HEALTH INSURANCE AND THE UNEMPLOYED

HEARING

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

FIRST SESSION

ON

S. 496

A BILL TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE HOSPITAL INSURANCE COVERAGE UNDER MEDICARE FOR UNEMPLOYED WORKERS AND THEIR FAMILIES

MARCH 7, 1975

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HEALTH INSURANCE AND THE UNEMPLOYED

MARCH 7, 1975

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

The committee met, pursuant to notice, at 10:20 a.m., in room 2221, Dirksen Senate Office Building, Senator Russell B. Long (chairman of the committee) presiding.

Present: Senators Long, Talmadge, Hartke, Byrd, Jr., of Virginia, Bentsen, Curtis, Fannin, Packwood, Roth, and Brock.

The CHAIRMAN. This committee will come to order.

Today, the Finance Committee will consider Senator Bentsen's proposal, S. 496, which is designed to use the medicare system to provide hospital insurance coverage to those unemployed persons receiving unemployment insurance benefits.

This is a particularly timely matter designed to deal with a distressing situation. Millions of fine Americans are out of work due to circumstances over which they have no control. Many of these people have a particular need for coverage against the high costs of health care at a time when their incomes are reduced and where a loss of group health insurance coverage has occurred as a result of their unemployment. We hope to hear the dimensions of the problem described in detail this morning by the Secretary of Health, Education, and Welfare and various witnesses from labor and health care provider organizations. We are also privileged to have the distinguished Member of the House from California, James C. Corman. I am sure we will all learn from this morning's testimony.

For myself, I must express some concern. As I have said, I agree that we should do something to help those unemployed people with their health insurance needs. On the other hand, I believe we need a broader approach which couples coverage of the unemployed with that of many millions of low-income Americans. To do otherwise would create serious inequities. For example, many of the working poor in this country have no coverage through employment and have incomes from work which are less than what many of the unemployed are receiving in weekly unemployment benefits. We need to help those people. A number of States are cutting back on their medicaid programs. For example, in a nearby State indigent and medically indigent are covered under medicaid for only 14 days of hospital care. There is an urgent need to help those people too.

There are an estimated 20 percent of the unemployed who are not covered under the unemployment insurance system. Their need for health insurance coverage is certainly no less than that of the people

who are covered for unemployment insurance. I am also concerned that we may be setting up what is labeled a temporary program in permanent form. I think we ought to find out today about the magnitude of administrative expense and redtape involved in these proposals, and the extent to which the coverage of the unemployed might further fuel health care cost inflation.

While I obviously favor a broader and more equitable approach, I agree with Senator Bentsen that, for reasons of administrative capacity, as well as the urgency of the problem, a broader program could not be implemented at this time. However, I want to make it clear that my own position is that if we enact something like Senator Bentsen's proposal, we make it effective for no more than 1 or 2 years, at which time a new program such as the low income plan—title II of the Long-Ribicoff bill of the last Congress—would become effective. The low income plan, which would be administered by social security, would take care of all of those millions of other people who I have indicated are not dealt with under the proposals to cover the unemployed. The unemployed could be enfolded into the low income plan by the simple procedure of deeming the unemployed eligible for such coverage. I do not think we should approach health insurance coverage for the unemployed without also at the same time including a program for the low income population which would become effective at a somewhat later date.

[The press release announcing this hearing and the bill, S. 496, follows:]

PRESS RELEASE

FOR IMMEDIATE RELEASE
February 20, 1975

COMMITTEE ON FINANCE
UNITED STATES SENATE
2227 Dirksen Senate Office Bldg.

FINANCE COMMITTEE SCHEDULES HEARING ON HEALTH INSURANCE COVERAGE FOR THE UNEMPLOYED

The Honorable Russell B. Long, (D., La.), Chairman of the Senate Committee on Finance, announced today that the Committee would hold a hearing on the provision of health insurance to unemployed workers.

The hearing will be held Friday, March 7, beginning at 10:00 a.m. in Room 2221, Dirksen Senate Office Building. Leadoff witness will be the Honorable Caspar W. Weinberger, Secretary of Health, Education and Welfare, who will present the Administration's views on this subject.

Senator Long stated: "In recent months unemployment in the U. S. has reached its highest level in more than three decades. Although most unemployed workers are eligible for unemployment benefits, many of them have no private health insurance coverage to protect them and their families if they become sick. The hearings will explore ways of dealing with this problem."

The Chairman noted that the Committee has pending before it S. 496, introduced by Senator Lloyd Bentsen. This bill would provide hospital insurance coverage under Medicare for unemployed workers and their families. The provisions of the bill would be in effect for one year; benefits would be paid from general revenues.

Requests to Testify. -- Senator Long advised that witnesses desiring to testify during this hearing must make their request to testify to Michael Stern, Staff Director, Committee on Finance, 2227 Dirksen Senate Office Building, Washington, D. C. 20510, not later than Tuesday, February 25, 1975. Witnesses will be notified as soon as possible after this cutoff date as to when they are scheduled to appear. Once the witness has been advised of the date of his appearance, it will not be possible for this date to be changed. If for some reason the witness is unable to appear on the date scheduled, he may file a written statement for the record of the hearing in lieu of a personal appearance.

Consolidated Testimony. -- Senator Long also stated that the Committee urges all witnesses who have a common position or with the same general interest to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Committee. This procedure will enable the Committee to receive a wider expression of views than it might otherwise obtain. Senator Long urged very strongly that all witnesses exert a maximum effort, taking into account the limited advance notice, to consolidate and coordinate their statements.

Legislative Reorganization Act. -- In this respect, he observed that the Legislative Reorganization Act of 1946, as amended, requires all witnesses appearing before the Committees of Congress "to file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument."

Senator Long stated that in light of this statute and in view of the large number of witnesses who desire to appear before the Committee in the limited time available for the hearing, all witnesses who are scheduled to testify must comply with the following rules:

(1) A copy of the statement must be filed by the close of business on Wednesday, March 5.

(2) All witnesses must include with their written statement a summary of the principal points included in the statement.

(3) The written statements must be typed on letter-size paper (not legal size) and at least 50 copies must be submitted before the beginning of the hearing.

(4) Witnesses are not to read their written statements to the Committee, but are to confine their ten-minute oral presentations to a summary of the points included in the statement.

(5) Not more than ten minutes will be allowed for the oral summary. Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Written Statements. -- Witnesses who are not scheduled for oral presentation, and others who desire to present their views to the Committee, are urged to prepare a written statement for submission and inclusion in the printed record of the hearings. These written statements should be submitted to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building not later than March 14, 1975.

PR #7

94TH CONGRESS
1ST SESSION

S. 496

IN THE SENATE OF THE UNITED STATES

JANUARY 30, 1975

Mr. BENTSEN introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend the Social Security Act so as to provide, for a 1-year period, hospital insurance coverage under medicare for unemployed workers and their families.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 226 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(j) (1) Notwithstanding the foregoing provisions of this section or any provision of title XVIII—

"(A) every individual who—

"(i) is unemployed,

"(ii) is not, and upon filing any appropriate application would not be, entitled under any other

provision of law to hospital insurance benefits under part A of title XVIII, and

"(iii) is not the dependent spouse (as defined in regulations of the Secretary), and

"(B) every individual who is the dependent spouse or dependent child (as defined in regulations of the Secretary) of an individual described in clause (A),

shall be entitled to hospital insurance benefits under part A of title XVIII for each calendar month for which the conditions prescribed in clause (A) or clause (B), as the case may be.

"(2) An individual shall be deemed to be unemployed for a calendar month only if, for the first week which ends in such month, such individual has established, under a State or Federal unemployment compensation law, entitlement to weekly benefits under such law. For purposes of the preceding sentence, an individual shall not be regarded as having failed to establish entitlement to a weekly benefit under such law for any week if a benefit for such week is not payable to him solely because he was unable to work because of illness or disease if such individual received a weekly benefit under such law for the week preceding the first week that he was unable to work because of illness or disease.

"(3) (A) The provisions of title XVIII relating to deductibles and copayments shall be applicable to individuals

deemed to be entitled to hospital insurance under this subsection.

"(B) The Secretary shall by regulation waive, with respect to individuals covered under the hospital insurance program established by part A of title XVIII by this subsection, any condition or limitation contained therein if, and to the extent that, he determines that the application of such condition or limitation would work a peculiar hardship or inequity on such individuals or would deny such individuals needed maternal and child health services.

"(C) Notwithstanding any provision of title XVIII, amounts otherwise payable under such title for any item or service provided to an individual entitled to benefits thereunder by reason of the preceding provisions of this subsection shall not be payable if, and to the extent that, any prepayment plan or insurance policy covering such individual is legally obligated to make payment for such item or service.

"(4) There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

"(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individ-

uals covered for hospital insurance under the preceding provisions of this subsection,

"(B) the additional administrative expenses resulting or expected to result therefrom, and

"(C) any loss in interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year in which it would have been if the preceding provisions of this subsection had not been enacted.".

(b) The amendment made by subsection (a) shall be effective only for the 12-month period beginning on the first day of the month following the month in which this Act is enacted.

The CHAIRMAN. And now, the committee will be pleased to hear from the distinguished Secretary of Health, Education, and Welfare, unless other Senators want to make a statement.

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

I am pleased that the Finance Committee has scheduled these early hearings on my bill S. 496, which would establish an emergency program of hospital health insurance coverage to the unemployed.

I believe that this program is a matter of some urgency. While it is true that we have had unemployment before, the current rate of 8.2 percent is the highest since the depression. Moreover, the costs of hospitalization have more than tripled since 1960, at a rate twice that of the cost of living; an average day in the hospital that cost $33 in 1960 is now estimated to cost $130.

The Bureau of Labor Statistics told us only last week that, "When workers lose their jobs, they also usually lose health insurance protection for themselves and their families, either immediately or within a month." The Washington Business Group on Health, which conducted a survey of over 200 large and small employers, found that, "with a few notable exceptions the employee will either have no health benefits or will be paying 100 percent of premiums within 90 days."

We are talking about more than 7.5 million workers, at least 6 million of whom are eligible for unemployment compensation coverage. We are also talking about their spouses and dependents. The reason this legislation is before us now is because of skyrocketing health costs and the sudden surge of millions of men and women on the unemployment rolls.

It is designed as an emergency measure, hopefully to be phased out within a year. I have long argued that we need comprehensive national health insurance, but the realities are that we are not likely to see final action on that measure for some time. In addition, the administration has indicated its opposition to the enactment of a major health insurance bill this year.

Faced with these realities, we have the choice of either walking away from a serious problem or enacting some intermediate program. I believe that the circumstances compel us to act.

It is obvious that any program designed for an emergency will create some administrative difficulties and inequities. That was true of the public employment measures already signed into law by the President. Our task is to minimize the inequities and to move with a program which is fair, relatively easy to administer, and responsible. That is why I chose to utilize the existing medicare program as a vehicle.

Medicare is an in-place system with a standardized benefit package, which means that all who take advantage of it will fare equally. It covers the most essential hospital services: operating and recovery room costs, lab tests, radiology services, medical supplies, and a wide range of rehabilitation services. I am frankly troubled by proposals that would merely continue to pay benefits to private insurance companies, since I find it difficult to justify the Federal Government subsidizing the very generous health packages negotiated by some groups while leaving other individuals with inferior plans or no plans at all in a position of relative disadvantage.

In short, I believe this approach to be the fairest and the most responsible we can now devise.

I want to welcome our distinguished witnesses to this hearing, and we look forward to this testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Brock.

Senator BROCK. Mr. Chairman, I am delighted we are considering the matter, but in doing so I urge we approach any proposal with full awareness of the complexities of the subject matter and the potential for setting a precedent for the future.

I know that those who espouse a particular approach will suggest the temporary nature of the problem and urge a short-term solution. But that is not going to happen, in my opinion. Whatever we do clearly will establish a pattern for future action in the field of national health insurance.

If there is validity to that point of view, then it seems to me that we must not let this particular time of difficulty obscure our perception of the long-range problem. Rather, we should act with deliberation to make absolutely certain that the plan we enact is the best one possible both in the short term and in the long term. For this reason I particularly regret the fact that we have yet to come to grips with the fundamental question of how best to deal with national health insurance, not only for the unemployed, but for the general public. We must do so in a fashion which is compatible with our free society and with the need for an approach which is not only cost effective, but human effective.

This year I too introduced a bill, S. 600, the Medical Expense Tax Credit Act. It has several unique features that make it both effective and uncomplicated. Basically, it provides that the Federal Government will act through the tax system as coinsuror of excessive medical expenses which run the risk of destroying the family's earnings or saving base, whether they are low income, unemployed, or what. It works by providing that when a family's expenses exceed a certain percentage of income, then we would coinsure 85 percent of all costs in excess of that stated amount.

Because the amount of assistance received is based upon income this built-in mechanism will provide for the unemployed without necessitating any new agency or set of complicated regulations. On the contrary, it uses the existing strength of our tax system and the existing strength of the finest health delivery system anywhere in the world in a unified effort to deal with a specific problem which faces the individual family today. In this manner, we would avoid any impediments to the practice of medicine, the longer lines in hospitals or the added weeks to the length of time needed to make a medical appointment. My bill will give assistance to those truly in need without wasting benefits on those who can afford to pay their own bills. I think it is a remarkably flexible plan which will accommodate today's economic problems just as well as those which we might face in the future. If we are going to deal with this special problem, Mr. Chairman, I hope that we do it in a way that will deal not only with today's unemployment problems, but those problems which we may face in the Nation tomorrow as well.

Thank you.

The CHAIRMAN. Mr. Secretary.

STATEMENT OF HON. CASPAR W. WEINBERGER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION, DHEW; STUART ALTMAN, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DHEW; HENRY E. SIMMONS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH, DHEW; THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION, DHEW; M. KEITH WEIKEL, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION SOCIAL AND REHABILITATION SERVICE, DHEW

Secretary WEINBERGER. Mr. Chairman, I appreciate very much this opportunity to appear before you today, and as you know, I and the administration are greatly concerned about the availability of health insurance at a reasonable price for all of our citizens. And of course we are also, as everyone is, very much troubled by the problems of the unemployed.

Health insurance has been a very important initiative of this administration. I have testified, as you know, on numerous occasions supporting the administration's proposal for national health insurance. We need a system in this country which will provide universal protection against health care costs for all Americans. The proposal we introduced last year, the Comprehensive Health Insurance Plan, would have done that and would have provided for the unemployed continued protection against the high cost of medical care. I am sorry it was not enacted last year.

Unfortunately, we find ourselves now in an economic situation which makes it temporarily impossible to pursue actively early enactment of a comprehensive health insurance bill. We should not, however, lose sight of the major goal that that bill was designed to accomplish, which was universal accessibility to financing for a comprehensive range of medical services. S. 496 does not do that. Instead, it is designed to aid a small number of the 25 million Americans who have no health insurance at all by providing the recipients of unemployment insurance benefits with the hospital service portion of medicare.

In fact, Mr. Chairman, while I can certainly appreciate the intent behind S. 496, passage of this bill, we think, would create gross inequities and enormous administrative problems. Furthermore, it would establish a new Federal program requiring well over a billion dollars in Federal spending, which is in direct opposition to the administration's current economic strategy.

Dealing with the problems of the unemployed is key to the administration's strategy for handling our current economic situation. And there are many things that are being done in an effort to alleviate the plight of those who, through no fault of their own, find themselves without jobs.

We have supported several major initiatives to help the unemployed:

The unemployment compensation program has been expanded to provide benefits for certain categories of workers not previously eligible. This will allow, over the course of 1 year, approximately 2 million

additional unemployed persons to become eligible for benefits and will result in $3.2 billion of new Federal expenditures for 1975. And those are planned and requested by the administration.

Recognizing that during this recessionary period many of the unemployed will remain out of work for longer periods of time, the administration has also supported an extension of the time during which unemployed persons are eligible for compensation. This provision will extend potential eligibility for benefits up to 52 weeks, a full year, and that will cost the Federal Government an additional $1.3 billion this year and that is planned for and requested.

Public service jobs which are providing employment for thousands of workers who would otherwise be unemployed have been created. Nearly $2 billion in Federal funds will be spent to provide the money necessary for this effort and this has been requested and is planned for.

These provisions coupled with the existing payment structure in unemployment compensation will result in over $20 billion being expended to benefit the unemployed in calendar year 1975. Over $8½ billion of this amount will come from Federal revenues. In addition, the tax rebate program, which is a crucial part of the President's economic strategy, will provide added income to the unemployed along with others in our society.

While many things have been and can be done to help alleviate the economic condition of the unemployed, I would suggest that building an in kind benefits program is not a constructive step. In addition to the proposals we are discussing today, there is currently before Congress, for example, a proposal that would pay home mortgage payments during periods of unemployment, or if income is otherwise substantially reduced.

Next we have to ask, what about utility bills and car payments? How far do we go and where do we stop in providing new in kind benefit schedules?

The main problem, of course, of the unemployed is not necessarily lack of health insurance. The major problem of the unemployed is they have lost their jobs and their income is reduced. And the most important thing that we can do to improve their situation is to improve the economic situation of the country so they can get back to work. The unemployed need money. They need money to provide for their basic needs until they do become reemployed, money until they are able to provide for themselves through their own employment. And the unemployment compensation program is the mechanism whereby such funds are disbursed.

As I mentioned earlier, we have supported a substantial expansion of unemployment insurance as a system, but I think there is a limit as to how much anyone can or should spend for this or for any other single purpose. When you look at the size of the total Federal expenditures and the size of the deficit, which, incidentally, has been added to substantially by the Congress' refusal to enact any of the rescissions that the President has requested, then you have to worry about whether you are not going to dry up the capital that is necessary under our system to be invested to produce jobs. That is the only thing that can ultimately cure the unemployment situation.

As I noted earlier, the cost of providing this one single program is high. Our cost estimates are to provide health insurance for the unem-

ployed range from a minimum of $1.2 billion at an 8-percent unemployment level with a limited benefit package, to about $3.1 billion if unemployment were to reach 10 percent and the benefits were to include both part A and part B of medicare. The cost of fully subsidizing part A coverage in S. 496 is $1.26 billion at an 8-percent unemployment rate. We could not estimate the cost of the maternal and child health benefits because of the lack of specification in the bill. We also assumed that those who accepted part B coverage through the buy-in provision would pay a premium roughly equal to the cost of providing covered physician services. If unemployment reaches 10 percent, the benefits in S. 496 would cost $1.6 billion. And these are of course only the costs for the first year of the program. And while I heard Senator Bentsen say it is to be a 1-year program only, if you will pardon me, Mr. Chairman, I have never yet seen a program that started out to be a 1-year program that ended up as a 1-year program, or indeed, any other program that has ever been stopped under any circumstances. So I do not think we can assume that it will be a 1-year program.

The program, I think, would, in all likelihood, be extended beyond 1 year and the yearly costs would increases dramatically. Many employers and health and welfare trust funds would, I am afraid, cancel those provisions in their policies which extend benefits into periods of unemployment, and would, as so many have done and are doing, rely on the Government to pick it all up. The ending of those provisions alone would add about $200 million to the annual cost of this program, and soon the benefits would be perceived as inadequate and more and more would be added.

But even more important than this fiscal issue, and I think this is important, there are a lot of other serious concerns about the equity of legislation of this kind. While I think it is desirable, of course, to have health insurance protection for the unemployed, we have to bear in mind that they are only a part of a very much larger segment of the total population that has no health insurance at all. There are, we believe, at least 25 million Americans who have no health insurance at all. In addition, there are about 35 million more who have totally inadequate protection, providing little help against the ever increasing cost of health care and typically providing coverage for a few days in the hospital, which is the most expensive care of all and sometimes is the least effective or the least needed.

About 60 million Americans, then, need protection and a very small, and we hope rapidly diminishing, number would be protected by S. 496, as the unemployment situation is corrected, through implementation of the administration's economic plan. Many of these 60 million people are employees working for employers who do not provide health insurance coverage and who cannot afford their own. There are the unemployed who are not receiving unemployment compensation, either because they were not in covered employment or because their benefits expired. And there are the early retirees not yet eligible for medicare. And all of these people would be uncovered by this bill.

With an unemployment rate of 8 percent, the Department of Labor estimates that approximately 7.4 million people are unemployed, and of this number 6 million would be eligible for unemployment com-

pensation. About 4.6 million of these would be eligible for the benefits that are provided under S. 496. While entitlement to another health insurance plan would not preclude eligibility under S. 496, the private insurance plan under the bill is to pay first and about 20 percent of the 4.6 million would have other coverage.

I certainly do not want to minimize the needs of the unemployed, and, obviously, testifying against a bill that is labeled of help to the unemployed is not an enviable position. But I think that the committee and the country are entitled to know the problems and the inequities that are involved in this bill. Furthermore, it represents, we think, a quick, easy, wrong solution, rushing in to try to solve a portion of a much bigger problem that has to be solved with other longer range measures. A bill that would provide health insurance coverage only for those receiving unemployment compensation certainly does not address the problems of millions more of those citizens whose needs are equally as great or greater. A high percentage of those eligible under this proposal will be young and single, and this is not the group that we believe is most in need of the benefit of health insurance protection.

Actually, we think the whole country needs health insurance, as we have testified repeatedly last year and as we are prepared to testify again next year.

Since the benefit package and the administration of this bill would be essentially the same as medicare, it is appropriate, I think, to compare the eligibility requirements for the unemployed to others eligible under the medicare program.

Those currently eligible for medicare must be 65, disabled, or suffering from a final-stage renal disease. Those are the categories that have been provided over the years. The unemployed need not meet any of these conditions.

Those who are currently eligible for medicare must meet a special insured status requirement. The unemployed would not need to meet that comparable requirement.

Those who are eligible for medicare because of a disability or requiring kidney dialysis have a waiting period of 24 months and 3 months, respectively, for those two programs. The unemployed would not have a waiting period.

The dependents of those currently eligible for medicare are not similarly entitled. The unemployed would have the same coverage for their dependents as they have for themselves.

In short, Mr. Chairman, you would be building in a whole mass of inequities and differences within the medicare program by adding this new program.

I think the point to be emphasized is that the eligibility criteria for current medicare beneficiaries are different and generally more restrictive than would be the case for the unemployed. It would be difficult to explain to a disabled person why he had to wait 2 years for medicare benefits under the statute, and why, even then, his children would not be eligible at all, when healthy unemployed persons and their dependents would have no waiting period. And both would be covered under this bill.

This is not to say that they should not have health insurance. We have said repeatedly that all Americans should be covered by health insurance. But the inequities built into this bill would certainly be very glaring and we think quite unjustified.

The equity issue, I think, comes even more strongly into focus when you consider that persons aged 65 and over who are not insured for part A of medicare can obtain such coverage only by paying a premium, which is now about $36 a month and will have to go up to $40 a month in July. Senate bill 496 would provide identical coverage for the unemployed at no cost.

Consider also, Mr. Chairman, the social security beneficiaries who are under age 65 and therefore cannot get medicare protection—workers who retire at age 62, wives, widows, children, dependents. Even though entitled to social security monthly benefits, they are not eligible for medicare in spite of the fact that the worker contributed to the social security system all through his employed career, and medicare is a benefit under that system.

Problems of equity are certainly not confined to S. 496. Other bills which have been introduced on this same subject, on which I will be testifying next week, present equally disturbing inequities. S. 625, for example, would provide health insurance for the unemployed through an extension of existing employer-sponsored coverage. Under that bill, anybody who had a policy would receive benefits; anybody who did not, would not. And those are clear problems of equity that I think would be quite indefensible.

At an unemployment rate of 8 percent, that bill, S. 625, would provide coverage for about 3 million of the unemployed at a cost of about $1.5 billion. Not only would the coverage be limited to just those unemployed who receive unemployment compensation, but it would be further restricted to those employees whose employers had covered them with health insurance, excluding about 1.2 million individuals from any coverage.

Even among those eligible under that bill, gross inequities are evident. I know that bill is not before you and so I will not devote too much time to it, but I wanted you to be aware of the fact that it is not just this bill that we think has equity problems. It is all of the measures that are introduced for this specific, narrow categorical purpose.

Let me turn now to another problem that Senator Bentsen has already alluded to, rather casually, I must say, and that is the problem of how you administer a program of this kind. Eligibility is tied to entitlement under Unemployment Compensation, so there would have to be involvement on the part of the State and local unemployment compensation offices to carry out the enrollment process. Unemployment is a transitional problem, fortunately. The figures we have indicate that over 40 percent of the unemployed remain so for a period of under 5 weeks. So that with all of the other problems, you would have the problem of eligibility being present for a few weeks, then not present for another few weeks, possibly for the same individual. He might be eligible for a few weeks, ineligible for 6 months, eligible again for 2 weeks, and ineligible for the rest of the year.

I think it is very fortunate that the duration of unemployment is only 5 weeks for the bulk of the people. It is longer for some others. But the fact is that intermittent, often brief periods of unemployment creates a very substantial degree of administrative problems in determining eligibility. We know that if a bill with limited eligibility is passed, you would intend that only the people eligible be paid and we would have to do everything we could to assure that that happened.

There are already very heavy workloads that are straining the capabilities of our employees administering unemployment compensation. Adding an unfamiliar program of health insurance—and this is at the State level, primarily—would severely compound already existing problems of providing cash benefits on a timely basis which is the primary way to help the unemployed.

It is all to easy for us, too, to assume that an existing system such as medicare could accommodate the administrative burdens of adding the unemployed individuals to its rolls without affecting its principal function, which is to assure the financial protection to the nearly 24 million elderly and disabled people who depend on it to help pay their medical bills. I do not think that assumption, that you could add this program with no serious dislocations to the primary beneficiaries of the medicare program, is accurate.

Coverage of the unemployed under this proposal would nearly double the size of the medicare rolls. An individual record would have to be established not only for the unemployed person but for his dependents as well, and that would be necessary, of course, to verify eligibility when claims for benefits are filed and to record utilization to determine deductibles and coinsurance.

Assuming an 8 percent unemployment rate, there would be approximately 10 million people—that is, 4.6 million unemployed plus all of their dependents—who would have to be added immediately to the system, a system which would have to be considerably enlarged to accommodate that new group of enrollees. Obviously, new people would have to be brought aboard and trained. This would be, I think, a very difficult task.

Let me just illustrate the magnitude of this task by contrasting some of the problems that we had with the administration of the supplemental security program to that of the S. 496 program. And again, the magnitude was not realized at the time it was added so abruptly to the statutes.

SSI had to obtain information from all State welfare files. It had to conform all of that information to the requirements of the SSA system. There was a different definition of disability at the State and Federal level. The effort involved information on 2½ million people. most of which was already in State files.

In contrast, S. 496 contemplates creating records for 4.6 million unemployed persons, plus all of their dependents who would be immediately eligible. There would not even be the waiting period. Yet we had 14 months to bring SSI into effect and that was an inadequate waiting period.

As I suggested previously, enactment of S. 496 would result in about 10 million people coming onto the medicare rolls, enrollees for whom records would have to be established. Most of the enrollment data re-

quired for these individuals would not be in State files because it would not have been needed for purposes of entitlement to unemployment compensation. So rather than relying on information already in State files, we would have to obtain the necessary information through an application-taking process. Each of the unemployed would have to be contacted to obtain the necessary identifying information on behalf of himself and his dependents. The idea that you can just use the unemployment insurance system is an attractive one, but it is an inaccurate one because it would not contain the information required to insure that those eligible were receiving the benefits.

It is not a task which can be performed simply or quickly. Once the records are established, we have to ask who would process all of the new claims. The social security offices are already severely strained in attempting to keep up with their current workload. There are bills before other committees to expand the black lung program and investigations going on to determine why SSA has been so slow in making black lung payments. We have approximately 1,300 social security local offices. The average workload per office would be about 3,500 claims just to process the 4.6 million people who are initially eligible, to say nothing of dependents. The ongoing annual workload would average 6,000 claims per social security office, to bring the newly eligible unemployed on the rolls. Compare that with last year's new claims volume figures for all of social security benefits. That was 8.1 million, or an average of 6,200 per social security office for the year.

So you can see what enormous additional burdens would be brought aboard by this bill. I am saying this now because we want everyone to know that these administrative problems are not something that you sort of toss aside with a wave of the hand, and say, "Of course there would be some administrative problems, but they could be easily solved." They could be easily solved after a very considerable period of time with considerable additional help and a very considerable period of dislocation to the social security, the medicare, and the black lung programs which are presently being administered by many of the same people.

Though there are a number of different ways of establishing eligibility, the point is we must have some system of identifying the eligible unemployed and their families, and it must be devised immediately because this bill would take effect immediately. And it must be devised, not only to bring people on the rolls, but to take them off when entitlement to unemployment compensation ends. And everybody in the country hopes that that would be a very brief time.

Right now, even when our economic condition is not at its best, the bulk of the people who are unemployed remain so for under 5 weeks. That is a very short span to bring them on, make them eligible, and determine whether claims were filed during that period and were valid.

S. 496 also stipulates that, where dual health-insurance coverage exists, the private insurer must pay first. We do not quarrel with that provision, but look what it does. Since about 20 percent of the 4.6 million potentially eligible under this proposal would have other insurance, coordinating benefits would be necessary on a sizable percentage of claims. According to the insurance industry, this process

is a particularly difficult administrative burden and it would be exactly the reverse of the burden that is now imposed by the medicare program. So everything would have to be changed to accommodate it. Under current medicare provisions, the medicare benefit is primary and pays first and any other coverage is secondary. This difference in paying medicare claims, depending on whether beneficiaries are conventional medicare recipients or unemployed persons, would be confusing for hospitals, medicare intermediaries, and other insurers.

Another administrative problem arises from the fact that presently medicare pays virtually no benefits for such services as obstetric and pediatric care, for obvious reasons. Coverage of the unemployed would require higher degrees of sophistication in medicare claims processing and for these particular new elements which have not been part of the medicare administration up to the present time, there would be new and different questions related to reasonable cost and medical necessity.

All of these are reasons, Mr. Chairman, why all of the health insurance bills introduced have provided a substantial leadtime to enable the planning to be done to have these programs start achieving benefits.

The SSI program allowed 14 months from enactment before the first checks were issued. The Congress recognized that providing that 14-month period was necessary—not on request from HEW because it was not a program we requested—but simply to allow leadtime for implementation. The SSI program will eventually reach perhaps 3½ to 4 million people, maybe more. This is a program that starts out with 4.6 million plus dependents, which brings it to 10 million people.

The other thing that I think has to be made clear to the committee is that there is no way in which any of these programs can be instituted in this fashion without causing serious problems to the existing medicare beneficiaries, the existing black lung beneficiaries, the existing social security beneficiaries. You cannot simply drop a program of this magnitude into that whole structure and expect that it will be implemented overnight. And that is not to say that we do not have good, able, and dedicated people. We have some of the finest people in the country working on these programs, but there are limits to human capabilities. And this bill, without any recognition whatever of that, attempts to say that there are certain administrative difficulties which will have to be overcome next week.

I should mention, Mr. Chairman, that the problems of administration are equally complex under the other bill, S. 625. Here again, employment offices would have the responsibility of establishing eligibility through entitlement to unemployment compensation. Then you would have the further examination of whether that individual had, while working, some kind of health insurance, and some mechanism would have to be established to check on that, which would require more than examination of the individual. It would require examination of all of the employers who are providing that coverage. Thousands of employers and health and welfare trust funds throughout the country would have to certify as to terminated employees' eligibility under some kind of preexisting plan that they might have had.

I will not belabor the difficulties of administration under S. 625 because that bill is not specifically before you. But I do want to illus-

trate again the magnitude of the problems caused by this whole concept of trying to rush in with a quick attempt to do something about a small piece of a very big problem in a way that will exacerbate and aggravate the attempts made to cure the big problem, which is to improve the economy, so that the jobs will be there and so that there will be some private investment encouraged that will produce jobs.

The points that I have made on costs and equity and administration represent our major concerns about the effects of this bill to provide health insurance just to certain unemployed. Specifically related to S. 496 is of course the work disincentive which would be created through the implementation of this bill.

This would be another situation in which certain benefits would be available to certain people—some, but not all of the unemployed—and, as we have seen repeatedly with AFDC and with other programs that have notches and limited numbers of beneficiaries, the fact that some people can become elgibile and others cannot, though they are perceived to be in the same situation, means that at least in some cases disincentives are built in for people to remain in the kind of situation they are then in.

Now, necessarily, this has been a very negative presentation, and I regret that, but I want to say in conclusion, Mr. Chairman, is that, were it not for the present economic situation, where bills of this kind, with $1 billion here and $2 billion there, are going to exacerbate this situation, we would be strongly urging the enactment of national health insurance, and we expect to be urging that in a very few months.

This year fiscal constraints and energy development have to be our priority. As you know, the President has asked for a moratorium on all new Federal spending programs, and this is clearly one of those. This year, therefore, we are delaying our initiatives on national health insurance. We are strongly committed to the principles of national health insurance embodied in the comprehensive health insurance plan, and a bill of that kind will be introduced next year.

Only through a comprehensive universal system of national health insurance can the health care needs of the unemployed be properly addressed in a way that avoids the inequities and the administrative problems I have discussed today. This can best be done by building on the strengths of the existing systems of health care delivery and financing and filling all of the gaps to provide needed health care protection for everyone in the country. The administration's comprehensive health insurance plan would provide universal financial access through comprehensive health insurance for all. These bills we are talking about would provide limited coverage for just a few, and I have not even mentioned the inadequacy of the benefit packages that are included.

They contain all of the unfortunate overemphasis of hospitalization that is the plague of most health insurance today, and not enough emphasis on the things that most people really need. Our health insurance program that covers everyone would have positive effects on the way health services are delivered by structuring the benefit package properly. In some ways these bills that we are talking about today would have adverse effects by providing greater coverage for more expensive forms of health care, resulting in further imbalance in the delivery system and further upward pressures on the cost of health care for everyone.

Our health insurance program would incorporate a variety of cost control features, and these bills would entail additional spending of virtually uncontrolled funds, thereby adding to the inflation we already have in health care. Our bill would provide a mechanism for insuring quality and the necessity of care. These bills would have little such control.

Mr. Chairman, our bill was not conceived overnight. It was well thought out, and it took about a year to work it out before it was presented to the Congress and before it was accepted by the administration as it was last year. Its features are designed to provide a comprehensive pattern for health insurance. Quick implementation of hurriedly conceived legislation can obviously have very long-term adverse consequences, particularly coupled with the total reluctance to stop any program once it starts.

This concludes my prepared remarks, Mr. Chairman. I would like to say, just to anticipate some of the questions that I know will be coming, that we share everybody's concern for the unemployed and the conditions that exist now. There is no monopoly on compassion or warm, humanitarian approaches to problems. But I think that the fact that there are so many defects with this bill has to be pointed out, even though I well understand the risks involved of being accused of being callous about the unemployed. I want to assure you that no one in this administration is in that category, but no one thinks that the compassion and the warmth and the humanitarianism that we feel about these problems should obscure the fact that these bills would do a very great deal more damage than they would good.

Mr. Chairman, I appreciate very much the opportunity to present this statement. I am accompanied today by people who are able to deal with perhaps specific aspects of some of the problems that are before you. Stephen Kurzman, of course, is our Assistant Secretary for Legislation. Dr. Stuart Altman is our Deputy Assistant Secretary for Health Planning and Evaluation. Dr. Henry Simmons is the Deputy Assistant Secretary for Health. Thomas Tierney is the Director of the Bureau of Health Insurance in charge of the medicare program, and Dr. Keith Weikel is in our Social Rehabilitation Service dealing with the medicaid program, in case you have any questions on that program.

And I would also ask that the omitted portions of my statement, which I did in the interest of your time and patience, which involve primarily S. 625, the Kennedy bill, might also go into the record because they are a part of all of the points that we wanted to get before you.

Thank you very much, sir.

The CHAIRMAN. Thank you very much, Mr. Secretary.

In order that every member would have a chance to ask his questions of the Secretary and to expedite this procedure, I am going to suggest that we limit ourselves to the 5-minute rule in the first round of questions, and thereafter if someone wants to ask additional questions, he will have the opportunity.

I yield my place to the Senator from Texas, Mr. Bentsen.

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

Mr. Secretary, we did not have a casual approach to the administrative problems of this program, as you suggested. That certainly was not the case. A great deal of time was spent in studying the alter-

native proposals and possibilities. It was felt after that study that the proposal that I introduced had the least administrative problems.

Secretary WEINBERGER. I am not prepared to deny that, but that does not mean that it is any easier.

Senator BENTSEN. Let me further say, Mr. Secretary, when you speak of 10 million people that you have to enroll and get records on, I cannot agree with you. One of your predecessors in office, Mr. Wilbur Cohen, supports the approach taken by this bill because he considers it easier to administer and more equitable. He also believes that the administrative problems could be minimized having the unemployment offices issue cards to the unemployed that they could present to the hospitals for easy clarification of eligibility. Therefore, you would not have to certify 10 million people, but only those who apply for hospital admissions. I take it you disagree with that assessment.

Secretary WEINBERGER. Yes, Senator, I would have to say it is a great deal easier to be unconcerned with the administrative problems if you are in Michigan, than if you are in Washington and responsible for them, because I know that the people who would be held responsible for any delays in implementing this program, which is at least twice as large as the SSI program for which we had 14 inadequate months, would be the people at this table. So I have no doubt at all that it is perfectly possible to get a number of people who are not connected with the Department or the government and who have no responsibilities now to say that it would be a comparatively simple task.

And I am not prepared to deny that your bill may have fewer administrative problems than some of the others that I have examined. But that is entirely a comparative exercise and one that does not relieve me of any of the worries that I have expressed.

Senator BENTSEN. Mr. Secretary, the people who would be utilizing this, who would apply for hospitalization, would be the only ones on which you would have to have a record.

Secretary WEINBERGER. Well, you have to have a record to check against the people who wish to utilize it to see if indeed they were eligible.

Senator BENTSEN. The point is I said the unemployment office would give the eligibility card, to keep up with the eligibility on the unemployment compensation anyway, and then they would only utilize it if they checked into the hospital, and there would be an easy verification at that point. Now, if you are opposed to both this bill and as you said S. 625, between the two of them, let me ask you which would be the easier to administer with all of the problems that you cite?

Secretary WEINBERGER. Well, I think it is an assessment of the relative degrees of misery, Senator, and it is awfully hard to make. But, Senator Kennedy's bill, possibly because it would require the double examination—that is, A, are you unemployed, and B, were you covered by somebody else's health insurance plan—might present a few more difficulties.

On the other hand, your bill requires that the private insurance be the primary payer, and that would require considerable consultation and coordination of payments. I would suspect that there is little to justify choosing between what I have to call, with all due respect, two evils.

Senator BENTSEN. Mr. Secretary, you have indicated that the administration thus far is in continuous opposition to the enactment of national health insurance this year.

Secretary WEINBERGER. No, sir. All I said was, this year was not the propitious time to do it.

Senator BENTSEN. Now, I have 5 minutes, Mr. Secretary. Let me finish my question.

Now, you have also indicated opposition to doing something along the lines of this bill or the other bill to cover the millions of newly unemployed. Now, let me ask you: what is your alternative for these people? Are we going to do nothing to try to help this unprecedented number of people who are unemployed?

Secretary WEINBERGER. Well, there are two answers to that, Senator. One is to use the system that has been built up and greatly expanded, the unemployment insurance system, which now lasts for up to 52 weeks, despite the duration of unemployment, which fortunately is a lot less than that for the great bulk of the unemployed, and to rely on that and existing health delivery systems that are in place, such as neighborhood health clinics and a number of others that have had substantial increases in their workload.

That is one answer. The other answer is to ask, why stop with health benefits? Why not pass bills that involve picking up the mortgage payments on homes, which is an equally serious problem involving shelter. Why stop with a bill with provisions that are also designed to help pay the fuel and energy costs? There is no stopping place when you pick out a limited group of the people who have severe dislocations at any one given, but fortunately limited, period of time. So I do not see any stopping place once you embark upon this kind of a categorical path for a small group of people and create additional inequities.

Senator BENTSEN. Mr. Chairman, I will ask for equal time later.

The CHAIRMAN. Senator, you will have your chance when we have an executive session. You can have all of the equal time that you want, but I would rather have a chance to have the last say, rather than the first say.

Senator Curtis?

Senator CURTIS. Well, I was late, and I lost my time.

The CHAIRMAN. Senator Fannin.

Senator FANNIN. Thank you, Mr. Chairman. Thank you, Senator Curtis.

Mr. Secretary, I was very impressed with your statement. I realize your compassion and great concern for the situation that exists. The complexities of the unemployment problem are almost beyond comprehension. You have approached this realistically, and I do feel that we have an opportunity to do a great deal more perhaps than what is contemplated by some, and still I realize the limitations we have. You brought out the limitations.

Isn't the real issue confronting S. 496 whether or not an unemployment health insurance program can be made to conform to the existing medicare program and administrative mechanism?

Secretary WEINBERGER. Well, as I indicated, Senator Fannin, I think there are very substantial difficulties in doing that. There are all of the equity problems that we mentioned where there would be

a whole second tier of beneficiaries of the medicare program represented by this bill, people whose dependents are eligible, people who do not have waiting periods, people whose eligibility is established in a different way, a number of different categories of beneficiaries within the same program.

I have tried to outline the administrative problems, and we have not tried to exaggerate them. We have been through smaller programs of this kind with the SSI, and while I am certainly not going to claim that that program is now in perfect shape, after a year of operation it is functioning, I think, extraordinarily well considering the difficulties that were involved in putting a program of that size into effect. That was the largest civilian program the Federal Government has ever undertaken, and this program would be larger than that. And you would put it into effect, under the terms of this bill, immediately and in a way that would be, if it is going to do any good at all, designed to start paying benefits at once. There is virtually no way that we could offer you anything less than something like a 90 to 95 percent error rate under circumstances of that kind.

You have shifting eligibility, people coming in for 5 weeks, people going off at that time, people—possibly 10 weeks—people whose health claims arose during that period, or just outside of it, and the problem of determining whether they were eligible to be paid.

Now, if the idea is simply to pay health claims for everyone of low income and no questions asked, that in itself is a fairly big job, but it does not have anything like the complexities that this bill would have.

Senator FANNIN. Well, I think it is fortunate you brought that out. How many new SSA employees would you estimate would be needed to administer S. 496?

Secretary WEINBERGER. I have not even begun to compute that, Senator Fannin. Based on the SSI program, in which we have had to ask for an additional 13,000 employees just to help us out of the problems that you and your colleagues quite properly raised to us about delays in payments in the SSI and the black lung program, I would suspect that we would have to add—and this would be a complete guess—at least the 15,000 additional that we have had to ask for SSI. And I would remind the committee of what you already know, that recruiting on this kind of a scale through the civil service system—competitive examinations, structuring new jobs, all of the rest of it—is a very lengthy, sluggish procedure, and frankly I would hope the unemployment situation would be materially improved before all those required procedures would be gone through.

Senator FANNIN. Our prayers are for that, too.

Mr. Secretary, would you elaborate on your statement on page 14 of your testimony concerning the possible work disincentives if S. 496 were enacted.

Secretary WEINBERGER. This is another of what is generally called the notch situation—that is, certain limited numbers of people—actually not all the unemployed, but only certain numbers of the unemployed would be eligible for the program. Whenever there are situations in which certain people can qualify for a program by certain limited factors, there is some disincentive to remaining at work if

the result of doing so is less beneficial than qualifying for some of the elaborate programs.

I do not have any idea to what extent that would be, but it is there every time some kind of a separate notch is created.

Senator FANNIN. Well, it is an important consideration. Thank you, Mr. Secretary.

The CHAIRMAN. Senator Packwood?

Senator PACKWOOD. I would like to address a question to Mr. Tierney. Could you tell the committee your background?

Mr. TIERNEY. Yes, Senator. Well, I first of all served in World War II as I guess most people my age did and then for 10 years I was practicing law in the city and county of Denver, and for the next 10 years I was president of the Colorado Blue Cross Plan, and since the inception of medicare, I have been Director of the Bureau of Health Insurance.

Senator PACKWOOD. Since the inception of medicare, the Director of the Bureau of Health Insurance?

Mr. TIERNEY. I should correct that, sir. I started in April of 1967, which was, I guess, 7 months after the beginning of medicare.

Senator PACKWOOD. You are now a career employee?

Mr. TIERNEY. Yes, sir.

Senator PACKWOOD. How old are you?

Mr. TIERNEY. Fifty-six.

Senator PACKWOOD. So, barring any decision of yours to retire, you would expect to remain in this position or an equivalent one even after the Ford administration terminates in 1980? [Laughter.]

Mr. TIERNEY. My pension rights are such that I assume I will be around until 2000.

Senator PACKWOOD. And it is your Bureau that will administer this program under Senator Bentsen's bill, if it goes into effect?

Mr. TIERNEY. Yes, sir.

Senator PACKWOOD. Considering that this program would go into effect the first day of the first month after passage, if we pass this bill in April, it would go into effect on May 1 and would last 1 year. Based upon your experience, how long would it realistically take you to get it going?

Mr. TIERNEY. When you say get it going, Senator, I would like to just explain——

Senator PACKWOOD. To pay benefits.

Mr. TIERNEY [continuing]. One thing. If you say, provide medicare coverage—in other words, these people become a part of the medicare program, I think it would take a very long time and possibly never really accomplish that because there is such a distinction between medicare as we know it now and as it would exist in this kind of a situation that it really would not be the same.

As far as simply issuing checks, if you mean that somebody has determined eligibility and we rely thereon, and simply accept a bill from a hospital and send them a check, that could be done reasonably soon.

Senator PACKWOOD. But I am talking about sending checks to eligible beneficiaries or to hospitals that are providing services for eligible beneficiaries. I realize you could send checks out on the first day or very close to the first day, but in terms of reaching the coverage that

Senator Bentsen is trying to reach, and that perhaps most of us would like to cover, how long would it take?

The program is going to end a year after it starts. How long into that first year would it take you to provide coverage for those who are determined to be eligible?

Mr. TIERNEY. Senator, I am not trying to evade your question. I am trying to throw some light on it. I do not think in a year we could provide, like we do for the aged or the disabled, medicare coverage. We could start a mechanism which would pay hospitals for people who were assumed to be eligible through some certification. I am guessing, but I would think within a month you could do that. You need some forms, but that is not really medicare coverage.

It has nothing to do with medicare. It is a new mechanism for paying hospital bills.

Senator PACKWOOD. What you are saying is within a month you could start to issue checks, but you are not sure that within a year you could actually be certain whether you were issuing checks for eligible beneficiaries?

Mr. TIERNEY. Yes, sir. That is correct.

Senator PACKWOOD. I have no other questions.

The CHAIRMAN. Senator Roth?

Senator ROTH. Mr. Secretary, I have just one question. You said that because of the fiscal constraints that you are delaying until next year new initiatives on national health insurance.

Secretary WEINBERGER. And all other new programs.

Senator ROTH. That is correct. Yes, sir. My question is this: we have already been discussing the long leadtime needed to put even a moderate health insurance program for the unemployed into effect. Why would it not be worthwhile for the administration and the Congress to proceed this year with the health insurance legislation recognizing that, once we adopt it, it will take a long leadtime to implement it? Why cannot we seize this as an opportunity to move ahead now?

Secretary WEINBERGER. Well, I think the feeling, Senator, is that, with the promotion, recommendation, and sponsorship of new programs at the same time the President is asking for very necessary restraints on the rate of growth of spending, you would establish an atmosphere under which the requests for restraint are not taken very seriously. That is why the President determined that there should be a moratorium on all new spending programs this year, with the exception of energy that has a special set of problems all of its own and is tied directly to the state of the economy as a whole.

Senator ROTH. Yes, sir, but what I am saying is you are not going to put it into effect this year anyway.

Secretary WEINBERGER. No, you certainly are not. All health insurance bills have at least a 2-year delay in them, and absolutely have to have for the reasons I mentioned earlier.

Senator ROTH. So I go back to the proposition that we ought to move ahead. As a matter of fact, you could have the effective date held in abeyance until the fiscal situation is ready. One of the criticisms of so many of the programs that we put into effect in the past is that there has not been sufficient planning. It seems to me that we ought to recon-

sider and see just whether we should not take advantage of this opportunity and move ahead, so that whatever we finally adopt, your agency will have some time to do some planning.

That is all I have, Mr. Chairman.

The CHAIRMAN. Senator Brock?

Senator BROCK. Mr. Secretary, I think the most cogent arguments against the Bentsen bill come from the cosponsor, Congressman Corman, in his own statement, and I would note on page 3 of his statement that he wanted to assure that the program could begin operating within a reasonably short period of time and the administrative procedures be streamlined as much as possible and that there is adequate question as to whether that is possible under this particular bill.

He also points out that neither of the two approaches we have talked about would cover the unemployed who are not eligible for unemployment compensation, and finally it covers only hospitalization.

Now, I share Congressman Corman's concern with this bill as well as the Kennedy bill, but it does seem to me that Senator Roth has made a pretty fundamental point, and that is the need to talk about any program in the context of those people who are disadvantaged, whether by circumstance of unemployment or circumstance of poverty, and you are not doing that.

I do not see how this Congress can go to the American people and justify a program which says, well, just because you are poor, it does not mean anything, but if you happen to be unemployed, it does. There are plenty of people who may be unemployed who have greater unemployment benefits under the SUB program, plus compensation, plus all of the rest of it than some people who at least are, in some sense of the word, gainfully employed, that they are exempted from any coverage at all.

I think the greatest problem I have with the political process at the moment is that this disenchantment that people feel about their government and the inequities they perceive in our legislative process, and if I might suggest to you or ask your comment rather, it does seem to me that whatever we do, whether it is some modification of the Bentsen-Kennedy-Roth-Brock-Long program, or the Weinberger program it should be related not to unemployment, but to income and to circumstances. Is that not a fair statement?

Secretary WEINBERGER. Yes, it is, and that is essentially the administration's comprehensive health insurance bill. The coverage is very broad, very comprehensive, would be required to be provided through the employer-employee arrangement, and the Government's only intervention would be to help those with low incomes obtain the same kind of coverage and also to improve the medicare benefits so that it equaled those of all of the others.

That is essentially the comprehensive health insurance plan, and I would certainly agree that that is a far more equitable and proper approach than the narrow, categorical approach of the one before you.

Senator BROCK. In essence that is what I think the chairman of the committee was saying when he referred to the Long-Ribicoff title II which relates to the poor, and that covers not only the unemployed, but those who are economically deprived for whatever reason. I personally very much appreciate your emphasis on that.

I do happen to disagree with the administrative concept in your bill, but I appreciate your willingness to at least support consideration of a broader program. Whether that will be implemented this year is up to us, I think, but I do think we ought to approach it from that concept.

Thank you very much.

The CHAIRMAN. Mr. Secretary, here is the problem that bothers me about all this, from the fiscal point of view. A tax expenditure in a very desirable area, I should think, would do as much to stimulate the economy as a tax cut, especially if you are looking at one of the high-priority expenditures, and a low-priority tax cut.

When we are looking at a $16 billion tax cut measure, I find myself wondering—and the same question is posed by a suggestion being sent to us by Senator Bumpers from Arkansas—would we not be better advised to spend some of this money in areas that cry out for activity? Compared to some of the items that you or I might place at the bottom of the priority list, among those tax cut items, would we not be better advised to provide health care to a lot of poor people, many of whom will suffer for the rest of their life the ravaging effects of illnesses with which they are afflicted at this point, rather than simply spend that money in a tax cut?

I am very much interested in providing for the low-income people, who do not have the money to pay for health care, whether unemployed or not. The same thing is true with regard to these catastropic situations where all of the family's resources have been completely wiped out. Would we not be better off to provide some money in that area, rather than just put it into a tax cut?

Secretary WEINBERGER. Well, Senator, I happen to disagree with you. I feel that tax cuts put the money in the hands of the people themselves to spend, and I have a great confidence in the ability of every person, whether he has a low income or not, to be able to make decisions that are best suited to him. I think that in addition to that, there is substantial waste and loss in more of these in-kind programs, and food stamps is a perfect example of it. I would infinitely rather have that cashed out, and have the people eligible have the cash and let them make their own food decisions or their own budget decisions, rather than have Government here in Washington assume the wisdom to do it.

I also think that you get much greater stimulation for the economy by a tax cut than you do by additional forced Government spending, which is nearly always likely to be accompanied by a certain amount of waste and a considerable amount of lost effort and time. So I would not agree with you. I am sorry. I would favor a tax cut. I think what we are apt to get here are tax cuts and expenditures, and the combination of the two can dislocate the economic system so that you are going to have a great deal more time and trouble achieving economic recovery than if we stayed within reasonable limits of stimulation through tax cuts, and encouraged some private investment. This is the only thing that can produce jobs and get us out of this situation.

The CHAIRMAN. Well, I fully concede to any Secretary the privilege of backing any program announced out of the White House. But I must say that it is difficult for me to accept the rationale of the administration. Last year, the program was not a tax cut, but a tax in-

crease—a 5 percent tax increase. Then this year, we are told, instead, cut taxes, but don't increase spending. Now, next year, you might come here with the program, increase expenditures; don't cut taxes.

I really think that all of these things need to be judged on their merits. In other words, in some areas, some people ought to pay more taxes. In other areas, we have some high-priority programs and people in crying need, for whom it would be justified in providing a spending program. And then, there are some areas where a tax cut would do a great deal of good.

I, for one, cannot buy the view that more Federal expenditures is a fine thing one year, and the next year it is all bad.

Secretary WEINBERGER. We do not buy that view, Senator.

The CHAIRMAN. You will be in here next year with the health insurance program.

Secretary WEINBERGER. That is not an expensive program, as these Federal standards go, if you would adopt the administration plan. If you adopt some of the other plans, you do have enormously expensive programs.

The CHAIRMAN. Mr. Secretary, your program will cost the consumer more than my program.

Secretary WEINBERGER. No, sir.

The CHAIRMAN. The only difference is, the approach you would use would do it by way of the insurance companies, on the theory, as I see it, that any Government activity is evil; while, if you achieve an even lesser result by way of private enterprise, that seems to be all right.

Secretary WEINBERGER. No. The general view I have, Senator, is that any Government action is not necessarily evil, but I would like to examine it pretty carefully to see if there is any chance that it might be more effective and result in better action than that carried on by the private sector. My experience with Government and the private sector has led me to feel that, ordinarily, you get a lot more effective use of your Nation's resources through the private sector. And you get a lot more individual freedom, which I think is a very important thing. The bigger Government gets, the less individual freedom you have.

The CHAIRMAN. My time has expired, Mr. Secretary. I am not going to complain about you taking most of it. Go ahead, Senator Curtis.

Senator CURTIS. Mr. Secretary, as I understand it, this hearing is on both bills before us? Well, at any rate, the Bentsen bill and the Kennedy bill both are written to be temporary programs. Is that right?

Secretary WEINBERGER. That is what they say, yes, sir.

Senator CURTIS. Now, if unemployment remains at a high level for a few years, and I hope it will not, do you anticipate that the pressures will be such that either of these programs, if adopted, can be discontinued?

Secretary WEINBERGER. Whether or not unemployment remains at a high level, Senator, I would anticipate that the pressures would be irresistable to keep either or both programs in effect permanently.

Senator CURTIS. Yes, sir. Now, is there anything in the Federal law that prevents unemployed people, if they do not have resources, from receiving medicaid at the present time?

Secretary WEINBERGER. It depends on the States.

Senator CURTIS. No, no. My question is, is there anything in the Federal law?

Secretary WEINBERGER. Federal law? No, I do not believe there is anything in the Federal law.

Senator CURTIS. That would preclude unemployed people from obtaining medicaid at this time?

Secretary WEINBERGER. Not under the Federal law. There are provisions in some States.

Senator CURTIS. Yes, sir. A State can make that decision if they want to. So, so far as the unemployed are concerned, we have a program now where all of those who do not have the resources to provide their own medical care can be taken care of, from the standpoint of Federal law. Is that true?

Secretary WEINBERGER. That is true. There are asset tests and other entry requirements into the medicaid program, but in my understanding, that is correct.

Mr. WEIKEL. No. In 24 States——

Senator CURTIS. No, no. I am asking only about the Federal law. Now, if the States do not want to take care of the poor people, that is their responsibility.

Mr. WEIKEL. But under the medicaid program, they would have to be categorically related.

Senator CURTIS. Not according to Federal law.

Secretary WEINBERGER. Well, it is not the individual State variations he is talking about. It is the overall Federal requirement. Medicaid is a State-administered program, for the most part.

Senator CURTIS. I understand. But is there anything in the Federal law that would prohibit giving of medical care under medicaid to an unemployed person, if he had no resources?

Mr. WEIKEL. Yes.

Senator CURTIS. What is it?

Mr. WEIKEL. The individual would have to be in one of the aged, blind, disabled categories—or in a family with dependent children. He could not, for example, be a single adult.

Senator CURTIS. I will accept single adult.

Mr. WEIKEL. Or a married couple without children would not be eligible under that case.

Senator CURTIS. All right.

But the Bentsen bill would take care of unemployed people regardless of their assets and other resources?

Secretary WEINBERGER. That is true. The only eligibility is drawing unemployment compensation.

Senator CURTIS. I want to commend the Department for taking the position against new programs. It is so difficult to reduce the cost of programs, and the costs just grow. It is almost impossible to discontinue a program. The big hope that we have for ever getting this Government into manageable proportions is to stop enlarging it.

I disagree with the administration's plans that are now on the shelf, with reference to national health insurance. We have a program for the aged. We have a program for the poor. I think before we start to debate which plan of national health insurance is the better or the best, that we should give the American people an opportunity to debate

the issue. Do you want the Federal Government to provide health care for people that are neither poor nor aged? I do not believe that at this time the American people are asking for it. I think there are groups, I think there are sizable numbers. But I believe it is generated by aspiring politicians.

Anyone that is knowledgeable of congressional procedures knows that we could take the administration's program on the floor of the Senate next year, and we would either get the Kennedy bill, or even halfway toward it. But I certainly commend you for your present stance against no new programs, and I would hope for continuation of that.

Senator HARTKE (presiding). Mr. Secretary, I understand it is my time, and let me say to you that I find myself in almost 100 percent disagreement with my dear friend from Nebraska, and I am sorry that you have taken such a reactionary stand against the people. But let me say to you, I am quite concerned about this immediate problem. I have just come from the Joint Economic Committee, where I was talking to them about the fact that some people are going to look for stabilization at 8.2 percent unemployment rate. I think the Bureau of Labor Statistics would tell the American people, if they would listen, that this is not a good figure, that there is disaster in it; because 580,000 people dropped out of the labor force. They are what is known as discouraged workers, and this is the highest number of discouraged workers in history. People are losing faith in their ability to get a job.

Now, having said that, let me ask you a question. There is another measure which we have introduced, and we do not claim that it is going to be completely successful. Basically, it provides for catastrophic coverage for the big illness, the accident, or the operation. However, we agreed to redefine and reconceptualize the meaning of catastrophic. We have made it relevant to the financial situation of the unemployed without going to complete coverage. We have also extended the coverage to all individuals who fall under the scope of any State or Federal unemployment compensation program, regardless of whether they had prior insurance or not. Full hospitalization will begin on the 16th day, as opposed to the 61st day as provided by the original catastrophic plan. Total out of pocket expenses for physicians and other medical services are $1,000, as opposed to $2,000 in the other program. Total co-payments would equal no more than $500, as opposed to the $1,000 envisioned by the Finance Committee catastrophic plan; and generally speaking, full coverage starts at about $3,000 rather than $10,000. This represents a basic reevaluation of the meaning of catastrophic, and one that is related to real needs.

Now, the States themselves, in such cases, would be expected to enter into agreements with the private carriers to provide the mandated coverage to the constantly-changing core of unemployed, and they would be reimbursed 100 percent for the insurance and the administrative costs by the Federal Government; financing would be from general revenues. I wonder if you have any comment, or is that just too quick to throw that at you?

Secretary WEINBERGER. No, sir. I cannot persuade myself that you would like my comments, and it is always disappointing to me to have to disagree with one of your measures. But I would have to sum it up by saying that I think that bill has all of the worst features of the

Long, Ribicoff, and the Bentsen bills combined. I can elaborate on that if you wish.

Senator HARTKE. That is a pretty good recommendation when you disagree, I would have to admit.

One of the problems that I see at this time is, when you come back to the unemployed, they are just in a special category, and I think everybody has pointed this out. And the situation creates a lot of desperate feelings, I do not mind telling you right now. The Indiana State Legislature is meeting, and it is not a very pleasant sight out there. There are people beating on the windows—they have windows around the State legislative hall—and they are beating on the windows, and we are just one step away from that. There is a demand for action in many of these areas. And I know that the President says he wants action out of Congress, but every time we start to move, the whole administration puts up a great big road block.

Secretary WEINBERGER. Well, Senator, I think what they are beating on the windows for, which I assume is a figure of expression——

Senator HARTKE. No. I am talking about actually physically beating on the windows.

Secretary WEINBERGER. They are not beating on the windows to have their doctors and hospital bills paid. The thing that would do the most good is additional cash for a longer period of time, and that is what has been asked by the unemployment insurance extension proposals that we have made.

Senator HARTKE. I am for that. I have no problems with that.

Secretary WEINBERGER. But the thing that helps people most in this condition, is not a paid visit to a doctor or a hospital. It is the situation that can give them more cash to provide better food and better housing conditions and clothing for their families, and things of that kind. That is what the unemployment insurance extension provides. What you are talking about here is a special, new separate set of programs to pay a special, separate set of bills; many of which, I am bound to say, Senator, are going to be absorbed anyway by doctors who, many years before medicare, treated free a great many patients who were unable to pay. And I, for one, do not believe that we have gotten so far away from that kind of rather noble contribution that a great many people made that we are going to have some of the problems that people have talked about. But you are not going to solve or relieve the principal problems of the people who are most affected—and they are serious problems, and people are deeply affected. You are not going to remove them by providing a new system of paying somebody's hospital or doctor bills.

Senator HARTKE. Well, the American Hospital Association is here to testify today, and I am just telling them—here comes a vote, and we are going to have to leave—and so is the American Medical Association. I am going to ask them whether they are willing to give a moratorium, as you have indicated.

Secretary WEINBERGER. Now, I did not say anything about a moratorium. I just said there is still a lot of nobility left in the American system, and I do not think we should feel it has been exhausted simply because we have had medicare and medicaid for 10 years. It relieved a lot of the necessity of that before.

Senator HARTKE. I just wish that you were right, and it is so sad to see a man so wrong.

Secretary WEINBERGER. There is always a possibility, sir.

Senator HARTKE. I tell you, so help me, I came here in 1959. My first assignment was a special committee on unemployment problems, and they talked about committees here being ad infinitum. It was headed by a fellow named Eugene McCarthy, one of the finest works ever done. I wish you would read some of that, and read the tragedy that is in there.

Secretary WEINBERGER. Nobody questions that at all.

Senator HARTKE. And go out, as I do, and read the tragedy on the unemployment lines, where they are stacked up for miles. And I tell you, I do not know in your own administration—when I talked to them this morning downstairs, not officially, but unofficially with the Bureau of Labor Statistics, you have a deep psychological and social problem in this country of people being discouraged, not alone in getting work, but discouraged with the system. And with all due respect—and you know I did not vote against your confirmation; maybe I should have, but I did not——

But the point of it is, as long as this attitude prevails, in my judgment, you are drawing the line sharper and sharper between those who feel that this system can sustain itself and those who feel it cannot.

Secretary WEINBERGER. Senator, your vote that you referred earlier to is one of the reasons I so reluctantly disagree with any of your proposals. But the simple fact of the matter is—and I think the President is as deeply affected as anybody by the problems of people who are unemployed—there are other and better ways to deal with that than simply guaranteeing payment of some of the bills of the unemployed.

Senator HARTKE. But the President has already said national health insurance is out for this year. He said he cannot afford it.

Secretary WEINBERGER. On a practical note, Senator, I cannot——

Senator HARTKE. Not on a practical note. On a practical note, it should have been in there several years ago. On a practical note, that is what the people are so damn mad about in this country.

Secretary WEINBERGER. We urged that last year as strongly as we could. On a practical note, the chairman of the Ways and Means Committee has said he will not reach it in this committee until October.

Senator HARTKE. That is his fault. I cannot help what the chairman of the Ways and Means Committee does—he does not run the process. He is in a league with the President of the United States. But I cannot understand it. I mean, he is a nice guy, but I would like to see some people who are in league with the people, for a change.

Now, these unemployed people—I was out there last weekend. I talked to them. They are concerned about their insurance running out, and their families not having that insurance, and it is going to be canceled on them, and they cannot get into any other program.

Secretary WEINBERGER. I talk with groups every day, and in all parts of the country, Senator; and I can tell you that in my opinion, there are a great many more justified worries than whether a hospital gets its bill paid or not, or whether a doctor gets his bill paid or

not. What these people need is more money and a job, and we are trying to provide both. Furthermore, we will delay the job business if we engage in further categorical, narrow, ineffective spending programs that will further disclocate the whole economy.

Senator HARTKE. All of those adjectives, I think, are ineffective, okay? But the fact is—and then I am going to go vote, too—I am for going ahead and providing jobs for these people. I am for extending unemployment compensation benefits, and I do not have any hesitancy. I am ready to vote on it tomorrow. I wish you people would come down here and get the people, at least of your own party, the Republican Party to help us do it. They are part of that foot-dragging you are talking about, and talk to our committee chairmen. I am not even saying that we should enact the program I have introduced—all I am saying is that we must do something. I am tired of doing nothing.

Secretary WEINBERGER. Your bill, Senator, if I might suggest, would use up a lot of valuable resources to take care of people who have to pay $3,000 of medical and hospital bills before they get any protection, under your proposal.

Senator HARTKE. All right, put it away and come up with something better.

Secretary WEINBERGER. We have.

Senator HARTKE. What, with CHIP?

Secretary WEINBERGER. Yes, sir.

Senator HARTKE. All right. But you have already condemned that to the graveyard this session. I mean, you are saying to me, for example, that if I am sick—figuratively—and need help, that you say, well, I have got a perfect cure for you, but I am not going to use it. Is that what you are saying?

Secretary WEINBERGER. No, sir. What we are telling you is that the cures that are proposed in these measures cannot possibly be put in effect to help other than a very limited sector of the population, and in their case the only good it does is to pay a few of their bills in a limited category. And what they need is more money and a job, and that is what our alternative is this year.

Senator HARTKE. Let me characterize what you are saying. You are saying there are an awful lot of people out there who have cancer, and because we cannot cure them all, do not do anything for those you can help.

Secretary WEINBERGER. No, sir. Senator, I would hate to have the hearing end on that kind of a note, because that is not what I am saying, and I am sure you know it.

Senator HARTKE. Well, I think that is what you are saying.

Secretary WEINBERGER. No, sir.

Senator HARTKE. All right.

Listen, I have to go vote, too.

Secretary WEINBERGER. Well, I can just stay here and testify.

[General laughter.]

Senator HARTKE. My understanding is that I am dismissing you.

[General laughter.]

Senator HARTKE. The staff tells me I am dismissing you. Mr. Woodcock, I understand that you will be scheduled as the next witness,

as soon as this vote is over. Oh, pardon me, you are not excused, Mr. Secretary. Mr. Bentsen wants to come back and question you at noon.

Secretary WEINBERGER. Okay. Are we in recess now?

Senator HARTKE. We are in recess now.

[A brief recess was taken.]

The CHAIRMAN (presiding). This hearing will come to order.

I am going to suggest that we excuse the Secretary temporarily and ask him if he could remain in the room for about 15 minutes in the hope that Senator Bentsen can return and ask the additional questions that he wanted. Otherwise, I think we will ask Senator Bentsen to submit his questions to the Secretary in writing.*

[The prepared statement of Secretary Weinberger follows. Hearing continues on p. 43.]

STATEMENT OF CASPAR W. WEINBERGER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the committee: I very much appreciate the opportunity of appearing before you today. As you know, I am greatly concerned about the availability of health insurance at a reasonable price for all our citizens, and I am also much troubled by the problems of the unemployed.

Health insurance has been an important initiative of this Administration. I have testified on numerous occasions supporting the Administration's proposal for national health insurance. We need a system in this country which will provide universal protection against health care costs for all Americans. The proposal we introduced last year, the Comprehensive Health Insurance Plan, would have done that and would have provided for the unemployed continued protection against the high cost of medical care.

Unfortunately, we now find ourselves in an economic situation which makes it temporarily impossible to pursue actively early enactment of a comprehensive health insurance bill. We should not, however, lose sight of the major goal that CHIP was designed to accomplish—universal accessibility to financing for a comprehensive range of medical services. S. 496 does not do that. Instead, it is designed to aid only a small portion of the 25 million Americans who we estimate have no health insurance protection by providing the recipients of unemployment insurance benefits with the hospital services portion of Medicare.

In fact, Mr. Chairman, while I can appreciate the intent behind S. 496, passage of this bill would create gross inequities and enormous administrative problems. Furthermore, it would establish a new Federal program requiring well over one billion dollars in Federal spending, which is in direct opposition to the Administration's current economic strategy.

Dealing with the problems of the unemployed is key to the Administration's strategy for handling our current economic situation. And many things are being done in an effort to alleviate the plight of those who, through no fault of their own, find themselves without jobs.

The Administration has supported several major initiatives to help the unemployed:

—The Unemployment Compensation Program has been expanded to provide benefits for certain categories of workers not previously eligible. This will allow over the course of one year approximately two million additional unemployed persons to become eligible for benefits and will result in $3.2 billion of new Federal expenditures for 1975.

—Recognizing that during this recessionary period many of the unemployed will remain out of work for longer periods of time, the Administration has also supported an extension of the time during which unemployed persons are eligible for compensation. This provision will extend potential eligibility for benefits up to 52 weeks and will cost the Federal government an additional $1.3 billion this year.

—Public service jobs which are providing employment for thousands of workers who would otherwise be unemployed have been created. Nearly $2 billion in Federal funds will be spent to provide the money necessary for this effort.

These provisions coupled with the existing payment structure in Unemployment Compensation will result in over $20 billion being expended to benefit the un-

*See p. 47.

employed in calendar year 1975. Over $8½ billion of this amount will come from Federal revenues. In addition, the tax rebate program, which is a crucial part of the President's economic strategy, will provide added income to the unemployed along with others in our society.

While many things have been and can be done to help alleviate the economic condition of the unemployed, I would suggest that building an "in kind" benefits program is not a constructive step.

In addition to the proposals we are discussing today, there is currently before Congress a proposal that would pay home mortgage payments during periods of unemployment, or if income is otherwise substantially reduced. What about utility bills and car payments? How far do we go in providing new "in kind" benefit programs?

The main problem of the unemployed is not lack of health insurance. The major problem for the unemployed is that they have lost their jobs. And the most important thing we can do for them is to improve the economic situation so they can get them back. The unemployed need money—money to provide for their basic needs until they do become reemployed—money until they are able to provide for themselves through their own employment. The Unemployment Compensation Program is the mechanism whereby such funds are disbursed, and as I mentioned earlier, the Administration has supported the extension of unemployment insurance system. But there is a limit on how much we can or should spend for this or any other single purpose.

As I noted earlier, the cost of providing this single program is high. Our cost estimates to provide health insurance for the unemployed range from a minimum of $1.26 billion at an 8.0 percent unemployment level and a limited benefit package, to a high of $3.1 billion, if unemployment were to reach 10 percent and the benefits were to include both Parts A and B of Medicare. The cost of fully subsidized Part A coverage in S. 496 is $1.26 billion (at an 8 percent unemployment rate). We could not estimate the cost of the maternal and child health benefit section because of its lack of specification. We also assumed that those who accepted Part B coverage through the buy-in provision would pay a premium roughly equal to the cost of providing covered physician services. If unemployment reaches 10 percent the benefits in S. 496 would cost $1.6 billion. And these are only the costs for the first year of the program. If as likely this program were to be extended beyond one year, the yearly costs would increase dramatically. Many employers and health and welfare trust funds would, I'm afraid, cancel those provisions in their policies which extend benefits into period of unemployment. The ending of these extension provisions alone would add nearly $200 million to the annual cost of S. 496.

Important as the fiscal issue is, I have even more serious concerns about the equity of legislating such a program as envisaged under S. 496.

While it may be desirable to provide health insurance protection to the unemployed, they are only a segment of the total population who do not have coverage. As I mentioned, there are 25 million Americans more who have no health insurance, and approximately 35 million more who have inadequate protection providing little help against the ever increasing costs of health care. Some of these approximately 60 million people would be protected by S. 496, but most would not. There are employees working for employers who do not provide health insurance coverage and who cannot afford their own; there are the unemployed not receiving unemployment compensation either because they were not in covered employment or their benefits expired; and there are the early retirees not yet eligible for Medicare.

With an unemployment rate of 8 percent, the Department of Labor estimates that approximately 7.4 million persons would be unemployed. Of this number 6.0 million would be eligible for unemployment compensation. About 4.6 million of these would be eligible for the health insurance protection provided under S. 496. While entitlement to another health insurance plan would not preclude eligibility under S. 496, the private insurance plan would pay first and about 20 percent of the 4.6 million would have other coverage.

I do not want to minimize the need of the unemployed, but certainly health insurance coverage only for those receiving unemployment compensation does not address the problems of millions more of our citizens whose needs are as great or greater. Moreover, a high percentage of those eligible under this proposal will be young and single. This is not the group that we believe is most in need of a benefit such as health insurance protection.

Since the benefit package and administration of S. 496 would be essentially the same as Medicare, it is appropriate to compare eligibility requirements for the unemployed to others eligible under the Medicare Program.

Those currently eligible for Medicare must be age 65, disabled, or suffering from end-stage renal disease. The unemployed need not meet any of these conditions.

Those currently eligible for Medicare must meet a special insured status requirement. The unemployed need not meet a comparable requirement.

Those eligible to Medicare because of a disability or requiring kidney dialysis have a waiting period of 24 months and three months, respectively. The unemployed would have no waiting period.

The dependents of those currently eligible for Medicare are not similarly entitled. The unemployed would have the same coverage for their dependents as they have for themselves.

The point to be emphasized, Mr. Chairman, is that the eligibility criteria for current Medicare beneficiaries are different and generally more restrictive than would be the case for the unemployed. It would be difficult to explain to a disabled person why he had to wait two years for Medicare benefits and why, even then, his children would not be eligible, when healthy unemployed persons and their dependents would have no waiting period.

The equity issue comes even more strongly into focus when you consider that persons aged 65 and over who are not insured for Part A of Medicare may obtain such coverage only by paying a premium, which is now $36 per month and will increase to $40 per month in July. S. 496 would provide identical coverage for the unemployed at no cost.

Consider also, Mr. Chairman, those Social Security beneficiaries under age 65 and therefore not entitled to Medicare protection—workers who retire at age 62, wives, widows, and children. Even though entitled to Social Security monthly benefits, they are not eligible for Medicare protection in spite of the fact that the worker contributed to the Social Security System and Medicare is a benefit under that system.

Problems of equity are not confined to S. 496. Other bills which have been introduced and on which I will be testifying also present equally disturbing inequities. S. 625, for example, would provide health insurance for the unemployed through an extension of existing employer-sponsored coverage.

At an unemployment rate of 8 per cent, S. 625 would provide coverage for approximately 3 million of the unemployed at a cost of approximately $1.5 billion. Under this proposal, not only would the coverage be limited just to those unemployed receiving unemployment compensation, but it would also be restricted to those employees whose employers offered coverage previously. Approximately 1.2 million individuals would be excluded because they had no health insurance through prior employment.

Even among those who would be eligible under S. 625, gross inequities are evident. The benefits for those eligible would range from nearly nothing to first dollar coverage for almost everything. There is a wide variation in the types and amounts of health coverage currently available through employers' group health plans. A recent survey response from 127 employers revealed premiums ranging from a low of $25 per month for family coverage to a high of $85. I do not believe it would be appropriate to fund from general revenues such plans when the variation in benefit levels is so great.

Would it be fair to the person eligible under a $25 per month health plan for the Federal government to continue that premium when another person eligible under an $85 per month health plan also had his full premium paid? Would it be fair to the working tax payers of this country, millions of whom have little or no health coverage, to use their taxes to continue paying a premium of $85 per month for some of the unemployed?

Let me next turn to another serious problem, that of administration. Because eligibility is tied to entitlement to Unemployment Compensation, there would have to be involvement on the part of State and local unemployment compensation offices to carry out the enrollment process. Unemployment is a transitional problem for many, even during periods of recession. Adhering to the requirements of S. 496 would require a system of rapidly bringing people on and off the rolls. Even in the best of circumstances, this would be a complicated process.

The additional administrative burden that would be placed on the unemployment insurance system to undertake this function would be very difficult for it to handle. Heavy workloads are already straining the capabilities of employees

administering unemployment compensation. Adding an unfamiliar program of health insurance would severely compound already existing problems of sending cash benefits on time to eligible unemployed persons.

Likewise, it is all too easy for us to assume that an existing system such as Medicare could accommodate the administrative burdens of adding the unemployed individuals to its rolls without affecting its principal function of assuring financial protection to the nearly 24 million elderly and disabled who depend on it to help pay their medical bills. I'm afraid that just isn't so.

Coverage of the unemployed under this proposal would nearly double the size of Medicare rolls. An individual record would have to be established not only for each unemployed person, but for all their dependents as well. This would be necessary to verify eligibility when claims for benefits are filed and to record utilization to determine deductibles and coinsurance. Assuming an 8 percent unemployment rate, there would be approximately 10 million people (4.6 million unemployed plus their dependents) who would have to be added immediately to the system, a system which would have to be considerably enlarged to accommodate the new enrollees. This would be an extraordinarily difficult and expensive task.

To illustrate the magnitude of this task, let me contrast the administrative problem of the Supplemental Security Income Program to that of the S. 496 program. SSI had to obtain information from State welfare files and conform the information to the requirements of the SSA system. This effort involved information on 2½ million people, most of which was already in State files. In contrast, S. 496 contemplates creating records for the 4.6 million unemployed persons plus their dependents who would be immediately eligible. As I suggested previously, this would result in approximately 10 million enrollees for whom records would have to be established. Most of the enrollment data required for these individuals would not be in State files because it would not have been needed for purposes of entitlement to Unemployment Compensation. Presumably, each of the unemployed would have to be contacted to obtain necessary identifying information on himself and his dependents. This is not a task which can be performed simply or quickly.

Once records are established, who would process all the new claims? The Social Security offices are already severely strained in attempting to keep up with their current workload. In addition to the 4.6 million unemployed who would have to be enrolled immediately there would be up to 8 million more individuals who would face some unemployment during the year. There are approximately 1,300 Social Security offices. The average workload per office would be over 3,500 claims just to process the 4.6 million persons initially eligible. The ongoing annual workload would average 6,000 claims per Social Security office to bring the newly eligible unemployed on the rolls. Compare that with last year's new claims volume figures for all Social Security benefits which totalled 8,100,000, or an average of 6,200 per Social Security office for the year!

There may be a number of different ways of establishing eligibility, but the point is that some system of identifying the eligible unemployed and their families must be devised not only to bring people on the rolls but to take them off when entitlement to unemployment compensation ends.

S. 496 also stipulates where dual health insurance coverage exists that the private insurer pay first. Since about 20 percent of the 4.6 million potentially eligible under this proposal would have other insurance, coordinating benefits would be necessary on a sizeable percentage of claims. According to the insurance industry, this process is a particularly difficult administrative burden. And it would be exactly the reverse of the burden now imposed by the Medicare program. Under current Medicare provisions, the Medicare benefit is primary, and any other coverage secondary. This difference in paying Medicare claims, depending on whether beneficiaries are conventional Medicare recipients or unemployed persons, will be confusing for hospitals, Medicare intermediaries, and other insurers.

Another administrative problem arises from the fact that presently Medicare pays virtually no benefits for such services as obstetric and pediatric care. Coverage of the unemployed would require higher degrees of sophistication in Medicare claims processing and cost accounting because types of care largely new to the Medicare program would be covered. New and different questions related to reasonable cost and medical necessity would have to be addressed by the Medicare system which did not have to be considered before.

I should mention, Mr. Chairman, that problems of administration are equally complex under S. 625. Here again, employment offices would have the responsi-

bility of establishing eligibility to health insurance through entitlement to unemployment compensation. Since S. 625 would extend the coverage the individual had while working, a mechanism would have to be established to verify eligibility through a previously existing health insurance contract and to pay premiums to the appropriate carrier.

Thousands of employers and health and welfare trust funds across the country would have to certify as to terminated employees' eligibility under a pre-existing health plan. Many of these employers and trust funds will be unable, or unwilling, to provide this certification, or will not understand the necessity of performing this function. There would be tremendous administrative problems involved in education and enforcement to ensure that these provisions are carried out. The difficulty of the problem is compounded because some of the unemployed are former employees of companies which are no longer in business. It would be very difficult to establish prior eligibility under an employer health insurance plan for these people.

And what of the State employment offices that must then pay the premium to keep the health insurance in force? What is their administrative capability to pay millions of dollars of premiums in varying amounts to thousands of health and welfare trusts, employers, or carriers?

Mr. Chairman, the points I have made on cost, equity, and administration represent my major concerns about the effects of S. 496 and other bills to provide health insurance for the unemployed. Specifically related to S. 496, I am also concerned about the possible work disincentives which could be created through the implementation of this bill. If the unemployed should have a single package of benefits which in some instances would offer better protection than they had while working, some may opt for unemployment compensation instead of a job. I am not suggesting this would be an overriding problem, but especially where there were health problems either for the worker or a family member, health coverage through unemployment insurance may seem an attractive alternative to a job where no health insurance was offered.

I regret the necessity of being totally negative; however, it is just not feasible nor affordable to provide health insurance for the unemployed in a manner prescribed by S. 496 or S. 625.

Let me assure you, were it not for our present economic situation, this Administration would strongly be urging enactment of national health insurance. This year, fiscal constraint and energy development must be our priorities and, as you know, the President has asked for a moratorium on new Federal spending programs. For this year, therefore, we are delaying our initiatives on national health insurance. Yet, I am strongly committed to the principles of national health insurance embodied in CHIP, and we will introduce a bill along these same lines next year. Only through a comprehensive, universal system of national health insurance can the health care needs of the unemployed be properly addressed in a way that avoids the inequities and administrative problems I have discussed today. This can best be done by building on the strengths of existing systems of health care delivery and financing, and filling all the gaps to provide needed health care protection for everyone.

CHIP would provide universal financial access for comprehensive health insurance to all. These bills would provide limited coverage for just a few.

CHIP would have positive effects on the way health services are delivered by the structuring of the benefit package. In some ways these bills would have adverse effects by providing greater coverage for more expensive forms of health care resulting in further imbalances in the delivery system.

CHIP would incorporate a variety of cost control features. These bills would entail additional spending of uncontrolled funds.

CHIP would provide a mechanism for assuring quality and necessity of care. These bills would have no such controls.

Mr. Chairman, CHIP was not conceived overnight. It was well thought out and its features designed to provide a comprehensive pattern for health insurance. Quick implementation of hurriedly conceived legislation can have long-term adverse consequences, which I suggest would be the result of enacting S. 496.

This concludes my prepared remarks, Mr. Chairman. My colleagues and I would be pleased to answer any questions you and other Members of the Committee may have.

HEALTH INSURANCE FOR THE UNEMPLOYED: COST ESTIMATES AND METHODOLOGY

Introduction

Two bills now pending before Congress would furnish health insurance to persons receiving unemployment compensation. S. 496 would provide Part A Medicare coverage. S. 625 would finance continuation of group health coverage available from the former employer.

Federal costs estimated for these proposals are presented in Table 1. Costs of variations on the Medicare coverage approach of S. 496 are also shown. These estimates include an allowance for claims processing but do not include other administrative costs associated with enrollment, management, and financial control. This paper discusses the data and methodology underlying these estimates.

TABLE 1.—ESTIMATED FISCAL YEAR 1976 TOTAL HEALTH BENEFIT SUBSIDY COSTS FOR S. 496 (WITH VARIATIONS) AND S. 625

[In billions]

	Unemployment	
	8 percent	10 percent
S. 496:		
Pt. A	$1.26	$1.66
Pts. A and B	2.38	3.13
Pt. A plus in-hospital physician coverage	2.02	2.66
S. 625	1.57	2.07

The estimates are the result of two distinct sub-tasks. The first entails estimating the population to be covered by each proposal. The second entails estimating for each proposal the average annual medical benefits. In the next section the total average UC population of persons receiving unemployment compensation (referred to hereafter as the UC population) during FY 1976 (estimated by the Department of Labor) is subdivided into family status categories (head of household, wife, etc.) which are further divided, as appropriate, according to employment status of spouse. This facilitates estimating the proportion of the UC population who would receive subsidized benefits. The subsidized group is further identified according to whether coverage is for the unemployed individual only or for his entire family.

In the next following section the estimated average benefits for subsidized families and individuals under each proposal are discussed. These average benefits, when multiplied by the corresponding population levels, give the desired cost totals.

Population analysis

The average UC population level for fiscal year 1976, derived from Department of Labor estimates of total number of UC benefit man-weeks, is shown in Table 2. Levels are shown for an assumed average 8 percent and 10 percent gross unemployment rate over the year.

TABLE 2.—AVERAGE POPULATION OF UNEMPLOYMENT COMPENSATION RECIPIENTS

	Unemployment rate	
	8 percent	10 percent
Compensation type:		
Regular	3,500,000	4,700,000
Extended	1,400,000	1,900,000
Supplementary [1]	1,100,000	1,300,000
Total	6,000,000	7,900,000

[1] It is assumed that supplementary unemployment assistance benefits will be extended beyond the existing December 1975 expiration date.

Source: Department of Labor estimates.

Table 3 presents the distribution of the UC population by family status. This profile has been estimated from special DHEW tabulations from the Bureau of the Census' Current Population Survey file. The tabulations select from all unemployed persons those having characteristics of the UC population subset.[1] These data, describing experience of recent years, have been further adjusted to account for the effects of current higher unemployment rates. In particular, the proportion of male heads of households has been increased.

TABLE 3.—INSURED UNEMPLOYMENT BY FAMILY STATUS (ESTIMATE)

Family status	Percent	Unemployment rate 8 percent	Unemployment rate 10 percent
Male heads of households	42.0	2,500,000	3,300,000
With spouse working full time	11.3	700,000	900,000
Other	30.6	1,800,000	2,400,000
Wife of household head	58.1	1,100,000	5,400,000
With spouse working full time	11.3	700,000	900,000
Other	6.8	400,000	500,000
Female head of household	5.0	300,000	400,000
Other relative of household head	23.9	5,400,000	1,900,000
Under 20 years	6.2	400,000	500,000
Other	17.7	1,000,000	1,400,000
Other individuals	11.1	700,000	900,000
Total	100.0	6,000,000	7,900,000

Table 4 displays relevant population estimates for S. 496. The provision of that bill that "dependent spouses" are not eligible for subsidized coverage is interpreted to disqualify any UC (male or female) with a spouse working full-time. The number of UCs disqualified on these grounds are shown in the "no coverage" column. (Notice that the "total column of Table 4 is identical to the first column of Table 3.)

All other UCs are eligible to enroll for Medicare Part A coverage, but any other available private health coverage is made the primary payer. This will apply to persons who have coverage still in force from their prior employment or who have coverage under a parent's employer's plan. The column in Table 4 indicating "secondary" coverage includes this particular group.[2] (Special cost factors described later apply to UCs in this category.) All others generate full benefits for themselves or their family and are located accordingly in the "family" and "individual" columns of Table 4.

Division of UCs into primary and secondary coverage is based on two data sources. The distribution of group coverage extensions by duration of extension is based on an analysis of sampled contracts covering firms of 26 or more employees undertaken by the Bureau of Labor Statistics. Over 70–75 percent of persons becoming unemployed who had group coverage would lose that coverage within 30 days of termination of employment.

[1] The CPS does not identify UC beneficiaries as such. The only direct reference in the CPS survey is the receipt of unemployment compensation at some time during the prior year.

[2] Contractual provision for post-layoff extensions of private group coverage would tend to diminish over time in the presence of subsidized coverage.

TABLE 4.—DISTRIBUTION OF THE UC POPULATION BY SUBSIDY CLASS, S. 496

[In percent]

	Class of subsidized coverage				
	Total	Family	Individual	Secondary [1]	No coverage
Male head of household:					
Spouse employed full time	11.3				11.3
Spouse not employed full time	30.6	26.5		4.1	
Female head of household	5.0	4.3		.7	
Wife of head:					
Spouse employed full time	11.3				11.3
Spouse not employed full time	6.8	5.8		1.0	
Other relative of head of household:					
Single, under 20 years	6.2		1.2	5.0	
Other	17.7		15.8	1.9	
Unrelated individual	11.1		9.4	1.7	
Total	100.0	36.1	26.4	14.4	22.6
Number of insurance units, 8 percent unemployment rate (millions)	6.0	2.2	1.6	.9	1.3

[1] Refers to persons with existing private coverage, either through coverage under parents' employer or with extended coverage remaining in force.

Table 5 describes the distribution of extended coverage for the other 25–30 percent.

Table 5.—Extension of private group health benefits by duration of extension

Duration:	*Proportion of workers having extended benefits (percent)*
1 month or more	25–30
3 months or more	18–20
5 months or more	10
12 months or more	5

This pattern must be juxtaposed with the distribution of UCs by duration of unemployment in order to assess the effect of extensions on qualification for subsidized coverage. Roughly 15% of all UCs with prior coverage are estimated to have some continued group coverage. It has been assumed that 90 percent of UCs who are households head and 70 percent of the others had group coverage in their former employment.[8] Combining these percentages with the 15 percent factor produces the divisions shown in the table.

The outcome of these manipulations is summarized on the bottom line of Table 4. About 23 percent of all UCs, 1.3 million out of 6 million, generate no subsidized coverage under S. 496, while 36.1 percent (2.2 million) are covered with their families and 26.4 percent (1.6 million) are covered as individuals. The remainder have some private coverage, with Medicare as the second payer.

Table 6 displays the allocation of UCs into subsidized coverage classes for S. 625. Some 49.9% would not be eligible for benefits due to their having (or being able to obtain) coverage through spouse or parent, having extended coverage still

[8] These factors are based on data from a supplemental survey attached to the March 1972 Current Population Survey. Some upward adjustment has been made to account for trend effects and other differences between the populations in question. See "Group Health Insurance Coverage of Full-Time Employees, 1972," W. Kolodrubetz, *Social Security Bulletin*, April 1974.

in force, or having had no coverage in former employment. The same assumptions discussed earlier apply: 90 percent of family heads and 70 percent of others had coverage, and 15 percent of UCs that had coverage still have it in force.[4]

TABLE 6.—DISTRIBUTION OF UC POPULATION BY SUBSIDY CLASS, S. 625

[In percent]

	Class of subsidized coverage			
	Total	Family	Individual	No coverage
Male head of household:				
Spouse employed full time	11.3	1.0		10.3
Spouse not employed full time	30.6	23.5		7.2
Female head of household	5.0	3.8		1.2
Wife of head:				
Spouse employed full time	11.3	1.1		10.2
Spouse not employed full time	6.8	5.2		1.6
Other relative of head of household:				
Single, under 20 years	6.2		0.5	5.7
Other	17.7		10.5	7.2
Unrelated individual	11.1		6.6	4.5
Total	100.0	34.6	17.6	47.9
Number of insurance units, 8-percent unemployment rate (millions)[1]	6.0	2.1	1.1	2.9

[1] Includes units with (a) coverage under spouse's or parent's group policy, (b) extended coverage remaining in force, (3) no coverage at former place of employment.

Health benefits per family and per individual

S. 496 Coverage Medicare Benefits.—Average benefits shown in Table 7 were computed, using standard actuarial methods, by the Social Security Administration Office of the Actuary. Independent estimates made by the SSA National Health Insurance Modeling Group were in close agreement.

TABLE 7.—AVERAGE MEDICARE BENEFITS FOR UC POPULATION, FISCAL YEAR 1976

	Primary coverage		Secondary coverage	
	Family	Single	Family	Single
S. 496 coverage:				
Pt. A of medicare [1]	$460	$160	$35	
Pts. A and B [2]	830	275	270	$100
Pt. A plus in-hospital physician coverage	705	235	235	70

[1] Includes an allowance for claims processing by intermediary: 6 percent of benefits for pt. A, 15 percent of benefits for pt. B and in-hospital physician coverage.
[2] Pt. B cost sharing is assumed for inpatient physician coverage.

"Secondary" benefits apply to those cases in which private coverage is in force (and is therefore the primary payer under the provision of S. 496) but does not provide as much coverage as Medicare. The amounts shown in Table 7 were based on a comparison of the mean value of Medicare benefits given in the table with a distribution of private group plans by total premium.[5] The method followed was to convert the 1970 data to a corresponding 1975–1976

[4] As an example of how these assumptions produce the allocation given in Table 6, consider the male head of household group. Coverage is assumed to be available through his spouse in 90 percent of the cases where the spouse is employed full time, thus the division of the 11.3 percent into 1.0 percent and 10.3 percent. If the spouse is not employed full-time, the family will not receive subsidized coverage if the UC himself either had no coverage (10 percent probability) or had coverage and still has it in force (90 percent times 15 percent). This implies that among the 30.6 percent of all UCs in the category, 7.2 percent (.10 plus the product .9 times .85, all multiplied times 30.6 percent) are not subsidized. The rest are subsidized together with their families, and are thus found in the family column of Table 6.

[5] This distribution was developed by B. Mitchell of the Rand Corp. using data from a 1970 survey conducted by the Center for Health Administration Studies and the National Opinion Research Center (CHAS–NORC) of the University of Chicago.

distribution, and then to calculate the mean difference between the Medicare premium and all private premiums (adjusted to account for their inclusion of coverage not included in Medicare) of amount less than the Medicare benefit.

Private group coverage.—Premium amounts per family or individual insurance unit used for estimating S. 625 costs as shown in Table 8, are based on data from the same 1970 survey by the Center for Health Administration Studies and the National Opinion Research Center of the University of Chicago referred to above. Premiums have been adjusted upward to reflect the increase of medical service prices during the 1970–1975 period.

Table 8.—Average Group Health Insurance Premiums for Full-time Workers, fiscal year 1976

Coverage:	Total premium
Family	$595
Single	320

The CHAIRMAN. Now, is Representative James Corman of California in the room? Is he here?

I will call Representative James Corman.

We are pleased to have you, Mr. Corman. We will be pleased to have your statement.

STATEMENT OF HON. JAMES C. CORMAN, A REPRESENTATIVE IN CONGRESS FROM THE 21ST CONGRESSIONAL DISTRICT OF THE STATE OF CALIFORNIA

Mr. CORMAN. Thank you, Mr. Chairman.

If it is permissible, Mr. Chairman, I would like to submit my written statement for the record and just very briefly mention some additional points and respond to questions if there are any.

What we are looking for in these hearings is the most equitable and workable way of providing some protection against the cost of illness for laid-off workers during periods of unemployment. There are lots of other health care problems, as the chairman well knows. But the plight of the unemployed is an immediate problem, and one for which I think we can put in place a program that will take care of their needs on an emergency basis. This will give us some time to address the basic problems that exist in our health system.

The two major approaches to this immediate problem are S. 496, introduced by Senator Bensten, which I have coauthored in the House, and S. 625, introduced by Senator Kennedy and coauthored in the House by Mr. Fraser.

Hopefully, this committee and Ways and Means will be able to agree on legislation that will meet the needs of the unemployed.

An issue that we need to pay particular attention to is which of the approaches will present the fewest administrative problems, or which can be put in place most rapidly. I suggest when we look at this particular problem that S. 496 would be easier to implement than S. 625.

The principal authors of both proposals concede that, because of limitations in coverage, both proposals need to be expanded. The Bentsen/Corman bill covers only medicare, part A. I would hope that the two committees might add medicare, part B, in part because physicians' services will be needed by a great number of people and, because if physician's services are left out there is likely to be some overutilization of hospital coverage.

Those who advocate the Kennedy-Fraser approach have suggested that we might cover under medicaid the approximately 20 percent of the unemployed who do not have in-place hospital coverage at the time they become unemployed.

If we look at the administration of the Kennedy-Fraser proposal, it means that some entity of Government would have to deal with some 400 insurance companies with an unlimited, or at least an unascertained, number of different health policies.

It seems to me there are four steps in the administration of any program. We have to identify the beneficiaries first. Second, we have to identify what benefits they get; and third, we have to ascertain that some benefit or health care was delivered to them; and last, that some specified amount is paid for that care.

The task of identifying the beneficiaries, it seems to me, would be relatively simple if it is to be coupled with their drawing unemployment compensation.

In identifying benefits, if we rely on the medicare approach, we know, and most of the people in the health care field know, precisely what benefits or medical services are covered.

If we go the Kennedy-Fraser route, further steps will include ascertaining whether there was private coverage. If there was, with what company; what were the benefits under the policy; and, very importantly, was the company willing to continue those benefits at some agreed-to premium, that agreement being between the Federal Government and the insurance company. All of these additional steps, it seems to me, lead to tremendous administrative problems.

The problem of whether or not a benefit has been delivered is relatively simple, and certainly would have to be ascertained under either program.

The last item of who gets paid, and how much, would vary substantially under the private insurance approach. And, of course, if the committee adopts the backup of medicaid for those who do not have coverage, we have at least 50 separate entities to deal with to ascertain what the benefits might be. They are very good in some States and very modest in others.

On grounds of equity and administrative feasibility, I would hope that this committee would look favorably on S. 496, and that we might expeditiously report out a bill in both bodies which would provide medicare protection for the unemployed while they draw unemployment compensation.

The CHAIRMAN. Thank you very much for your statement, Mr. Corman. Your entire statement will be printed as you presented it to us in addition to your summary.

Mr. CORMAN. Thank you, sir.

The CHAIRMAN. Thank you for appearing before us today.

[The prepared statement of Representative Corman follows:]

PREPARED STATEMENT OF JAMES C. CORMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

SUMMARY

(1) Current economic conditions—inflation and recession—have amplified the inadequacies in the existing methods of receiving and paying for health care, and require us to accelerate the process that will lead to enactment of a comprehensive National Health Insurance program.

(2) An emergency, stopgap measure is needed to assist laid-off workers who have lost their private hospital insurance coverage. This must be done as equitably as possible and with a minimum amount of administrative cost and complication.

(3) The Medicare approach contained in similar bills introduced by Senator Bentsen in the Senate and Congressman Corman in the House, appears to be the easiest and fairest way to deal with the emergency problem of assisting the unemployed obtain needed health care.

(4) This approach, as presently contained in S. 496 and H.R. 3208, would entitle an individual receiving weekly benefits under a Federal or state unemployment compensation plan—and his dependents—to the same hospital insurance coverage provided under Part A of the Medicare program. Benefits under the program would be paid out on a retroactive basis. The eligible unemployed would not pre-enroll.

(5) As drafted, these proposals cover only hospital services and do not include the unemployed who are ineligible for or have exhausted Unemployment Compensation benefits. Expansion of this approach—in terms of benefits and coverage—should be examined by the relevant committees.

STATEMENT

Mr. Chairman, I appreciate the opportunity of testifying before your Committee on the critical matter of assisting the unemployed to meet their health needs.

Current economic conditions—inflation and recession—have amplified the inadequacies in the existing methods of receiving and paying for health care. The need for a comprehensive and universal National Health Insurance program has never been more apparent.

Rising medical prices are making it increasingly difficult for families to afford needed health care.

In the coming months, millions of laid-off workers will lose the private health insurance coverage that is contingent upon their employment. Most of them will be joining the 40 million Americans who have never been able to obtain or afford private health insurance. Laid-off workers who had no insurance will lose their ability to pay for health needs when they lose their job.

When a worker is laid-off, he is not forced to withdraw his children from public school. He does not forego police protection or give up his basic civil rights. And, he and his family should not be forced to go without needed health care.

Access to medical care should not be contingent upon income, location and employment status as it is under present arrangements. A program assuring all families equal access to comprehensive and catastrophic health needs is long overdue.

Because we do not have National Health Insurance, and because it will take two to four years to begin operating a comprehensive health system once it becomes law, some emergency, interim health measures are necessary. These measures are not a substitute for National Health Insurance. In fact, the conditions that necessitate these stopgap measures require us to accelerate the process that will lead to enactment of comprehensive National Health Insurance legislation.

I am pleased to have joined with a distinguished Member of the Finance Committee, Senator Bentsen of Texas, in introducing a proposal (S. 496/H.R. 3208) that will assist laid-off workers who have lost their private hospital insurance coverage. The objectives of this bill are to provide a feasible and fair way to help the unemployed meet their major medical expenses, with the least amount of administrative cost and complication.

As presently drafted, this bill would provide that, upon hospitalization, an individual without private insurance coverage, who is entitled to weekly benefits under a Federal or State unemployment compensation plan, would be eligible for the same hospital insurance coverage provided under Part A of the Medicare program. A dependent spouse and dependent children would also be entitled to this hospital coverage.

The deductibles, co-payments and limitations that are contained in Medicare would apply to the covered unemployed and their families. The Secretary of HEW, however, would be authorized to waive cost-sharing provisions and limitations, particularly for childbirth and treatment of children.

General revenue funds would be appropriated to the Federal Hospital Insurance Trust fund in the amount necessary to cover benefits paid out and administrative expenses incurred under this program.

Benefits under the program would be paid out on a retroactive basis. The eligible unemployed would not pre-enroll. Only if they or a member of their family enter a hospital would they have any contact with the program. It would be up to the hospital to determine: first, that the family does not have adequate private insurance coverage; and second that a member of the family is receiving Unemployment Compensation benefits. The hospital would then treat the charges as it does bills of other patients payable under Medicare.

This legislation obviously is not the perfect solution to the problem. The only equitable and adequate solution would be a universal National Health Insurance Program. As an emergency, stopgap measure, however, I believe the Medicare approach contained in the Bentsen/Corman Proposal is superior to the alternative suggested in Senators Kennedy and Javits' bill (S. 625), under which the government would pay the premiums on pre-existing health insurance contracts.

In order to implement and operate the program outlined in S. 625 (the Kennedy/Javits Proposal), we would have to establish a new office within the Department of Labor. This office, or state Unemployment Insurance offices working under DOL authority, would have to reach individual agreements with the 300 to 400 insurance companies and all of the employers and employees that would be involved, and then negotiate any premium increases requested by insurance companies after they have experience rated the temporarily unemployed that they cover.

In their testimony before the Ways and Means Health Subcommittee, Blue Cross and Blue Shield said they would want to be able to adjust premiums paid by the government according to the benefit expense of those eligible through unemployment, and that the government should be prepared to meet premium increases. Also, if there are changes in the benefits or premiums for the working employees in a company, I assume these same adjustments would have to be made in the insurance contract for the temporarily unemployed who would be eligible were they at work.

There are severe inequities in the approach contained in the Kennedy/Javits bill. It would be inequitable to those who do not have health insurance contracts to continue and to those who have insurance contracts that provide limited coverage. In other words, we would be using general revenues to finance comprehensive and complete existing health insurance benefits for some and totally inadequate health benefits for others. The self-employed, and laid-off workers whose employer or insurance company refused to participate, would not receive benefits.

Furthermore, under this approach the Federal government will be paying from $1 billion to $2 billion to hundreds of private insurance companies with virtually no monitor or control authority or mechanisms.

There are administrative problems and deficiencies in the proposal submitted by Senator Bentsen and myself. I was aware of some when the bill was introduced, and have been informed of others during recent hearings. The hearings before the Health Subcommittee of Way and Means, however, have generally reconfirmed by initial judgment that the medicare approach is more equitable and workable than the Kennedy/Javits alternative.

I do have several specific concerns about the Bentsen/Corman proposal that I hope this Committee as well as Way and Means will consider in its deliberations. First, I want to be assured that the program we enact can begin operating within a reasonably short period of time and that administrative procedures are as streamlined and simplified as possible.

I am concerned that neither of the two major approaches would cover the unemployed who are not eligible for Unemployment Compensation, either because they work in uncovered occupations or have exhausted their benefits. We should consider expanding coverage to these individuals.

The Bentsen/Corman Proposal, as drafted, covers only hospitalization. We should examine the feasibility of adding physician services as under Part B of Medicare.

Also, this legislation maintains the Medicare deductibles and copayments. Consideration should be given to waivers of the deductibles and other limitations under certain conditions, such as childbirth and treatment of children. On February 6, I introduced a bill, H.R. 2088, along with another distinguished member of this Committee, Senator Ribicoff, that would freeze at their 1974 levels the deductibles and copayments patients have to pay under Part A (hos-

pital coverage) of the Medicare program. I hope this bill freezing Medicare cost-sharing provisions will be considered in conjunction with legislation to assist the unemployed.

I am pleased that the House and Senate are giving immediate attention to the problems of the unemployed in obtaining needed medical care, and hope that an adequate solution will be found.

Whatever we do on an emergency and interim basis, however, must not deflect nor detract from the process leading to enactment of a National Health Insurance program.

Thank you again for allowing me to appear before this Committee and express by views on this critical matter.

The CHAIRMAN. Next, I will call Mr. Leonard Woodcock, president of the United Automobile Workers International Union.

Mr. Woodcock, we are very happy to have you with us today. I hope we will have a better representation on the committee as you proceed. They are voting in the Senate right now, as you know.

Mr. WOODCOCK. I understand the problems, Mr. Chairman.

The CHAIRMAN. As a matter of fact, I am going to miss the vote to hear you, so I hope you can explain my absence from the vote to some of my constituents.

STATEMENT OF LEONARD WOODCOCK, PRESIDENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW, ACCOMPANIED BY MELVIN GLASSER, DIRECTOR OF UAW SOCIAL SECURITY DEPARTMENT

Mr. WOODCOCK. I have with me Mr. Melvin Glasser, who is director of our Social Security Department, who, for our questions, is more qualified than I to meet their technical aspects.

If I may, I would like to have the full statement printed in the record and simply excerpt from it.

The CHAIRMAN. That will be done.

Mr. WOODCOCK. Mr. Chairman, it is frequently asserted that American workers are probably the highest paid in the world. But they are also the most insecure. When their often tenuous hold on jobs is broken, they often lose not only their income, but they have the specter of illness and injury hanging over them without health insurance coverage.

Now, while the membership of the UAW in the automobile, and agricultural implement industries have the benefit of negotiated plans to supply supplemental unemployment benefits, a substantial portion of our UAW members, and of course millions——

The CHAIRMAN. If I might just ask you to suspend your testimony for a moment, I would like to advise the Secretary of Health, Education, and Welfare that Mr. Bentsen cannot return at this time. He is tied up on the floor. So we will excuse you, Mr. Secretary, and I will ask Senator Bentsen to submit any additional questions he has in writing to you.

Secretary WEINBERGER. Fine. Thank you, Mr. Chairman. We will be glad to answer them.

[The following questions were submitted by Senator Bentsen, with answers supplied by the Department of Health, Education, and Welfare:]

Question 1. Can you detail for the Committee some of the administrative problems we would face if the Committee added Medicare Part B to the benefit package now in S. 496?

Answer. Most of the administrative problems relating to S. 496, with or without Medicare Part B, are generic to the use of the Medicare system to provide coverage for the unemployed. As I mentioned in my testimony, these include:

(1) the application process necessary to record and establish eligibility;

(2) the process necessary to have some certification of eligibility generated by employment offices; and

(3) the systems requirements of maintaining health care utilization to determine the status of deductibles and co-insurance.

The problems associated with these activities relate to the numbers of people involved. At an unemployment rate of 8%, approximately 10 million people would be added to the system and in any given month over two million people would be going on and coming off the eligibility rolls.

Adding Part B would create additional difficulties, principally in two areas:

(1) Part B claims handling and associated carrier administrative problems; and

(2) handling the premium collections associated with Part B eligibility.

Part B Claims Handling

Assuming an average 8% unemployment rate during the life of the bill, there would be approximately 10 million people eligible at any given point in time. Added to the current Medicare rolls of 23.2 million, this represents an increase of some 43%.

Currently, about 80 million claims are processed under the Part B program. If the proportion of claims to beneficiaries were the same for the unemployed and their families as for the present beneficiary population, this could rise to almost 115 million claims a year.

To handle such a staggering increase in claims workload, the Part B carriers who are currently under contract with the Social Security Administration to pay Medicare claims would have to increase their present staffs totaling 16,300 employees to over 23,000. Training and equipping such a sizeable increase in the work force would be a tremendous administrative task. Delays in paying claims would develop not only for the newly covered unemployed group but also for the present aged population because of the inability of the carriers to recruit and train staff, expand office space, obtain supplies and handle other logistical problems before the workload descended upon them.

Under S. 496, Medicare would pay only after any private insurers had paid. Under the present program, providers, private insurers, and Medicare intermediaries are working under the opposite concept—that Medicare pays first. Expanding S. 496 to include Part B means that physicians' offices and billing services will be added to those who need to adjust their procedures to accommodate this concept. At the time a Medicare claim is processed, the intermediary or carrier will need to know how much the other parties have paid. This means either (1) the Medicare intermediary or carrier must contact any other third parties or (2) the provider or individual submitting the Medicare claim must certify that all third-party claims have been submitted and specify the amount paid. Adding Part B would increase the number of cases subject to this special handling; it also enlarges the number of organizations using these special procedures by including the 47 Part B carriers and virtually all physicians' offices and billing services.

Part B Premium

If Medicare Part B were added to the benefit package, the Committee would need to decide whether the benefits for the unemployed would be financed by premiums paid by the unemployed and matched by the Government from general revenues which is the method of financing the Medicare program today. If the unemployed are not required to pay premiums, there would be an inequity between that group and the aged and disabled who presently pay premiums. On the other hand, if premium collections are made from the unemployed, they would have to be made either by deducting premiums from unemployment checks or by mailing monthly bills to the unemployed individual. Under either arrangement, the premium collection operation would present almost insurmountable administrative problems.

Question 2. In your testimony, you indicated that the present health delivery system could take care of the problems of the growing numbers of unemployed. The American Hospital Association, however, said that hospitals over the last several years have experienced a decreased operating margin of revenue over expenses of from 2.2 percent in 1971 to 0.8 percent in 1973. Moreover, 63% of community hospitals had a negative operating margin or, in fact, an operating loss. Is it realistic to say that the hospitals can take on now an even greater burden of charity or bad debts without substantially increasing charges to paying patients?

Answer. My statements in the testimony relating to this issue were in response to Senator Hartke's comments about the plight of the unemployed in Indiana and the fact that they were beating on the windows of the State Legislative Hall to demonstrate their feelings. I suggested that they were not beating on the windows to have their doctor and hospital bills paid, but to get their jobs back or, absent that, to have more unemployment compensation for longer periods during their unemployment.

I am not suggesting that all health care services for the unemployed be rendered free of charge. What I am suggesting is that consideration should be given to a person's ability to pay, and inability to pay should not and would not be an impediment to providing needed health care services. Hospitals, physicians, and other providers of health care have traditionally provided health care to those in need of their services.

Certainly it is not an ideal situation when people with those needs do not have the ability to pay. That is the reason we have suggested and promoted national health insurance. However, a categorical, in kind program of covering hospital expenses for the unemployed particularly considering our current economic problem is not an appropriate response.

Question 3. You also mention in your testimony that unemployment compensation can take on some of the burdens of medical expense. If the average unemployment compensation check is $68 a week and most family insurance policies cost approximately $50 a month, is it realistic to assume that unemployed workers will opt to continue health insurance coverage after their group policies expire?

Answer. I expect that some unemployed will drop health insurance coverage, particularly if their monthly premium for health insurance should constitute 15%–20% of their income. I have no illusions that the unemployed will be as well off and able to afford all the necessities and niceties of life that were available while they were employed. The question is, to what extent should the Federal government pick up payment for unemployed persons simply because they are unemployed.

To many of the unemployed maintaining car payments or mortgage payments may be considered more important than continuing health insurance coverage. Should the Federal government determine what is most important and provide added subsidy only for that? The individual is in the best position to determine what his greatest needs are and how best to address those needs within the constraints of reduced income through unemployment.

Mr. WOODCOCK. As I was saying, while many of our members do have supplemental unemployment benefit plans and with those plans health protection, there are many members of the UAW who do not, and of course millions of other workers who do not have such protection.

In addition, the SUB plans are now being rapidly depleted. The Chrysler salaried worker SUB fund is expected to run dry in 2 weeks. The Chrysler hourly worker SUB fund will run out in the first week of April, and the General Motors hourly worker SUB fund will run out in May.

There are 127,000 General Motors workers on indefinite layoff, and 27,500 on temporary layoff. Twenty-six thousand of those on indefinite layoff did not work long enough to become eligible for SUB, and therefore have never been eligible for continuation of health benefits. An additional 7,000 General Motors workers have already exhausted

their SUB eligibility and therefore are not receiving extension of health benefits from the General Motors Corp.

A study released last week by the Department of Labor shows that even for the minority of unemployed workers whose health insurance coverage continues into their unemployment, such coverage has ceased within the first 3 months.

Two-fifths of laid off workers who had health benefits while working may expect these benefits to continue at least 1 month. But three-fifths continue benefits only until the end of the month in which the layoff occurred.

And in those plans where employees contribute to the monthly premiums, 78 percent have no continuation of benefits after layoff.

Faced with a huge medical bill, the only recourse an unemployed worker with no health insurance has, other than spending his lifetime's limited savings, is to rely on whatever protection State medicaid programs may provide. And that, of course, requires impoverishment and a needs test before it can be implemented.

I might say, Mr. Chairman, that other modern nations have long solved the problem of emergency health benefits for the unemployed by establishing national programs of health insurance or health service. The Canadian worker, for example, has his basic health care needs met with no direct cost, or a minimal cost, whether employed or unemployed. In Ontario, for example, a worker has prepaid coverage for the first 3 months of layoff, and then pays, starting with the fourth month, $22 a month for continued family coverage.

With regard to S. 496, we agree Senator Bentsen has introduced a bill which, of course, provides medicare part A tied to hospital insurance, and also with the qualifier being the receipt of unemployment insurance.

We also agree that as far as the part A portion is concerned it is the most easily administered of the plans now under consideration.

However, I would like to say if part B is introduced, then that ease of administration ceases to exist with regard to the medical coverage. This bill, however, is a positive response to a crisis situation. The Bentsen bill would primarily assist only workers who are hospitalized, as it now stands, and would not cover the $92 for the first day of care, or the required $23 per day co-pay during the 61st to 90th day of hospitalization.

Now, very frankly, Mr. Chairman, at this juncture we are supporting S. 625. This emergency action requires a program which is simple, and easily and quickly administered. Accordingly the program must use mechanisms already in place, inadequate, I admit, as they may be.

It would provide for continuation of a worker's private health insurance coverage which was lost when his employment was terminated. The Federal Government would pay the premiums involved from general revenues, either to the private carrier or to the worker's last employer. Eligibility would be determined simply by the worker's being in receipt of unemployment insurance, rather than by a hospital or doctor at the point of service.

S. 625 has the great advantage in that it can be promptly implemented with much less difficulty than the other proposals.

S. 625 is obviously the best for our membership so long as they are unemployed because it does not lower their health benefits.

However, Mr. Chairman, I would like to emphasize the majority of our unemployed members would receive proportionately fewer advantages from S. 625 than would workers outside the UAW. Our members who are laid off from Ford, from American Motors, and the major agricultural implement companies, John Deere, Caterpillar International, and Harvester, where the SUB funds continue to be in sound fiscal condition, would not receive benefits under S. 625. They would be eligible for employer-paid continuation of health insurance coverages.

Furthermore, even at General Motors and Chrysler, under another contractual provision negotiated in 1973, UAW members laid off after October 1 of this year would receive continuation of coverage related to seniority rather than their eligibility under the SUB plan. This means, then, that the continuation after October 1 of health insurance coverage in those two big companies will no longer be dependent upon the solvency of the SUB fund, but instead related to length of service.

Our support of S. 625 therefore is based in part on the recognition that a portion of our unemployed members would be helped by it. We support the bill because by and large the unemployed who are not UAW members need it more than our people do.

I would like to say, Mr. Chairman, we draw attention to two technical amendments which we think would strengthen S. 625. Now obviously the most serious defect in S. 625 and in S. 496 is that they ignore the health needs of Americans who have never had employer-related health insurance. To assist these persons, we propose the use of State medicaid programs as an amendment to S. 625, but with three important changes. No. 1, the removal of all current eligibility conditions in State medicaid programs for these workers, including eligibility requirements for categorical aid and asset and income tests.

No. 2, medicaid entitlements would be based solely on proof of receipt of unemployment insurance. Now that would not obviously go to the full category, but would take a sizable number of them.

No. 3, Federal general revenue financing of benefits and of State administrative costs.

This special and temporary medicaid benefits program should be funded entirely by the Federal Government, because the industrial States which are being hardest hit by unemployment are also being hit the hardest by reduced tax revenues.

I would say, Mr. Chairman, that those who suggest the Federal Government ignore the problem of continuing health insurance for the unemployed are wide of the mark, because neither the unemployed nor the problem will go away. Many hospitals and clinics may be driven into bankruptcy as they are swamped with members of unemployed workers' families with genuine medical emergencies for which there is no choice but to provide care.

Now, others suggest the Federal Government cannot afford the large costs involved in this 1-year proposal, and are saying that there should be a mandate to the employers to pay for the continuing coverage. This approach is both impractical and unrealistic. But by and large, the employer whose business is in such bad shape as to require large and

substantial layoffs is hardly in an economic position to assume substantial new and unanticipated costs of health care coverage for the unemployed.

Mr. Chairman, we draw attention with regard to catastrophic coverage, as to what, in fact, can be catastrophic with regard to the bulk of working people.

I would hope, Mr. Chairman, that this Congress would go on with the job of fashioning a decent comprehensive national health insurance program because, in fact, had we one today, this problem would not be before us.

Senator PACKWOOD [presiding]. Mr. Woodcock, let me congratulate you on the kind of coverage that the automobile workers have. I think it is one of the best health insurance plans that I have seen. It would go a long way towards solving some of the problems of the employed in this country, if the Government simply mandated your level of coverage and employer financing for all workers, with a carryover of coverage during unemployment.

Let me understand how the benefits would be provided, under either the Bentsen bill or the Kennedy bill. We are talking about, in both cases, reimbursing a carrier to continue or provide benefits. Is that right?

Mr. WOODCOCK. In the case of S. 625 we are reimbursing the carriers through the employer or directly.

Senator PACKWOOD. Right. Now who is the carrier for your benefits?

Mr. WOODCOCK. Well, with regard to the bulk of the companies, it could be either the Blues or sometimes commercials; in the same company sometimes both, depending on the area or the State.

Senator PACKWOOD. It is pretty much a local option as to which carrier is chosen? Are all programs privately carried, either by commercials or by the Blues?

Mr. WOODCOCK. They are all privately carried, except where the individual exercises the option to go into a prepaid group plan.

Senator PACKWOOD. Are you satisfied with their degree of efficiency? With their payout ratios?

Mr. WOODCOCK. Well, given the continuance of the present circumstance and system, we are relatively satisfied. Certainly it is far from perfect, and we have grievance procedures to try and handle the inevitable problems that come up.

Now, with regard to the payout, as far as the operation of the system is concerned, obviously that is subject to abuses, cost overruns which we think S. 3 would remedy over time.

Senator PACKWOOD. What is the Blues payout ratio in Michigan, in terms of premium dollar in and claims payment out?

Mr. WOODCOCK. Dr. Glasser can answer that question.

Mr. GLASSER. If I could clarify that, Senator. Do you mean what percent is paid in claim as against premiums?

Is that the question?

Senator PACKWOOD. Yes.

Mr. GLASSER. In the Blues, nationally it runs roughly 92 percent, 93 percent; for the commercials, the last numbers ran in the neighborhood of 20 percent for all—this is not for UAW, these are national figures—roughly 20 percent. We would estimate that if you took the

weighted averages of the Blues and the commercials, they run slightly under 14 percent.

Senator PACKWOOD. Wait a minute. Runs under 14 percent?

Mr. GLASSER. I am not apparently being clear enough. The figure of under 14 percent represents administration, profits, retentions, or, if you would like to reverse it, slightly over 86 percent is paid to providers for claims that are made for every dollar.

Senator PACKWOOD. And in the Blues you said around 90 percent?

Mr. GLASSER. In the Blues it is different. It is less for Blue Cross. It is in the 5 percent or 6 percent area. It is in the 8 percent, 9 percent area for Blue Shield.

Senator PACKWOOD. Because Blue Shield is paying doctor bills, by and large, and they are smaller claims and, therefore with higher per claim administrative cost ratios.

Mr. GLASSER. Yes.

Senator PACKWOOD. But Blue Cross has as good or a slightly better payment record than medicare in terms of premium dollar in and claims paid out?

Mr. GLASSER. I do not believe so. I do not have the figures precisely in hand. I think the medicare figures are slightly better; but you see there is a defect in this line of reasoning because medicare is dependent on Blue Shield and the commercial carriers, in fact, for paying the claims. So, when you say that medicare's record is slightly better or slightly worse, you are not really saying much because they are using the private carriers as their intermediaries.

Senator PACKWOOD. I just want to make sure if one of these bills passes that you do not feel that we are not wasting our money by paying it out to carriers where their overhead is so great that we are not getting our dollar's worth, or that we are paying for a lot of overhead and profit, and it is not getting out to where you want it to go.

You are not worried about that risk? Or, at least under the circumstances, you feel that is a risk we should take?

Mr. GLASSER. We believe that we are paying too much out to the private carriers. Yes, we do, sir. We believe that the program as outlined in S. 625 as we have endorsed it, unfortunately has to use the mechanism. And we believe we have no choice for a year. We think it would be unfortunate if it would be locked in.

Senator PACKWOOD. So, you are saying for the moment we are kind of stuck, good or bad, whether rates are reasonable or unreasonable. The Government will simply pay them, and if the program goes on for longer than a year, we will start to look into it. It is the only available mechanism now.

Mr. Woodcock, bringing it back now to the automobile workers, so I understand, what are your unemployment benefits now? You have your supplemental plan and your State benefits. Take Michigan. I realize you have people all over, but take Michigan. What are your unemployment benefits for your laid-off worker—forgetting the supplemental plan—the State benefits for a moment?

Mr. WOODCOCK. If the worker is entitled to supplemental unemployment benefit payment, then regardless of the State he is brought up to 95 percent of his net; that is after-tax take-home pay minus $7.50 per week; plus the fact that as long as he is so entitled at the present

time the company, whichever it may be, is paying out of its corporate treasury the premiums for his health care coverage.

Senator PACKWOOD. Now, how long do those benefits last? Does it depend upon seniority?

Mr. WOODCOCK. First of all, you must have a year of seniority at point of layoff for any entitlement. Such an entitlement would then be up to 6 months. Two years' seniority at the point of layoff, the protection would be up to 1 year, and the maximum is 1 year. As the funds begin to be drawn down, as they have been in this present crisis, then as they come down you surrender one credit-unit to collect a week of benefits. But as the fund drops at certain trigger points it takes more than one credit-unit to get 1 week of benefits. The benefit amount does not drop. The length of time for which you can get it drops.

Senator PACKWOOD. I will tell you what my worry is. I go home to Oregon and this bill has been passed. I have relatively few auto workers in Oregon, but many lumber and sawmill workers. They will say, "We are working and we are making less than the automobile workers' unemployment benefits, and they are getting their medical benefits paid in addition. That is not fair." I am not quite sure how to answer that question.

Mr. WOODCOCK. Well, in the statement, Mr. Chairman, first of all, with regard to Ford, American Motors, and the three big companies in the agricultural implement section of our union, the SUB funds are in sound fiscal condition. They will get no benefit from S. 625 or S. 496. With regard to General Motors and Chrysler——

Senator PACKWOOD. Say that again. They will not get any of these insurance benefits?

Mr. WOODCOCK. They will not get any of these medicals.

Senator PACKWOOD. Why is that? Where is there any provision in the bill that stops it?

Mr. WOODCOCK. There is nothing in the bill, but in our private contracts with these companies they are still eligible, because the SUB funds are continuing; and as long as they continue, the company pays for their health premiums.

Senator PACKWOOD. So there is eligibility only when the SUB funds have run out and you are down to just State unemployment compensation, or do they run out at the same time?

Mr. WOODCOCK. No, no. The SUB funds can run out irrespective of State compensation.

Senator PACKWOOD. I see.

Mr. WOODCOCK. Now, with regard to General Motors and Chrysler, the Chrysler fund will run out if things continue as they are, early in April. The General Motors fund will run out early in May. So, they could potentially get the benefit of these bills.

However, even in those two companies, our contract provides that as of October 1 of this year, entitlement to health protection is based upon length of service and not upon receipt of SUB. So, even in those circumstances it would run only until the first of October.

Senator PACKWOOD. In your statement you have indicated that those who are not on unemployment compensation should have health benefits extended to them and paid for by the Government. At what level should these benefits be provided—at the State medicaid or

medicare benefit level? What level will you try to bring these benefits up to?

I see Mr. Glasser is nodding his head. Is that what you are suggesting?

Mr. WOODCOCK. We are proposing the State medicaid benefit without, however, the means test and the asset disburial. Again, the ticket to it would be the receipt of unemployment insurance.

Senator PACKWOOD. So if they do not have unemployment compensation or are not entitled to it, they would not be covered?

Mr. WOODCOCK. These would be people who, while employed, had no health coverage.

Senator PACKWOOD. Yes.

Now, you would tie it to unemployment compensation. But what if they are not eligible for unemployment? Shouldn't they be covered at all? Because they would not be covered under medicaid either under these circumstances?

Mr. WOODCOCK. If they were otherwise eligible for mediciad, of course, this would not interfere with it. It would not get to the group who are not sufficiently improverished to qualify for medicaid under the normal rules unless they had a previous employer relationship entitling them to unemployment insurance. This is the administrative problem.

Senator PACKWOOD. Would you be inclined to support Senator Bentsen's bill if surgical and medical benefits were added?

Mr. WOODCOCK. Well, what troubles us there, and we recognize the sincere effort that is made here—as I said, we agree as long as it is part of medicare, it is the most easily administered. But at the point part B of medicare is added, as Representative Corman suggested, then the comparative weight of administrative ease falls, in our opinion, to S. 625.

Senator PACKWOOD. I have no other questions, Mr. Chairman.

The CHAIRMAN [presiding]. Senator Bentsen?

Senator BENTSEN. Mr. Woodcock, if we were to enact either my bill or Senator Kennedy's bill, would you feel that that would assist, sort of a phase-in, or would you feel that that was an impediment to bringing about national health insurance, which we both very strongly support?

Mr. WOODCOCK. Well, I am taking it at face value, and I really believe that whatever is done, whether it be your bill or the other bill or some compromise that meets the problem, that that would be in effect for 1 year; that being so, I would think it would create an incentive for the Congress to go on with the job of giving a health insurance program across the board so that we do not meet this problem again at the next crisis, whenever that may be.

Senator BENTSEN. Well, you and I are both concerned about the administrative problems of this, and it seems to me that the Secretary really missed the point on my bill, because it could be set up where we do not really have any administration question until a claim is made, and eligibility could be set up very easily by the unemployment offices issuing a card, and then all the hospital would have to do is call to see if the person was still eligible for unemployment compensation.

So it would not be putting 10 million people under this plan. Would you agree with that?

Mr. WOODCOCK. Yes; certainly. And, you know, you talk about a number of 10 million, but I think the statistics will bear that only 1 out of 3 approximately would have any demand within that year. So we are not talking about 10 million; we are talking about 3⅓ million. So the whole thing was grossly overdrawn, in my opinion.

Senator BENTSEN. Now, one of the other things that concerns me very much about the Secretary's statement—and, unfortunately, I had an intervening commitment where I could not stay to further question—but he cited the costs at 8 percent unemployed, and then he cited the costs at 10 percent unemployed. I could not help but wonder if he thought that was a realistic possibility in this year. I assume he did, or he would not have thrown it out there as a figure that might develop this year, the $3 billion in costs.

Mr. WOODCOCK. Well, I would make the same assumption, Senator. I would like not to believe that administration spokesmen would come down here and simply pick a figure out of the air and try to frighten people unless they think it has some validity.

Senator BENTSEN. Does it concern you on the other bill that you would have people having their premiums paid by the Federal Government and yet have great disparities in those premiums, do you think there might be a constitutional question involved?

Mr. WOODCOCK. Well, we have not gone to the point of whether there would be a constitutional question involved.

Yes, it does concern us. It is an obvious inequity, and in the statement we list several things which are obvious inequities. But it is a quick way to take care of an emergency problem.

Senator BENTSEN. Mr. Woodcock, I congratulate you on the health benefits and the broad coverage that you have been able to achieve for the people who work in your union and industry, but, unfortunately, I do not think it is representative of what we see in hospital plans across the country, and that does give me concern as to how we achieve equity.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Mr. Woodcock, the employees in the automobile industry are benefiting from the very fine work done by your union and by you over the years to obtain supplemental unemployment benefits. How long will those benefits hold out?

Mr. WOODCOCK. Well, in the case of—taking some of our employers—first of all, not all of our employers, do we have SUB plans with them. In the aerospace industry, for example, it was found to be impractical, and many of the smaller marginal employers just cannot afford it. But in the case of Ford, International Harvester, Caterpillar, Harvester, and John Deere, those plans are in sound fiscal condition unless there is, well, as long a recession as the administration budget predicted. If that prediction does not come true, and we have the necessary things done and begin to recover during this calendar year, those plans will continue through.

The General Motors plan will, unless things begin suddenly to turn around, run out in early May. The Chrysler salary fund will run out in 2 or 3 weeks. The Chrysler hourly rated fund will run out in early April, again, unless there is a sudden turn around.

The CHAIRMAN. I have been thinking about suggesting a substitute for some part of this tax cut package or an add-on to it: that we consider trying to do something to stimulate the purchase of homes and, perhaps, the purchase of new automobiles. If automobile companies find that they cannot continue these rebate plans, the sales of automobiles are going to fall off. What do you think about the suggestion that some of us have thought about, that we ought to give a tax credit for some part of the purchase price, perhaps as much as 10 percent or $200 of the purchase price, of a new automobile during this period when the automobiles are in surplus supply?

Mr. WOODCOCK. Well, Mr. Chairman, you have put me in a very difficult position. Since I have been asked this question before, before some other congressional bodies, let me say this: It is our belief, looking at the history of every recession post-World War II, the industry that has led the way out of the recession is housing, and housing has been in a distressed condition longer than automobiles, several months longer. And if programs are put in place to make mortgage credit available at a reasonable rate of interest, if housing began to recover and we get the emergency tax cut—which I heard you wonder if we could not spend that money better other places—we put in place a substantial increase in public service employment and go on with the other necessary things, that then, given the stimulus to housing, I think this economy will begin to recover.

The problem with the tax credit for automobiles—what about appliances; what about consumer hardgoods, all of which are in equally distressed condition and I think the business of a tax cut and the other things which will be demands on the Treasury—I may be strung up for saying this, but I think they take precedence. The automobile industry will recover when the economy recovers. That has been the history.

The CHAIRMAN. You are not testifying to the proposed tax cut now. You will in a day or 2. The tax credit will be discussed.

I find myself thinking that the companies need customers more than they need some shiny new equipment to replace equipment that has a considerable life left to it. And, frankly, I have been thinking about the possibility of suggesting that we use the tax credit approach to try to stimulate housing. I realize, and would be the first to say, that if interest rates or profits or increased wage demands are going to eat all of that up, it might not accomplish a lot, but I would hope we could all cooperate to get a housing boom going, and help that industry that has been depressed. I do not have any doubt that the average fellow who is laid off in the construction trades is a potential buyer of an automobile. We might get the economy going that way. What I am concerned about is a tax cut for a great number of people who might not spend it. I find myself wondering if we are doing much for the economy with a tax cut for the middle-income and upper-income people if they just take the money and do not put it to any beneficial use, do not buy anthing with it.

Mr. WOODCOCK. Well, Mr. Chairman, that is why, as far as we are concerned, we are supporting a tax rebate and a reduction of taxes weighted towards the middle- and low-income groups rather than what the administration proposed. Some of the automobile companies say that the administration's proposal makes more sense, because

getting $1,000 rebate, which would cut in at around $38,500, all of those people will rush out and buy cars. That is nonsense. The savings rate in the last quarter of 1974, when the economy collapsed, went from 6.6 to 8.5 percent. If you could separate out those with $20,000 incomes and up, I am sure the savings rate went up from 11, probably 15, 16 percent.

There is some indication of a revival of confidence. Now, if you give that money to the middle- and low-income groups, they will spend it because they have to spend it, and it has a regenerative effect on the total economy. I think it would do a lot of good.

The CHAIRMAN. Well, I agree with that argument. I just find myself thinking, suppose we just limit this approach to those in the upper-middle and upper-income tax brackets and simply tie that part of the tax cut to a condition that they have to buy something that we would like for them to buy. Housing, of course, is one thing I would like to see moving. I would like to also see them buying automobiles, appliances, and other things. I think of a man who talked to me who finds his business in bad shape at the moment because of the oppressed conditions in this country in the real estate area. He said to me, I hope they do not just give this tax cut to some fellow who is going to take the money and not buy something. What I need is a customer a lot more than I need a tax cut.

And I hope that when we are through, that we do use it in a way that is going to most efficiently generate some additional spending.

It would probably help if Congress would recapture some of the powers it gave the Federal Reserve Board. I just wonder whether we have got it in the right hands when we have got it over there, with the tight money, high interest rate man in charge, who gave us three good solid recessions under Eisenhower. It looks like he is going to give us another one under Mr. Ford. He is a very personable, very likeable sort of a fellow, but at the same time a man whose economic philosophy, I think, is a little out of step with yours.

You are very much in favor of trying to get those interest rates down, are you not?

Mr. WOODCOCK. Oh, absolutely. If we do not effectively increase the money supply, which, in fact, has had a negative factor since December, the tax cut is not going to do the job it otherwise could do.

The CHAIRMAN. That is one of the things that has forced it up, the fact that the money supply has been tight. You know that as well as I do.

Senator Roth?

Mr. WOODCOCK. May I say, Mr. Chairman—excuse me, sir—with regard to the automobile industry, heavy truck production, which has held up at good levels until the last 30 days, as of March 1, by mandated action, they had to have an anti-skid control brake system, which has added $1,500 to the price of those trucks. Now, those heavy trucks carry a 10-percent excise tax, and I would hope that the staff of this committee and this committee could take a look at that, because it so happens that if that excise tax were taken away, it would just about countermand the price increase that has gone with the skid control device.

The CHAIRMAN. Senator Roth?

Senator ROTH. Mr. Woodcock, I discussed with you by telephone some weeks ago the problems of the automobile industry which has

suffered so very seriously from the recession. It does seem to me that one of the primary purposes of the tax cut should be, hopefully, to stimulate the automobile industry.

One question I have—and I agree that we want to give much of the relief to the lower income people, and yet it has been my understanding that at the same time those that are most likely to buy the cars—and I guess there are surveys and studies on both sides of the question—but that, generally speaking, those that buy the cars are probably in the $10,000 to $25,000 bracket.

Now, as I understand the House bill, it would give those groups roughly $100 to $150, a few $200, of rebate, and the administration proposal would go roughly from $100 to $450. My question to you is, might it not be wise, particularly if we are going to increase the overall package, to give a little more to the so-called middle class in the hopes that, they are the ones that are likely to buy what we call the big ticket items, whether those be cars or otherwise? If we are going to increase the overall package, would you favor leaving the lower incomes where they are in the House version but try to sweeten the package as far as the middle-income group is concerned?

Mr. WOODCOCK. Well, as far, Senator, as that portion of the program that has come out of the House, with regard to the rebate program on 1974 incomes, I do not think that is going to do very much with regard to big ticket items, even it was the administration's proposal, up to $1,000. I support a substantial reduction in withholding taxes effective July 1, because I agree with you that the purchases of new cars will start at $10,000, $12,000 on up, but the people in those categories—and in terms of numbers, they are the biggest numbers—make their decisions on buying a new car: number one, do they have a need for it, but, number two, do I have a reasonable expectancy of keeping my job, and can I fit the payment into my monthly budget. They are riding around in a downpayment, for the most part.

The car they have meets the downpayment. Can they fit that into their monthly budget, and that is why the Labor and Management Committee, when we made our recommendations to the President on the 30th of December of 1974, all of the labor side agreed it was more important to reduce withholding taxes, precisely because of that monthly budgetary problem.

And I think that is the best way in which the automobile industry and the other hardgoods industries can be given help.

Senator ROTH. So when you talk about the withholding, are you suggesting just the withholding? Would they still have to pay at the end of the year, or would they cut back?

Mr. WOODCOCK. No; I am talking about a tax cut which would be reflected in reduced withholding.

Senator ROTH. I see.

The rebate proposed by the automobile industry, however, has been some help in selling cars in the last couple of months, has it not?

Mr. WOODCOCK. Oh, yes. But you know we had a very strange market. First of all, through the 1960's and the beginning part of the 1970's the percentage of disposable income being spent for automobiles in this country ran between 4½ and 5 percent. Taking the percentage of disposable income now; people are buying automobiles at the rate of 2.8 percent. It is not simply that income is being reduced, but the

portion that is being spent for automobiles is part of a shrinking number.

You know, we have been selling cars, domestics, at a rate of about 9½ million cars a year. In 1973 we scrapped 8 million cars. Last year is the first time since World War II that we scrapped more cars than we built in this country. So the market is there. It is a question, in part, of restoring confidence, and I think affirmative action by the Congress, by the Government, would begin to restore that confidence.

When you look at the Gallup Polls and the Harris Polls, you see those who think we are going over the cliff is beginning to reduce in number, which is a sign of reviving confidence. And I think if the Congress does the necessary things, that we can begin to turn this economy around, and in your State of Delaware, certainly with the Chrysler plant, it is back at work this week for the first time since the beginning of December.

Senator ROTH. That is correct.

One of the discussions in this area, and the chairman did bring up some discussions about tax cuts, is the need for quick action, and this committee decided to try to separate tax reforms from oil depletion—but he promises we will have a vote on that at a later time.

Do you feel that time is of the essence?

Mr. WOODCOCK. Absolutely.

Senator ROTH. Would you support separating the two; would you care to comment on that?

Mr. WOODCOCK. Our position when this issue was in the House, was that, first of all, as far as we are concerned, we are for the elimination of the oil depletion allowance, except we were in favor of the amendment, which was defeated by 16 votes on the House side, of continuing it for the producers without retail outlets and with a 3,000 barrel or less per day production. I think that makes sense, because I think the record shows that most of the reserves in this country have been found by wildcatters, not by the huge oil companies, and since time is of the essence, yes, I agree. It makes sense to separate the two, not as a means of avoiding it, but as it has been, as I understand it, in the Senate.

Senator ROTH. My position is very similar to yours.

Mr. WOODCOCK. So at the predictable time there will be a chance to vote up or down on that question.

Senator ROTH. Would you favor some kind of tax incentive, for example, to try to get people to buy small cars? Are you taking any position on that?

Mr. WOODCOCK. I take it, Senator, you are using the term "small" as more fuel efficient?

Senator ROTH. That is correct.

Mr. WOODCOCK. That is not necessarily true. Some of the smallest cars built and sold are the biggest gas guzzlers around.

Senator ROTH. Let me amend my statement.

Mr. WOODCOCK. A more fuel efficient car—we might be using the taxing mechanism for that, to say, okay, there will be a tax against the inefficient car and tax credits for the domestically produced, I hope, fuel efficient cars.

We will be saying before the Senate Commerce Committee next week that, No. 1, we support the 5-year pause in emission, providing that is tied in with an ongoing job of reaching better fuel economy,

and that should be on a mandated basis, and the same certification process used as was used for emissions. We set the standard, okay, it should be here, and on a sales-weighted basis so that it would say 20—if they have got some coming in at 18 miles per gallon, they have got to have an equal equivalent coming in at 22 miles per gallon, or whatever, and that there be a financial penalty against the producer.

The reason we are opposed to the tax mechanism being used against the owner, if we are doing this to conserve a dwindling resource, then I do not know why somebody should be allowed to drive around a car, say 5 years from now, or buy one that gets 7 miles to the gallon just because he can afford it. We should not be allowed to produce such cars. And, yes, there should be mandated requirements. But we are satisfied that that cannot be done unless the industry is given greater relief in meeting additional emissions requirements in the same period.

Senator ROTH. Do you favor what the EPA recently announced? I have not had a chance to study it yet. It is somewhat different from what the President or from what you proposed.

Mr. WOODCOCK. Yes, the EPA departed from what the President proposed, which was the modified California standard, and they give relief for 3 years and then change it again for the last 2. I think we will be inclined to the point—and I say we will be inclined because we have an outside consultant with whom we are now discussing this in preparation for our testimony next week—that to give stability we think whatever standard is put out now should be maintained for 5 years, providing two things, the mandated fuel business and also a mandate for ongoing research, not only in the emissions area but in alternative power sources. And I think, too, the Government should contract such research and not simply wait for the automobile industry to come up with it.

Senator ROTH. Thank you very much, Mr. Woodcock. That was most helpful.

Senator BENTSEN [presiding]. Senator Packwood?

Senator PACKWOOD. I have no questions.

Senator BENTSEN. Thank you very much, Mr. Woodcock, you have been most helpful.

[The prepared statement of Mr. Woodcock follows:]

PREPARED STATEMENT BY LEONARD WOODCOCK, PRESIDENT, INTERNATIONAL UNION, UAW

Mr. Chairman, members of the Health Subcommittee of the Committee on Finance: My name is Leonard Woodcock. I am President of the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW. With me is Mr. Melvin Glasser, Director of the UAW Social Security Department. I represent our one and a half million UAW workers and retirees and their families—some five million Americans who are covered by our negotiated health insurance benefits programs.

Mr. Chairman it is frequently asserted that American workers are probably the highest paid in the world. But they are also the most insecure. When their often tenuous hold on jobs is broken they lose income, they cannot meet payments on heavily mortgaged homes and they have hanging over them the spectre of illness and injury without health insurance coverage.

As of today, 7.6 million American workers, a disproportionately large percentage of them blue collar workers, are currently unemployed and their numbers are increasing. The unemployment rate in Detroit is over 21%. The national unem-

ployment rate may well climb to between 9 and 10% in the next few months. Twenty to twenty-five million workers will be unemployed at one time or other in 1975—7 or 8 million of them for periods of 3½ months or more. Taking into account their dependents, this means that the lives of 40 to 50 million Americans—nearly 1 in 4—will be scarred by the disgrace of America's not providing useful work for all who need work. For every person who is actually laid off, there are two or three who fear they will be.

The membership of our Union has been very hard hit by this depression. At the end of 1973, the UAW had 700,000 employed auto workers. The U.S. unemployment rate was under 5%. As of the week of March 3, 1975, over 211,000 auto workers have been indefinitely laid off, about 30% of our auto workforce. Hundreds of auto supplier companies have totally closed out or sharply reduced production. For that same week, an additional 47,200 auto workers were temporarily laid off. While other auto workers are still on the job, they are taking home substantially less pay as a result of working one week on and one week off.

While our membership in the Auto and Agricultural Implement industries have the benefit of negotiated plans to supplement Unemployment Insurance, a substantial portion of our UAW members and millions of other workers are not protected by the SUB plans. These have been designed to assist workers for relatively short periods of unemployment. These plans are now being rapidly depleted: The Chrysler salaried worker SUB fund is expected to run dry in two weeks; the Chrysler hourly worker SUB fund will run out in the first week in April while GM's hourly worker SUB fund will run out in May.

There are 127,000 GM workers on indefinite layoff and 27,500 on temporary layoff. Twenty-six thousand of those on indefinite layoff have not worked long enough to become eligible for SUB, and therefore have not been eligible for continuation of health benefits. An additional 7,000 GM workers have already exhausted SUB eligibility and therefore are not receiving extension of health benefits from the Corporation.

A new study released last week by the Department of Labor reports that even for the minority of unemployed workers whose health insurance coverages extend into their layoff such coverages cease within the first three months.

Two-fifths of laid-off workers who had health benefits while working may expect these benefits to continue at least one month. But three-fifths continue benefits only to the end of the month in which the layoff occurred.

And in those plans where employees contribute to the monthly premiums 78% have no continuation of benefits after layoff.

This new data highlights how very serious and extensive is the problem of layoff without continuation of any kind of health benefits.

In the national pattern after coverage runs out, the unemployed may convert to individual policies, usually providing less in benefits at a higher cost than union-negotiated group policies. Comparatively few do this in the trauma of lost jobs and the adjustment to living on unemployment benefits. In Michigan, an auto worker with a family faces a current monthly premium of as much as $97 to keep his former employer-financed health coverages in effect. This can represent as much as 25% of his or her monthly Unemployment Insurance benefits. With average increases in health insurance premium rates in Michigan of over 30% now being proposed, our laid-off members have to choose to spend their Unemployment Insurance checks to continue their health coverages or on food, heating, clothes and mortgage principal and interest.

In response to rapidly increasing health care costs, the Congress passed Medicare and Medicaid in the 1960's. This resulted in increased services to millions of Americans but also in further skyrocketing costs and inflated prices. A day of hospital care cost $43.58 in 1966 and shot up to $110.77 in 1974, an increase of 165%. The increase in average weekly unemployment benefits has not kept pace with the increase in hospital costs. Average weekly unemployment benefits increased from $39.05 in July 1966 to $66.61 in July 1974, an increase of 72%, less than half the rate of increase in hospital costs. The average weekly unemployment benefit is still $49 or below in six states. In 1974, average hospital costs per day were $110.77. This Congress also needs to take action now to federalize and raise the level of state unemployment benefits.

Faced with a huge medical bill, the only recourse an unemployed worker with no health insurance has, other than spending his lifetime's limited savings, is to rely on whatever protection state Medicaid programs may provide. Medicaid requires impoverishment and a needs test before a worker gets it. Many workers

whose families require medical care are therefore forced to spend all their savings, carefully husbanded over a period of years, before becoming eligible for Medicaid. And many doctors and hospitals reject Medicaid eligibles who are often the lowest paid workers with the greatest medical needs. This is because providers are often inadequately reimbursed for their services by poorly administered state programs.

Other modern nations have long solved the problem of emergency health benefits for the unemployed by establishing national programs of health insurance or health service. The Canadian worker, for example, has his basic health care needs met with no direct cost, or minimal cost, whether employed or unemployed. In Ontario, a worker has prepaid coverage for the first three months of layoff and then pays $22 a month for continued family coverage thereafter. In Western Germany, an unemployed worker's health insurance continues indefinitely—there is no end to it. As long as the worker is employed, his contributions to the health insurance fund are paid partly by himself and partly by the employer. When he becomes unemployed the same central federal agency which makes his unemployment insurance payments sees that his contributions to the health insurance fund are continued. These countries and other industrialized countries such as Great Britain and France have taken the necessary action to provide public programs of health care—not as an emergency measure but as a right to all citizens whether employed or unemployed.

For four years the previous two Congresses have had before them well thought out national health insurance proposals at least one of which, S. 3, would eliminate the problem of emergency health benefits for the unemployed. The price of previous Congressional inaction is one the present Congress is being asked to pay.

I am not here to argue with previous Congresses or the Administration. I ask only that we learn from our previous experience and act accordingly.

In the face of emergency unemployment, our Union is asking for an emergency, admittedly imperfect stopgap program which will provide continuing health insurance coverage for those who have lost their jobs.

THE BENTSEN BILL (S. 496)

Senator Bentsen has introduced a Bill which would provide Medicare Part A (hospital insurance) benefits to workers and their families who receive Unemployment Insurance benefits, but who do not have private health insurance coverage. In addition, outpatient maternal and child health benefits, to be defined by the Secretary of HEW, would be provided. Legislative authority would expire after one year.

The Bentsen Bill represents a positive response to a crisis situation. Under it, workers who currently have limited health insurance benefits would receive broader health benefits under Medicare Part A. Our UAW members, on the other hand, would receive less adequate benefits than they now have. The Bentsen Bill would primarily assist only workers who are hospitalized, and would not cover the $92 for the first day of care, or the required $23 per day co-pay during the 61st to 90th day of hospitalization. It would provide even more limited benefits thereafter. More important, the Bentsen Bill entirely ignores the worker's doctor costs, whether incurred in the hospital or outside.

We have drawn up an example of a situation which might easily face an unemployed auto worker in Michigan in 1975. Early in the year, the worker requires an emergency gall bladder operation. Later in the year his youngest son has a broken leg. As illustrated in the Appendix to this testimony, S. 496 would just not help him enough. The worker would still have to pay approximately $1,324 from his savings. However, if S. 625 passes, all of his medical care bills would be paid.

S. 496 has the disadvantage of potentially increasing hospitalization because benefits such as drugs, laboratory, and X-rays are covered but not outside of the hospital. It would increase admissions to often overcrowded city and county public general hospitals while aggravating the financial condition of private voluntary hospitals. Last week, published reports indicated that Miami's public Jackson Memorial Hospital was flooded by emergency patients while smaller voluntary hospitals were actually facing bankruptcy because of a lack of admissions. At Jackson, stretchers were being set up in lobbies to administer oxygen and intravenous solutions. The executive director of the local health planning council blamed the sagging economy for the crisis situation.

Also, we are not clear concerning the operation of maternal and child health services coverage which would be added to Medicare Part A under the bill. There are, we know, such services provided now under existing public programs. We assume that this Bill envisages additional coverages.

Once we start designing new benefits, new administrative machinery is required to handle them. There just isn't time to do this in a program which must start at once if it is to help the unemployed.

THE KENNEDY, JAVITS, SCHWEIKER, WILLIAMS BILL. (S. 625)

Emergency action requires a program which is simple, and easily and quickly administered. Accordingly, the program must use mechanisms already in place, inadequate as they may be.

S. 625 would provide for continuation of a worker's private health insurance coverage which was lost when his employment was terminated. The federal government would pay the premiums involved from general revenues, either to the private carrier or the worker's last employer. Eligibility would be determined simply by the worker's being in receipt of Unemployment Insurance, rather than by a hospital or doctor at the point of service. S. 625 has the great advantage in that it can be promptly implemented, with much less difficulty than other proposals.

S. 625 is best for our membership so long as they are unemployed because it does not lower their health benefits.

I wish to make clear, however, that the majority of our unemployed members would receive proportionately fewer advantages from S. 625 than would workers outside the UAW. Our members who are laid off by Ford, American Motors and the major agricultural implement companies where the SUB funds continue to be in sound fiscal condition, would not receive benefits under S. 625. They would be eligible for employer-paid continuation of health insurance coverages.

Furthermore, even at General Motors and Chrysler, under another contractual provision negotiated in 1973, UAW members laid off after October 1, 1975 would receive continuation of coverage related to seniority rather than to SUB credits. This means continuation of health insurance coverage will no longer be dependent on the solvency of the SUB fund. Rather it will be related to length of service.

Our support of S. 625 is therefore based in part on the recognition that a portion of our unemployed members would be helped by it. We support the bill because by and large the unemployed who are not UAW members need it more than our people do.

There are two technical amendments I would like to propose to S. 625. Under Section 401(c)(1), the provision is made for what we in the Union would call "non-duplication of coverage." The provision as now worded is neither clear nor equitable. The unemployed worker should be entitled to benefits under the bill, if the benefits of his currently employed spouse are not substantially lower than his own, and if the currently employed spouse is not paying more than half of his or her employer-sponsored health benefit premiums.

Under Section 401(c)(2), the language of the provision should be amended to more clearly indicate that an employer has an obligation to continue his health benefits plan as of a specified date, February 7, 1975, and not to allow cancellation or alteration of an employer's plan to provide health benefits in anticipation of emergency legislation.

We are well aware of the limitations of S. 625. It will continue the costly, unregulated private insurance administration of health care benefits. It will also do nothing to improve the inadequate insurance coverages which were available to lower-paid workers, now unemployed and uninsured. But S. 625 would act as an emergency stopgap measure for millions of unemployed Americans in the next few months, if they fall ill and require care they cannot possibly finance. The most serious defect in the bill is that it ignores the health needs of Americans who have never had employment-related health insurance.

To assist these persons, we propose the use of state Medicaid programs as an amendment to S. 625, but with three important changes:

1. The removal of all current eligibility conditions in state Medicaid programs for these workers, including eligibility requirements for categorical aid, and asset and income tests.

2. Medicaid entitlement to be based solely on proof of receipt of Unemployment Insurance.

3. Federal general revenue financing of benefits and of state administrative costs.

This special and temporary Medicaid benefits program should be funded entirely by the federal government, because the industrial states which are being hardest hit by unemployment are also being hit the hardest by reduced tax revenues.

In summary we recognize the following limitations of S. 625, even with our Medicaid amendment:

1. It ignores the unemployed who are ineligible for Unemployment Insurance;

2. It is inequitable in that those who have had low health benefits while employed would continue to receive only those coverages. Those who had better benefit programs when they worked, would have better coverages when laid off.

3. It does nothing to control the skyrocketing costs of medical care which is often unnecessary, fragmented and impersonal.

4. It does nothing to control the ever-increasing premium rates of private insurers or replace the ineffective and costly administration of health care benefits by the unregulated private insurance industry.

On the positive side, S. 625 would continue coverage for those unemployed who have had health care benefits, so long as they receive Unemployment Insurance. And, with the addition of a federally financed Medicaid program, S. 625 would provide coverage as well for millions of Americans who had no health care benefits prior to their unemployment. This Bill is a stopgap emergency response but a necessary bill to meet an emergency crisis situation.

CLOSING COMMENTS

Some suggest that the federal government ignore the problem of continuing health insurance for the unemployed. But as we well know, neither the unemployed nor the problem will go away. And many hospitals and clinics may be driven into bankruptcy as they are swamped with members of unemployed workers' families with genuine medical emergencies for which there is no choice but to provide care.

Others suggest the federal government cannot afford the large costs involved in this one-year proposal. Accordingly, they would mandate employers to pay for the continuing coverage of their laid-off or discharged employees. This approach is both impractical and unrealistic. By and large, the employer whose business is in such bad shape as to require large layoffs is hardly in an economic position to assume substantial new and unanticipated costs of health care coverage for the unemployed.

Still others urge provision to the unemployed of catastrophic health insurance benefits. In this regard, a recent study of Michael Meyer has reported that less than one percent of the U.S. population has over $5,000 in total medical expenses each year. The vast majority of these, Medicare or psychiatric patients, do not receive unemployment insurance benefits and so would not be eligible for coverage under an emergency bill. But for an unemployed worker's family, as I have attempted to demonstrate in this testimony, uninsured medical expenses of $500 to $1,000 may be a catastrophe. And the unemployed population so endangered will be in the neighborhood of 25 million people this year. Their numbers are far greater than those who could be involved in the traditional catastrophic illness programs. Theirs is an immediate need that calls for prompt action by this Committee and by Congress.

We are proposing a stopgap measure to provide health insurance benefits for the unemployed. This cannot take the place of or lead to the type of comprehensive national health insurance which has been so long delayed in this country. Something must be done now. The passage of S. 625 (with our proposed Medicaid add-on) can demonstrate to the unemployed millions that this nation does have the leadership and the will to act quickly to protect American families against crippling health care costs in the current and worsening economy.

And concurrently I trust this Congress will get on with the business of passing a decent comprehensive national health insurance program. The country should not be forced to rely on another stopgap solution to meet the next national health care emergency.

APPENDIX

An example: Comparison of a Michigan Unemployed Auto Worker's Out-of-Pocket Costs Under S. 496 and S. 625 (UAW worker or worker with no continued health benefits, who would become eligible for Medicaid).

	S. 496	S. 625 [1]
Laid off employee needs emergency gall bladder operation:		
1. Hospital bills;		
(A) 7 days at $100 per day	$700	
(B) Drugs and other hospital services	430	
Total hospital bill	1,130	Paid in full.
2. Medical bills:		
(A) Surgeon's fees	500	
(B) Surgical assistants	100	
(C) Anesthetist's fee	90	
Total medical bill	690	
3. Grand total	1,820	Do.
4. Medicare pt A pays	1,038	Do.
5. Patient pays	782	Do.
Child breaks leg (fracture of Tibia and fibia) later in year:		
1. Hospital bills:		
(A) 3 days, at $100 per day	300	
(B) Drugs and other hospital services	220	
Total hospital bill	520	Do.
2. Medical bills:		
(A) Surgeon's fee	240	
(B) Anesthetist's fee	60	
(C) X-ray (3)	75	
(D) Change of cast	75	
Total medical bill	450	Do.
3. Grand total	970	Do.
4. Medicare pt A pays	428	Do.
5. Patient pays	542	Do.
Grand total family annual health bill	2,790	Do.
Medicare pt A pays	1,466	Do.
Family pays	1,324	Do.

[1] With medicaid add-on as proposed in Mr. Woodcock's testimony.

Senator BENTSEN. Ladies and gentlemen, we stand in recess until 2 p.m.

[Whereupon, at 12:47 p.m., the committee recessed to reconvene at 2 p.m., the same day.]

Senator BENTSEN [presiding]. The hearings will come to order. Dr. Gehrig, if you would take the witness table, please. First, let me apologize to each of you for the delays that we are encountering, and I would like to tell you it is going to get better, but I think it is going to get worse. It is going to be all afternoon and probably on into the night. The chairman and I will try to spell each other some.

Would you proceed, Dr. Gehrig, and we will see if we can manage under these circumstances? Otherwise, we will have to postpone the balance of today's hearings.

STATEMENT OF LEO J. GEHRIG, M.D., VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY ALLAN J. MANZANO, DIRECTOR OF FINANCE, AMERICAN HOSPITAL ASSOCIATION

Dr. GEHRIG. Thank you, Mr. Chairman.

I am Dr. Leo Gehrig, vice president of the American Hospital Association. With me is Mr. Allan Manzano, director of finance for the association. The AHA represents some 7,000 member institutions—including most of the hospitals in the country.

Mr. Chairman, I have a longer statement, and I would like to submit that for the record in the interest of the time of the committee, and I will try to take from my statement some of the key points.

Senator BENTSEN. That is fine, Dr. Gehrig.

Dr. GEHRIG. We welcome the opportunity to testify before this committee today on the very important matter of health insurance for the unemployed. We appreciate the concern of the committee in the emerging and pressing problem of protecting the many Americans who have lost or will lose their employer-sponsored health insurance benefits through unemployment. This subject is addressed in your bill, Senator Bentsen, S. 496. The potential threat to the health and well-being of the Nation's work force and their families from the loss of health insurance coverage is a matter of great concern to all of us.

While most meaningful national health insurance proposals would provide a solution to this problem should it occur in the future, such an approach in the context of national health insurance, because of the time required for legislative action and program implementation, would not provide needed action for this immediate and, hopefully, short-term problem. Therefore, we believe that a program of action should be developed for a short period independent of national health insurance.

The magnitude of loss of health coverage through unemployment is difficult to assess. The problem does not appear to correlate directly with unemployment statistics. Furthermore, coverage and the nature of the health insurance provided also varies greatly from employer to employer.

A review of the available data on postemployment coverage reveals, I believe, that the provisions of postemployment benefits provide little assurance that the laid-off worker, the recession victim, has continuity of coverage upon separation. The immediate problem is, in fact, a concern for the health of the victim of our present recession. It obviously is also of concern to hospitals that they remain fiscally responsible in order to provide services to all individuals in their community. We have made preliminary inquiries in a number of States to determine the impact of unemployment on hospitals. Unfortunately, Mr. Chairman, I am unable to provide the committee today with meaningful information on the experience of all hospitals, or even a statistically significant segment. Our difficulty stems from the fact that hospitals do not collect such data regarding the unemployed. Further, because of the short-term continuing coverage that some employers provide following a layoff, we do not believe that what data we have measures the problem which will be faced in the months immediately ahead.

Two symptoms of the problem, however, are evident in many areas, and these really are anecdotal. The rate of payment of accounts receivable has slowed in recent months, and the increase in charity work and in bad debts is significant. These factors, of course, are undoubtedly influenced by both unemployment and the general economic situation. Hospitals, which are largely not-for-profit institutions, have during the past several years experienced a decreased operating margin of revenue over expenses of from 2.2 percent in 1971 to 0.8 percent in 1973. While these figures are averages, in 1973, 63 percent of community hospitals in this country had a negative operating margin or, in fact, an operating loss.

Therefore, while every effort will be made to provide needed services without regard to ability to pay, the basic capability to provide any services at all depends on the continued existence of fiscally responsible institutions. Further, revenues needed to cover the costs of care provided without reimbursement—charity or bad debts—must be obtained by increasing charges to paying patients.

In looking at the legislative proposals, Senator Bentsen, we were looking for a solution to this problem. In the AHA studies, in its analysis of proposed legislation, we find, unfortunately—and you know this all too well—that inequities appear inevitable in any short term, workable kind of action. We hope that the congressional hearings on this matter will bring to light some approaches that will minimize these inequities.

I need not repeat the contents of your bill to you, and certainly I believe, from what I have heard you say and in the printed word, you have identified that your bill, too, deals in areas which are, in fact, inequitable. And while, as I have stated, some inequities appear inevitable, whatever approach is decided upon, we are very concerned about the workability of the proposed program. The medicare approach in S. 496, as written in the bill, would present hospitals with major operational problems in the area of determining eligibility. The hospital would somehow have to determine that the individual seeking hospital benefits under this new program is, indeed, receiving cash unemployment assistance, or is the spouse or dependent of such a person. The hospital would have to somehow be able to determine whether

an individual had paid the required deductible amounts, and whether there was a continued eligibility in cases of individuals who were probably frequently moved on and off unemployment rolls.

In addition, however, to the operational problems faced by hospitals in your bill, we believe it also creates a very, very significant problem of administration for the medicare program; and here, I think, the Secretary underlined some of these concerns much better than I can this morning. Certainly, medicare eligibility is basically geared to a permanent status in the program, a status attained by achieving the age of 65 or a condition of long term disability. A system which would allow for temporary eligibility geared to unemployment is wholly untried within the medicare program. The need to generate a new system on a national basis appears difficult of accomplishment within the limited time frames necessary for this proposed emergency program. In addition, eligibility of spouses and dependent children is also untried within medicare, which is essentially an individual eligibility program. The problems inherent in this eligibility issue are enormous, and the operational requirement for rapid implementation is crucial.

It would appear to us more prudent to not disturb medicare already stressed with the implementation of the disabled and renal disease program and new regulations, with this problem of the unemployed and their dependents. While we recognize that the eligibility identification and tracking are not going to be simple in any program, we believe the State agency which administers the unemployment compensation laws, together with the existing employer-based health plans, constitute the best mechanism to administer a program for a population that they are already serving.

The American Hospital Association believes that the most feasible program for providing health insurance for the unemployed would be one which does the following. It would provide Federal general revenue funds to make payments to health insurance carriers—or employers which administer health and welfare trusts—which agree to continue employment-based health insurance for unemployed individuals; provides continuation of employment-related health insurance benefits for each individual who is entitled to receive compensation under Federal or State unemployment programs, including the special unemployment assistance program; provides such benefits for all persons entitled to receive such benefits under the same type and scope of benefits as if the worker continued to be employed; provides Federal funds for the administrative carriers and employers; provides that the State unemployment agency shall certify eligibility and be reimbursed for the cost of doing so, and be a short-term program.

In summary, Mr. Chairman, the American Hospital Association would like to express its support for the concept of a temporary emergency program to provide health insurance benefits to the unemployed and their families. For the reasons I have stated, we strongly urge against the use of the part A medicare mechanism, as proposed in your bill, and urge instead a mechanism similar to the one I described, which would provide Federal funds to extend existing employer-employee health insurance programs. While such a program, like all others suggested to date, contains inequities, we believe that it is more workable and capable of early implementation.

Senator BENTSEN. Doctor, insurance companies pay hospital charges, in contrast to cost reimbursement proposed by Blue Cross and medicare. Do hospitals get more money from insurance companies which pay their charges than they do when the Blue Cross pays for the actual cost? Do they or do they not?

Dr. GEHRIG. Blue Cross is an intermediary for the medicare program. It does work on a reasonable cost-reimbursement basis. However, in terms of Blue Cross plans independent of medicare, it is in fact a negotiated rate.

Senator BENTSEN. Do they not reimburse mainly on the cost basis?

Dr. GEHRIG. Not all of them, Senator.

Senator BENTSEN. Mainly, I asked you.

Dr. GEHRIG. There are a good number of them that do reimburse.

Senator BENTSEN. All right.

Now, does the fact that you get more money from insurance companies than you would under medicare, and at a greater expense to the Government and to the taxpayers, I might add—does that influence you at all in choosing which one of these bills you support?

Dr. GEHRIG. Senator Bentsen, that really has not had any influence in our decision. I assume that you may believe I am talking tongue in cheek. I am not. Our concern with regard to the approach really stems to our feeling of——

Senator BENTSEN. I must say, you amaze me, Doctor; because with some of the problems hospitals are having these days, I would really be quite amazed if the administrators said that they would not favor the plan that would reimburse them more, and that they were not motivated by the fact that it would reimburse them more.

Dr. GEHRIG. Well, Senator, I am sure you do not want to hear our woes about the inadequacies of, for example, medicare participation across the board, in bad debts and charity care, et cetera. These are things, I am sure, if that were the basis of our discussion, we would bring out. But very frankly and honestly——

Senator BENTSEN. Doctor, let us talk about another point, the question of the first payment being made by the insurance company, under my plan, if the part of the plan was still in effect. But you have got the same kind of a problem under the other bill, where you have deductibilities and that sort of thing. So, you have the same administrative and mechanical problems, it seems to me.

Dr. GEHRIG. Senator Bentsen, I am influenced rather considerably, not only in our own evaluation but in the discussions I have heard before other committees, and the comments. I think, by those who are in a better position than I to discuss the operational potential. I am sure you will have statements or presentations by the carriers, and it seems to me that they have faced up to this issue. I do not intend to put their words in my mouth, but it is my general understanding that they see this as a situation, while difficult, one that they are able to accomplish. I think this is quite in contrast to the story that we heard this morning from the Secretary, in posing the problems of overlaying this program on already a very heavy——

Senator BENTSEN. Let me tell you. The Secretary this morning tried to use a 10 million person eligibility figure for my bill, which I think is a totally erroneous figure, because you could be administering this plan and enrolling only those people who utilized the services; and

Wilbur Cohen has stated you could use your employment offices to develop your eligibility, that all you would need is a phone call to the employment office to determine the eligibility. And you disagree with that?

Dr. GEHRIG. Well, my own feeling is—and not taking a position with regard to the Secretary's statement of numbers—it seems to me he very clearly stated that as you looked at the operational requirements of this program and this adaptability to a program that is not used to an in-and-out type of eligibility, there are some very real operational problems; and here, obviously, these would be magnified by numbers, and I am really not in a position to pick one or another position on it.

Senator BENTSEN. Well, the Secretary was saying that there were administrative problems in both plans, but I finally felt that the balance of what he said was that there were fewer administrative problems in the plan I proposed than the other one. I looked at the other plan and discarded it, because I thought it was unduly complex, and led to much more serious inequities and serious constitutional questions as to whether you used the Federal taxpayer's money to pay someone a much higher premium on their insurance policy, and someone else a much smaller one.

Dr. GEHRIG. Well, Senator, I certainly appreciate——

Senator BENTSEN. Well, I have got to go back over to the floor. I apologize to you and to the others who are waiting to testify. I understood the chairman was on his way to spell me on this, and I assume he will be here in a moment. So we will stand in recess for a moment.

Dr. GEHRIG. Certainly.

[A brief recess was taken.]

The CHAIRMAN [presiding]. I just want to ask a couple of questions.

Dr. Gehrig, under the proposal you support, federally subsidized payments would be made by insurers to hospitals and other facilities which are ineligible for medicare because of substandard health and safety conditions. Is that correct? Do you support that?

Dr. GEHRIG. No, I do not believe that is correct, Senator. The control of the safety standards of hospitals, as a provision of care, is obviously something that is of considerable concern at the State level, and we are not here pleading for that. We have, however, recommended along the direction of Senator Kennedy's bill, that Federal payments be made to continue existing employer coverage.

The CHAIRMAN. Do I take it that you recommend excluding substandard hospitals from any proposal?

Dr. GEHRIG. We have not encouraged the use of substandard hospitals at any time, Senator.

The CHAIRMAN. And you would recommend excluding them?

Dr. GEHRIG. I believe that hospitals have to meet reasonable standards, yes, sir.

The CHAIRMAN. Precisely. What effective cost and quality-utilization controls would you recommend be included to assure proper expenditure of the as much as $2 billion of tax money involved in these proposals?

Dr. GEHRIG. Senator Long, in looking at this proposal, I would like to contrast it with our proposal on national health insurance, where we see the introduction of significant controls, both in quality utiliza-

tion, the financing of capital investments, et cetera. These controls are all included in our national health insurance bill, and we believe in the long haul these will be very important. I think it, however, important in this situation that I explain we are concerned that if we are going to move at all in the present problem, it must be expeditiously; and I do not see this as a reasonable mechanism for implementing something which we hope will not be a long-term program, and will address itself meaningfully to this issue. We could have an excellent program, I am sure, with the assistance of the Government and on the private side, if we had 4 or 5 years to develop it. But if we are going to address this issue, I think it is quite meaningless to look at the perfection that we may be able to obtain in national health insurance.

The CHAIRMAN. Thank you very much, sir.

Dr. GEHRIG. Thank you, Senator.

[The prepared statement of Dr. Gehrig follows:]

PREPARED STATEMENT OF DR. LEO J. GEHRIG, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

SUMMARY

A. Continuity of health insurance coverage when a worker becomes unemployed is generally limited or not provided at all under employment-related programs. This threat to health of victims of the recession is cause for great concern. It obviously impacts also on hospitals.

1. Impact on hospitals which is beginning to be felt and likely will increase is shown in the following:

(a) Payment of accounts receivable of health care institutions have slowed;

(b) Charity care and bad debts have increased;

(c) Operating margins of hospitals is down from 2.2 percent in 1971 to 0.8 percent in 1973, and in 1973, 63 percent of community hospitals had operating losses.

2. All paying patients should share equitably in meeting the full financial requirements of health care institutions including charity services and bad debts. The fact that Medicare reimbursement fails to cover a proportionate share across the board of charity care and bad debts adds to difficulty hopsitals face in trying to remain fiscally sound and to provide needed services in their communities.

B. The AHA believes legislation to establish a temporary, emergency program to alleviate this problem should be a short-term expedient solution not involving the complex issue of national health insurance, and it must be capable of prompt implementation.

COMMENTS ON S. 496

All the current legislative proposals which address this problem would involve inequities. S. 496, the bill before this Committee, does not provide coverage for unemployed persons who are not eligible for unemployment compensation; does not cover physician's services; would require those unemployed who are covered (and who are already hard-pressed) to make Medicare copayments and meet Medicare deductibles; would present administrative problems for hospitals; and would create major problems of administration for the Medicare program.

(a) Hospitals would face administrative problems in determining original eligibility, determining whether deductibles have been paid, and in tracking continued eligibility for those who move on and off the unemployed rolls.

(b) The bill would burden Medicare with additional problems at a time when it is already stressed with implementation of programs for renal disease and for the disabled.

Medicare is not geared to temporary coverage.

Medicare has no experience in coverage of children.

Covering entirely new type of patients under Medicare would necessitate significant modifications of the program's financial policies and of hospital cash planning and pricing structures.

The cost of the program S. 496 would authorize would have to be kept separate from the regular Medicare program and this would not only pose serious administrative problems for both providers and SSA, but could also jeopardize the stability of the trust fund.

For the above reasons, the AHA believes it would not be prudent to add the emergency program proposed in S. 496 to the Medicare program.

The AHA recommends instead that legislation embodying the following principles be enacted to provide health insurance for the unemployed, and is testifying before other committees of Congress in support of such legislation.

1. Provide federal general revenue funds to continue employment-related health insurance for unemployed individuals.
2. Provide this benefit to all persons entitled to receive compensation under federal or state unemployment programs.
3. Provide the same type and scope of benefits as if worker had continued to be employed, with provisions to avoid double coverage.
4. Provide federal funds for administrative costs of carriers and employers.
5. Provide that state unemployment agencies shall certify eligibility and be reimbursed for their costs in doing so.
6. Be limited to one year.

We believe such a program would be both workable and capable of early implementation.

STATEMENT

Mr. Chairman, I am Leo J. Gehrig, M.D., Vice President of the American Hospital Association. With me is Mr. Allen J. Manzano, Director for Finance of the Association. The American Hospital Association represents some 7,000 member institutions (including most of the hospitals in the country; extended and long-term care institutions; mental health facilities; and hospital schools of nursing), and over 20,000 personal members. We welcome the opportunity to testify before this Committee today on the very important matter of health insurance for the unemployed, and we will address our remarks in particular to the bill introduced by Senator Bentsen, S. 496, which is before the Committee.

We appreciate the concern of this Committee in the emerging and pressing problem of protecting the many Americans who have lost or will lose their employer-sponsored health insurance benefits through unemployment. This subject is addressed in Senator Bentsen's bill. The potential threat to the health and well-being of the nation's work force and their families from the loss of health insurance coverage is a matter of great concern to all of us.

While most meaningful National Health Insurance proposals would provide a solution to this problem should it occur in the future, such an approach in the context of National Health Insurance, because of the time required for legislative action and program implementation, would not provide needed action for this immediate and, hopefully, short-term problem. Therefore, we believe that a program of action should be developed for a short period independent of National Health Insurance.

The magnitude of loss of health coverage through unemployment is difficult to assess. The problem does not appear to correlate directly with unemployment statistics. Furthermore, coverage and the nature of the health insuance provided also varies greatly from employer to employer.

The AHA has been investigating the problem in an attempt to evaluate its magnitude. We were able to see a preliminary and unissued report by the U.S. Department of Labor which analyzed 77 employer-based health benefit plans for employers of 1,000 or more. The most relevant data appear to relate to the provisions for extension of benefits upon layoff. Extension of benefits in the report was defined as eligibility for benefits for more than two months after separation.

Of the 77 employers, 74 provided basic medical insurance and 56 major medical coverage. Of the 74 offering basic medical insurance, 47 (or 64 percent) provided for some continuity of coverage. Of the 56 offering major medical, 28 (or 50 percent) provided for such continuity.

Of the 47 plans providing for continuity of basic medical coverage, 26 (or 45 percent) provided continuity without contribution by the laid off worker. For the 28 providing continuity of a major medical plan, 12 (or 43 percent) did not require worker contribution. Eligibility for the post-layoff program was available in only 18 of the 26 noncontributory basic medical plans and in only 8 of the major medical plans.

In summary, of the 77 plans reviewed, only 13 offered continuity of coverage to all employees without contribution for basic medical plans and only 8 did so for major medical plans. The availability of coverage after employment without the worker's contribution is crucial since the amount of contribution is probably a major element in the worker's decision as to continuation of health insurance protection.

In this study the length of post-employment coverage varied widely among the plans and in many instances varied within individual plans depending upon length of employment. This limited study, which includes the kinds of firms most likely to offer significant health benefits, nevertheless does demonstrate that the conditions of post-employment coverage provide little assurance that the laid off worker, the recession victim has continuity of coverage upon separation.

The immediate problem is in fact, a concern for the health of the victim of our present recession. It obviously is also of concern to hospitals that they remain fiscally responsible in order to provide services to all individuals in their community. We have made preliminary inquiries in a number of states to determine the impact of unemployment on hospitals. Unfortunately, I am unable to provide the Committee today with meaningful information on the experience of all hospitals or even a statistically significant segment. Our difficulty stems from the fact that hospitals do not collect such data regarding the unemployed. Further, because of the short-term continuing coverage that some employers provide following a layoff, we do not believe that what data we have measures the problem which will be faced in the months immediately ahead.

Two symptoms of the problem, however, are evident in many areas. The rate of payment of accounts receivable has slowed in recent months and the increase in charity work and in bad debts is significant. These factors, of course, are undoubtedly influenced by both unemployment and the general economic situation. Hospitals, which are largely not-for-profit institutions, have during the past several years experienced a decreased operating margin of revenue over expenses of from 2.2 percent in 1971 to 0.8 percent in 1973. While these figures are averages, in 1973, 63% of community hospitals in this country had a negative operating margin or, in fact, an operating loss.

Therefore, while every effort will be made to provide needed services without regard to ability to pay, the basic capability to provide any services at all depends on the continued existence of fiscally responsible institutions. Further, revenues needed to cover the costs of care provided without reimbursement (charity or bad debts) must be obtained by increasing charges to paying patients. Unfortunately, government programs such as Medicare do not equitably share in these costs.

The American Hospital Association has long expressed its concern with the failure of the Medicare cost reimbursement system to pick up its proportionate share of bad debts and charity costs of the institution. The logic behind this refusal to acknowledge bad debt is Medicare's contention that the program can only pay its own costs. While Medicare and other cost-based payers do, in fact, recognize bad debt attributable to their respective patients, by not assuming a proportionate responsibility for the cost of providing care to those who cannot pay, they place a disproportionate responsibility for this cost upon those patients who pay the actual charges for their services either directly or through private insurance. This resultant problem is made even more severe during a period of recession as the potential for bad debts increases, and an increasingly smaller population is required to assume a greater burden. Certainly the fiscal responsibility for paying the cost of care for those patients unable to do so because of the loss of employment and income should be a responsibility shared by all participants in health financing without regard to the source and character of the payment mechanism.

LEGISLATIVE PROPOSALS

In an effort to find a solution to the problem, the American Hospital Association, in its studies and its analysis of proposed legislation, finds that unfortunately inequities appear inevitable in any workable plan of action. We would hope that congressional hearings on this matter will bring to light some approaches that will at least minimize these inequities.

S. 496, introduced by Senator Bentsen, would incorporate an unemployment health benefits program into the existing Title XVIII of the Social Security Act by providing that an individual who is entitled to weekly benefits under a federal or state unemployment compensation plan would be eligible for the same hospital

insurance coverage provided under Part A of the Medicare program, with deduction of amounts payable for such services under any other prepayment plan or insurance policy. A dependent spouse and dependent children would also be entitled to this hospital coverage.

There are several obvious inequities contained in this approach, including: lack of coverage for unemployed people not eligible for unemployment compensation; lack of coverage of physician services; and the requirement that hard-pressed unemployed people would have to make regular Medicare-type copayments and meet Medicare deductible amounts.

While, as I have stated, some inequities appear inevitable, whatever approach is decided upon, we are very concerned about the workability of the proposed program. The Medicare approach in S. 496, for example, would present hospitals with major operational problems in the area of determining eligibility. The hospital would have to somehow determine that the individual seeking hospital benefits under this new program is indeed receiving cash unemployment assistance or is the spouse or dependent of such a person. The hospital would have to somehow be able to determine whether an individual had paid the required deductible amounts and whether there was continued eligibility in cases of persons who frequently move on and off the unemployment rolls.

In addition to the operational problems faced by hospitals, S. 496 would also create major—and perhaps unsurmountable—problems of administration for the Medicare program. Medicare eligibility is basically geared to permanent status in the program, a status achieved by attainment of age 65 or of a condition or long-term disability. A system which would allow for temporary eligibility geared to unemployment is wholly untried within the Medicare program. The need to generate a new system on a national basis appears difficult of accomplishment within the limited time frames necessary for this proposed emergency program. In addition, eligibility of spouses and dependent children is also untried within Medicare, which is essentially an individual eligibility program. The problems inherent in this eligibility issue are enormous, and the operational requirement for rapid implementation is crucial.

Inclusion of the unemployed within Medicare would place the whole program in fiscal uncertainty since the method of cost reimbursement and the characteristics of the payment process leave both provider and payer uncertain of revenues and costs until a cost reporting period is terminated and an audit and settlement completed. The fiscal expectations of institutions are based upon budgets which consider historical patterns of the proportionate share of patients under various kinds of insured coverage. Shifting the basis of reimbursement for a major portion of this population introduces significant shifts in revenues which can require major modification to pricing structures and cash planning for hospitals. Use of the Medicare vehicle for the proposed emergency program would also require significant modifications to the Medicare program's financial policies.

Similarly, revisions to the present system for collecting cost data under Medicare will be required. Past experience has shown that this process is exceedingly time consuming.

Nor can time be saved by implementing such revisions retroactively. Hospitals collect and assemble their financial data to conform with requirements of the existing cost reporting system and are unable to retroactively reconstruct data neither collected nor reported.

Financial implementation also would be complicated by the need to insure that the cost of this program would be kept discrete from the basic Medicare program with its trust fund and separate employment tax base. The existing Medicare program also provides for optional coverage of out-of-hospital medical costs under Part B. If this coverage is not provided under the proposed emergency health benefits program, crucial elements of service which have been available to many individuals under employer-sponsored plans will be denied. But we recognize that Medicare Part B coverage would give even greater administrative problems in the collection of the monthly premium and in the determination of the premium under a situation involving a changing eligible population and one with dependent spouse and children coverage. In fact, the relevance of Medicare Parts A and B cost-sharing and benefits packages to a working population is in question since they were designed for unique segments of the population, the aged and disabled.

In general, it would appear more prudent to not disturb Medicare (already stressed with the implementation of the disabled and renal disease program

and an entire battery of new regulatory problems) with the population of the unemployed and their dependents.

While we recognize that the eligibility identification and tracking are not going to be simple in any program, we believe the state agency which administers the unemployment compensation laws, together with the existing employer-based health plans constitute the best mechanism to administer a program for a population which they are already serving effectively.

The American Hospital Association believes that the most feasible program for providing health insurance for the employed would be one which does the following:

Provides federal funds to make payments to health insurance carriers, or employers of health and welfare trust, which agree to continue employment-based health insurance for unemployed individuals.

Provides continuation of employment-related health insurance benefits for each individual who is entitled to receive compensation under federal or state unemployment programs, including the special unemployment assistance program.

Provides that the individual and his family receive the same type and scope of benefits they would have received had the worker continued to be employed.

Provides that the federal government make arrangements to pay insurance carriers—and when appropriate, employers or health and welfare trusts—to continue the unemployed worker's health insurance, plus a reasonable additional amount for administrative costs.

Provides for arrangements to be made for state unemployment compensation agencies to certify individuals as eligible for the health insurance benefits program. The federal government would reimburse the states for their costs.

Requires unemployed workers whose spouse or parent is employed, to enroll wherever possible in health insurance benefits through their employment-based health insurance program, and receive their health insurance coverage there rather than under this federal program.

Expires one year after enactment.

In summary, Mr. Chairman, the American Hospital Association would like to express its support for the concept of a temporary, emergency program to provide health insurance benefits to the unemployed and their families. For the reasons I have stated, we strongly urge against the use of the Part A Medicare mechanism, as proposed in S. 496, and we urge, instead, a mechanism similar to one I have just described which would provide federal funds to extend existing employer-employee health insurance programs. While such a program, like all others suggested to date, contains certain inequities, we believe it is both workable and capable of early implementation.

We will be happy to answer any questions you may have.

The CHAIRMAN. The next witness will be Mr. Bert Seidman, director of the department of social security, the AFL–CIO. Mr. Seidman, I would hope that you could summarize your statement. If you agree with Mr. Woodcock, for example, I think you could perhaps summarize some of this, and stress the points that have not yet been said for the record.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL–CIO; ACCOMPANIED BY RICHARD SHOEMAKER AND JAMES O'BRIEN

Mr. SEIDMAN. Thank you very much, Mr. Chairman. I certainly will endeavor to do that.

My name is Bert Seidman. I am the director of the department of social security of the AFL–CIO, and with me to my left is Richard Shoemaker of the same department, who is our expert in the health field; and Mr. James O'Brien, who is in the same department, and who is an expert in the unemployment insurance field. There have been quite a lot of questions related to unemployment insurance, and I think Mr. O'Brien can help us in answering some of those questions.

Mr. Chairman, the AFL–CIO welcomes the opportunity to present its views with regard to S. 496, introduced by Senator Bentsen. We are fully in accord that something must be done for workers who have not only lost their jobs, but also their health care coverage under their employer-employee benefit plans. The unemployed can neither afford the high premiums for individual health insurance policies, nor the cost of an illness without insurance. We therefore hope that Congress will enact, without delay, a program to provide health insurance for the unemployed.

Now, Mr. Chairman, we have endorsed S. 625, and we think that is the best route to go. But we are glad to see that there is a considerable degree of agreement on the objectives. The objective that I have sensed here, with the exception of the Secretary of HEW, I am sorry to say, is that there should be, as rapidly as possible, some way of providing health insurance for the unemployed who have lost their coverage.

It is true that many collective bargaining contracts provide for a continuation of health insurance coverage after layoff, but the duration varies greatly. Some contracts continue the coverage for only a month. Other contracts continue health insurance protection for a full year. Duration of coverage may be based upon seniority.

Just last week, the Bureau of Labor Statistics released a study that showed that fully 60 percent of workers covered by employer-employee benefit plans can expect no continuation of their health insurance at all. The other 40 percent can expect continuation for at least 1 month, but only 20 percent provide for a continuation for 3 months or more. There is some possibility of unemployed people getting coverage through spouses; 19 percent of the men had a wife who was employed; 16 percent of unemployed wives had a husband who was working, and some of these spouses may have had health insurance coverage which could then apply to the unemployed member of the family.

We did understand until this morning that HEW had estimated the cost of covering those on unemployment insurance with health insurance as follows—and I gather now that the estimate is somewhat changed, but not very much; coverage under medicare, part A, $1½ billion; coverage under medicare, parts A and B, $2.6 billion; continuation of existing private health insurance, $1.8 billion; and if coverage under medicaid for those who did not have group coverage is added to continuation of existing benefits, then $2.1 billion.

Now, we would like to emphasize that the program we support is not a substitute, and does not in any way lessen our commitment to our support for the National Health Security bill, S. 3, introduced by Senator Kennedy. We regard health insurance for the unemployed as an emergency program to meet an emergency situation. In fact, if the Health Security bill had been enacted, we would not be in the situation we are in today, because it provides for universal coverage and eligibility for benefits is not based on attachment to the labor force.

With your permission, Mr. Chairman, I would like to introduce into the record two statements adopted by the AFL–CIO at executive council on February 17, 1975. The first of these reaffirms our support for health security, and the second states our policy with regard to health insurance for the unemployed.

At the time the executive council considered the health insurance for the unemployed statement, there were only two bills before the Congress, namely S. 496 and S. 625. In deciding which bill to endorse, the AFL–CIO executive council measured the bills against the following criteria. One, there would have to be an administrative mechanism already in place to administer the program. Two, determination of eligibility for benefits would have to be made, in any case, by the Federal-State unemployment offices. Three, the program should be relatively noncontroversial. Frankly, we thought that the health insurance industry would probably oppose extension of the public medicare program, but would favor retaining unemployed workers who had previously been covered under their employer-employee group contracts. Testimony before the various committees that has taken place thus far has confirmed that supposition. We do have the impression that the groups which are most directly concerned; the American Medical Association, the insurance industry, the Blues, and so on, are prepared to undertake this kind of a program. Whether they would be prepared to undertake a program which involved the utilization of medicare. I do not know.

I must say that I was very much disturbed to hear the Secretary this morning, and the very, very negative view that he put forward; and I would feel that under these circumstances particularly, we would be taking a great risk if we went the route which involved depending on the Secretary and his people to get a program underway. And this, actually, now concerns me even more than before I came in here this morning.

The AFL–CIO executive council statement calls for an amendment to S. 625, which the executive council endorsed, in order to provide health protection under medicaid to workers receiving unemployment compensation who were not covered by health insurance by their prior employer; and if your committee does consider S. 625, we would respectfully request that the committee amend it to include specifications generally that Mr. Woodcock proposed this morning, and I will not repeat them now.

S. 496 covers the unemployed only under part A of medicare. Now, we think that physician services are the most important part of medical care, and are necessary in order to keep beneficiaries out of the most expensive component of care, namely the hospital. And therefore, if this committee should decide to report out S. 496, in spite of our preference for the approach of S. 625, we would urge that S. 496 be amended to include part B as well as part A of medicare, and also that consideration be given to eliminating the medicaid deductibles and copayments, at least for mothers and children.

Mr. Chairman, the AFL–CIO wishes to thank you and the members of your committee for moving so promptly with these hearings, and for your concern about the health of the unemployed. And we hope that the Senate will act with equal dispatch to enact a bill to provide health insurance for the unemployed.

Mr. Chairman, I would appreciate it if our full statement could be included in the record, and my colleagues and I would be glad to answer any questions that you might have.

The CHAIRMAN. Thank you very much, Mr. Seidman.

Of recent date, your group has been taking the view that they were opposed to a piecemeal approach to health insurance coverage for any segment of the economy, although you did previously support medicare, which was a piecemeal approach in that it did not include all beneficiaries. And I think you supported extending medicare to the disabled.

I have been trying to press for legislation that would have made health care benefits available to all of the poor throughout the entire country, and those who are near-poor. So far I have not had much luck in trying to persuade your people to be for that. Is your present position consistent with your attitude that you oppose piecemeal legislation in this health insurance area?

Mr. SEIDMAN. We do not regard this as related, Mr. Chairman, in any way to the question of national health insurance. We continue to be in favor of universal, comprehensive national health insurance, along the lines of the health security program. We hope that the Congress will move on that as rapidly as possible. We certainly do not buy the viewpoint of this Administration that consideration of comprehensive national health insurance should be postponed. But this is an emergency situation involving millions of people. We think it calls for emergency legislation, which can be enacted as rapidly as possible, in order that millions of people who have lost their health care coverage can have it restored to them as quickly as possible for the duration of this emergency. But this has not changed in any way whatsoever our commitment to the health security program; and as a matter of fact, on the very same day that our executive council endorsed S. 625 as emergency legislation, on the very same day they reaffirmed their support for the health security bill.

The CHAIRMAN. My point is that so far you, and I believe your great organization, which in general does a magnificent job for the working man of this country, have been taking the view that you did not want anything that was a piece of something. You wanted all or nothing.

I am in agreement with a lot of what you want to do. However, I have felt that we must take an incremental approach, rather than do it all at one time, just as we did it incrementally when we passed medicare and medicaid. I think that we ought now to make another large stride forward. But I have not been able to, in good conscience, go along and buy your whole program. There are a lot of good things in your bill that I am willing to support. But I find myself saying, why can we not pass that much to take care of these poor people, and then reserve the quarrel about some of the other things for a little later? You have opposed this. I would have to ask you, is this bill for coverage of the unemployed not a piecemeal matter itself? It helps some people, but it leaves a lot to be desired, does it not?

Mr. SEIDMAN. Well, we do not regard this as a piecemeal approach to national health insurance at all; and just as Mr. Woodcock did, we acknowledge that what we are proposing is simply continuing something which we have criticized very strongly. But it is what people have had up until now. This legislation would not have been necessary if health security had been enacted. It has not been enacted, and we want to make sure that these people have at least the limited kind

of coverage that they had until now, during the period that they are unemployed and are receiving unemployment insurance.

The CHAIRMAN. Well, I hear you, but I do not quite agree with you. It seems to me that what you are advocating here, is what I have said many times myself. I have said it about other measures—and I might be inclined to feel that way about this one, that it is a good bill as far as it goes. In the last analysis, that is about all you can say about any bill. I have not seen any bill that has solved all the world's problems. I certainly have not seen any bill that solved all the health problems since I have been around here, for 26 years. There is no point in our belaboring the fact. I think I understand your position, and you understand mine.

Is the need for health insurance coverage for the working poor and the unemployed who are not covered by unemployment insurance any less urgent than that of the unemployed who are covered by the unemployment system?

Mr. SEIDMAN. I do not think that the need is any less. I think that the opportunity to get that kind of coverage immediately is very much less, and I do not think that we should deprive one large group of people from getting immediate health care coverage—coverage that they have had all along—because we have not done anything about some other people.

The CHAIRMAN. My proposal, Mr. Seidman, is that we take care of all of them, the fellows that you have in mind as well as those poor souls that did not have a job to begin with. What is wrong with that?

Mr. SEIDMAN. Well, I am in favor of taking care of people. It depends on what you mean by taking care of them. I think that most of the people who would be covered, for example, by either S. 496 or S. 625, would not be covered for any kind of basic coverage under the bill that you and Senator Ribicoff have introduced, if that is what you had in mind.

The CHAIRMAN. That is just not so. We had three facets of that bill, and one facet of it is to federalize medicaid under Federal standards, to greatly increase the number of people who would have it available to them, and to have what we would call a spend-down available to everyone. In other words, if a person is not eligible for medicaid because he has, let us say, earnings $200 above the poverty level for his whole family, when he has paid the $200 out for medical care, he would then be eligible for the Government to cover all of the rest of it.

Mr. SEIDMAN. One of the basic disagreements that we have had—we have discussed this difference of opinion in this committee in the past—is that we are not in favor of a means test approach to a national health insurance program. I think that is a basic part of the program that you are talking about. And even the bills that we are talking about here today, S. 496 and S. 625, with all of their imperfections, do not involve the means test approach.

The CHAIRMAN. It looks to me as if you have got a means test when you say that a fellow has got to be unemployed to have the benefit of this; that is a means test of its own. It seems to me as though it is a much less fair means test when you say that you have got to be covered by unemployment insurance. Here is some poor soul that needs health

coverage twice as bad, and because he is not protected by unemployment insurance, he isn't covered.

For the sake of human compassion and social justice, how can you justify denying it to the poor soul who needs it, when he is in far worse economic condition, while you are providing it to the fellow who is covered by unemployment insurance?

Mr. SEIDMAN. The fellow who is covered by unemployment insurance has suddenly had his income reduced down to one-third or one-fourth of what it was before, and is not in a position to go out and get a private health insurance policy. And that is why we are in favor of this approach.

The CHAIRMAN. Let us talk about social justice. You want to provide this benefit to a man who has lost his job and who is drawing unemployment insurance. Yet here is a fellow who is equally as sick. He does not even have unemployment insurance. He has got zero. How can you justify giving it to the person who has got a regular check coming in, his unemployment insurance, and deny it to some poor soul that has got nothing, just zero. He is dying.

Mr. SEIDMAN. I am not suggesting that we are in favor of denying it to these people. That is why we are in favor of the program that we are supporting, the health security program, which would provide it to everybody, and as far as we are concerned, we were in favor of the Congress going ahead with the hearings and the development of that program 5 years ago, Mr. Chairman.

The CHAIRMAN. All I am saying, Mr. Seidman, is you and your organization would oppose what I am trying to do for the poor on the basis that that is piecemeal legislation, and then you come in with a piece that is a lot smaller than my piece. How are you going to justify that? It seems to me as though the least you could do is to go as far as I want to go and not cover just the person who is drawing unemployment insurance checks, but the poor soul who is not getting any money and needs the help worse.

Mr. SEIDMAN. In our minds the distinction, Mr. Chairman, is that your program is what you would regard as national health insurance for the time being, and what we are talking about is simply continuing the coverage that people have had all along and going ahead as rapidly as possible to put in a comprehensive program of national health insurance.

The CHAIRMAN. If we label my bill "emergency," would you go along with that?

Mr. SEIDMAN. I did not hear what you said, sir.

The CHAIRMAN. If you label my bill an emergency bill, would you go along with that? That is the only difference I can see that you are talking about. You say yours is an emergency, and what I am talking about is not. If I call mine an emergency, will you go along with it?

Mr. SEIDMAN. I do not think that your bill is an emergency bill, and I do not think it has been represented up until this time as an emergency bill.

The CHAIRMAN. I think you have made your position clear, and that is all we can do. I just submit to you that I would like to do more for the poor than what you are proposing here. The principal fault with your proposition is that there are people who are as de-

serving or more deserving that should not be left out. I hope we can do something for them.

Now, what happens if the former employer has gone bankrupt?

Mr. SEIDMAN. If the former employer has gone bankrupt, then I would say that S. 625 does not deal with that situation, and I would say that the worker in that circumstance should be treated the same as the worker who had no coverage, because if the former employer went bankrupt, that worker would not have continued to have health insurance coverage, and therefore he would be in that category.

The CHAIRMAN. In general, do unemployed individuals have higher claims costs than a comparable group of employed persons?

Mr. SEIDMAN. I would see no reason that that would be true. Generally speaking, the unemployed, particularly in this kind of an economic situation, tend to be younger people, and those who have been hired the most recently. I would see no reason to think that their claim costs would be higher.

The CHAIRMAN. I am told that the insurance companies feel that it would be higher, and they want more money in order to do that.

Thank you very much, Mr. Seidman.

Mr. SEIDMAN. Thank you, Mr. Chairman.

[The prepared statement of Mr. Seidman with attachments follows:]

PREPARED STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR, AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. Chairman, the AFL–CIO welcomes the opportunity to present its views with regard to S. 496 introduced by Senator Bentsen (D-Tex.). We are fully in accord that something must be done for workers who have not only lost their jobs but also their health care coverage under their employer-employee benefit plans. The unemployed can neither afford the high premiums for individual health insurance policies nor the cost of an illness without insurance. We, therefore, hope that Congress will enact, without delay, a program to provide health insurance for the unemployed.

The problem is most serious. There are now 7.5 million workers out of work. Still another 3.8 million are working only part-time and, according to the Joint Economic Committee another 800,000 workers have dropped out of the labor force because they can't find jobs and have become discouraged. Unemployment is, therefore, more serious than the official unemployment rate figure of 8.2 percent.

Insured unemployment for the week ended February 8, 1975 increased by 117,300 to a total of 4,986,200 as 38 states recorded higher volumes. The insured unemployment rate climbed from 7.4 percent in the previous week to 7.6 percent. This was the highest rate of insured unemployment for any week since March, 1961. One year ago, the volume of insured unemployment was 2,604,300 and the insured unemployment rate was 4.1 percent.

The economy appears to be slipping into a deeper depression. Investment in business equipment is down 8.5 percent since September 1974. Investment is down because markets are contracting. This reflects the fact that the purchasing power of the average worker's weekly take home pay has dropped 5.4 percent in the last year. Investment tax credits can help stimulate investment, but not if there is no market for the goods and services that new capital investment creates.

The number of workers who have been unemployed for more than 26 weeks has increased from 6.2 percent of the unemployed in January 1974 to 8.3 percent in January 1975. The unemployed face the grim prospect of exhausting their unemployment benefits and of being without any income at all. This will cause a further reduction in demand and a reduction of the gross national product. Labor, government, academic and employer economists as well as economic indicators all support the expectation that unemployment will continue to increase in the months ahead.

The millions of unemployed workers are having a hard time stretching their meager unemployment insurance checks to pay for food and keeping up rent or mortgage payments. They certainly can't also shoulder the high cost of the health insurance they lost at the time or soon after they lost their jobs.

Many collective bargaining contracts provide for a continuation of health insurance coverage after layoff, but the duration varies greatly. Some contracts continue the coverage for only one month. Other contracts continue health insurance protection for a full year. Duration of coverage may be based upon seniority.

The Bureau of Labor Statistics released a study, "Health Benefit Coverage of Laid-Off Workers," just last month. The study showed that 40 percent of workers covered by employer-employee benefit plans can expect continuation of their health insurance for at least one month, and only about 20 percent provide for continuation for three months or more.

Among unemployed men, 19 percent had a wife who was employed and 16 percent of unemployed wives had a husband who was working. It can be presumed that most of these wives had health insurance coverage for the family through their employers.

We understand that the Department of Health, Education, and Welfare has estimated the cost of covering those on UI with health insurance as follows:

	(Billions)
Coverage under Medicare Part A only	$1.5
Coverage under Medicare Parts A and B	2.6
Continuation of existing private health insurance	1.8
Continuation of existing benefits plus Medicaid for those who did not have group coverage while employed	2.1

The above estimates assumed an unemployment rate of 8 percent and that 25 percent of all terminations of employment are in situations where the employer continues coverage of the laid-off workers. We, therefore, believe these HEW estimates may be on the high side because the BLS study indicates 40 percent, and not 25 percent, can expect continuity of coverage for at least one month. On the other hand, HEW estimates as to the rate and duration of employment may be underestimated which would understate costs.

Not only would the health care needs of the unemployed be served by a program to provide continuation of health insurance coverage for laid off workers, but so would the financial needs of hospitals and other providers. Hospitals, in particular, are now being faced with a mounting burden of unpaid bills as more and more of the unemployed do not have the resources to pay for their hospitalization. More and more unemployed workers are forced to apply for coverage under the Medicaid program. This is putting an increasing burden on the states when they are already hard pressed to meet their financial obligations.

It is to be emphasized that the program we support should not be considered as a substitute for nor a lessening of our commitment in support of the National Health Security bill (S. 3) introduced by Senator Kennedy (D–Mass.) with many cosponsors. Health insurance for the unemployed should be considered an emergency program to meet an emergency situation. In fact, if the Health Security bill had been enacted, we would not be in the situation we are in today. Unlike other national health insurance bills, S. 3 provides universal coverage, and eligibility for benefits under the program is not based on attachment to the labor force nor conditional on a record of employment.

The AFL–CIO position is that we have an emergency that needs to be dealt with now. At the same time, we urge that hearings be held as promptly as feasible on national health insurance in order to arrive at a permanent solution for the unemployed and everybody else. With your permission, Mr. Chairman, I would like to introduce into the record two statements that were passed by the AFL–CIO Executive Council on February 17, 1975. The first of these reaffirm our support for Health Security and the second states our policy with regard to health insurance for the unemployed.

At the time the Executive Council considered the Health Insurance for the Unemployed Statement, there were only two bills before Congress; namely, S. 496 introduced by Senator Bentsen (D–Texas) and S. 625 introduced by Senator Kennedy (D–Mass.). In deciding which bill to endorse, the AFL–CIO Executive Council measured the bills against the following criteria:

1. There would have to be an administrative mechanism already in place to administer the program.

2. Determination of eligibility for benefits would have to be made in any case by the Federal-state unemployment offices.

3. The program should be relatively noncontroversial.

Both S. 496 and S. 625 meet criteria (1) and (2) above, but S. 496 would likely generate some opposition. It was felt that the health insurance industry would probably oppose extension of the public Medicare program but would favor retaining those unemployed workers who had previously been covered under their employer-employee group contracts. Also, any change in benefit structure would likely generate some opposition. Coverage under Medicare would mean many workers would have better health insurance than they had before, but many would have poorer coverage. By maintaining benefit levels at exactly what they were prior to layoff, every unemployed worker would have exactly what he had in the way of health benefits when he was employed. In other words no one would be hurt, and no one would gain more than he had before. The AFL–CIO Executive Council favored a noncontroversial bill that could be enacted as fast as possible and S. 625 best met this criteria.

Events have indicated the Executive Council made the right decision. Representatives of the providers and of the insurance industry have indicated to us they will, in general, support a bill along the lines of S. 625.

The Senate Finance Committee has jurisdiction over Medicaid. The AFL–CIO Executive Council statement calls for an amendment to S. 625 in order to provide health protection under Medicaid to those workers receiving unemployment compensation who were not covered by health insurance by their prior employer. Should the Senate Labor Committee refer S. 625 to this Committee for amendment we respectfully request that the Committee include the following specifications:

1. Receipt of unemployment compensation and lack of prior coverage under an employee-employer health benefit plan should qualify the applicant for Medicaid without an income or asset test.

2. The full cost of Medicaid benefits for the unemployed should be borne by the Federal government without cost-sharing by the state. The state should be reimbursed in full for the administrative costs of the program.

S. 496 covers the unemployed only under Part A of Medicare. Physician services are the most important part of medical care and are necessary in order to keep beneficiaries out of the most expensive component of care; namely, the hospital. If, therefore, the subcommittee decides to report out S. 496 in spite of our preference for the other approach, we would urge S. 496 be amended to include Part B as well as Part A of Medicare. Lastly, consideration should be given to eliminating the Medicare deductibles and copayments, at least for mothers and children.

The AFL–CIO wishes to thank you, Mr. Chairman, for moving so promptly with these hearings and for your concern about the health of the unemployed. We hope the Senate will act with equal dispatch to enact a bill to provide health insurance for the unemployed.

Statement by the AFL–CIO Executive Council

Health Insurance for the Unemployed

There are now 7.5 million unemployed workers in the United States, 8.2 percent of the labor force.

According to the Library of Congress more than 90 percent of the workers laid off during 1974 lost their health insurance coverage. A survey of health insurance contracts indicates at least two out of three workers have no health insurance after being unemployed for one month or more. Thus, if unemployed workers wish to continue their health insurance after coverage is terminated, they must pay the premium, usually at exorbitant individual rates, at a time when they are financially pressed and least able to do so.

Stripped of their group coverage and denied Medicaid because they are not poor enough, a serious illness in the family could leave some unemployed workers bankrupt. Many will postpone needed medical care for themselves and their families because they won't be able to pay sky-high doctor bills with meager unemployment insurance checks. This situation is intolerable and would not have existed had Congress enacted National Health Security which provides

health benefits for all residents of the United States whether they are employed or unemployed.

The AFL–CIO Executive Council, therefore, calls upon Congress to give highest priority to early enactment of the Corman-Kennedy Health Security Bill (H.R. 21 and S. 3). However, there is no way that the Health Security program could be implemented, even if passed immediately, for at least one year. Therefore, at its meeting last month, the AFL–CIO General Board called for Federal legislation to provide health care to the millions of workers who lose their health insurance coverage under employer-employee plans when they become unemployed.

A bill (S. 625) introduced by Senators Kennedy (D.-Mass.), Williams (D.-N.J.), Javits (R.-N.Y.) and Schweiker (R.-Penna.) would simply extend existing or prior coverage provided by the unemployed worker's last employee-employer health benefit plan. The premium cost for continuation of this coverage would be paid from Federal general revenues. The program would be administered by the existing unemployment insurance offices and could be implemented almost immediately after passage.

Enactment of this bill would meet the critical need for the continuation of health insurance protection for the unemployed. But many jobless workers didn't have health care coverage when they were working and now that they are living on meager unemployment insurance payments certainly cannot afford to obtain it. To meet the health care needs of these jobless workers and their families. S. 625, when enacted, should provide for their coverage under Medicaid.

With this necessary change, the AFL–CIO Executive Council, therefore, endorses S. 625 as an emergency program to assure health care coverage for the unemployed and their families.

HEALTH SECURITY

The Congress must ignore the President's veto threat and begin immediate consideration of national health insurance legislation.

The health of the American people is just too important for further delay.

National health insurance was a major issue in the 1974 elections. A majority of the members of Congress promised their constituents they would seek early action on national health insurance and pledged their support to one of the many bills that have been introduced.

We expect they will keep their pledge.

The AFL-CIO reaffirms its wholehearted support of the National Health Security program introduced in 94th Congress as H.R. 21 in the House by Rep. James Corman and as S. 3 in the Senate by Sen. Edward Kennedy.

We support Health Security because it is the only program that would provide quality health care as a matter of right for all Americans, financed through tried, proven and accepted social insurance principles.

Only Health Security provides universal coverage; a comprehensive, simple standard of benefits; strong cost and quality controls; no deductibles and no coinsurance; reform of the health care delivery system; and strong consumer representation.

Only Health Security, of all the proposals thus far presented, would provide comprehensive coverage for unemployed workers when they lose their employer-employee health insurance because they are laid off.

Additionally, the Health Security bill reintroduced this year has been improved and strengthened without compromising principles we believe essential to national health insurance.

The new bill includes the following improvements over earlier versions:

1. Sound financing through an increase in the ceiling on individual contributory taxes from $15,000 to $20,000.

2. Grants for local nonprofit agencies to develop and provide social care services to the aged and chronically ill.

3. Protection for the employment and benefit rights of employees in health care institutions.

4. Use of free-standing centers for treatment of alcohol and drug abuse, family planning and rehabilitation as providers of health care.

5. Participation of optometrists and podiatrists as eligible providers under the regulation of the Health Security Board.

We reject the claims of the Administration that social progress must be postponed in times of economic difficulty. Millions of Americans cannot obtain or afford medical care. They need help as soon as possible.

The Congress has a responsibility to the people to develop a national health insurance program. We call on the Health Subcommittee of the House Ways and Means Committee, where the action starts, to begin hearings immediately.

The CHAIRMAN. Next we will call upon Mr. Malcolm C. Todd, M.D., doctor and president of the American Medical Association.

He will be accompanied by Dr. Russell B. Roth, M.D., immediate past president of the AMA and by Mr. Harry N. Peterson.

I am happy to see you gentlemen with us again. We would be pleased to know what your views on this proposal are.

STATEMENT OF DR. MALCOLM C. TODD, PRESIDENT, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY DR. RUSSELL B. ROTH, IMMEDIATE PAST PRESIDENT, AMERICAN MEDICAL ASSOCIATION AND HARRY N. PETERSON, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN MEDICAL ASSOCIATION

Dr. TODD. Mr. Chairman, I am Dr. Malcolm C. Todd, president of the American Medical Association, and with me on my left is Dr. Russell B. Roth, immediate past president of our association, and Mr. Harry N. Peterson, the director of our department on legislation.

We are very pleased to have this opportunity to join members of this committee in seeking a solution to the health insurance needs of the unemployed. I have a prepared statement, Mr. Chairman, that I would like to have introduced into the record, but in the interest of time, perhaps we could make a few comments that would be pertinent to this issue, and then I would ask that you might direct questions to my colleagues that are here.

First of all, we sense the problem of health insurance for the unemployed is one of necessity. Second, we believe it should be self-limited, that it should indeed be short term and of not more than 1 year's time. Certain views were expressed on this this morning and yesterday, and I think that you would share with us the view that any program of this type would have to resolve the difficulty of cutting this program off, and we certainly share this view.

I think that it is obvious that there are two options that your committee must consider at this time. One is to go the medicare route, and the other is the unemployment compensation route. The American Medical Association prefers the latter. There are always a great number of administrative problems any way that you go, and the AMA does not want to take a position to tell you how this should be done, but I think that the previous discussion and our concerns are certainly shared by your committee. There will be a great many administrative difficulties encountered, regardless of which way is taken.

The actual subject of tax credits have been introduced and mentioned in both testimony yesterday and today. This is, of course, a new aspect in this, but there is a possibility that this could be discharged to the employers, and then they would be given a tax credit from their own returns.

I think that one other observation that is extremely important in regard to the unemployed, if they were placed under the medicare

program, is the fact that under Public Law 92–603, the premiums for part A were set at $33 monthly for each individual not otherwise covered. Since then, under the formula there established, the premium has risen to the current $36 monthly charge, and is scheduled to rise to $40 on July 1. The other point is, of course, medicare is geared to individual coverage and not to group coverage, per se.

Once again, Mr. Chairman, I would like to stress the emergency nature of the program the fact that a need does exist today, and that to be effective, action on this measure must be expeditious. In the interest, of timeliness, it is imperative that the program be built within and as an extension of the existing system, utilizing the existing programs and agencies to effectuate and accomplish the goals that are sought in this legislation.

Mr. Chairman, Dr. Roth, and Mr. Peterson, and I will be pleased to respond to any questions you might have, and let me assure you we will be willing to work with you in any way to resolve this problem.

The CHAIRMAN. Thank you very much. Any questions, gentlemen?

Senator BYRD. Thank you, Mr. Chairman.

Doctor, you mentioned that this should be a temporary program. Is that the way you discussed it: an emergency, temporary program?

Dr. ROTH. Correct.

Senator BYRD. What do you mean by temporary?

Dr. ROTH. Senator Byrd, we have basically agreed that the time limit should probably be the end of June 1976. We are showing optimism in hoping that by that time there will be some fundamental changes in the unemployment situation.

We recognize as well as anyone that when one starts a program in Government, the difficulty is to stop it. It seems to me there are some terminal points. Certainly, if a program of national health insurance were enacted, most everyone has agreed that that would have the effect of terminating any temporary program. This would be true if our own proposal from the American Medical Association were adopted, because this would put good insurance coverage within the reach of everyone financially.

So we trust that we are not being naive, that if a termination date is put into the law, it will indeed terminate at that point.

Senator BYRD. Thank you.

The CHAIRMAN. Senator Bentsen?

Senator BENTSEN. Thank you, Mr. Chairman.

A number of us are concerned, as you are, I know, about continued inflation in health care costs. Now, if we have an emergency measure, as we are talking about here, if it was free of the cost controls of medicare, do you not think that would exacerbate the inflation problem more?

Dr. ROTH. If I may also respond to that, Senator Bentsen, we are fully aware of that, and we have taken the position that if our information is correct and if the unemployment situation picture is as dire as we are assured it is from statistics from Government, then we do feel that there is a problem not only for the people covered, but also for the institutions that are involved in providing this service. And we have heard the position taken by the Administration and so volubly set forth this morning by the Secretary that they are, among other

things, not in the position to afford this and take the added inflationary pressures at this time.

If indeed this is true—and this will depend on your judgment and not ours—but if it is true, rather than see the entire program shelved and nothing done, we have suggested that one way in which expenditures might be limited is to make this truly an emergency kind of a program.

Now, the chairman in jest suggested that you might put an emergency label on other programs, but it seems to me that——

The CHAIRMAN. I was thinking, if I might interrupt, just to be sure you understand—I was thinking if we called my bill an emergency, maybe we could get mine through.

Dr. ROTH. Yes, sir, I appreciate that, and we are suggesting that if the Administration feels that the fiscal limitations on this issue are the paramount consideration, rather than do nothing about it, we make further efforts to contain the costs of the measure; and so we would be willing to suggest that you should consider limiting the benefits of this emergency program to problems of medical necessity.

Senator BENTSEN. How do you decide where to draw the line on medical necessity?

Dr. ROTH. This is decided every day, many times in every hospital in the land. If I call the admitting office for a patient, the first question to me is, "Doctor, is this an emergency?" If it is not, if it is an elective procedure (let us say surgery) and there is no emergency about it, I will get an appointment date, an admission date 3 weeks from my initial call.

However, this has to be a professional decision. There is no way of avoiding the responsibility, and I assure you it is not a legislatively mandated responsibility that we would be happy to take on. But if this is what is necessary in a program, we will suggest thinking about ways and means of accomplishing this goal.

Senator BENTSEN. You talk about elective services and suggest that the program not cover them. Is that in part what you were just talking about?

Dr. ROTH. This is precisely what I am dealing with, yes, sir.

Dr. TODD. I think this would have to be a professional judgment, Senator Bentsen. We have to make this decision every day with our patients and our admissions to hospitals and treatment that they receive, as to whether this is routine medical care or whether it is an emergency medical care procedure that has to be undertaken.

Senator BENTSEN. Of course, I was looking very much at costs too, and that is why I put only medicare part A in the bill, and I was also looking at the administrative problems that would come about from including part B.

You point out that medical care would not be covered in S. 496. If the benefit package were expanded to include inpatient physician services, would you feel any different toward the legislation?

Dr. ROTH. Well, Senator, I would say that since we are advocating meeting this emergency, and we are favoring the alternative, or an alternative route of doing this under the employment compensation approach, which would extend the coverage to which the previously employed individual had been the subject, that the answer to this question has to be yes, because I do not think that there are any, of at least

not many, fragmented programs. Most of them where they are based on employer-employee financing or negotiation, cover medical services, as well as hospitalization.

Dr. TODD. Another consideration, Senator, on the medicare approach, would be the fact that part A of course is not voluntary, and part B is a voluntary approach. You do not have all covered under that approach. This would constitute some administrative problem.

Senator BENTSEN. I do not believe your statement got to the point of the unemployed who did not have previous health insurance coverage. Did you get into that in your statement?

Dr. ROTH. No, sir, this is one of the recognized——

Senator BENTSEN. What would you do about this?

Dr. ROTH. Well, unhappily this is one of the numerous shortcomings in this emergency issue, and I suppose you can only cope with that in the longer range national health insurance approach. I doubt that you can encompass it in an emergency bill, but if they did not have any while they were employed, they are not worse off in that particular respect now.

Senator BENTSEN. Well, you know, my bill does cover it.

Dr. TODD. That is a good point, Senator.

Senator BENTSEN. Well, let me say, gentlemen, I am appreciative of the positive things that you have offered in this statement, even though you do not favor my particular solution to the problem.

Thank you very much, Mr. Chairman.

The CHAIRMAN. That concludes these hearings. Thank you very much, gentlemen.

[The prepared statement of Dr. Todd follows:]

PREPARED STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION BY MALCOLM C. TODD, M.D.

Mr. Chairman and Members of the Committee:

I am Doctor Malcolm C. Todd, President of the American Medical Association. With me are Doctor Russell B. Roth, immediate past President of the American Medical Association, and Doctor Ernest T. Livingstone, Chairman of our Council on Legislation, who will join in responding to any questions which you may have. Also accompanying us is Harry N. Peterson, Director of our Department of Legislation.

We are pleased to have this opportunity to join with members of this Committee in seeking a solution to the health insurance needs of the unemployed. The current recession has imposed a tragic toll upon society. The 8.2% unemployment rate, the double digit inflation of the last year, and the specter of further economic decline have challenged the continued enjoyment of a way of life which we as a society so shortly ago assumed to be invulnerable. The cold statistics recording business failures, declines in real disposable income, increases in unemployment and in federal deficits, and similar data, however, do not reflect the full and personal impact of this recession upon individuals and their families. Because of its seriousness the nation as a whole is aware that prompt action is required to reverse this situation. Unified efforts are essential in preventing further economic declines and in reducing the human suffering increasingly prevalent throughout society. The medical profession is committed to these goals.

As this Committee is aware, the American Medical Association has supported legislation for comprehensive national health insurance in the previous three Congresses. Another American Medical Association bill will be presented shortly to this Congress. All of us have participated in an ongoing discussion aimed at making high-quality health care available to all Americans. The debate has extended over many years. As a consequence, during this interim period, valuable insights have been gained and many factors affecting our delivery system have been improved. Moreover, because of this extended discussion I would suggest

that perhaps costly errors great in magnitude and irreversible in nature have been prevented. Further consideration is in order if we are to develop a fiscally sound, humanly responsive, and publicly accountable national health insurance system.

New factors have now been introduced into this debate. Seven and one-half million Americans are now unemployed, and their continued health insurance, provided through past employment, is jeopardized by termination of employment. Thus, the plight of these individuals calls for fast remedial action. We urge that a system of temporary health insurance for the unemployed be enacted to alleviate existing strain and suffering while allowing us to continue our efforts to develop the best possible insurance legislation for the long run.

As I have stated, the individual crisis of unemployment has been compounded by the loss of health care insurance for millions of workers.

From these circumstances we can reasonably infer that all possible expenditures are being deferred by those families and that each such family lives in fear of incurring health expenses for which they cannot pay.

The magnitude of this problem is compounded in the fact that some health care institutions of this country are approaching fiscal jeopardy. Also, private health insurance plans, faced with loss in membership, will be less able to spread the risk and may find that their premium structures are inadequate to the task before them.

It is incumbent upon us to devise a method under which health coverage is continued for the unemployed individual and his family, and to afford such protection without disruption to the health delivery system.

Mr. Chairman, most families are, under normal circumstances, covered by employer-employee health insurance coverage. Accordingly, the large volume of practical experience with respect to health insurance contracts lies within the context of the standard employer group health system. A temporary health insurance program could be placed in operation on an expedited basis by taking advantage of the expertise of the private sector and by maintaining a system of coverage familiar to consumers. Thus, we are advocating that a temporary program be instituted which would, during the period of unemployment, continue the worker's insurance coverage for himself and his family. We therefore support legislation to accomplish this desirable goal, and we believe that any such program should be built upon the existing unemployment compensation system, one which affords a ready mechanism for implementation of a temporary program.

There is contained within the unemployment compensation system an existing mechanism for identification of claimants as eligible, and for determining the period of eligibility based on compensation benefits. The state agencies which administer the unemployment compensation program can assume an effective role in administering the program to make insurance protection available to unemployed persons and their families. While the program will be funded from the general revenues of the federal government, premium can be paid on the basis of certification of entitlement by the state unemployment compensation agency.

It has been suggested that a simple extension to the unemployed of Part A insurance coverage under the Medicare program would solve our immediate difficulty. This approach is taken in S. 496. Such coverage would restrict the benefits to hospital care. While hospitalization does represent the highest cost element in health expenditures, major pitfalls are inherent in such an approach. For one thing, hospital care contemplates medical care, as well, and such medical care would not be covered. For another, any proposal which would condition the payment for services upon a hospital admission could only be expected to increase pressure for utilization of expensive care facilities and further aggravate inflationary costs.

Moreover, the administration of a temporary health insurance program through the enlistment of the Medicare bureaucracy would place an immediate and intolerable burden upon an already strained bureaucracy. Procedures and benefit structures familiar to patients under their normal insurance coverage would be replaced with the unfamiliar and complex Medicare format. This would entail a massive public education campaign. Evidence of eligibility would have to be prepared, issued, and certified; and current evidence indicates that the Medicare system is ill-equipped to accomplish such a vast undertaking, especially in an expeditious manner.

It would be far better, in meeting the needs on an immediate basis and within the context of a temporary program, for the federal government to assume the financial obligation of paying for a continuation of existing insurance coverage

while certifying the eligibility for such coverage through the existing unemployment compensation agencies. This calls for action which preserves the agencies and economies of employer group health insurance and would protect these plans from financial destruction or prohibitive premium increases.

One additional observation is pertinent to including the unemployed under the Medicare program. Under P.L. 92-603 the premium for Part A was set at $33 monthly for each individual not otherwise covered. Since then under the formula there established the premium has risen to the current $36 monthly charge and is scheduled to rise to $40 on July 1. As you know, Medicare is geared to individual coverage and not group coverage. Thus, the premium for a family of 4 on July 1st could come to $160 monthly, or $1,920 annually, and this would cover only Part A benefits. Granted, a new age factor with attendant variances in expected utilization, would pertain and apparently the premium structure would not be the basis for payment. Nevertheless, we are left with speculation and conjecture concerning the cost and utilization of the projected coverage. We think it would be unwise, for this and other reasons, to introduce into the Medicare program unpredictable elements. We recommend that S. 496 not be adopted and that the unemployed not be blanketed into the Medicare program.

Mr. Chairman, I want to point out one additional feature of our proposal, which has been introduced in the Congress, providing for a continuation of coverage through employers. Through this bill we have suggested, as an item for discussion at hearings, that coverage should not be made for elective services. I want to put this into perspective, and to stress that this should be considered in the light of increasing national budgetary problems. We would not want all help for the unemployed to be sacrificed because of charges that a full continuation of coverage would be too expensive. Thus we have suggested consideration of reduced benefits by eliminating coverage for elective services. However, if the Congress should determine that the government has the financial capability of meeting the cost of continuing benefits at the level of coverage existing at time of termination of employment we would certainly support such action.

In closing I want again to stress the emergency nature of this program. The need exists today and, to be effective, action on this measure must be expeditious. In the interest of timeliness, it is imperative that the program be built within, and as an extension of, the existing system, utilizing existing programs and agencies to effectuate and accomplish the goals sought in the legislation before you. The program should not be encumbered with such considerations as PSRO, Medicare regulatory controls, or other undue governmental regulations. The program should be retained in and operated through the existing private mechanisms to best accomplish the immediate goals.

Mr. Chairman, we will be pleased to respond to any questions which the committee may have.

Senator BYRD. Mr. Chairman, could we have the record show that the Senate was in session and voting a great deal during the entire time that this hearing has been in progress, and for that reason some of us have not been able to be here for the entire committee meeting, since you cannot be in two places at the same time.

Senator BENTSEN. Mr. Chairman, I would like unanimous consent to introduce a letter from the International Brotherhood of Teamsters in support of the legislation.

The CHAIRMAN. Without objection, agreed.

[The letter referred to by Senator Bentsen follows:]

INTERNATIONAL BROTHERHOOD OF TEAMSTERS,
CHAUFFERS, WAREHOUSEMEN & HELPERS OF AMERICA,
Washington, D.C., February 14, 1975.

Hon. LLOYD BENTSEN,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BENTSEN: Yesterday we concluded our Emergency Economic Conference and among the resolutions adopted was a call for the Congress to "Enact Emergency Legislation to provide hospitalization to the unemployed."

Like yourself, we do not believe such a measure should in any fashion delay the enactment of a comprehensive National Health Insurance Law.

We belive any bill to provide Emergency Health care to the unemployed must give due recognition to: (1) The nature of the cost of such a proposal; (2) The equities of all unemployed workers; and (3) The temporary nature of the measure.

On balance, we believe your bill, S. 496, is the most realistic approach in this area, and our reasons are these:

First, according to your introductory remarks enclosed, the bill, when enacted, will cost something on the order of $2.1 billion. By any measure, this is a considerable sum. Yet the costs of medical care have grown to such proportions in recent years your estimate may be understated.

In that connection, it is our view that your bill contains two very important cost-saving features, one being the use of an existing bureaucracy to administer the proposed legislation and the other being an existing benefits formula—Medicare—for payments to unemployed workers.

In addition, the use of existing standards will reduce the opportunity foes of national health insurance might have to delay implementation of that program.

Our second reason for supporting your bill is closely related to the first. The benefit formula of Part A of Medicare will ensure that all workers receive equal treatment. We realize there are some proposals which would favor some workers over others, but owing to the importance of enacting this legislation, fairness for all should be the foremost standard. Also, any multi-tier approach would tend to increase administrative costs and decrease benefits.

Finally, we would again stress the emergency nature of this proposal. Your time limitation of one year from date of enactment appears to be a very sensible approach to the situation. If at the time of the expiration of the Emergency-oriented law, adverse conditions remain, we believe the matter should be considered together with the comprehensive National Health Insurance Bills.

In closing, we would again urge speedy adoption of S. 496; and if we can be of assistance in this matter, please contact our office.

Thank you.

Sincerely,

FRANK E. FITZSIMMONS,
General President.

[From the Congressional Record, Jan. 30, 1975]

(By Mr. Bentsen)

S. 496. A bill to amend the Social Security Act so as to provide, for a 1-year period, hospital insurance coverage under medicare for unemployed workers and their families. Referred to the Committee on Finance.

MEDICARE COVERAGE FOR THE UNEMPLOYED

Mr. BENTSEN. Mr. President, during the calendar year from December 1973 to December 1974 total joblessness in this country increased by over 2.1 million individuals.

The jobless rate now stands at 7.1 percent as opposed to 4.8 percent only a year ago; that represents one of the steepest climbs in unemployment since the Second World War.

The rapid escalations in unemployment have created some severe economic dislocations in our economy: unemployment compensation applicants have swelled dramatically, more working class individuals are turning to food stamps, and the social services in our society are being compelled to serve a broader range of people.

Congress has taken some significant steps to address the problems of the 6.5 million men and women out of work. We have passed major public works employment legislation, and we have extended unemployment compensation benefits.

There is, however, one major gap in our efforts to protect the unemployed, and that is in the area of medical coverage. According to Library of Congress estimates, it is probable that more than 1.74 million workers have lost their hospitalization coverage since December 1973. and this figure does not, of course, include the workers whose coverage had lapsed prior to that time.

For the unemployed man or woman who confronts the possibilities of a debilitating illness while uncovered by medical insurance, the anxieties are con-

siderable. Hospital costs have tripled in the last 10 years. A day in the hospital cost, on the average, $33 in 1960, but in 1970 it cost $115. The costs of health care have escalated at twice the rate of the rise in the cost of living. Many of the newly unemployed are ineligible for medicaid, and, if they are, they find that the coverage fluctuates widely from State to State. Therefore, they find checks that may range from $90 to $125 per week, and unable to afford the high costs of purchasing health insurance policies for themselves or their families.

If they or members of their families require hospitalization, they find frequently that group hospitalization and surgical plans cease their coverage at the end of the calendar month in which termination of employment occurs. In fact, then, they are open to the possibilities of enormous debt and to the reality that hospitals may refuse to admit them without health insurance coverage.

I have long been on record arguing that we need a comprehensive national health insurance program, which would address these critical problems in a uniform way. I believe that we must be particularly concerned with the plight of the 25 to 30 million Americans who have no health insurance coverage whatsoever, many of whom are on welfare and ineligible for unemployment compensation.

The hard fact, is however, that we may not have a major health insurance bill before us for some time. To meet the urgent problems of the unemployed, we are going to require an emergency, stop-gap health insurance program.

Today, I am introducing such a measure. It attempts to treat in an equitable way the millions of unemployed workers and their dependents who require protection against the burdens of hospital costs.

It is in no way a substitute for national health insurance; the high priority for that program still exists. It is, rather, an attempt to meet an emergency situation in the fairest possible way.

Briefly, the bill provides that an individual, if entitled to weekly benefits under a Federal or State unemployment compensation plan, would be entitled to be enrolled in the medicare, part A, program, which is directed to hospital costs. A dependent spouse or a dependent child or children would also be entitled to the basic medicare coverage, and in addition to that, they could receive a maternal and child health benefit package which would be devised by the Secretary of HEW.

All of the deductibles and co-payments under medicare would apply to these newly covered individuals.

To avoid unnecessary costs, benefits under the proposal would not be paid to the extent that any prepayment plan or insurance policy is still in effect, following termination of the individual's employment.

General revenue funds would be appropriated to the Federal Hospital Insurance Trust Fund in order to place in the fund the amount necessary to leave it in the same position it would have been in if the proposal had not been in effect.

Because the bill is designed as an emergency measure, it will be effective only for the 12-month period after the law is enacted.

Mr. President, it is obvious that any program developed for an emergency will result in some inequities. We recognized that when we passed the emergency public employment measure. But if we wait for comprehensive long-term health insurance bill, we may well end by helping neither the very poor nor the unemployed over the near term, and the problem is a near-term problem.

I have considered other proposals before advancing this one in its present form. Although I remain open-minded on the final structure of this program, I believe that using medicare has several advantages. In the first place, it is an in-place system, which would not require an additional layer of bureaucracy. It has a standardized benefit package, which means that all who take advantage of it will fare equally. Finally, it covers the most essential hospital services: Operating and recovery room costs, lab tests, radiology services, medical supplies, and a wide range of rehabilitation services.

If we find that the final cost estimates from HEW can be revised downward, we stand ready to amend the final benefit package.

We have received a preliminary estimate that the coverage under part A would require some $2.1 billion in general revenues, but these estimates are currently being refined. I recognize that this is a substantial sum, but I believe that the need for the legislation is so compelling that we are justified in offering this kind of protection to the millions of unemployed now facing an uncertain economic future compounded by the fears that catastrophic illness will eat up whatever savings they now have.

I intend to continue to press for comprehensive health insurance, but we cannot allow this program to await the outcome of the debate on that issue, which promises to be long and protracted.

I commend to my colleagues this legislation and invite their cosponsorship.

[Whereupon the hearing was recessed subject to call of the Chair.]

Appendix—Communications Received by the Committee Expressing an Interest in These Hearings

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Statement by Tim Lee Carter, a Representative in Congress From the State of Kentucky

I would like to thank you, Mr. Chairman, for inviting me here today to give testimony on this very crucial issue for millions of Americans.

As testimony here no doubt will show, firm statistics are difficult to pin down on the exact magnitude of the problem which the legislation I have sponsored, H.R. 3932, and that proposed by other members of Congress, seeks to alleviate. However, we do have approximately 7.5 million persons currently out of work, with 3.8 million of those laid off. And, a U.S. Bureau of the Census survey three years ago estimated that up to 70 per cent of the work force had private health insurance coverage through their place of work.

Loss of a job usually means the end of group health insurance coverage as the policies are contingent upon employment. While most carriers provide for conversion of a group policy to an individual one, this means greater expense for individuals just at the time they will be receiving a reduced income through unemployment compensation.

The advantage of group plans provided through one's employer is that such coverage is substantially less expensive than comparable coverage purchased on an individual basis, in part because the employer frequently shares in the cost of his employees' coverage. To convert to an individual policy then, an unemployed person not only would have to allocate money from his substantially reduced income, he would do so through absorbing the cost previously borne by his employer.

A survey by the Washington Business Group on Health of 127 of its participating employers draws the conclusion that even with employer-paid extension plans during lay-offs, "the replies indicate that, with a few notable exceptions, the employee will either have no health benefits or will be paying 100 per cent of the premiums within 90 days." I think that it is clear that the majority of workers laid off and facing the prospects of continuing to meet mortage or rent payments, provide food and clothing for themselves and their families and make payments on previous purchases will fall into the former category.

As a physician and a 10 year member of the House health subcommittee, I have a very particular concern for the health and well-being of our people. It is this concern which has prompted me to join in support of providing for the medical needs of our eligible unemployed workers through extending the hospital insurance under Medicare to them and their families.

I favor this approach because of the relative simplicity of its administration and, especially, because of its comparatively lower cost.

It should be relatively simple to administer because no new bureaucracy would have to be set up.

It should cost less because it would allow the federal government to come to the aid of the unemployed only when assistance with medical costs actually was needed and then to help with the most expensive portion of medical care—hospitalization.

The population group we are seeking to help is the unemployed. This group, Mr. Chairman, is among the most vulnerable to sickness.

Studies of changes in life, one by an associate professor at Johns Hopkins University, M. Harvey Brenner, have revealed that there are more hospital admissions during national economic down-turns. Other studies reveal that there

is more disability following a "change in life" such as the death of a family member, or a change in location or job. Certainly, we are in an economic downturn and certainly we must consider the movement from employed to unemployed a "change in life." If these studies are accurate, then we can expect a marked increase in hospital admissions from those least able to pay for the cost of their hospitalization.

Since the average cost of hospitalization during 1974 was $130 per day, imagine if you will the coal miner, factory worker or even the white-collar worker having to manage the cost of hospital care for any of the conditions that affect this population at risk: ischaemic heart disease, cerebrovascular disease, respiratory disease and lung cancer, cancer of the breast, uterus and ovaries.

These conditions are distributed normally among the American people as a whole, be they employed or unemployed. But when they are employed, most people are protected by the group insurance they have at their job. The uninsured unemployed would be virtually helpless to pay for their hospitalization and supportive services, however. Certainly this legislation would not prevent such disease or accidents from occurring but at least we can protect those who must pay for them from having to go into bankruptcy.

Imagine for a moment someone forced out of a job owing to circumstances beyond his control, who then suffers a heart attack. The average cost of his hospitalization alone, not including ambulance charges, doctors' fees, post-operative care, drugs or home care, would amount to approximately $2,500 for an average 21 day hospital stay, including the average five-day stay in an intensive care unit (without supportive services) at $185 per day. With full supportive services, it would cost approximately $4,000 for the same period of time. With full, maximum health insurance coverage provided through one of the major carriers, the cost to the individual would be approximately $600. Without such coverage, the individual would have to reach into his savings, if he had any, to pay the $2,500 for the most basic hospitalization, or the $4,000 for complete care. Where would this person get this money if unemployed and without health insurance? What would he have to mortage?

Incidentally, one factor contributing to the high cost of hospitalization is the increasing cost of premiums for liability insurance. In my state of Kentucky alone, 23 hospitals recently were notified that their carrier no longer would provide insurance at the rates they had been charging. These 23 hospitals had to seek new insurers, some of whom would not offer coverage for less than 10 times what had been paid previously. Obviously, the hospitals will absorb this increased cost by raising the amounts they charge for patient care. And the problem of malpractice insurance and its impact of the cost of medical care, I might add, is not one confined to Kentucky.

While we have a responsibility to come to the aid of the unemployed, we must recognize that we have a greater responsibility to all Americans, employed and unemployed, to effect a solution which is most equitable and which has the most reasonable cost.

It can be argued that inequity is inherent in whatever we do to help the unemployed with this health-related problem because of the millions of Americans who also are unable to meet the high costs of medical care but who do not fall into the category of the unemployed. However, that is a matter which must be addressed separately. Because of the recession within our economy, we have millions of individuals being laid off and losing the health insurance they would have had if they could have remained on the job. I am confident that with the existing and planned anti-recessionary measures our economy will turn around and many of these individuals will be able to go back to work. In the meantime, we have an emergency situation, and we must deal with it with emergency legislation.

Given the prerequisites that our solution be equitable, economical and of an emergency nature only, I believe the approach that I and others are supporting should be adopted.

The equity of this approach derives from the fact that, using general revenue funds, the Congress would provide for equal, basic hospital care under Part A of the Medicare program.

The Part A program would help pay the cost of medically necessary covered services for up to 90 days of inpatient care. Covered services in a hospital include the cost of room and meals (including special diets) in semi-private accommodations, regular nursing services and services in an intensive care unit

of a hospital. They also include the cost of drugs, supplies, appliances, equipment and any other services ordinarily furnished to in-patients.

While I believe the intent of this legislation should be to protect the unemployed against bankruptcy by helping with the most expensive aspect of medical care—hospitalization—it cannot afford to save them from all expense. Therefore, the deductibles and co-payments in effect for the regular Medicare program would remain in effect for the eligible employed and their families.

The comparative ease of setting up this program results from the fact that it would not entail setting up a new bureaucracy to administer it. The help promised could be made available immediately upon enactment. It also would not burden the states' unemployment compensation programs with additional work when they already are faced with a difficult task simply administering the unemployment program itself.

Unemployed workers would not have to pre-enroll in the Medicare program. Only if they or a member of their family needed hospital care, and the hospital determined that they had insufficient health coverage and were receiving unemployment compensation, would its provisions go into operation. The hospital would handle the charges for eligible medical services the same way that it does those for others payable through Medicare.

Because our presently high levels of unemployment should begin to drop, it seems to me foolish and wasteful to set up an involved program which would only be dismantled 12 months later. The legislation I am supporting has a 12 month life, but for the same reasons it would be able to go into operation almost immediately, it would be relatively simple to end because it uses a system already in existence.

In summary, I would like to emphasize my support for providing a temporary, emergency program to provide health benefits to the unemployed who previously had such coverage at their place of employment. I strongly support adoption of the legislation providing these benefits through the Medicare program, as in the bill I am sponsoring, rather than through the other methods broached thus far.

NATIONAL ASSOCIATION OF MANUFACTURERS,
Washington, D.C., March 14, 1975.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate, Dirksen Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The National Association of Manufacturers appreciates this opportunity to comment on the subject of providing health care for the unemployed.

The NAM, speaking for American industry, has a vital concern in national health insurance and limited approaches thereto, such as health care for the unemployed, as employers are the single most involved private providers of health care benefits in the United States. In our statement submitted to your committee last year, we enumerated the objectives of any national health plan:

1. Target benefits primarily to those people for whom present health care is unavailable;
2. Provide effective controls on the rapidly expanding costs of health care;
3. Acknowledge the economic impact of massive new health costs on employment and on the private sector's ability to provide goods and services;
4. Improve health care availability and delivery;
5. Build upon the strengths of the existing system rather than move toward a Federal takeover of a viable portion of the private sector.

The NAM reaffirms its support of those objectives for any legislation that may be enacted by the 94th Congress.

American industry questions the efficacy or equity of enacting piecemeal and selective health care proposals for special classes of citizens such as the unemployed. We believe that health care for the unemployed should be considered in the overall legislative context of national health insurance for all citizens.

Pending proposals providing health care for the unemployed would use the present Federal-state unemployment agencies as the administrative vehicle, at least to the extent of certifying eligibility. Whether the particular approach is via Medicare, Medicaid or continuation of the last employer's coverage, certain inequities are both obvious and serious:

—Those who have exhausted their unemployment benefits and may be most in need will not be eligible.
—Eligibility for health care should not be dependent on eligibility for unemployment.
—State employment security systems are already strained to capacity in meeting the current case workloads without imposing additional administrative burdens.
—Under proposals providing continuation of the last employer's coverage, basic coverages will differ and to that degree can be most discriminatory.
—Many employers provide coverage for laid-off workers and thus would be penalized in effect for doing so.
—What happens to any premium excess resulting from experience rated premium refund formula in group insurance; Is the excess a windfall for the insurance company, or others?

Despite these and other inequities, we realize Congress may desire to provide special health care coverage for those receiving unemployment compensation. If so, we urge consideration of the following concepts:

1. If the coverage is to be of long duration without a specified termination date, proposals providing continuation of the last employer's coverage are preferable. The major deficiency of such proposals are their administrative complexity while their primary advantage is utilization of the existing health care system.

2. If coverage is to be of brief duration and with a reasonable termination date, then the use of the Medicaid system is recommended. It would be administratively simpler although the means test is considered by some to be a liability.

In either case, a careful audit of claimant utilization, types of claims, cost, etc. would be highly desirable as a useful tool in helping to establish reliable cost estimates on any national health insurance proposals. With projected Federal deficits of over $80 billion for fiscal years 1975 and 1976, a decline in industrial productivity in 1974, a 13.7 percent increase in 1974 unit labor costs, American industry is in not position to generate employment if confronted with costs of new programs, however desirable, which tend to soar beyond original estimates.

We would appreciate having this statement made part of the record of the hearings.

Sincerely,

RANDOLPH M. HALE,
Assistant Vice President.

STATEMENT OF ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Testimony on proposals to nationalize medical care of the unemployed makes clear that these proposals provide many proponents of so-called national health insurance a convenient cover for continued efforts to destroy the private practice of medicine, and substitute compulsory, politicalized medical care.

The Association of American Physicians and Surgeons urges this Committee to reject proposals to nationalize medical care of the unemployed for these reasons:

1. They represent an unwarranted assumption by the federal government of conduct that is properly the responsibility of state and local governments. There are sound reasons why insurance has always been a state and local responsibility. Less intervention by the federal government is called for—not more.

Such proposed legislation represents another usurpation of power by the federal government, contrary to the fundamental concept of our republican form of government.

2. What is billed as a temporary answer to an emergency would, if adopted, most certainly become a permanent program. The experience of the past 45

years teaches us that there is nothing so permanent as a temporary usurpation of power by the federal government.

Honesty requires admission of the fact that this would not be a "temporary stop-gap"—but an opening wedge to one more permanent program.

3. Enactment of this program would further exacerbate inflation, which is itself the terrible price Americans are paying for 45 years of excessive intervention by the federal government.

Senator Kenuedy estimated that a health program for the unemployed such as he proposes would cost as much as $1.5 billion. That's a familiar figure. $1.5 billion was the estimated annual cost by the bureaucracy of Medicare—which is now costing $14 billion a year!

4. Chief proponents of these proposals to extend usurpation of federal power are also proponents of compulsory political medicine—which they euphemistically and deceptively label "national health insurance."

5. This program would open yet another door to bureaucratic meddling in medical care that would further accelerate costs and feed inflation.

Anyone familiar with the propensity of the bureaucracy to multiply geometrically will have no trouble visualizing the nightmare of yet another medical care program wedged between the mess of medicare and medicaid.

The vulgar assumption that there is a definable limit to so-called free medical care that can be supplied by government is absurd. Demand for care, without cost at point of consumption, is infinite.

And most importantly, the cruel and destructive tax of inflation will inflict the worst injury on the poor and on those ostensibly being helped—the unemployed. And all in the name of compassion, which is synthetic.

There is nothing in these proposals that even remotely suggests an interest in attacking the real cause of the problem of unemployment—economic recession bred by inflation, inflation that is the product of irresponsible deficit spending by a profligate federal government.

In fact, it is frightening and tragic that the proponents of government intervention seek to hide the truth about inflation by attemping to blame everyone else but government for our problems.

For example, the statement was made in explaining the Emergency Health Benefits Program introduced in both the House and Senate that: "It does nothing to restrain the inflationary practices of hospitals and other providers."

Nowhere is there a single word about restraining the inflationary practices of the Federal Government—the real culprit!

AAPS members strongly challenge the assertion that only the Federal Government can do the job of taking care of medical bills of unemployed because state treasuries are being emptied by falling revenues and rising costs that result from unemployment.

Unemployment is not the root cause of falling local revenues.

And it is not just the treasuries of state and local governments that are being emptied. The pockets of individuals are being emptied, too, by the perpetual motion suction-pump operated by the Federal bureaucracy.

This pump must be turned off, or this country's free institutions are doomed.

If we continue to invent crises to deceive the American people into accepting more government intervention, if we continue to use real emergencies as excuses to push government deeper into private affairs, if we continue to ignore the tragic consequences of inflation, which is caused by government spending, we are a nation inviting—no, begging for—disaster.

If fiscal sanity is not restored to government, if we keep on following the false Keynesian ideology that government must intrude on the slightest pretext into every nook and cranny of private affairs, we are going to end up like Britain—a third or fourth rate power headed for bankruptcy and ignominy. The Keynesian philosophy is one of the greatest frauds of the century.

A nation that uses tax money extracted from its citizens, and the more subtle tax of inflation, to buy ever greater government control over its people is a nation bent on suicide. And, by definition, there is no future in suicide.

This is a good place to begin the long journey back to sanity in government, and to restoration of our faith in local self-government.

NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

MARCH 10, 1975.

This statement is presented on behalf of the National Council of Community Mental Health Centers (NCCMHC), representing 317 community mental health centers, most of which receive federal funding under the Community Mental Health Centers Act, and all of which receive federal funds from one source or another, and another 119 agencies which are developing CMHC programs or which have a direct interest in community mental health.

National Council of Community Mental Health Centers strongly endorses the concept of health insurance coverage for unemployed workers and their families to be financed by the federal government. The need for legislation to protect these people from health care costs has been well documented, and the number of individuals and families affected makes action in this area imperative.

Of the various measures proposed to alleviate the problem there are some which will merely add to the costs of health care, while providing no encouragement for the most efficient use of health care resources. The escalating costs of Medicaid and Medicare warn against merely underwriting the costs of care. We must ensure, for example, that treatment which can be provided more efficiently and effectively through outpatient or other ambulatory service programs is not provided on an inpatient basis; that care provided through comprehensive systems (such as community mental health centers, community health centers, health maintenance organizations) is fully covered; and that care, especially primary care, is accessible to all.

A number of bills recently introduced (HR 4003, HR 3165, HR 3166, HR 3228 and S 625, and S 951) would authorized the federal government to assure continued health insurance coverage for unemployed workers and their families by paying the premiums for the coverage they previously received through their employers. These bills have a number of very serious drawbacks:

—they do nothing to improve the system of care or to ensure maximum use of existing resources

—they fail to provide a mechanism for controlling costs and quality of care

—they would continue inequitable coverage, by providing different benefits to different individuals (on the basis of the coverage such individuals were receiving under their health insurance policy when employed)

—they would continue the inequities and discrimination which is generally apparent in health insurance policies (for example, most private insurance companies discriminate against mental health care and where such coverage is provided it is generally limited to more expensive inpatient care, resulting in inappropriate hospitalization in many cases)

—they ignore the needs of unemployed workers who had no health insurance coverage when they were last employed, but who are equally incapable of purchasing insurance through the private market.

—they would provide a two-billion dollar bonanza for private insurance companies, which would act as middlemen between the federal government and the insured individuals, and hence be more expensive than proposals for direct federal health insurance

—many of these bills also would require the establishment of a new bureaucratic mechanism to administer the program in the Department of Labor, which has no experience in managing a health insurance program.

Other bills (HR 3208, HR 3932 and S 496) would provide coverage for the unemployed and their families under the Medicare program. The one serious drawback in these proposals is that coverage would be provided only under Part A of Medicare. Part B, which provides coverage for outpatient and other ambulatory care and aftercare, would not be available to these individuals. If these bills were enacted without change, they would seriously effect the delivery system by emphasizing expensive inpatient care. However, were coverage provided to unemployed individuals and their families under both Parts A and B of Medicare most of the objections cited above, would be met.

For instance, equal coverage would be available to all, regardless of the coverage they had previously received under a private policy and regardless of whether or not they had previously been covered at all. The program could be administered routinely by the Social Security Administration, which has years of experience in operating Medicare and which has the administrative machinery in place. In this regard, it should be noted that an expansion of the Medicare program would be easier for SSA to manage than the new Supplementary Security Income program which ran into a number of snags, mainly because it was a brand new program. The experience with SSI should warn us against setting up another new system in the Labor Department, when the SSA Medicare program can be utilized instead.

A quality and utilization control mechanism is already set up (or in the process of being set up) through the Professional Standards Review Organizations authorized under the Social Security Act for monitoring Medicare and Medicaid services.

The costs of providing this essential coverage would also be kept to a minimum by utilizing Medicare, as the federal government would pay providers for care provided, rather than paying insurance premiums for all covered individuals.

However, while providing coverage under Parts A and B of Medicare would be far more equitable and less costly than continuing previous insurance coverage for unemployed workers, it will not improve the system for delivery of health care services. Medicare, as well as private insurance companies, discriminates against small comprehensive care centers, such as community mental health centers and community health centers. It also discriminates against mental health coverage in general (by eliminating inpatient care to a certain number of days during the patient's lifetime, and limiting care under Part B to 66½% of costs or $312.50 a year, whichever is less). However, in this respect Medicare is more comprehensive than many private insurance policies.

NCCMHC therefore urges that legislation to provide health care coverage for unemployed workers and their families be enacted swiftly. Such legislation should:

—cover all individuals receiving unemployment benefits, regardless of whether or not they had previously been covered under a private insurance policy

—provide hospital insurance coverage under Part A of Medicare and supplementary insurance coverage under Part B (with no premium charged for Part B coverage)

—amend Title XVIII to include community mental health centers which meet certain standards as providers of care under Medicare and eliminate existing restrictions on mental health coverage

Further details on NCCMHC recommended amendments to Medicare are contained in the attached position paper. Briefly, we recommend amendments to Title XVIII as follows:

—include CMHCs which meet the definition of such centers in the Community Mental Health Centers Act as providers of care for inpatient services under Part A

—amend Part B to specifically include under the definition of medical and other services "all services of community mental health centers which meet the definition of such centers in the Community Mental Health Centers Act, whether provided in the center facility or in disbursed service elements affiliated with the center"

—repeal the provision which limits the total number of days of mental health care a person can be reimbursed for in his lifetime, and replace it with a limitation on spell of illness coverage which should be the same as for other forms of care

—repeal the limitation on reimbursement under Part B for mental health services (now limited to $312.50 or 66½% of the expenses incurred).

Enactment of these amendments and of legislation to provide coverage under Parts A and B of Medicare for unemployed workers and their families will ensure improvements in the delivery system and an emphasis on ambulatory and other noninstitutional care. We should avoid the mistake of earlier years of funding health services for a certain population group without at the same time ensuring that costs are contained, care is accessible to all in need, and the quality of care provided is monitored (in this case through the PSROs set up to review Medicare and Medicaid services).

While legislation to protect the unemployed is urgently needed, it is vital that we not rush into law a measure which could compound our present problems in

health delivery. Although the pending legislation is clearly intended to be temporary; it is likely that it will be extended beyond the proposed one-year period and even become the basis for a program of national health insurance. Thus, if all the ramifications are not carefully examined, the new law could prove detrimental to future federal efforts to improve the system for delivery of care.

POSITION PAPER: NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

HEALTH INSURANCE FOR AGED AND DISABLED—MEDICARE

Background.—As Congress begins serious work on proposals for national health insurance, it is important to review the operation of existing federal third party payment programs designed to bring health care to specified population groups by underwriting costs. The Medicare program, designed to cover the costs of certain health services for elderly and disabled persons is one such program, and one which has generally not provided significant reimbursements to community mental health centers.

Whether or not national health insurance is enacted in the next few years, there is a need for improvements in Medicare. As the present time, both Congress and the Administration are proposing that CMHCs become less financially dependent upon federal categorical grants, and transfer their support to third party payment systems, including Medicare. Yet at the same time, CMHCs are finding that restrictions built into Medicare prevent their receiving adequate reimbursement for services to the elderly and the disabled.

If CMHCs are to become more fully self-supporting, it is essential that the Federal Government provide a system to reimburse centers for essential services to those unable to pay.

Problem.—Currently, some centers are obtaining substantial revenue from Medicare (in terms of number of elderly persons served) but many others run into difficulties because:

—free standing CMHCs have found it impossible to qualify as providers of care under the inpatient program as they do not meet the definitions (which are more suited to large psychiatric or general hospitals)

—CMHCs are not able to receive reimbursements for home health services, because the law is not specific on their eligibility

—some intermediaries have excluded CMHCs from Part A or Part B reimbursements because the centers receive federal grants (policy on this issue is being clarified by the Social Security Administration and this should not remain a problem)

—limitations on the costs of covered mental health services excludes some patients

—some CMHCs cannot qualify for reimbursement for services provided through their satellite programs (which are not co-located with the main center facility and which do not have a physician on the premises).

Position.—NCCMHC urges swift enactment of a number of amendments to Medicare to increase reimbursements to CMHCs through this program. These amendments should:

—include CMHCs which meet the requirements set for such centers applying for financial assistance under the Community Mental Health Centers Act as providers of services for inpatient care under Part A

—amend Part B to specifically include under the definition of medical and other services, "all services of community mental health centers which meet the definition of such centers in the Community Mental Health Centers Act, whether provided in the center facility or in disbursed service elements affiliated with the center"

—repeal the provision in Medicare which limits the total days of mental health care a person can be reimbursed for in his lifetime, and replace it with a limitation on spell of illness coverage which should be the same as the limit for other forms of care

—repeal the limitation on reimbursement under Part B for mental health services (now limited to $312.50 or 66⅔% of expenses incurred.)

Attached is a list of these amendments.

SUMMARY OF NCCMHC SUGGESTED AMENDMENTS TO MEDICARE LAW

Part A—Inpatient coverage

(1) Limitation on coverage.—Medicare limits mental health coverage to a total of 190 days during the patient's lifetime, Sec. 1812 (b) (3). This section should be repealed.

Inpatient mental health care should be limited, not by the total number of days of care in a lifetime, but for each spell of illness. This would encourage shorter hospital stays and accent ambulatory care (which is both less expensive and more desirable for most patients). A lifetime limitation on care, on the other hand, could exclude from coverage persons in desperate need of such care.

The limitation placed on inpatient mental health care per spell of illness should be the same as those now in the law for other forms of care (i.e. 90 days, plus a lifetime supply of another 90 days which can be used at the patient's discretion except that services are not covered for more than 150 days per spell of illness).

(2) Inpatient psychiatric hospital services.—Definition of Psychiatric Hospital: The definition of a provider of care for inpatient mental health services under Medicare accents care in psychiatric or large general hospitals. Free-standing CMHCs are unable to obtain reimbursement from Medicare for services to elderly patients.

This situation could be ameliorated by including in the definition of a psychiatric hospital (Sec. 1861 (f)): "community mental health centers meeting the definition of such centers in the Community Mental Health Centers Act"

Part B—Supplementary benefits

Part B provides coverage for medical and other services provided to persons who are not inpatients. Many services of community mental health centers qualify for support under this Part. However, some centers have found it difficult or impossible for various reasons to get reimbursement through Part B.

As centers are required to rely more and more upon third party payments, and as categorical grants are de-emphasized in favor of national health insurance schemes, it is important to ensure that the federal government does not *discourage* the utilization of community mental health centers for mental health care. NCCMHC therefore recommends that Sec. 1861 (s) be amended to add a new paragraph to the definition of "medical and other services" to include: "all services of a community mental health center whether provided in the center facility or in disbursed service elements affiliated with the CMHC, which center meets the definition of such centers under the Community Mental Health Centers Act"

Also, Sec. 1833 should be repealed. This would have the effect of removing the limitation on reimbursement under Part B for mental health care (now limited to $312.50 or 66⅔ percent of expenses incurred).

PREPARED STATEMENT BY BLUE CROSS ASSOCIATION, HAROLD G. PEARCE, SENIOR VICE PRESIDENT

Mr. Chairman and Members of the Committee, I am Harold G. Pearce, Senior Vice President of the Blue Cross Association, the national organization of the 73 Blue Cross Plans in the United States.

Begun in response to community need in 1929, Blue Cross Plans have grown from a year-end membership in that year of 1,500 persons to our present enrollment of well over 80 million. In addition, the Blue Cross system serves as an intermediary, under contract with government, for the Medicare, Medicaid, CHAMPUS, and other public programs.

In total, the Blue Cross system has programs and systems in place serving nearly half the population of the United States. Our non-profit, independent Plans serve local and national market under policies set by community-oriented boards[1] and comprise a major component of the American health system.

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[1] As of December 31, 1973, 68 percent of the Board members of Blue Cross Plans were representatives of the general public (10% were hospital trustees) and 32 percent represented the providers of health care (19% were hospital administrators and 13% were physicians).

As a representative of the Blue Cross system, I commend this Committee and the Congress for assigning a high priority to the subject we are addressing today: health benefits for the unemployed. This country's system of health and welfare benefits for the working population has been developed in large part through the efforts of employers and unions and, as presently constituted, is dependent on a relatively stable employed population. During a period of unusually high unemployment, such as we see today, a significant number of people lose their health benefits along with income.

Because today's need is so immediate and compelling, it is necessary to fashion an expedient program of health benefits for the temporarily unemployed, while longer range solutions are being debated. The challenge in designing and implementing such a program can only be met by concentrated effort of all parties concerned: employers, the health industry, and the federal government.

Several conceptual alternatives may be considered, each with advantages and disadvantages to all parties involved. At least two of these alternatives are represented in legislation before Congress. From our perspective, the following options should be debated:

1. *Design a uniform program of essential basic institutional and professional care financed by the Federal Government and administered by the private sector*

On the positive side, greater equity to the temporarily unemployed is achieved by making the same benefits available to all in his category.

There are problems in this approach. Probably the most difficult would be the length of time required to set up such a program. Several months would be required to deliver benefits. Decisions would have to be made on many details, e.g., eligibility, benefit structure, flow of payment from government to carrier, prevention of duplicate coverage, and the treatment of an unemployed person with a working spouse. Such a uniform benefit program would at the same time increase and decrease benefits over coverage during employment, creating a communication problem in familiarizing beneficiaries with new levels of coverage.

2. *Extend Medicare benefits to the unemployed, with the administration of the program continuing through Medicare carriers and fiscal intermediaries*

Medicare benefits are directed toward a population with unique needs. One result is that the program covers a scope of health services more comprehensive than many current health insurance contracts. A question exists whether this full range of benefits is appropriate for a short-term project aimed at a healthier, more youthful population.

Also, some aspects of the Medicare regulations have been specifically designed for the over 65 population. An example is the nursing differential in the provider reimbursement formula. This and other unique features designed for the existing Medicare population would have to be modified.

As presently designed, Medicare requires significant deductibles and coinsurance for both hospital and medical services (Parts A and B). It is questionable whether many temporarily unemployed, lacking the private supplemental insurance held by many Medicare beneficiaries, would be able to pay these amounts. This problem exists for private coverage, to varying extents, as well.

3. *Provide entry into the various state Medicaid programs for the temporarily unemployed*

Enhancing this option is the fact that a system for administering health benefits through Medicaid exists.

However, there are several drawbacks to this route.

—Medicaid administration and benefits are very uneven from state to state.

—There is little assurance that all state Medicaid forces would be able to cope with a suddenly increased load.

—Because the provision of health benefits for the unemployed is expected to be a short-term program, it is difficult to envision that it would be economically feasible, under either a Medicaid or Medicare pattern, to recruit and train additional temporary staff for a short-term swell in recipients.

—The current Medicaid program is a welfare program, requiring recipients to spend down their resources in order to qualify. It is possible to waive the spend-down provisions of the medicaid program for the temporarily unemployed. However, this would require already burdened Medicaid administra-

tors to develop dual administrative eligibility requirements for a single program.

—The general benefits provided under Medicaid are directed toward providing for the health needs of the poor and near-poor on a long-term basis. It is questionable that they are appropriate for the short-term needs of the temporarily unemployed.

4. *Establish a uniform amount of money provided by the Federal Government directly to the temporarily unemployed*

With this money the person would be urged to continue through his current carrier, health coverage available on a conversion contract.

The main problem in this approach is that there is no assurance that a temporarily unemployed person, faced with other pressing needs, would, in fact, use the funds to purchase a conversion contract. Use of scrip rather than cash would introduce other complications.

Another drawback is that at the present time not all health insurance carriers provide for conversion privileges. Thus, some of the temporarily unemployed would have no guarantee of access to continued protection.

5. *Provide through payment from general revenues for the continuation of health benefits enjoyed during employment through the employer*

This option would be easiest and least expensive to implement. By mandating cooperation by the employer, use could be made of existing machinery for covering a vast majority of the temporarily unemployed. Familiar benefits would be involved, reflecting local differences in health services and practices.

Where the employer is no longer in business, it will necessitate the development of a short-term eligibility system flowing from the unemployment compensation office to the carrier that covered the person as an employee.

Probably the most troublesome feature of this route would be the inequities of benefits protection and federal contribution. It would involve different levels of coverage to people dependent upon the coverage they held when they were employed.

6. *Additional concepts*

There is no easy or apparent solution to the problem. Tradeoffs must be made among such elements as equity, time, and expense; A new, complete system would be expensive and time-consuming to set up and dismantle. A fast, low-cost program is bound to involve inequities in protection, although no more, necessarily, than now exist.

A useful way to minimize conflict might be for the federal government to make available a uniform level of financing for existing benefit programs. Depending upon at what level the subsidy is set, an additional, and much more manageable, payment would be required in the working group setting.

If existing benefits through the working environment are to be supported in any form, it might be advantageous to permit employers, up to a year, to claim a tax credit for payment of premiums. If no tax is owed, a refund could be arranged. Such a bottom-line transaction would not affect other taxes owned. It would cut down on the necessity of moving funds and thus save time and money.

The record should state that even now Blue Cross Plans are doing everything possible to continue health benefits. All Blue Cross Plans provide for conversion privileges. Any person leaving a job, and therefore leaving a group, can convert his coverage as soon as his group benefits expire. This applies to persons laid off as well as those leaving for any other reason.

Depending upon the program design decided on by Congress, we could ask our Plans to open up their enrollment immediately to the working spouses of all recently unemployed, so the employed spouse might convert to family membership and thereby protect the unemployed and dependents. Such changes are usually limited to specified enrollment periods. For the duration of this emergency situation, we could ask that Plans allow such changes whenever desired.

In summary, we recognize the need to use extraordinary means to meet current needs. We commit the resources of personnel and experience of the Blue Cross system to cooperate with the Congress in answering this critical problem.

PREPARED STATEMENT OF THE CHAMBER OF COMMERCE OF THE UNITED STATES
BY ANDREW A. MELGARD[1]

MARCH 7, 1975

The Chamber of Commerce of the United States welcomes this opportunity to present its views on the various legislative proposals that have been introduced recently to provide health insurance for unemployed workers and their families on a temporary and emergency basis.

This issue is of vital concern to our membership which embraces more than 47,000 business enterprises, 3,600 trade and professional associations, and local and state chambers of commerce. The underlying membership is more than 5,000,000 individuals and firms.

These comments are under three major headings, as follows:

1. "Basis for Chamber Comments," including our positions on current unemployment policies and the need to assure quality health care for all Americans.
2. "The Employment Situation: January 1975."
3. "Legislative Proposals," including a discussion of the pros and cons of the "Medicare approach" and the "extension of employer plans approach." We recommend consideration of an alternative approach, the use of the Medicaid system.

BASIS FOR CHAMBER COMMENTS

The Nation faces three difficult problems: the severe recession and resulting unemployment, the continuing inflation, and the energy crisis. The Chamber recognizes that there is no easy or quick solution to these problems, but has developed a comprehensive set of recommendations for national policy against recession and inflation. A coordinated approach to both recession and inflation is imperative.

Among the Chamber's recommendations are a new approach to unemployment, as follows:

New Approaches to Unemployment Policies

A tax cut and easing of credit will stimulate employment and reduce unemployment associated with the recession. Also to reduce hardship caused people by recession-related unemployment, the National Chamber supports the use of unemployment compensation and public service unemployment programs. Such programs automatically provide income, but recede as unemployment declines.

Public service employment programs should have clear self-destruct limits. They also should be applied only in areas where the rate of unemployment has been no less than 6.5 per cent for three consecutive months.

However, there is need for careful analysis of current unemployment. A significant number of today's unemployed are out of work for reasons not related to economic recession. They have either quit their jobs, or reentered the labor force, or are seasonally unemployed or have never worked before.

Such unemployment should be dealt with by means that are noninflationary, such as:

—Removing obstacles which stand in the way of job opportunities for teenagers.
—Implementing the Comprehensive Employment and Training Act.
—Urging the expansion of career and economic education in schools.
—Eliminating restrictive measures by labor unions that limit the supply of workers in major trades and industries.
—Resuming federal publication of national job vacancy statistics.

New approaches to the Nation's health care needs

The Chamber supports the national goal of a health care system that would assure quality care for all Americans. Such a system should maximize the advantages of individual freedom of choice and flexibility.

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[1] Director, economic security, education and manpower section, Chamber of Commerce of the United States.

The Chamber supports national health insurance legislation that provides universal, comprehensive coverage built on our current systems. We also support the development and optimum utilization of quality health manpower, increasing the effectiveness of delivery systems, and measures to assure efficiency and control of costs.

Any national health insurance program should recognize certain basic principles. It should:

—provide for universal financial access to health care through both private and public means;
—protect individuals and families against the devastating impact of very costly and prolonged illness;
—build on our existing hospital and medical care delivery system with underwriting and administration supplied by private enterprise;
—protect individuals and families against the devastating impact on very costly and prolonged illness;
—provide a benefit "package" which is comprehensive in scope;
—provide for cost-sharing on the part of beneficiaries; and
—provide for effective measures to help contain spiralling costs.

When such a program is adopted, the unemployed will have health coverage, as will those who are on welfare or who are low-income individuals. Unfortunately, we appear to be several years away from having such a permanent solution to the problem.

The dilemma

The present problem is whether or not we should adopt a temporary emergency program of health coverage for those laid off employees who are receiving unemployment compensation but who have no health insurance coverage. This would be an additional and costly new social insurance program.

The ideal solution is to get laid off workers back on the job where they will once again have earned income, health coverage and a full range of employee benefits. It is questionable whether a new social insurance program will contribute to such a solution. But it is certain to add to the enormous budget deficit.

The Chamber has concluded that there should now be a moratorium on all new federal programs and spending, other than energy programs. A major contribution to inflation has been the growth of government faster than the growth of the overall economy. Government at all levels now absorbs almost 35 percent of the Gross National Product. It employs one out of every six workers. At the federal level alone, the debt is some $495 billion, of which over $100 billion has been added in the past five years. Further expansion of government would not only be inflationary, but would further encroach on the private sector.

The National Chamber believes there is a vital need now to study the adequacy of measures used to maintain stability in the economy and to evaluate the whole question of the size and role of the public sector in a society basically committed to private ownership and a market economy.

This position does not mean there is any lack of concern among employers for the plight of the unemployed during this severe recession. All employers are anxious to get back into full production and quickly rehire laid off employees. Long range employers want the economy and their businesses to grow. This will afford more job openings for the millions of young Americans who will be new entrants into the labor force.

A picture of employer commitment to higher employee income appears in the Chamber's latest biennial *Employee Benefits Survey for 1973*. Exhibit A shows the increases in wages and employee benefit costs from 1963 to 1973. Average weekly earnings increased from $107.52 to $189.96, or some 77 per cent. Weekly employee benefit costs increased from $27.52 to $62.12 per employee, or some 126 percent—almost twice as fast as weekly earnings.

It should be noted, however, that weekly costs for employee benefits vary from industry to industry, and from company to company with a given industry.

Exhibit B shows these costs by industry. The cost per employee per week ranged from $81.88 to $37.79.

All told, it is estimated that employers paid over $230 billion in 1974 for employee benefits. Further increases are expected in the years ahead.

A second way to look at non-wage income supplements is to study the growth of transfer payments as a source of personal income. This includes items like social security payments (based on 50–50 employer-employee payroll taxes) and unemployment insurance (primarily based on the employer payroll tax) which go to people not working. Transfer payments have grown from $33.3 billion in 1962 to an estimated $158.8 billion in 1975.

This means that in addition to our "market economy", we also have a growing "transfer economy". Traditionally in America, citizens received their incomes from the productivity of their labor or from the productivity of their property. The way citizens obtain income has been changing in the last forty years with the growth of the various components of the "transfer economy".

The transfer economy has arisen from the attempt to reconcile demands for equity and justice in the distribution of income and wealth with the requirement for efficiency in the marketplace. There is concern that the rapid growth of the "transfer economy" may be weakening the linkage among work, property and income. Such a linkage is necessary for the efficient operation of the marketplace.

Some would argue that the growth of transfer payments is evidence of a growing welfare state. Whether this proves correct or not, certain welfare states in Europe are recognizing the need to stimulate the growth of the private sector. For example, Sweden's policy of encouraging business reflects its recognition that a welfare state needs a vigorous business community to support it financially.

What this means is hard choices, or trade-offs—whether to go further into debt by starting now a new social insurance program to provide health coverage for the unemployed, or whether to defer such additional and possible inflationary deficit spending? Whether to spend several billion dollars to get employees back to work where they will have health benefits or to introduce a new social insurance program that could weaken the linkage between work and income?

Against this background, we would like to examine the current unemployment picture, review the legislative proposals before the Committee and suggest consideration of an alternative approach.

THE EMPLOYMENT SITUATION: JANUARY 1975

The unemployment rate in January was 8.2 per cent. This is the highest point since World War II. Total employment (as measured by the monthly survey of households) was 84.6 million. Unemployment totaled 7.5 million. The expectation is that the situation will worsen before it improves.

Unemployment is an all too clear reality for the person unemployed, but a complex concept to deal with on a national basis. Our current unemployment results from cyclical, frictional, structural and seasonal factors. In addition, any particular rate of unemployment depends for its meaning on the way unemployment is defined and measured.

The Current Population Survey, a monthly survey of 47,000 households, provides the major source for unemployment information in the United States. It covers the labor force status of household members aged 16 and over to determine who are employed, unemployed, or out of the labor force.

Persons are classified as unemployed if they were not employed during the survey week but were available for work and have made a specific effort to find a job at some time within the preceding 4 weeks, or if they were waiting either to report to a new job within 30 days or to be recalled to a job from which they were laid off.

Exhibit C compares our current employment picture with that of 1958, when we had the highest previous rate since World War II. The number of households has increased from about 51 million to about 70 million. The number of employed has increased from 63 million to 84.5 million.

The makeup of our labor force has changed significantly. Males 20 and over are now only 56 per cent of our labor force as compared to 64 per cent in 1958. Interestingly, the rate of unemployment for this group was slightly higher in 1958.

In 1958, females 20 and over plus both sexes ages 16 to 19 were about 36% of the labor force. This January these two groups totaled almost 44 per cent of the

labor force. The current rate of unemployment is now higher for females than males, a reverse of the 1958 situation. The worst rate continues to be for the 16–19 age group, which at 20.8 per cent is about one-third higher than in 1958. More than half our unemployment is among women and the teenage group.

One fact that seems to surprise many is that for every one hundred households we have over one hundred and fifty people working. This is for households with heads under age 65, and, of course, some of these jobs are low-income, or part time. Nonetheless, it shows the degree to which American households are committed to working and to increasing or maintaining their incomes.

The jobs per household figure has some relevance to the legislative proposals. First of all, two or more workers per household is a form of unemployment insurance—household self-insurance. If one employee in the household is laid off, household income maintenance is provided through the incomes of those who continue to work plus the tax-free unemployment payments received by the person laid off. In addition, a laid off spouse or other young dependent may be able to pick up health insurance coverage under the policy of the spouse who continues to work.

Exhibit D shows household data on the reasons for unemployment. Slightly over half the unemployed lost their job. The other half either left their last job, are reentering the labor force, or are seeking their first job.

Exact statistics on the number of individuals who have lost their health insurance coverage are difficult to determine. The statistics in Exhibit D narrow the problem to the 3.8 million who have lost their jobs. We have no figures on how many of these individuals have their health insurance coverage continued for any where from 30 days to 1 year, how many have or purchase individual health coverage, how many may have or pick up coverage through a policy covering a spouse or other relative, how many have income at levels that qualify them for Medicaid, how many of them are elderly and qualify for Medicare, and how many have coverage under previous policies because of pre-existing conditions. In addition, other medical coverage may be available under automobile insurance policies, disability riders on life insurance policies, and other insurance policies. It would be helpful to have a clearer picture to be able to gauge the extent of the problem, price out the cost of the various proposals, and determine what duplication the proposals may cause.

Another factor is the average mean duration of unemployment which the BLS reported was 10.7 weeks in January 1975. This poses the question of how administratively you can efficiently provide temporary, emergency health coverage for the period involved.

Finally, most informed persons now regard an average overall level of unemployment of 5%, or even a little higher, as normal in today's economy. This means the recession-caused part of our current unemployment is about 3 percentage points of the total 8.2 percentage points. This translates into about 2.7 to 3 million jobs. The crucial problem is to get these people back to work. Then, we can start to work on the remaining group and future entrants into the labor force. This all requires policies directed toward investment spending and capital formation to create jobs.

LEGISLATIVE PROPOSALS

Medicare Approach (H.R. 3208 by Rep. Corman and S. 496 by Senator Bentsen)

These similar bills would amend the Social Security Act to use Part A Medicare to pay hospital costs of individuals entitled to weekly benefits under a Federal or State unemployment compensation plan. A dependent spouse or a dependent child or children of such an individual would also be entitled to the basic coverage, and in addition, they would receive a material and child health benefit package to be devised by the Secretary of HEW. All Medicare deductibles and copayments would apply to these newly enrolled or covered individuals. But, to avoid unnecessary costs, benefits would not be paid for any individual who had an insurance policy or prepayment plan covering "such item or service."

If adopted, this amendment to the Social Security Act would be effective for one year. It would be financed out of general revenues. The preliminary estimated cost is $2.1 billion.

The advantages claimed for this approach are that it would utilize an existing system and not require an additional layer of bureaucracy. It has a standardized benefit package which includes deductibles and co-insurance. It covers the most

essential hospital services: operating and recovery room costs, lab tests, radiology services, medical supplies and a wide range of rehabilitation services. It is secondary coverage if another health plan is effective.

The problems with this approach are:

1. It would take the Medicare program which is specifically designed for the aged and which is primarily self-financed through taxes on earnings and payrolls and load on to it a general revenue financed program for some unemployeds under 65 and their spouses and children. There is concern that this could water down the services being provided the elderly. Our senior citizens living on fixed incomes have been hardest hit by inflation and should not have to run the risk of having their own specifically designed health program weakened.

2. In a broader sense, it is essential that we maintain public confidence in our Social Security system. The 1974 Annual Report of the Trustees estimated a long-term 3% taxable payroll deficit in Social Security. Experts reporting to the Senate Finance Committee have estimated the deficit will be 6% of taxable payroll. The Ways and Means Committee has just learned that the trust funds may be depleted by 1980. Eight former HEW Secretaries and Social Security Commissioners were so alarmed at "attacks on the system" that they recently felt constrained to issue a defense of "Social Security: A Sound and Durable Institution of Great Value." At such a time there would be a grave risk in loading on to the Medicare part of Social Security temporary health coverage for some unemployeds under 65 and their dependents. We cannot afford to have public confidence in our Social Security system undermined.

In addition, the proposal is not equitable, nor is that claim made for it. This raises the question of whether general revenue funds should be used in this fashion. Further, whatever the cost may be, should the Congress increase the expected deficit with such a new social insurance program?

Extension of Employer Plans Approach (H.R. 3165 by Rep. Hastings and S. 625 by Senators Kennedy, Javits, Schweiker and Williams)

H.R. 3165 would amend the "Public Health Service Act" and use the Secretary of HEW to administer the emergency health benefit program. S. 625 would amend the "Emergency Jobs and Unemployment Assistance Act of 1974" and use the Secretary of Labor for administration. Both bills propose to provide qualified unemployeds with the same health benefits package they had with their previous employer. To accomplish this, the Secretary of HEW or Labor would be authorized to enter into arrangements with insurance carriers, employers, employee welfare benefit plans, and State agencies to pay appropriate premiums plus any additional administrative expenses to continue the unemployeds previous health coverage.

These are temporary bills terminating on June 30, 1976. Various costs are cited. In the Congressional Record of February 7, 1975, Senator Kennedy stated, "We estimate over 8 million unemployed and their families, a total of nearly 25 million Americans, will benefit from the program during the course of the program." Later, he stated, "We estimate the cost of the program to be between $1 and $1.5 billion assuming an unemployment rate of 8 percent." Senator Williams estimated a cost of $1.75 billion based on a 9 percent jobless level with 3.5 million eligible workers at an average premium cost of $500 per year. Senator Javits estimated a cost of $1.5 billion based on 3 million eligible unemployed workers. Senator Schweiker assumed "that this program may cost at least $1 billion and may reach $1½ billion." Whatever the cost, it would be paid from general revenues.

The advantages claimed for this approach are that it would utilize existing private mechanisms on a voluntary basis to provide the coverage. Senator Kennedy stated, "The fact is, by passing this bill, we will be rescuing more than the worker. We are also rescuing the hospitals, the clinics, the health maintenance organizations, and the doctors."

Some of the disadvantages of the bill as stated by Senator Kennedy are:

"It does not assure comprehensive coverage;

"It does not cover every American, or even every unemployed worker;

"It does nothing to restrain the inflationary practices of hospitals and other providers;

"It does nothing to assure health services are actually available in every community;

"It does nothing to assure the quality of health care."

In addition, there is no claim that this proposal is equitable, but the hope is that "the inequities and shortcomings in this approach" can be corrected during committee deliberations. This effort to have employers extend their private programs would be unsuccessful because of the costs involved, the administrative impracticalities and the inequitable results.

An Alternative Approach

The Chamber recommends that, in the course of deliberations, the Committee consider another alternative, the use of the Medicaid system. As with Medicare, the administrative machinery is in place and could probably be started as quickly as any other approach, if not quicker.

This approach would be to amend Title XIX of the Social Security Act to provide a temporary emergency program for a new category of persons, the unemployeds and their dependents not otherwise eligible for Medicaid or Medicare and who have no other health coverage. This particular program could be limited to a basic package: inpatient and outpatient hospital service, x-ray and lab services, physician services and prescribed drugs. Appropriate deductibles and co-insurance features could be added to limit costs. This program, like the others, would be funded out of general revenues and should be limited to a short period.

The Chamber has already recommended to Congress that when national health insurance is adopted, it should include a state insurance pool to provide health coverage for low-income individuals including the unemployed. Under this comprehensive approach, Title XIX (Medicaid) would be repealed and the low-income state insurance pool would replace it. Using a temporary Medicaid type approach for unemployeds during this recession would help accomplish the purposes of the "Congressional Budget and Impoundment Control Act of 1974" (P.L. 93-344). It would allow pilot-testing and improve the information base in advance for determining the effectiveness of the forthcoming national health insurance program. In other words, if Congress should decide to temporary cover the unemployed during this recession, it would be helpful to pilot test a program which could become one of the basic building blocks of national health insurance, i.e., coverage for the unemployed, the low-income and the poor. This approach would build on our existing private health insurance system since the states would be utilizing existing carriers.

EXHIBIT A

WEEKLY EXTRA BENEFIT COSTS PER EMPLOYEE

	1973	1963	Percent change
Social security taxes	$10.13	$3.23	+214
Private pensions (nongovernment)	9.67	4.19	+131
Paid vacations	8.96	4.62	+94
Insurance (life, sickness, accident, hospitalization, etc.)	8.79	3.12	+182
Paid rest periods, lunch periods, wash-up time, etc	6.56	2.90	+126
Paid holidays	5.67	2.79	+103
Unemployment compensation taxes	2.25	1.83	+23
Profit-sharing payments	2.15	.96	+124
Paid sick leave	2.12	.75	+183
Workmen's compensation	1.77	.87	+103
Christmas or other special bonuses	.71	.54	+31
Contribution to employee thrift plans	.42	.10	+320
Employee meals furnished free	.42	.33	+27
Discounts on goods and services purchased from company by employees	.29	.21	+38
Other employee benefits	2.21	1.08	+105
Total employee benefits	62.12	27.52	+126
Average weekly earnings	189.96	107.52	+77

Source: "Employee Benefits 1973," Chamber of Commerce of the United States.

EXHIBIT B

Weekly extra benefit costs by industry—1973

	Per employee per week
All industries	$62.12
Manufacturers:	
Petroleum	81.88
Chemicals and allied products	71.56
Transportation equipment	67.12
Primary metal	65.29
Machinery (excluding electrical)	63.02
Fabricated metal products (excluding machinery and transportation equipment)	62.33
Rubber, leather and plastic products	60.02
Stone, clay and glass products	58.83
Food, beverages and tobacco	58.15
Instruments and miscellaneous products	57.98
Electrical machinery, equipment and supplies	55.38
Printing and publishing	54.87
Pulp, paper, lumber and furniture	53.73
Textile products and apparel	35.27
Nonmanufacturing:	
Public utilities	75.33
Banks, finance and trust companies	64.31
Miscellaneous industries (mining, transportation, research, warehousing, etc.)	61.38
Insurance companies	61.33
Wholesale and retail trade (excluding department stores)	45.10
Department stores	37.79

Source: Employee Benefits 1973, Chamber of Commerce of the United States.

EXHIBIT C

EMPLOYMENT IN THE UNITED STATES: 1958 AND JANUARY 1975

	Year 1958	January 1975 seasonally adjusted data
Unemployed rate (percent)	6.8	8.2
Total population (millions)	174.1	212.9

	Households (thousands)					
	Estimated from 1955 and 1960 data			1974 data		
	Total	Male head	Female head	Total	Male head	Female head
Total	50,830	41,775	9,055	69,859	53,862	15,997
Head 65 and over	9,500	6,025	3,475	13,877	8,076	5,801
Head under 65	41,330	35,750	5,580	55,982	45,786	10,196

	Employed and unemployed (thousands)									
	Employed		Unemployed		Percent	Employed		Unemployed		
	Number	Percent	Number	Percent	Unemployed	Number	Percent	Number	Percent	Percent Unemployed
Total	63,036	100.0	4,602	100.0	6.8	84,562	100.0	7,529	100.0	8.2
Males, 20 and over	40,411	64.1	2,682	58.3	6.2	47,490	56.2	3,025	40.2	6.0
Females, 20 and over	19,043	30.2	1,242	27.0	6.1	29,932	35.4	2,624	34.9	8.1
Both sexes, 16–19	3,582	5.7	678	14.7	15.9	7,140	8.4	1,880	25.0	20.8
Jobs per household (head under 65)			1.525					1.511		

Sources: Bureau of Labor Statistics and Bureau of Census, with percentages and jobs per household computed by the Chamber of Commerce of the United States.

EXHIBIT D

TABLE A-5.—REASONS FOR UNEMPLOYMENT

Reason	Not seasonally adjusted		Seasonally adjusted					
	January 1974	January 1975	January 1974	September 1974	October 1974	November 1974	December 1974	January 1975
Number of unemployed (thousands):								
Lost last job	2,519	4,858	1,987	2,256	2,418	2,840	3,190	3,831
Left last job	757	780	738	745	834	784	788	760
Reentered labor force	1,227	1,905	1,239	1,592	1,450	1,670	1,762	1,924
Seeking 1st job	504	637	679	726	770	784	778	858
Percent distribution:								
Total unemployed	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Job losers	50.3	59.4	42.8	42.4	44.2	46.7	48.9	52.0
Job leavers	15.1	9.5	15.9	14.0	15.2	12.9	12.1	10.3
Reentrants	24.5	23.3	26.7	29.9	26.5	27.5	27.0	26.1
New entrants	10.1	7.8	14.6	13.6	14.1	12.9	11.9	11.6
Unemployed as a percent of the civilian labor force:								
Job losers	2.8	5.3	2.2	2.5	2.6	3.1	3.5	4.2
Job leavers	.8	.9	.8	.8	.9	.9	.9	.8
Reentrants	1.4	2.1	1.4	1.7	1.6	1.8	1.9	2.1
New entrants	.6	.7	.8	.8	.8	.9	.8	.9

TABLE A-6.—UNEMPLOYMENT BY SEX AND AGE

Sex and age	Not seasonally adjusted			Seasonally adjusted unemployment rates					
	Thousands of persons		Percent looking for full-time work						
	January 1974	January 1975	January 1975	January 1974	September 1974	October 1974	November 1974	December 1974	January 1975
Total, 16 years and over	5,008	8,180	81.0	5.2	5.8	6.0	6.6	7.2	8.2
16 to 19 years	1,271	1,732	53.5	15.5	16.7	17.1	17.4	18.1	20.8
16 to 17 years	606	746	25.1	18.8	18.5	18.8	19.5	21.2	22.6
18 to 19 years	665	985	75.1	13.2	16.0	15.7	15.8	16.0	19.6
20 to 24 years	1,170	1,829	87.0	8.3	9.4	9.4	10.5	11.7	12.4
25 years and over	2,567	4,619	89.0	3.2	3.7	4.0	4.4	4.9	5.7
25 to 54 years	2,122	3,938	90.5	3.3	3.8	4.2	4.7	5.1	6.1
55 years and over	445	681	80.0	2.8	3.0	3.1	3.2	3.7	4.2
Males, 16 years and over	2,764	4,644	85.6	4.3	5.0	5.4	5.7	6.4	7.2
16 to 19 years	707	972	54.6	14.1	16.9	16.5	17.1	17.4	19.8
16 to 17 years	365	439	26.4	18.2	18.4	17.9	19.7	21.1	22.3
18 to 19 years	341	533	77.9	11.4	16.6	15.2	15.1	14.9	18.2
20 to 24 years	648	1,070	90.9	7.7	9.1	9.4	10.4	11.2	12.6
25 years and over	1,409	2,602	95.0	2.6	3.0	3.4	3.7	4.2	4.8
25 to 54 years	1,130	2,189	97.0	2.6	3.1	3.6	3.9	4.4	5.1
55 years and over	280	412	84.2	2.6	2.8	2.7	2.8	3.4	3.9
Females, 16 years and over	2,244	3,535	75.0	6.5	6.9	7.0	7.8	8.5	9.7
16 to 19 years	564	759	52.0	17.1	16.5	17.8	17.6	19.0	22.1
16 to 17 years	241	307	23.1	19.6	18.6	20.0	19.3	21.4	23.0
18 to 19 years	324	452	71.9	15.3	15.3	16.2	16.6	17.3	21.1
20 to 24 years	522	759	81.6	9.0	9.7	9.5	10.7	12.4	12.2
25 years and over	1,157	2,017	81.2	4.2	4.8	4.9	5.7	5.9	7.1
25 to 54 years	992	1,750	82.3	4.5	5.1	5.2	6.1	6.3	7.6
55 years and over	165	268	73.9	3.0	3.5	3.7	3.9	4.4	4.9

Source: Bureau of Labor Statistics, U.S. Department of Labor.

PREPARED STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, SUBMITTED BY PAUL M. HAWKINS

This statement is filed on behalf of the Health Insurance Association of America in opposition to S. 496. The Health Insurance Association of America is an association of 325 insurance companies which write approximately 85% of the health insurance written by insurance companies in the United States.

We recognize the serious health insurance problems that have been created for a large segment of our population as a result of our present economic dislocation. For many years our companies have urged employers to provide for continuation of coverage for their employees for as long as they could possibly afford. But even with that effort, the results have obviously not been sufficient to meet the needs of the large number of unemployed people and their families.

The private health insurance industry's concern with continuity of coverage is not only evidenced by strongly promoting it in the sale of our regular business, but it is also an important ingredient in the proposal which we support for national health insurance. The *National Healthcare Act*, first introduced in 1970 and shortly to be reintroduced in both Houses of Congress by Senator Thomas J. McIntyre and Representative Omar Burleson, provides for a coordinated program of uniform, comprehensive benefits for everyone—employed or unemployed, poor or near poor. In today's period of high unemployment, the *Healthcare Act* would meet the problem without the need for additional special legislation or a sharp increase in the level of Federal financing. It provides, for example, that a laid-off employee would have his coverage continued for a considerable period under his employer's plan, following which he would be transferred to a state plan with the same or better standard benefits. We would respectfully commend the proposed *National Healthcare Act* to your thoughtful consideration once you have dealt with this emergency situation.

Our industry is most anxious to cooperate in every possible way in solving the present difficult situation.

However, we must oppose S. 496 for several reasons.

First, Medicare benefits are particularly directed at the needs of the elderly. The average unemployed family of today would find them unsuitable to their primary needs.

Second, the Medicare approach would be difficult to substitute for the group insurance programs which most employers have since Medicare is an individual program. It is necessary to enroll, bill, and maintain eligibility and status files one by one. This approach works satisfactorily for the elderly, who enroll once and for life. It is quite inappropriate for a temporary program whose beneficiaries will be constant turnover.

Third, Medicare (Part A) requires a $92 deductible for the first 60 days of hospitalization, and $23 a day deductible for the 61st through 90th day. For an individual who is unemployed, these payments under the Medicare system would be difficult to meet.

Fourth, the Bureau of Health Insurance, the carriers, and intermediaries for the Medicare Program would have difficulty in taking on large numbers of new beneficiaries in a very short period of time as the bill would require. Additional hardware and personnel would be costly, if obtainable, and difficult to obtain in a relatively short period of time.

Fifth, as has been indicated by leading advocates of legislation to protect the unemployed, it should be kept entirely separate and distinct from consideration of any future national health insurance program. With this we agree. However, we fear the implications of expansion of Medicare for this particular purpose would point in the direction of a form of national health insurance which we unalterably oppose.

While we have expressed strong opposition to S. 496 in meeting the serious problem confronting the Nation, the approach proposed in S. 625 seems to us to be more desirable. We support its principles. We feel a national program for continuation of existing health insurance coverage for the unemployed can be made to work with reasonable effectiveness and economy.

The principles of S. 625 make sense to us because;

1. They are least disruptive of present practices for employees, employers, and insurance carriers;

2. They provide an immediate, although somewhat imperfect, answer to an urgent problem;

3. They do not add to the distress of the unemployed by forcing them to resort to the welfare process; and

4. They afford insurance carriers the opportunity—and the challenge as well—to assist in this national emergency by doing what they are in business to do.

The companies which we have had a chance to consult are ready to take on this emergency program on a reasonable basis that recognizes the possibility of increased claims costs and the inherent administrative complexities.

We are well aware that S. 625 presents some troublesome conceptual and practical problems which we have discussed in our testimony presented to the Senate Labor and Public Welfare Committee on March 6.

To develop and implement such a program under forced draft is no small task. It is one that requires high technical competence and broad experience in a wide variety of situations. The Board of Directors of the Health Insurance Association of America authorized the creation of a special task force of actuarial, claims, systems, and management experts—drawn from a wide spectrum of our member companies—to be available to assist the Congress and the Executive Branch in developing the necessary procedures to implement a program along the lines of S. 625.

Our special Work Group on Health Insurance for the Unemployed is ready to get down to work in developing these implementing procedures further, in cooperation with your staff and other carriers.

The insurance companies of America are ready, are willing, and have the demonstrated capabilities to help handle this emergency.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS, PRESENTED BY CHARLES B. SONNEBORN, VICE PRESIDENT

Mr. Chairman, the National Association of Blue Shield Plans appreciates this opportunity to present our views concerning legislation to provide health benefits to the temporarily unemployed.

The Association consists of 71 locally-based, not-for-profit medical care prepayment Plans, employing 55,000 people and covering 73 million private subscribers and an additional 12 million as agents for government programs. Two of every five Americans look to Blue Shield for financial protection against health care expense.

For the record, we have testified before, and we still believe, that health legislation should fit into a broad consideration of the individual's needs—that it is preferable to consider housing, diet, sanitation and other factors which impact on health in a priority scale with health services. However, given the unique nature of these circumstances, we will confine our remarks to the issue of health benefits for the unemployed. The current situation is unusual for health insurance legislation, in that if it requires legislation, it requires emergency legislation. This imposes certain criteria, and we will comment in that context.

First, any attempt to provide emergency relief for the unemployed must rely upon existing mechanisms. There is no opportunity for extensive restructuring if benefits are to be delivered rapidly. Furthermore, any extensive use of a new mechanism or a new benefit approach would involve lengthy debate and be likely to polarize opinion. This poses the distinct possibility that no action could be taken in time to achieve the basic purpose.

Second, the program must be simple. There will be little opportunity for major re-education of patients, employers, and providers of health care services. Neither can systems be extensively redesigned if the program is to be implemented on an emergency basis.

Mr. Chairman, we believe that the Social Security mechanism is not the best approach to the problem being addressed here today. To extend coverage to the unemployed through the use of the Medicare program, it would be necessary to create an additional system within a system. The current program is designed to extend specific benefits to a specific population. Eligibility and administration are geared to individuals. The system is not set up to accommodate families with various age groups and different health care needs.

As one practical example of the differences, family contracts tend to aggregate deductibles. Medicare does not, nor can it easily be re-programmed to do so. A family of four hospitalized after an accident would incur four separate $92 deductibles on the first day. The design is simply inappropriate for this population.

The group coverage of the employed population reduces both underwriting concerns and administrative cost, making possible better benefits at less cost.

The efficiency of bulk processing for premium collection and eligibility maintenance is obvious. This is especially germaine to the current unemployment situation, when mass lay-offs cause great influxes of people at one time.

Medicare is simply not designed to make use of the efficiencies of group processing.

It is necessary to enroll, bill and maintain eligibility and status files one-by-one. First, a new account and records for each individual and family member must be established with the Social Security Administration. This entails an initial eligibility determination and a re-confirmation of this eligibility on a continuing basis. Eligibility cards must be issued and updated periodically.

Under the present Medicare system, termination is not a problem. The unemployed population will flow in and out of the system, necessitating new procedures involving substantial administrative cost. Medicare works satisfactorily for the elderly who enroll once and for life; it is quite inappropriate for a temporary program with constant turnover.

Some of the administrative costs are not available to us, but it is quite clear that the administration of the program would absorb millions of dollars which could otherwise be used to purchase care.

Another problem in using the Medicare program is the beneficiary and provider education requirements. Such providers as children's hospitals and pediatricians will have to become familiar with Medicare benefits and administration for the first time. Explaining the program to the unemployed individual and members of his family will be an enormous problem, quite unnecessary in some alternative approaches.

Further, Medicare is committed by statute to pay benefits without regard to other coverage, such as that of an employed spouse. While the commitment could be reversed by legislation, present Medicare programming has no capacity to identify duplicate coverage. The potential saving from subrogation and coordination of benefits in private coverage could be a quite significant percentage of total program cost.

Finally, we would oppose the Medicare approach because variations in unemployment would result in large additions to carrier workloads in some areas. This would be difficult to accommodate. The problems of recruiting and training staff for the needs of a temporary but major source of beneficiaries, and then dismissing that staff after 12 or 13 months of operation, are a nightmare.

Mr. Chairman, there are several alternatives to the Medicare approach. We would like to discuss these briefly.

An alternative would be to assume that the Medicaid program could serve the unemployed. This could be achieved either by applying the present eligibility criteria to the unemployed, or by waiving those criteria on the basis of unemployment.

We would oppose this alternative, because Medicaid administration is quite uneven from state to state, and there is little assurance that all areas could cope with the increased workload. And as with Medicare administration, it is difficult to recruit and train additional staff for a temporary program.

If the present eligibility criteria were retained, unemployed individuals would have to spend their resources down in order to qualify. We have previously testified before the House Ways and Means Committee that the unemployed are a special class, with different financial commitments and different longer term prospects. The spending down requirements would have a pronounced effect upon their ability to maintain the living patterns to which they are committed, and to which they will presumably return when employment resumes.

Finally, were the eligibility criteria to be waived, very substantial increases would be necessary in federal and state spending. It is questionable that either federal or state governments could afford the required outlay without consequences elsewhere in the economy.

Another alternative would be to design a uniform program of essential institutional and professional care, to be furnished by carriers, with the financing of the program a responsibility of the federal government.

This approach would be more practical than either of the first two. It would, however, fail the test of speedy implementation. The necessary organizational, contractual, and administrative problems could take several months, and create as a result substantial communication and education problems. We would not dismiss this approach as unworkable, but it is less easily implemented on an emergency basis than the next alternative, which is:

To extend present group coverage through a continuation of group eligibility. Each carrier would administer the same benefits for the unemployed as they held through their present group contracts, with eligibility certified through the unemployment insurance mechanism. The carrier would bill the federal government for the premium for that portion of the group which is eligible through unemployment.

We have previously testified that Blue Shield believes it is a proper role for government to identify those groups who cannot finance their own health insurance, and to provide such financing.

Such an approach will result in some inequities. For example, the self-employed and some very small group employees will not qualify. We assume that Medicaid will assist these people, despite the shortcomings of the Medicaid approach. Continuances of group coverage is not a cure-all, but it will provide relatively fast assistance to the majority of the people who need it. This intent must be recognized. This alternative does present some policy issues.

It will be argued, for example, that it is inequitable because it provides different levels of coverage to different individuals through general revenues. Clearly this is true, and there is some inequity in it. Nevertheless, the intent is to continue *existing* coverage, and it could be argued that the tax deductibility of the coverage already provides varying levels of government support. We have strongly supported in the past, and we still do, the principle that minimum levels of coverage should be established and enforced. Without departing from that objective, we do not believe that emergency legislation is the proper vehicle in which to address the issue.

The employees of an employer who goes out of business could not benefit from this concept, unless the unemployment compensation agency identified the group and certified its eligibility to the carrier. We would recommend that any bill incorporate this provision.

An important question is whether the program should be voluntary on the part of employers and carriers, or whether it should be mandatory for both. We believe that a voluntary program would lead to uncertainty, since the unemployed individual would not be sure that his coverage would continue, and to confusion, since the administration of eligibility would not be uniform. Exception should be made for individuals with employed spouses, who could and should claim the unemployed individual as a dependent for health insurance purposes in existing group coverage. With this exception, however, we believe that smooth operation and equity would both be best served by requiring all employers and all carriers to participate in the program.

A corollary is that the federal government, in assuming responsibility for the coverage of the unemployed, should also assume responsibility for additional and necessary administrative costs on the part of employers and carriers.

In addition to the policy considerations, there are administrative concerns of which, Mr. Chairman, your Committee should be aware.

Eligibility determination should properly be a function of the unemployment compensation agencies of the states. Blue Shield proposed this device to the Ways and Means Committee in May, 1974, and we believe it wholly appropriate. We did not, however, anticipate the emergency conditions under which it might be implemented. The ability of the insurance carriers to function quickly would be dependent upon the efficiency of the unemployment compensation agencies in determining and conveying eligibility information. We are frankly uncertain as to the ability of the agencies to perform on short notice. Federal funds may be necessary to support additional manpower or systems for conveying eligibility information. This function is considerably simpler than a corresponding increase in Medicare or Medicaid workloads.

A related problem is the termination of eligibility. While we can assume that employers would report eligibility as they now do, presenting relatively few administrative problems either to themselves or to the carrier, we cannot assume that the termination of eligibility will be on the same uniform basis. Where an employer calls back his work force, the problem is relatively simple. Where the employer does not call back the work force, and eligibility terminates by a process of individual attrition, the problem is much more difficult. The only simple and practical method we can suggest is a monthly recertification of eligibility to the employer by the unemployment compensation agency. This could be by direct communication, or by furnishing a slip to the employee for forwarding to the employer. In the absence of recertification, the individual would be considered re-employed, and the original employer would remove him from the list sent to the carrier.

A great deal of group coverage is negotiated between management and labor. Binding agreements between them sometimes expand the scope of benefits. These changes occur at stated times, and will in some cases come due while the program for the unemployed is in effect. As a matter of orderly administration, these expansions should apply to the temporarily unemployed who would be eligible were they at work. The government should expect this, and not freeze the benefits it subsidizes, creating, in effect, two groups for a single employer.

Similarly, carriers will be forced to adjust premiums in the year to come. In most cases, this will be directly related to benefit expense, which is a product of unit cost and utilization. This is a necessary and legitimate cost of maintaining coverage. To the extent that groups accept it, the government should be prepared to meet premium increases for its own beneficiaries.

It is obvious that the additional requirements of this program will generate some additional administrative costs. This would be true if only because carriers will have to prepare two billings per group. We do not wish to profit from this program. Neither do we wish to exhaust reserves of our private subscribers in subsidy to a program for which the federal government has assumed responsibility. We feel, therefore, that additional administrative allowances may be necessary for the special requirements of this program, and that the legislation should make due provision for this. Given diverse nature of carriers and their coverages and workloads, additional administrative cost should be negotiable, and an appropriate mechanism established in law for this.

An unknown factor, of some significance is the utilization of services by the unemployed. Blue Shield has always provided for conversion by members of groups to individual coverage. Obviously, not all unemployed individuals have exercised this conversion privilege. In general, those anticipating medical expense do. We simply don't have complete experience with the group as a whole. On one hand, we have observed actuarially significant increases in the incidence of elective treatments during periods of unemployment. On the other hand, we are aware that the practices of unemployment compensation commissions in at least some states actively discourage elective utilization. It may also be that high unemployment produces a more representative group actuarially.

We expect to assume the risk of reasonable utilization variances. But should this utilization, with which none of us has much experience, assume really substanital and unforeseen dimensions, there will be no source of funds for benefit expense except the reserves of the private subscribers. To the extent that experience can be charged in normal fashion, it is practical to use those reserves. But should the government require segregation of the experience, we would expect reasonable limits to be established on either gain or loss, with retrospective reconciliation with the federal government.

Finally, we should consider reasonableness of administrative cost for this program. Recognizing that there is very little that can't be improved, we have always prided ourselves on the relative efficiency of our operations. However, those operations have been developed over a period of years to meet a relatively stable workload on a relatively permanent basis.

The whole premise of operating an emergency program through pre-existing coverage is that there is maximum efficiency in maintaining an individual in the group from which he comes and to which he is likely to return. The staffing and systems problems are more manageable than they could be in any alternative, since the carrier is geared to an established workload. Nevertheless, some problems will arise. If the program is to be implemented quickly, there may be some duplication and some waste. We could avoid this in a phased-in implementation over a period of several months. We may not be able to avoid some of it in a crash implementation.

It is essential that the Congress recognize at the outset the conditions which it is imposing. While we are not suggesting that the carriers should be relieved of accountability, we are pointing out that they cannot implement this program rapidly and be held responsible, several years hence, for standards of efficiency which will seem appropriate when the stresses of the moment are forgotten. Appropriate waivers from the usual standards of acquisition for government programs should be legislated, consistent with good faith and the intent of the program.

Mr. Chairman, it may seem odd that we have opposed one approach to health care for the unemployed that is pending before your Committee, identified an alternative, and devoted a great deal of our statement to a critique of that alternative. Perhaps we should repeat our basic premise: from the administrator's

point of view, a continuation of group coverage is more suited to the needs of the unemployed, more efficient, less costly, more quickly deliverable, and altogether more practical than other alternatives. Like any broad-scale program, it does present some problems. We have tried to be honest about what those problems are, and how they can be resolved. We remain firmly convinced that the problems associated with adding the unemployed to Medicare and Medicaid are far more difficult.

In summary, Mr. Chairman, we support the concept of extending the benefits of pre-existing group coverage to the temporarily unemployed. It is not a perfect solution. It is not even as good as it could be if it were debated and refined for three or four months. It is, however, a reasonable response to the problem, and on that basis, and with the concerns we have expressed, the Blue Shield Plans stand ready to implement it on behalf of the nation's unemployed.

THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS,
Washington, D.C., March 19, 1975.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate,
Washington, D.C.

DEAR CHAIRMAN LONG: Enclosed is a statement of the National Association of Life Underwriters (NALU) commenting on various legislative proposals dealing with emergency health problems. NALU did not seek to testify personally before your Committee, but the Association did wish to convey its opinion with respect to this issue. We would request, therefore, that the Association's view be included in the printed record of the Committee's hearings.

Sincerely,

MICHAEL L. KERLEY.

Enclosure.

STATEMENT OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

The National Association of Life Underwriters (NALU) wishes to take this opportunity to comment on the concept presently incorporated in several legislative proposals which would make health insurance benefits available on an emergency basis to those American workers who have recently become jobless because of the dramatic spread of the current economic recession in the United States and who, because of this phenomenon, have lost their health insurance.

NALU is a Washington-based trade association whose 1,000 member state and local associations have in turn over 130,000 members actively engaged in the marketing of life and health insurance products in virtually every community in the United States. NALU feels competent to comment on the emergency health problem because life underwriters are in contact daily with people in the community and are intimately acquainted with the problem the current high jobless rate has caused, including the dislocation of normal health insurance benefits.

Life underwriters are deeply troubled by the severe financial loss people are exposed to when health insurance benefits are lost along with a job. Of course, whenever and wherever possible, life underwriters are assisting recently unemployed workers to extend their current benefits, convert their former benefits or acquire health insurance coverage on an individual basis to make up for insurance lost because of unemployment. In many instances, however, the drastically reduced income unemployed persons experience makes it impossible in many cases for them to afford even moderate individual health insurance coverage.

NALU supports legislation which will temporarily fill the gap created by high levels of unemployment and make it possible to extend health insurance coverage to recently unemployed individuals and their families on the same basis as they were covered before becoming unemployed. Two approaches to solving the problem are covered by this statement. One method, sponsored by Sen. Edward M. Kennedy in the Senate and Rep. Paul G. Rogers in the House and embodied in S. 625 and H.R. 4003 respectively, would direct the Secretary of Labor to pay directly to insurance carriers the premiums necessary to extend for up to one year a laid off worker's benefits. S. 625 and H.R. 4003 would both rely upon existing health insurance structures and methods for the most part, and maintain the affected group in place for a temporary period of time.

Another approach, sponsored by Sen. Lloyd Bentsen and Rep. James C. Corman and contained in S. 496 and H.R. 3208, respectively, would attempt to accomplish the same goal by making recently unemployed persons eligible for Medicare Part A benefits. While arguments can be made for and against both approaches, NALU prefers the method taken by S. 625 and H.R. 4003, each of which would maintain the individual's status quo, relying on mechanisms to deliver health insurance benefits which are presently in place and operational.

A third alternative, H.R. 5000, has been put forward by the Chairman of the Subcommittee on Health, Committee on Ways and Means, Rep. Daniel Rostenkowski. Frankly, NALU has not seen an actual copy of this bill, but from general descriptions published by the Committee, NALU has reservations about the approach suggested by H.R. 5000. The bill, while relying on the private sector, seems to consider the problem as a long-standing one while most observers view it as a temporary emergency. NALU would prefer that short-term problems be solved currently, and the long-term health care picture addressed in a comprehensive national health insurance bill.

The need for emergency health insurance legislation has been brought about, of course, because of the recent economic recession which has caused widespread unemployment in major industries, and, through a rippling effect, touches virtually every employer and employee in the United States. Most employed workers enjoy numerous "fringe" benefits from employment including health insurance, and, while it need not be the case, it is oftentimes indeed quite true that when a worker loses his job, he loses his health insurance as well. This occurs not necessarily because health insurance is unavailable anywhere else, but rather because it often represents an expense which an unemployed person simply cannot pay.

It has been recognized by most witnesses who have testified before the various Congressional committees now considering emergency health legislation, that if a national health-care insurance program had been in place at this time, the need for emergency legislation would have been obviated. While the spectrum of national health insurance proposals ranges from those which would create a completely federal structure controlling virtually every aspect of the health-care system to those which would merely make the money available to operate the current system, most if not all of these proposals contain a program to cover temporarily unemployed persons to guarantee that by virtue of unemployment a person would not be denied effective access to the health-care system.

The National Health Insurance plan supported by NALU, the "National Health Care Act" sponsored in the last Congress by Sen. Thomas McIntyre and Rep. Omar Burleson is no exception. "The Health Care Act" would provide that a laid off worker would automatically have his health insurance benefits continued for a significant period of time, and, if still unemployed at the end of that period, the worker would be transferred to a state plan that would be required to have the same minimum benefits as the employer-employee plan that covered the worker while employed. The fact is, though, that no comprehensive national health insurance plan is presently in force, and so the need arises for emergency treatment of a problem that everyone hopes will be of short duration.

As noted above, NALU supports the proposal sponsored by Sen. Kennedy and Rep. Rogers because we think the approach taken by these gentlemen is appropriate for the times. S. 625 and H.R. 4003 perceive the situation to be grave at the present moment and would call upon the existing health care structure to respond accordingly. This we believe the system is ready to do, but it needs the funding of the Federal government in order to accomplish the task.

Emergency situations call for emergency action, the salient ingredients of which are speed and effectiveness. While it is recognized that there is some inequity in spending federal funds to continue health insurance programs which may treat some workers less generously than others, the objective of the emergency proposals is to get as much health insurance benefits to unemployed workers as quickly as possible. With a structure in place, the existing health insurance system offers the most realistic expectation that these benefits will be delivered in a minimum of time. In fact, health insurance industry witnesses have indicated that the program can be implemented with virtually no lead time whatever, although it is anticipated and expected that certain administrative problems will arise which will need to be solved. However, most private insurance carriers have indicated the capacity and the willingness to tackle this job, and NALU believes they should be given the chance.

This is not to say the Medicare system could not do the job in the final analysis if given the task. However, in view of the emergency's, temporary nature, it seems to NALU that Medicare should not be asked to do the job.

Medicare was designed to cover individual persons 65 and over who have left employment permanently for the most part and who will spend the rest of their lives in the Medicare system. As such, Medicare is geared toward a continuing long-term financing of health insurance benefits and would not be well equipped to handle a temporary emergency such as we have now. Workers will constantly be moving in and out of employment, a fact which presumably would cause Medicare extreme administrative problems. And, even if the adjustments are made, the end result would be the delivery of hospital benefits only to the unemployed.

While hospital benefits are critically important, providing them alone would probably only encourage usage in the hospital of medical services which would normally be performed on an ambulatory basis. Also, the Medicare extension bills make no provision for the availability of Medicare Part B benefits on an optional basis, although this could easily be adopted. However, it seems likely that unemployed persons would have just as much difficulty in paying the optional Medicare Part B premiums as some of the elderly poor do now.

When considering the magnitude of the problem and the solutions at hand, NALU's conclusion is that the workers to be served by emergency health insurance legislation would be much more efficiently served by a program which utilizes the current delivery system now in place and which provides those benefits as quickly as possible. NALU, therefore, endorses the concepts of S. 625 and H.R. 4003 and recommends that the Congress adopt them as quickly as possible.

Position Statement of the Washington Business Group on Health

The Washington Business Group on Health is most appreciative of this opportunity to present our views on the complex issue of health insurance for the unemployed.

In providing our position for your consideration, we recognize that whatever action the Congress finally takes on this issue will have a significant impact upon the larger issue of national health insurance. We have tried to be consistent with our guiding principles on NHI, a copy of which is attached for your information. Also attached is a copy of our Statement of Organization so you may become better acquainted with our background, membership and purpose.

This paper will, briefly, state our position, describe the process by which that position was developed, and suggest a series of elements which we feel should be contained in any legislation passed on this important topic.

Our position

We support the intent of Congress to act in the interests of the many millions of unemployed Americans and their dependents who now face the severe hardship that can result from the dual loss of employment and health insurance protection.

We believe that the problem Congress is addressing is an employment issue rather than a health issue and therefore should be treated in the same manner as other congressionally approved programs to aid the unemployed. Our study of this seemingly simple yet technically complex issue has led us to the conclusion that the best approach is to extend the benefits a laid-off person had while employed. We feel this is consistent with the recent extensions of unemployment compensation. Similarly, we feel the health insurance extensions should be funded from the general revenues and that the program should be of a temporary nature.

Position development

Unemployment is a topic with which our members are all too familiar. A quick look at our membership list will show that many of the nation's hardest hit employers belong to the WBGH.

Before the relationship of health insurance and unemployment even entered the legislative arena, we felt the need to gather more and better information about the extent of the problem. We were especially interested in learning what employers generally do during periods of extended lay-off.

Unable to find reliable, existing sources of this information, we conducted, during February, a fast survey of 200 firms from which 127 responses were received. Those 127 represent some 4.3–5.3 million workers.

The full survey report is attached. We have tried, during the past weeks to share our results, unscientific as they may be, with all pertinent congressional committee staffs, the Administration and related professional and special interest organizations. It is gratifying that this information was used during the hearings.

During the past month we have held a series of meetings of our Steering Committee and special Technical Committees comprised of a cross section of disciplines and representing employers with a mix of employment and health insurance levels. Arguments supporting every known position have been presented, debated and analyzed. The full membership received background material, including a draft position paper, and assembled in Washington on April 16 to further debate the issue. Guidelines were established for the Steering Committee and, on April 17, the Steering Committee approved the position this paper espouses.

The Washington Business Group on Health is fortunate to have among its membership many of the nation's leading private insurance carriers. Their views on this issue have been expressed through the Health Insurance Association of America. We recognize that their position is not fully compatible with this paper but we also feel that our organization is strengthened by the mix of positions and open dialogue such differences represents.

In reaching our position, we measured the alternatives against the following criteria:

1. cause the least disruption of the existing health system.
2. prompt implementation.
3. result in the least intervention by the government.
4. cause the least possible impact upon the unemployment insurance system.
5. the program should be temporary.
6. the program should not try to correct all the inequities of our health system.

Recommendations

The following recommendations represent items which are significant elements of our overall position:

1. One of the most difficult aspects of this entire issue is the inherent inequity of providing health insurance benefits only for those who already had such benefits. We are convinced that the program can be expanded to include those who are unemployed yet had no benefits to extend. For those with no prior benefits it would be impossible to use Medicaid, or a modified Medicaid approach for those unemployed who are receiving unemployment compensation and who would otherwise receive no protection from this emergency legislation. Clearly, their emergency is at least as great as that facing those who have previously been protected through employment-related insurance.
2. Specifically guarantee the confidentiality of health records.
3. Before deciding whether to support a premium or claims payment approach, conduct an actuarial analysis to determine which approach will be more consistent with the legislation's emergency-abating intent and the budget deficit.
4. The legislation should specifically exclude those who, upon lay-off, are eligible for other government sponsored health insurance programs. Strikers should also be excluded.
5. Nearly every organization which has testified and every Congressman who has commented on the proposed legislation has noted its relationship to National Health Insurance. We feel that, whatever program is finally implemented, it will contain and develop valuable lessons for the design and conduct of NHI. For this reason, we suggest the legislation appropriate funds sufficient for an independent monitoring and evaluation of the effectiveness and impact of this emergency program.
6. There is concern among our members that the integration of health insurance with unemployment insurance will permanently alter the latter. Among the problems we foresee and which we would hope to have addressed in the final legislation are: (a) avoid using this emergency program as an excuse to raise the flat rate UI tax base from $4,200.00 to $6,000.00, as some have proposed. (b) grant State UI offices sufficient emergency administrative funds to prevent this new task from making UI certification a mere "rubber stamp" approval. (c) keep UI as an experience rated program therefore separating the costs incurred by the new health insurance element from the traditional unemployment element. (d)

the pros and cons of equalizing eligibility requirements and durations for all states should be argued apart from any consideration of the new and temporary health insurance element.

7. The legislation should exclude coverage of dental care. After careful review of those employer paid plans which now provide such care, we have determined that the cost impact would far exceed parity with the medical care value received. The disparity is even greater when one considers that only a very small percentage of the group plans provide this coverage yet its continuation would drive the total program cost up dramatically for all.

8. Insurance carriers should enact an immediate open enrollment policy for any employee whose spouse had provided the family coverage until lay-off. Bureau of Labor Statistic information reveals 19% of unemployed males have a working wife and 16% of unemployed women have a working husband.

9. We recommend that the legislation mandate cooperation and participation by all affected employers and carriers. Frankly, our membership is not united on this point. But most feel the program must reach all employers and carriers in order to be effective and not create further inequities.

From an administrative point-of-view, we feel a mandatory program to be the most realistic and cost-effective. The program simply will not work if employers and carriers can opt in and out at will.

Lastly, we should note that several of our members have questioned the constitutionality of a mandatory program. Our support does not imply a legal determination. We leave the issue of the legislation's legality to the Congress and courts but do wish the record to show our uncertainty on this point.

An issue

A number of our members have existing contracts which provide extended health insurance for as long as a year after lay-off. While the percentage of such employers is small, they represent a very large number of total employees and an even larger percentage of those recently laid-off. We would like to call attention to the problem such firms face as they must continue paying for the same extended benefits that other firms will now have, through general revenue financing.

Conclusion

The Washington Business Group on Health has tried to give due deliberation to all known proposals on the topic of health insurance and the unemployed.

We have taken a position which, frankly, is not easily accepted by many of our members.

But we must act, and act now! And, while very open to improvement, we feel the extended benefits approach to be the action most suited to the objective of this legislation.

We very much appreciate this opportunity to share our views.

WASHINGTON BUSINESS GROUP ON HEALTH,
Washington, D.C., March 14, 1975.

NATIONAL HEALTH INSURANCE: A STATEMENT OF PRINCIPLES

The attached Statement of Principles has been developed through a deliberative process involving the participation of many members of the Washington Business Group On Health and its Advisors. The Principles are presented with the hope of providing a focal point for a business position on this major national issue.

STATEMENT OF PRINCIPLES

Introduction

Recognizing that access to health care for all Americans is a national objective; and recognizing that the development of a National Health Insurance (NHI) program is being seriously considered by both the Congress and the Administration as a means of providing said health care, the Washington Business Group on Health (WBGH) has developed this Statement of Principles in an effort to assist the national dialogue on this issue.

The Principles which follow were not developed to address any of the specific bills and legislative proposals now under consideration. The Washington Business Group on Health, reflecting a unique degree of cooperation and consensus, presents these principles as a cohesive unit which represent our view of the critical and interrelated elements necessary for any National Health Insurance program.

Readers of this statement should understand that it is based upon the assumption that a National Health Insurance program will become law in the not too distant future. Therefore, we are primarily addressing ourselves to the substantive issues of what such a program might contain and how it could be administered and financed.

THE WASHINGTON BUSINESS GROUP ON HEALTH

Supports (1)

The concept of a comprehensive NHI program providing adequate coverage for all Americans, including protection against the catastrophic financial conditions which may arise from major medical problems.

Supports (2)

The concept that the program should be based upon the principle of benefit value equivalency. This would allow such private programs as will equal or exceed the Federally mandated benefits without requiring such private programs to provide additional coverage beyond the point of benefit value equivalency.

Supports (3)

The underwriting of benefits in a NHI program by the private sector. The program should be conducted under Federal guidelines administered by the U.S. Department of Health, Education and Welfare, and implemented at the State level.

Supports (4)

The principle that participation in a NHI program should be mandatory for all employers with one or more employees. However, more study is required with regard to the policy of compulsory participation by an individual. The particular problems of part-time and temporary employees and the question of duplication of coverage must also receive special consideration and analysis.

Supports (5)

The financing of employer-employee plans through shared premiums.

Supports (6)

The financing of adequate coverage for the poor, near-poor and medically indigent from general revenues.

Supports (7)

The principle that no payroll taxes (other than that for the continuation of Medicare) be used for financing a NHI program.

Supports (8)

The principle that any NHI program be implemented on a phased-in schedule of benefits over a period of years sufficient to recognize the impact of such a program upon both the prevailing national economic conditions and the ability of the health delivery systems to respond to that impact.

Supports (9)

The use of equitable cost control measures such as: (*a*) alternative delivery systems; (*b*) provisions for effective peer and utilization review; (*c*) incentive reimbursement systems including prospective budgets; and (*d*) co-insurance and deductibles, but with a limit on the medical expenses that could be borne by each covered family.

Supports (10)

The principle that any NHI program should seek to bring about greater efficiency in the nation's health care system.

Conclusion

This Statement of Principles is by no means all-inclusive. However, it does establish the basic guidelines for a national health insurance program which our growing membership feels would retain the best of our existing, essentially private health system while simultaneously improving the quality and accessibility of that system for all Americans.

Development of this Statement has resulted in a growing awareness of many factors which have a great impact upon the cost of health care delivery and which we feel should receive serious deliberation during the preparation of national health insurance legislation.

Among these issues is the serious problem of medical malpractice liability which is currently contributing to escalating health care costs, and a reduced number of practising physicians.

The Washington Business Group on Health presents this Statement of Principles as a unique blend of the beliefs, concerns and experience of its members. In the development of this Statement of Principles the WBGH has had the benefit of advice from representatives of the American Hospital Association, Blue Cross Association, the National Association of Blue Shield Plans, the Business Roundtable, the Health Insurance Association of America, the National Association of Manufacturers, the American Medical Association, and the Chamber of Commerce of the United States of America. It is our hope that these principles will be of assistance to all who are or will be involved in the difficult task of developing national health insurance legislation.

STATEMENT OF ORGANIZATION

The Washington Business Group on Health is a membership organization comprised of employers which have a common interest in national health insurance and closely related legislation. Founded in July, 1974, at the suggestion of The Business Roundtable Health Legislation Task Force, the Washington Business Group on Health is supported by more than 100 Charter Members and a growing number of general members.

Organizationally, the WBGH (structured along the lines of the former Washington Pension Report Group) is guided by a Steering Committee and staffed by International Resource Management, Ltd., an independent consulting firm under contract to the Washington Business Group on Health. The Steering Committee is chaired by John F. Rudy, Director of Governmental Relations for The Goodyear Tire & Rubber Company. The Treasurer is Allan Cors, Vice President and Director of Government Affairs for Corning Glass Works. The Staff Director is Willis B. Goldbeck.

Eleven firms are members of the Steering Committee. The Committee relies heavily on the advice from representatives of the Chamber of Commerce of the U.S., the National Association of Manufacturers, The Business Roundtable and a distinguished group of health care and coverage organizations including the American Medical Association, Blue Shield and Blue Cross Associations, the Health Insurance Association of America and the American Hospital Association.

Also assisting the Steering Committee are Technical Groups which consists of health, benefits, finance and other technical experts drawn from the membership on an as-needed basis.

The members' representation is two-tiered with the members' Washington Representatives providing political expertise while the designated Home Office Representatives, generally from the employee benefits field, provide technical experience.

The Steering Committee meets regularly with key officials in the Executive Branch and Congress and with other knowledgeable people in the health field, trying to develop legislative concepts which are acceptable to the business community and are politically feasible.

The WBGH is guided by a Statement of Principles on National Health Insurance. Policy results from staff analysis, Technical Group deliberation, and Steering Committee recommendations to the full membership.

WBGH staff is restricted to an educational, coordinative and administrative support role. The individual member firms conduct their own, normal lobbying efforts.

Fully cognizant of both the difficulty and the necessity of achieving a united business position on critical national health issues, the WBGH functions as a forum for the consideration of national health legislation issues as they impact upon the private sector business community.

WASHINGTON BUSINESS GROUP ON HEALTH

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April 1, 1975

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WASHINGTON BUSINESS GROUP ON HEALTH,
Washington, D.C., February 15, 1975.

SPECIAL REPORT

Survey findings: Health insurance and the unemployed

The great increase in unemployment has resulted in a call for legislation to provide health insurance for those who have been covered under their employer's plans but will loose that protection once laid-off.

According to the largest *Business Week*, "since September, payrolls have shrunk by 1,549,000 workers . . . most of the job loss has been in manufacturing which had a 1.4 million reduction in jobs."

Congressional estimates translate the 8.2 unemployment rate to mean more than 3,000,000 workers with prior health insurance coverage will be loosing that protection. Over the next year this ratio would "yield" over 8 million unemployed and 25 million dependents in the eligible category.

Without addressing other segments of the population in need of health insurance, and freely acknowledging that many inequities exist among those who have some coverage, several legislative proposals have come forward. All address this specific group . . . those who, were it not for the current inflation-recession crunch, would have some degree of employment-related health insurance.

As an organization comprised of 127 of the nation's foremost employers, the Washington Business Group on Health felt responsible for collecting as much information as possible about the extent of the problem, existing employer plans to deal with the problem, and potential solutions. The information, once collated and analyzed, would be given to appropriate members of Congress, the White House and Executive Branch.

Primary among the functions of the WBGH is an ongoing effort to be a positive influence in the dialogue about national health insurance. Since the advocates and detractors of the aforementioned legislation for the unemployed have both related it to NHI, we felt it well within our purpose to assume a significant role in this important public policy debate.

A short, quickly designed survey was distributed to the WBGH membership (118 at that time), members of the Council on Employee Benefits and select other employers. The universe of potential participants was 200 employers. To date, 127 replies have been recorded. Our analysis of the data will be ongoing but this report will present our preliminary findings.

Please note that this survey and its analysis seek only to provide broad indicators of the scope of the problems and current employer policy. It does not claim to be a scientifically valid sample nor statistically pure. It should be further noted that the individual replies are confidential. This office will be happy to discuss our report with any interested parties, but will not honor any requests for information which would identify specific respondents.

A list of the employers represented in this survey can be found in Appendix A.

Preliminary Findings

Definitions.—We asked for information on union, non-union and "other" categories of employees. For this report, due to the wide range of replies and definitions of non-union, we are using only union and other.

By "laid-off," we meant something extensive and we suggested 4 months or more as an example of such a lay-off.

Question. How many employees are represented by the respondents?

Total: 4.3–5.3 million.

Union: 2.0–2.5 million.

Others: 1.8–2.3 million.

The total is more than the sum of "union" and "other" because several respondents provided only an aggregate figure.

Question. What types of employers responded?

Size: Most were very large but all sizes had some representation.

Geographic: A good national spread with the South least well represented.

Type of business: A wide range including auto, retail, steel, petroleum, utilities, manufacturing, banking, pharmaceutical, mining, insurance and chemicals.

Gap: The construction industry was under represented. The survey did not include public service employees, agricultural, self-employed or domestic workers.

Question. What is the extent of the layoff problem?

Of the 127 respondents, 69 stated that they had some employees in a permanent or extended lay-off status attributable to the overall economic conditions; as opposed to traditional lay-offs of a seasonal or short-term nature.

Not all of the 69 provided a numerical breakdown of those laid-off, but for those which did, the following analysis can be developed.

Total: 357,963 (including several which were provided in aggregate).

Union: 259,350.

Other: 36,685.

It should also be noted, and will be further discussed later, that the above totals do NOT include those who were laid-off prior to being eligible for participation in the health benefits program. Nor do these figures include part-time and temporary employees.

ANALYSIS BY CATEGORY OF BUSINESS

Category	Union	Other	Total
Auto (big 3 only)	207,200	7,400	214,600
Retail		6,100	6,100
Utilities			None
Manufacturing	50,120	20,435	[1] 132,533
Petroleum	285	215	500
Insurance			None
Banking			None
Mining			None
Pharmaceutical	250	400	650
Chemicals			None
Steel	1,495	2,135	3,630

[1] Includes 52,000 from 2 firms which gave aggregate figures.

Question. What is the predicted change in the layoff pattern for the next 12 months?

Many, including the auto industry, did not answer this question. For those that did, few expect more than a 2% increase; many expect a decrease and for those which predicted an increase of over 2% the number of employees currently laid-off was generally a very small amount making the increase more dramatic in percentage terms than in absolute numbers.

Question. How many employees have been laid off before becoming eligible for participation in a health plan?

The data clearly shows that most employers do have a waiting period before new employees "earn" the right to participate in the company health plan. The duration varies but is most typically 30 days and generally no more than 90 days. It is equally true that most employers, in times of economic stress, lay-off first those who were hired last.

Therefore, it is easy to see that the probability exists for many to be laid off before gaining entrance into the health plan. This was one of the few questions that many refused to answer; possibly indicating that the numbers would look bad, and frequently indicating that they simply do not keep good records of such lay-offs because the employee's departure has a slight impact upon company personnel operations.

A number of those firms which did provide specific data showed a high correlation between the total number of lay-offs and those not yet eligible to participate.

Question. Do employer health plans contain a major medical or other form of "catastrophic" coverage?

Yes: Nearly all said that they did, and nearly all of these do so for both their UNION and OTHER employees.

Question. Is there a deductible and/or co-insurance requirement for the major medical coverage?

Yes: For a very high percentage of the respondents, both the deductible and co-insurance are required . . . and are required in equal amounts for both UNION and OTHER employees.

The most typical requirements are deductibles from $50–100 with a 20% co-insurance.

Question. Is coverage that is normally provided for dependents continued during a period of layoff in the same manner as that of the employee?

Nearly 100% of the respondents said YES. But many added the proviso that the dependent's share went to 100% employee paid even if the employer had previously been paying a share.

Question. Did employers know the layoff provisions of their major suppliers?

This question was prompted by the experience of the auto industry where the major suppliers are frequently covered under the same or similar UAW contracts. However, few other respondents provided any information.

Question. Do employers have special programs under study or development that would apply to the current layoff problem?

No: There were a few which said they would start such a study if they were faced with massive layoffs. Few of those which are faced with just such a problem have actually started a study. Notable exceptions included one firm which stated their simple program: "we will waive the employee's share of the premiums for the duration of their layoff."

Question. What is the average monthly per capita cost of the health plans?

It must be noted that a more accurate source of this information would be the insurance providers, but we asked the question to get some feel for the extent of coverage that was prevalent among our respondents. The average was: Individual $18.00; family $50.00. The range was: Individual $8.40–28.32; family $25.00–85.00.

We have checked with the insurance providers and find this to be an accurate analysis.

Question. What is the number of employees who, because they are temporary or part-time, are not covered by any of the employer's plans?

Of the 127 respondents, 38 said they had people in this category. 33 of the 38 provided a "head-count", several listing 25 or fewer. Total: 263,003.

Most of these are in the retail trade and it must be noted that some of the large retail firms did not answer this question indicating that the total is actually higher.

NOTE.—None of these are in the category of awaiting eligibility to join the company plan.

Question. We received three types of responses to the overall request for information about methods of extending coverage during periods of layoffs.

A. Although not specifically mentioned in the questionnaire, many of the respondents identified the employees' right to "convert" their group plan to an individual policy. The typical result of conversion is both reduced benefits and 100% premium payment by the individual.

B. We did ask if the employees would be allowed to keep their group plan with full benefits, if the employee paid the premium. 37 companies said YES and added that the time periods ranged from three months to Indefinite. 6 months was the most common and in most cases, when the employee takes over, he pays 100% of the premium.

C. We also asked what formula the companies have to provide an extension of their group plans during layoffs. 86 said they had some such formula. Almost all of the 86 had a formula for both union and other employees although not at the same level in all cases.

The most common period for employer paid extension is from 30–90 days.

There are a great many different plans and these have not all been analyzed yet. They are generally based on seniority. On the average, the extension, including both the employer and employee paid periods, does not run beyond 6 months . . . but there are notable exceptions running from 1 to 2 years and beyond.

"Last day of the month following the month of layoff" is a very common plan. Interestingly, the number of firms which provide better major medical protection for their salaried employees is balanced by companies doing more for the union workers. A large majority have identical plans.

In sum, the replies indicate that, with a few notable exceptions the employee will either have no health benefits or will be paying 100% of the premiums within 90 days.

Where layoffs reach up the senority ladder to those with 2 years' and then 10 years' service, the employer paid extension period more frequently increases to 12 months but this is still a minority of the 127 responses.

WILLIS B. GOLDBECK.

APPENDIX A

Survey Respondents: * = WBGH Member

A B Dick Company
ACF Industries
AMF, Incorporated*
A.O. Smith Corporation*
Aetna Life & Casualty*
Air Products and Chemicals
Allis-Chalmers*
Aluminum Company of America*
American Can Company*
American Cyanamid Company*
American Smelting & Refining*
American Telephone and Telegraph Co.*
Armstrong Cork Company*
Armco Steel Corporation*
Ashland Oil
Atchison, Topeka and Santa Fe RR Co.*
Atlantic Richfield Company*

B.F. Goodrich Company, The*
Babcock & Wilcox Company, The*
Belk Stores Services
Bethlehem Steel Corporation*
Budd Company, The*

C.T. Hellmuth & Associates, Inc.*
Campbell Soup Company*
Carrier Corporation
Caterpillar Tractor Company*
Chicago Bridge and Iron Company*
Chrysler Corporation*
Chase Manhattan Bank
Citibank of New York
Cities Service Company*
Clark Equipment Company*
Coca-Cola Company, The*
Continental Can Company, Inc.*
Corning Glass Works*
Crown Zellerbach Corporation*

Deering Milliken, Inc.*
Dillingham Corporation
Dow Chemical Company, The*
Dravo Corporation
Dresser Industries

Eastman Kodak*
E.I. DuPont de Nemours & Company*
Emerson Electric
Equitable Life Assurance Soc. of US*
Esmark, Inc.*

Federated Department Stores, Inc.*
Firestone Tire & Rubber*
Ford Motor Company*

Garfinkel, Brooks Brothers, Miller & Rhoads
General Dynamics Corporation*
General Electric Company*
General Foods
General Mills, Incorporated*
General Motors Corporation*
General Tire & Rubber Company, The*
GENESCO, Inc.*
Gerber Products Company
Goodyear Tire and Rubber Company, The*
Greyhound Corporation*
Gulf Oil Corporation*

Heinz U.S.A.*
Hercules, Incorporated*
Honeywell, Incorporated*

International Harvester*
International Minerals and Chemicals

Jewel Companies, Inc.*
Jones and Laughlin Steel Corporation*

LTV Corporation, The*
Libby-Owens-Ford Company*
Litton Industries

Martin Marietta Corporation*
Mead Corporation, The*
Melart Jewlers
Mobil Oil Company*
Monsanto Company*
Montgomery Ward

Northern Natural Gas Company*
Norton Company

Owens-Illinois*

Pfizer, Incorporated*
PPG Industries*
Pepco
Philadelphia Electric
Philip Morris, Inc.*
Polaroid
Proctor & Gamble Company, The*
Prudential Ins. Company of America, The*
Public Service Company of Colorado (Includes Cheyenne Light, Fuel & Power Company, Western Slope Gas Company and Fuel Resources Development Company)
Public Service Electric and Gas Company

Quaker Oats

RCA*
Ralston Purina*
Reynolds Metals*
Rockwell International*

SCM Corporation*
Scott Paper Company*
Sears, Roebuck and Company*
Shell Oil Company*
SmithKline Corporation*
Singer Company, The*
Sherwin-Williams Company, The*
Sperry Rand Corporation*
Stanley Works, The*
Standard Oil Company of California*
Standard Oil Company (Indiana)*
Stauffer Chemical Company*
Sundstrand Corporation*

Tenneco
Texas Instruments, Inc.*
Thalhimer Brothers, Inc.

U.S. Steel Corporation*
Union Camp Corporation*
Union Electric Company*
UNIROYAL, Incorporated*
United Aircraft Corporation
Utah International

Warner-Lambert*
Westinghouse Electric Corporation*
Western Union Telegraph
Whirlpool Corporation*
Whittaker Corporation
Woodward and Lothrop

Xerox*

Responses of the following firms arrived too late to be included. A review of the information they provided indicates that it would not change any of the results presented in the preceeding report.

Sun Oil Company*
Connecticut General Life*
Boeing*
Gould, Inc.
Southern Pacific Company
Olin Corporation*