they are paid over to the suppliers or represent reimbursements of earlier payments made by the patients.

The committee believes it desirable to provide specific rules requiring information returns to be filed with respect to payments in excess of $600 during the calendar year to suppliers of medical goods and services, whether the payments are made directly to the supplier or to the patient or other third party in reimbursement for payments to the supplier. To omit reporting of payments where they are not made directly to the supplier could encourage the use of indirect payments in order to avoid reporting for Federal income tax purposes.

Explanation of provision.—The committee has added to the bill a provision requiring the filing of an information return for payments of $600 or more made during the calendar year to a supplier of medical goods and services. The reporting requirement covers payments to doctors, dentists, and other suppliers of medical and health care services. It also covers payments for medical and health care goods and services such as medicine and orthopedic and prosthetic devices, and medicine and other goods and services rendered, furnished or dispensed by doctors, dentists, and other suppliers of medical services.

The requirement also applies to payments made to any person in reimbursement for amounts paid or payable to a supplier. For example, an insurance company must report as payment to a doctor an amount paid by it to a patient in reimbursement of amounts paid or payable to the doctor by the patient.

All payments, whether made directly to the supplier or to another person in reimbursement for amounts paid or payable to the supplier must be aggregated in determining the amount paid during the year.

The following exceptions from these requirements are provided:

(1) The reporting requirement does not apply to payments not made in the course of a trade or business. For example, the requirement applies to an insurance company that pays an insured patient's doctor bill for medical services or reimburses the insured patient for the amount of the doctor bill, but it does not apply to the patient himself when he pays a doctor, because he is not making the payment in the course of a trade or business.

(2) The provision does not apply to the payment of wages subject to withholding by an employer (with respect to which a statement is made under section 6051), a payment to a tax-exempt organization described in section 501(c)(3), or a payment to an agency or instrumentality of the United States or a State or political subdivision of a State.

(3) The provision does not apply to payments for goods or services dispensed or supplied by a noninstitutional pharmacy.

(4) The reporting required does not apply to any payment to an individual by his attorney or agent, or to any payment made by a person with respect to which a return is made by any other person.

(5) In the case of a payment in settlement of a claim which includes reimbursement for amounts paid or payable to a supplier of medical and health care services

or goods, reporting is required only to the extent that these amounts have been separately identified to the person making the payment. (The payment must contain determinable sums specifically attributable to identified persons.) For example, if a casualty insurer makes a lump sum settlement which encompasses not only medical expenses but also compensation for personal injuries or property damage, the medical expenses must be reported only to the extent they have been separately identified to the insurance company.

(6) In many cases, the amount of expenses for medical and health care goods and services is greater than the amount reimbursed by the insurance company. This may be the case, for example, where the insurance company reimburses only a specified percentage of medical expenses, or where no reimbursement is made for a fixed initial amount, such as $100. The bill gives the Secretary of the Treasury or his delegate regulatory authority to provide for the determination of the amount paid to each supplier in these cases where the reimbursement covers more than one supplier, and the payment does not separately state the amount paid in reimbursement of amounts paid or payable to each supplier.

The committee recognizes that the provisions requiring reporting of payments to persons in reimbursement for amounts paid or payable to suppliers will impose an additional burden on insurance companies and other organizations from whom reporting is required. However, the committee believes it is necessary to require reporting of these payments to prevent a shift to indirect payment of doctors and other suppliers which would undermine the effectiveness of the requirement that direct payments be reported. The committee expects that the Commissioner of Internal Revenue will work with the insurance industry and with other reporting organizations to devise methods of reducing the cost of complying with the new reporting requirements.

The committee also recognizes that amounts reported as payments to suppliers which are actually payments to other persons in reimbursement for amounts billed by suppliers will not always accurately reflect the actual income of the supplier. The committee anticipates that the amounts reported under this provision will be helpful to the Internal Revenue Service in selecting returns for audit and in providing background information with respect to the audit of returns of suppliers, but it does not intend that the reports be used as evidence in themselves of income received by the supplier.

The bill provides that the information supplied in the information return with respect to any person is to be furnished to that person on or before January 31 of the following calendar year. For example, if a separate form is supplied to the Internal Revenue Service with respect to each payee, a copy of the form is to be sent to the payee.

The bill also amends Title XI of the Social Security Act to require the Secretary of Health, Education and Welfare to provide for similar reporting with respect to Medicare and Medicaid payments. The Secretary is required to keep records showing the identity of each person who receives payments under Medicare and Medicaid programs, and under programs for maternal, child health, and crippled children services under Title V of the Social Security Act, and the aggregate amounts paid to the individual under each program. In order to carry out this requirement, the Secretary is given the authority to require information from all persons, agencies or agents administering or assisting in the administration of these programs. The suppliers are required to be identified by the identifying number required to be included in the information return.

The bill requires the Secretary of Health, Education and Welfare to submit to the Senate Committee on Finances and the House Committee on Ways and Means an annual report identifying each person paid a total of $25,000 or more during the preceding year under Medicare or Medicaid programs or programs for maternal, child health, and crippled children services under Title V of the Social Security Act. This report will facilitate the committees' exercise of their legislative responsibilities with respect to these programs.

Effective dates. The provisions requiring reporting with respect to Medicare, Medicaid, and Title V payments, whether by the Secretary of Health, Education and Welfare or by private carriers and other organizations, are to be effective with respect to calendar years beginning after 1968. However, in the case of these payments made during 1969 to suppliers of medical and health care services and goods, the time for filing returns and for furnishing statements to the payee is the last day of the fourth month after the date of enactment of the bill. With respect to other payments, the bill applies to payments made on or after January 1, 1970.

○