DETROIT REVOLUTIONARY MOVEMENT RECORDS

BOX 7 OF 16

FOLDER 21

NATIONAL HEALTH COVERAGE

NATIONAL LAWYERS GUILD

NATIONAL HEALTH COVERAGE FOR THE JET AGE

1967 AND FORWARD

National Lawyers Guild

Committee on Social Legislation

NATIONAL LAWYERS GUILD
NEW YORK CITY CHAPTER
38 PARK ROW • NEW YORK, N. Y. 10038
BA 7-0385

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January 30, 1967

We are pleased to enclose our report entitled "National Health Coverage for the Jet Age - 1967 and Forward". It is a critique of Medicare and other aspects of Federal provisions for health insurance.

Recommendations relative to the law and administration are made:

1. as to extent of hospitalization coverage (p.6);
2. as to better control over hospital reimbursements (p.7);
3. as to better control over doctors' fees payments (pp.13-15);
4. as to permitting a fair and reasonable trial period for Federal State Aid to the medically indigent (pp.23-25);
5. as to coverage for the permanently disabled under 65 (p.26);
6. as to coverage for dependents and survivors of persons over 65 or permanently disabled (p.26);
7. as to extensions of coverage to other items of medical and dental expense presently excluded (pp.27-28);
8. as to the elimination of disqualification of persons because of membership in certain proscribed organizations (pp.29-30);
9. as to new hospital facilities in areas where existing institutions fail to comply with civil rights laws (p.30);
10. as to the methods of financing Medicare (pp.31-33);
11. and finally, as to ultimate expansion to cover the entire population (pp.34-35).

We hope this will prove useful and informative to you. Additional copies are available at our office.

National Lawyers Guild
Committee on Social Legislation

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NATIONAL HEALTH COVERAGE FOR THE JET AGE*

1967 and Forward

It has been more than two decades since former President Truman urged medical care insurance on a national level and a bill was introduced to accomplish it.[1] The national government's interest in the health of the people goes back even further, manifesting itself in projects in the field of public health, special hospitals, research grants, etc. It has been recognized for over a century that the health of Americans is as important as education, housing, etc., if not more so. Federal participation has vastly expanded, and governmental involvement on the State and local levels has been ever increasing. Nevertheless, the need has always far outdistanced the governmental assistance.

Throughout this period, and still today, millions of Americans could not and cannot afford, and did not and do not receive adequate medical care. In many areas, particularly rural ones, there have not been enough medical personnel or health facilities available. But even where they are available, the cost of adequate care is so great that most people

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* Report of Committee on Social Legislation, National Lawyers Guild

1 S. 1606; H.R. 4730; 79th Cong. November 19th, 1945, known as the "National Health Act of 1945".

cannot meet the cost of serious illness. The unemployed, the low-wage employed, the low-income self-employed, suffer more sickness, remain sick for longer periods, and at the same time are the least able to cope with the cost of adequate medical care. The middle income people too either can't pay for the cost of a serious illness or find their life's savings consumed by it.[2]

Great strides have been made over the past twenty years in meeting this problem. Many people have been covered by union or employer insurance or prepaid medical plans[3]; private groups have afforded similar coverage to members; many individuals who could afford the premiums have obtained coverage of one kind or another to meet this problem in whole or in part; public welfare and private charities have expanded their contributions to the medical care of the very poor.

The greatest leap forward in this direction occurred in 1965-1966, when Congress enacted The Social Security Act

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2. "Health care has become so expensive that virtually no one, including the relatively well-off person at the height of his earning power, can afford to pay the cost of major, prolonged illness unless he has effective insurance." The Status of the Social Security Program and Recommendations for its Improvement, Report of the Advisory Council on Social Security (1965), page 32.

3. The most recent Department of Labor report lists 128,500 such plans, most established since 1945.

Amendments of 1965, effective in 1966.[4] These Amendments created what has been popularly known as Medicare, providing extensive medical care for most Americans over 65 years of age.[5] It has been estimated that 19 million Americans aged 65 and up will be covered, and that 10 million of these previously could not afford adequate medical care. However, these Amendments went substantially further, in that they also provided for Federal grants to States of 50% and over of the cost of medical care and rehabilitation which the States will provide for persons "whose income and resources are insufficient to meet the costs of necessary medical services"[6]-- persons who are not necessarily on relief or welfare, but who are medically indigent, and who may be under or over 65. The Amendments also provided for Federal grants to the States of up to 75% of the cost of administering the plan, including the cost of training doctors and other skilled personnel.[7] The States are qualifying for these Federal grants,[8] and it is to be hoped that within a few years that segment of the population between the poor and those able to insure or otherwise meet

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4. Public Law 89-97, 89th Cong., 1st Sess.
5. These are contained in a new Title XVIII of the Social Security Act.
6. New Title XIX, Sec. 1901, Social Security Act [Section references hereafter are to the Act, unless otherwise noted].
7. Sec. 1903.
8. See page 21 , infra.

normal[9] medical care costs will be covered.[10]

However, the medical care provisions in the 1965 Amendments do not go far enough in meeting the needs of people over age 65; and, as to persons under 65, only scratch the surface. They also will need changing to meet the problems disclosed in administration during the first years of experience. This report by the National Lawyers Guild will endeavor to outline the provisions and point out some of the more fundamental difficulties and shortcomings, and urge certain changes and betterments.

PART I

HOSPITALIZATION COVERAGE

The hospitalization provisions are contained in Part A of Title XVIII, Sections 1801 through 1817 of the Social Security Act as amended by Section 100 through Section 102 of the "Social Security Act Amendments of 1965";[11] and can be summarized as follows:

1. In-patient hospital services for up to 90 days during any spell of illness, the patient paying $10 per day for thirty days in excess of 60 days. The patient pays a deductible of $40 for each spell of illness hospitalization.

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9. But see Note 2, supra.
10. It has been recently estimated that when all of the States have qualified, some 30 million medically indigent Americans will be afforded adequate medical care under these provisions.
11. Public Law 89-97, 89 Cong., 1st Sess.

2. Post-hospital extended care in an approved facility for up to 100 days during any spell of illness, with the patient paying $5 per day after the first 20 days.

3. Post-hospital home health services under the supervision of a physician for up to 100 visits, including nursing care and therapy, during a one-year period after the beginning of each spell of illness.

4. Out-patient hospital diagnostic services, with the patient paying a $20 deductible and 20% coinsurance.

That Medicare is long overdue is signified by the fact that in the first four months of its operation, some 1,600,000 people received care under its hospitalization provisions and more than 19 million are eligible for its hospitalization coverage.[12]

A desirable feature of "Part A" has been in the field of integration. Hospitals must sign statements that they are complying with the Civil Rights Act in order to qualify under Medicare and the Public Health Service has assigned more than 400 persons to administer the Civil Rights Act compliance program and to inspect applicant hospitals. When the program began, there were about 350 hospitals in the South which were eligible

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12. New York Times (October 27, 1966)

but excluded on the civil rights issue. This has since dwindled to about 150[13], and, as a consequence, Negro doctors and nurses have been granted increased access to hospital staff privileges, and previously inaccessible hospitals have been opened to Negro patients.

However there are several unfortunate features of the law which should be corrected. Among these is exclusion from coverage of services rendered to the patient by hospital radiologists, anaesthetists, pathologists and physiatrists (physical therapists).[14] There is no logical reason for their exclusion since their services constitute a normal part of any hospital treatment, particularly where surgery is performed. The effect is to compel the patient to pay his $50 medical expense deductible under Part B and, in addition, to pay 20% of the fees charged by the above excluded hospital physicians. Thus, the hospitalized patient is faced with a deductible of $40 for the hospital, $50 for the medical deductible, 20% of the above hospital physicians' fees and the fees of his personal physician. For the person dependent on social security benefits, this can be a great hardship. The law should be revised to include the fees of all hospital physicians as part of the hospital expense covered by Medicare.

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13. New York Times (October 27, 1966).
14. Section 1832 (2) B.

One aspect of the program that is receiving concerned attention by the government is the mounting cost of hospital care, a factor that can seriously impair the effectiveness of Medicare. Costs have been rising steadily, far more rapidly than the overall cost of living, and the end apparently is not in sight. Dr. Edward L. Crosby, executive vice-president of the American Hospital Association, predicted recently that hospital costs will jump during the next year by at least 20 and possibly 30 percent. Some authorities have been predicting hospital costs of $100 per day by 1975, and others anticipate this figure will be reached by 1970.

The present reimbursement formula practically guarantees payment of costs, plus allowances for depreciation and an additional 2 percent for improvement of services, in short, the equivalent of a cost-plus contract. Except for providing staff utilization committees to cut down on excessively long stays, neither the Medicare law nor the reimbursement formula imposes any controls on hospital expenditures. The hospitals are guaranteed payment by a mere showing that they have spent the money.

Standards of hospital operation should be established to insure detailed attention to economies through avoidance of duplication and coordination of hospital facilities. Otherwise, costs are bound to rise precipitously. Supervision of hospital costs cannot be left to the doctors and hospitals alone. The Federal government must participate in such supervision to control such costs.

PART II

SUPPLEMENTARY MEDICAL COVERAGE

In addition to the Hospital Insurance provisions of the Social Security Act Amendments of 1965, Part B of the same Act covers Supplementary Medical Insurance Benefits.[15] Unlike the Hospital Insurance which automatically covers almost all people 65 or over, Medical insurance is a voluntary plan, which must be specifically elected and paid for at the rate of $3.00 per month by those persons over 65 wishing its protection. The government contributes a like amount each month.[16] The salient features of the medical insurance coverage are as follows:

COVERED

1. Medical and surgical services by a physician including consultation, and home, office or institutional calls.[17]
2. Services and supplies incident to the above professional services of the physician, X'rays, diagnostic tests, medical supplies, drugs which cannot be self-administered, and similar services which would ordinarily be included in his bill.[18]
3. Home health benefits, where patient has either not been hospitalized, or has used up his visits

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15. Sec.1831.
16. Sec.1839, Sec. 1840.
17. Sec.1832.
18. Sec.1832

under the hospital insurance program. This includes payment for services furnished by a home health agency operated primarily for the treatment of mental illness.[19]

NOT COVERED

1. Routine physical checkup, eye examinations for prescribing, fitting or changing eyeglasses for refractive error only.
2. Services of chiropractors, chiropodists, podiatrists, optometrists.
3. Hearing examinations for hearing aids.
4. Dental care.

Medical insurance pays 80% of the reasonable charges (see definition hereafter) for covered service in any one calendar year after a $50 deductible is met each year by the insured.[20]

What is probably the most important problem facing the new Medicare program is the rapidly spiraling rise in medical costs.

Doctors' fees have risen sharply within the past year. A limited survey conducted by this committee amongst general practitioners brought out that since the beginning of this year, they raised their charges for office and home visits from 20% to 40%, most of the increase coming after July 1.

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19. Sec. 1832.
20. Sec. 1833.

There are reports that the fees for the elderly, however, have been hiked even more. Under Blue Shield, participating surgeons, assistant surgeons and anesthetists agree to accept the insurance program's fee schedule, which is below the customary charge, for patients falling within certain income limits. These limits are $2800 for single persons and $4,000 for a family under Blue Shield Plan A, and $4,000 for a single person and $6,000 for a family under Plan B. But although the great majority of the aged fall within these limits, the patient's income is not a factor under Medicare regulations, and doctors are allowed to bill at their full private-practice rates. Furthermore, prior to Medicare, many doctors charged elderly patients who were not subscribers to Blue Shield, less than the prevailing fees and sometimes free. With their fees coming from the government rather than directly from their patient, this practice of reduced fees for elderly patients has ceased for the most part according to an officer of the New York Blue Shield, which the Social Security Administration has chosen to administer Part B coverage of Medicare in this area.

Social Security regulations provide two methods of paying doctors for treating Medicare patients and leave it up to the physician to pick the one he prefers. Under the direct billing method, the patient pays the doctor and is then reimbursed for 80% of established reasonable charges. This permits the doctor to charge whatever he wants and he is not bound by the

reasonable charge criteria discussed below. Thus, although there is no limit on what the elderly patient may be charged under this method, the patient can only recoup 80% of the reasonable charge. It is even possible for an elderly person to be required to pay more than he would have paid prior to Medicare. The alternative is the assignment method,whereby the physician charges the patient only 20% of reasonable charge and takes an assignment for the balance of 80% which he submits to the carrier for reimbursement.

Blue Shield in New York stated that at least 50% of the applications for reimbursement under the program came from patients who were directly billed - but refused to divulge whether rates indicated thereon were in excess of the established reasonable charges. Again, the committee's limited survey described above found that the physicians it interviewed were directly billing in at least 80% of the cases. In fact, the House of Delegates of the American Medical Association at its convention a few days before Medicare went into effect on July 1, 1966, adopted a resolution recommending that doctors charge their Medicare patients directly.

In those cases where the physician accepts the assignment of his fee, he agrees to be bound by a reasonable charge which is to be determined by the carrier selected by the government to administer the medical insurance program in his particular community. The two criteria set out in the law which

must be considered in determining reasonable charges are:

1. The customary charges for similar services generally made by the physician, and
2. The prevailing charges in the locality for similar services.

The term Customary Charge refers to the amount which the individual physician usually and most frequently charges his patients for a specific service in similar medical circumstances. The reasonable charge would not be higher than the individual physician's customary charge. The customary charge for different physicians may of course vary.

The term Prevailing Charge refers to those charges which fall within the range of charges most frequently and most widely used in a locality for particular medical procedures or services. Prevailing charges are derived from the overall pattern existing within a locality.

The reasonable charge is the lower of the customary charge or the prevailing charge.

However, the reasonable charge that the physician seems to be bound by does not prevent physician's fees from rising, although it sounds as if it might.

In a reference guide for physicians issued by the Social Security Administration in June 1966, the following appears respecting customary charge.[21]

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21. Guide for Physicians, Social Security Administration No. OASI-876, page 21-22.

"A physician's customary charge is not necessarily a static amount. Where the physician alters his charge for his patients generally, his customary charges change; accordingly, these changes would be recognized in determinations of reasonable charge for the services he renders to Medicare beneficiaries."

Thus, the customary charge can be raised at the whim of each individual doctor.

The prevailing charge, on the other hand, while it cannot be raised by an individual doctor, can be raised if enough physicians in the locality increase their fees.

It is debatable whether Medicare sent doctor bills skyrocketing or whether doctor bills have sent Medicare costs soaring beyond a point that was never anticipated. Whichever came first, both the President and Congress have directed their attention at climbing medical costs. President Johnson has ordered an inquiry by the Department of Health, Education and Welfare, the Council of Economic Advisers and the Labor Department.

Continuous scrutiny of Part B of the Medicare program should be maintained. Shortcomings should be noted, analyzed and corrected. Prompt measures should be undertaken to stop the runaway costs of the program from diluting coverage.

The following changes in the regulations are recommended:

1. Direct billing of a patient by the physician should be eliminated. As indicated above, discontinuance of direct billing will eliminate fees in excess of the reasonable charge for the service. Secondly, it is administratively simpler and

is easier on the patients who aren't faced with the problem of paying the bill and then waiting for reimbursement. The assignment method imposes no hardship on the medical profession. Physicians treating Workmens Compensation beneficiaries wait for their fees to be paid by the carrier liable for payment and agree to accept a schedule of fees permitted by regulations of the Workmens Compensation Board, and under the conventional Blue Shield Program and other Health Insurance Plans they have accommodated themselves to the assignment method.

On the other hand, it is an ordeal for many of the elderly patients to fill out the necessary forms, no matter how simple; and the vigil of waiting for the check to arrive is attended by nervous uncertainty by this group who are at a stage of life when picayune matters become vexatious problems. And most important is the simple fact that many of the elderly persons seeking medical treatment have no income other than Social Security payments which are not that ample to enable the patient to advance the doctors fee.

2. The concept of a reasonable charge based on criteria that can be manipulated by the doctors by the simple expedient of raising both their customary charge and prevailing charges, should be discarded and instead a schedule of fees should be enacted which will require the approval of the Social Security Administration or some specially constituted board of physicians and laymen, or by Federally aided State planning agencies. The

determination of reasonable charges should be based on schedules thus determined.

PART III

GRANTS TO STATES FOR MEDICALLY INDIGENT

Although Title XVIII of the Act, the Medicare provisions heretofore discussed, drew the bulk of public attention, Title XIX, entitled "Grants to States for Medical Assistance Programs", may well have a greater long-range impact on the health of the American people. For the first time, the Federal government has recognized its responsibility to assist the States to furnish

> "...(1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families attain or retain capability for independence or self-care..." 22

A. Coverage Under Title XIX.

States participating in Title XIX programs must, as a minimum, provide medical care for all their public assistance recipients; i.e., those receiving money payments under the Old-Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to Families with Dependent Children programs. The States need go no further than this. But if a State decides to provide medical care for persons eligible therefor except for their income under one of the above programs,

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22. Sec. 1901.

it must provide similar care under all the programs.[23] Thus, if the State's program calls for medical care for persons over 65 who are not receiving public assistance (i.e., the aged medical indigent), it must provide aid for the medically indigent in the other categories, i.e., the medically indigent blind, the medically indigent permanently and totally disabled, and the medically indigent families under the Dependent Children programs. A State is thereby prohibited from discriminating among its medically indigent groups, and is compelled to provide "across-the-board" medical aid for the medically indigent.

A State may provide full and comprehensive medical care for all medically needy children under age 21, even if the family's income exceeds the maximum for the Aid to Families with Dependent Children program. Thus, children in families whose income may cover the family's basic needs will be eligible for medical assistance under Title XIX if the family's income is insufficient to meet the children's medical needs.

Finally, the State must make a

> "satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance with a view towards furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility requirements with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care."[24]

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23. Sec. 1902 (10)
24. Sec. 1903 (e)

B. Scope of Services

No later than July 1, 1967, States offering a Title XIX program must provide, at least (a) inpatient and outpatient hospital services, and for payment of the reasonable cost of the former; (b) physician's services, whether furnished in the home, the office, in a hospital, or a nursing home; (c) nursing home services for persons over 21 years of age; and (d) laboratory and X'ray services.[25]

In addition to the foregoing mandated services, Federal matching funds will be available for programs which provide (a) any type of State-recognized medical or remedial care; (b) dental service, including dentures; (c) home health services, private duty nursing services, clinic services, physical therapy and related services; (d) prescribed drugs, prosthetic devices and prescribed eyeglasses; (e) inpatient hospital or nursing home services for persons over 65 years in a tubercular or mental institution, and (f) any other type of recognized care approved by the Secretary of Health, Education and Welfare (hereafter referred to as the Secretary).[26]

C. Financing

Beginning with the first calendar quarter of 1966, the Federal government will pay quarterly to each State with an

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25. Sec. 1902 (a)(13); Sec. 1905 (a)(i)-(v).
26. Sec. 1905 (a)(1)-(5)

approved plan no less than 50% (55% for Puerto Rico, the Virgin Islands and Guam), and no more than 83% of the State's medical assistance expenditures, based upon a formula which varies in relation to the State's per capita income and which is weighted in favor of the poorer States.[27] The State's expenditures may include the cost of premiums under Part B of Title XVIII.[28] There is no ceiling on a State's expenditures for medical assistance in which the Federal government will participate. A State may not reduce its expenditures for medical assistance below that prevailing prior to its participation in the Title XIX program.[29] Indeed, the Federal share will be "sweetened" by 5% if the State maintains its current level of expenditures.[30]

The Federal government will pay, in addition to the foregoing, 75% of the administrative costs for compensation and training of the professional and administrative staffs administering the plan and 50% of the remaining administrative expenses.[31]

Federal contributions will be met from the general revenues of the United States;[32] unlike the greater portion of the Title XVIII program which is financed by taxes on payrolls paid by employers, employees and the self-employed.

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27. Sec. 1905 (b)
28. Sec. 122, Pub. L. No. 89-97, 89 Cong., 1st Sess.
29. Sec. 1902 (c)
30. Sec. 1903 (c) (1)
31. Sec. 1903 (a)(2)(3)
32. Sec. 1901

States which, on January 1, 1970, do not have a Title XIX program also will lose Federal matching funds for medical care for recipients of cash assistance payments.[33]

By July 1, 1970, a State must finance the non-Federal share of the Title XIX program from its funds or, if funds from local government subdivisions, i.e., cities, counties, etc., are being used to finance the program, demonstrate that a reduction in or elimination of funds from such local sources will not impair the plan's effectiveness or operation.[34]

Insofar as over-all cost of the Title XIX program is concerned, Congress estimated that the program

> "will increase the Federal Government's contribution about $200 million in a full year of operation over that in the programs operated under existing law."[35]

D. Eligibility and Benefits

By the enactment of Title XIX, Congress intended to protect the basic income which a family needs for its support from the consequences of an illness which it could not afford. Persons in families with incomes below this minimum level qualify for benefits under Title XIX. It is obvious, however, that a uniform, nation-wide standard could not be established because of the wide disparities throughout the country. Consequently, Congress left it to the States to fix standards of eligibility, but imposed restrictions on the States' discretion, apparently

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33. Sec. 1905 (b)
34. Sec. 1902 (a)(2)
35. 1965 U.S. Code Cong. & Ad. News 1952

as a result of its unfavorable experience with the eligibility standards[36] established by the States under the (1960 Kerr-Mills) Medical Assistance for the Aged Act.[37] Only immediately available income and resources can be considered in establishing the level of income for medical assistance.[38] The income standard must be sufficiently flexible not to cause denial of assistance to persons suddenly confronted with high medical bills. Moreover, and of first importance, States may no longer cast financial responsibility for illness upon relatives, e.g., adult children are not responsible for parents' medical bills. Spouses are responsible for spouses and parents for children under 21 years of age and for blind and disabled children of all ages. Responsibility of kin goes no further.[39] States are forbidden to impose a residence requirement for Title XIX eligibility or to exclude any United States citizen residing in the State.[40] A State must provide medical assistance to residents temporarily out of the State.[41] The State plan must cover deductibles under Part A of Title XVIII and may impose a charge for Part B expenditures only if reasonably related to income.[42] States may not recover medical

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36. Address by Fred H. Steininger, Director, Bureau of Family Services, Department of Health, Education and Welfare to Bergen County Medical Society, May 10, 1966.
37. See Sec. 601, Pub. L. 86-778, 86 Cong. 2 Sess; see also 21 <u>Law in Transition</u> (Fall, 1961), 207, 208.
38. Sec. 1902 (17)(B)(C)
39. Sec. 1902 (17)(D)
40. Sec. 1902 (D)(3)(4)
41. Sec. 1902 (16)
42. Sec. 1902 (15)

assistance payments from the recipient, except only from the estates of recipients of such assistance over 65 years of age, and then only after the death of the surviving spouse and only if there is no surviving child under 21 years of age or blind or permanently disabled.[43]

E. Participating States

As of December, 1966, 25 States, Guam and Puerto Rico had plans approved by the Secretary and in operation and the plans of several others were awaiting approval.[44] The States range in location from Pennsylvania to Hawaii and in population from California to North Dakota. Summaries of the plans, as approved, are available[45] and we do not propose to deal with them here. Suffice it to say that the varying plans demonstrate the flexible response to the needs and requirements of the individual States which Congress sought to insure.

Public attention has been largely focused on New York's Medicaid plan.[46] Denounced as "socialized medicine" because of income eligibility standards "that are too high and out of reach of the State's resources",[47] Medicaid is defended as a program which will establish "...a single comprehensive program

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43. Sec. 1902 (18)
44. New York Times, December 11, 1966
45. Department of Health, Education and Welfare, Bureau of Family Services, Washington, D.C. 20201
46. Chapters 256 and 257, Law of 1966; 1966 McKinneys Sess. Laws 275 et seq.
47. "This is socialized medicine...It's just free medical care for everything." (sic) Marion B. Folsom, former Secretary of the Department of Health, Education and Welfare, quoted in the New York Times, May 15, 1966; see e.g., Wall Street Journal, July 11, 1966; New York Times, May 21, 1966.

of uniform, high-quality medical assistance for all who are in need of such care"[48] within the criteria mandated by Title XIX.

The New York State Department of Welfare, which administers the Title XIX program in New York, has promulgated regulations under which a family is considered medically indigent if the income of a sole wage earner in a family of two is less than $4,000, in a family of four is less than $6,000, and in a family of six is less than $7,700, in each case after allowances for income taxes, health insurance premiums, premiums on $1,000 of life insurance for each member of the family or savings of $1,000 for each family member for burial services, the homestead and "essential personal property.[49] However, the legislature has now established a deductible where the gross income of the wage earner exceeds $4,500.[50]

State officials estimate that more than one-third of the population of New York would qualify for medical aid under this program and that the first year costs would be approximately $532 million and ultimate annual costs under $1 billion. However, Federal officials have estimated that the total annual cost of New York's program would ultimately reach $1.4 billion.[51] The Federal share of the State-estimated first-year cost of $532 million will be about $217 million.[52]

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48. Message of Gov. Rockefeller to the New York Legislature, March 9, 1966, 1966 McKinneys Sess. Laws 2989
49. Bulletin No. 132, May 11, 1966, Department of Social Welfare, State of New York, Albany, New York
50. Chapter 802, Laws of 1966, 1966 McKinney's Sess. Laws 1732
51. New York Times, September 5, 1966
52. New York Times, November 16, 1966

The New York plan has generated sentiment for limiting amendments to Title XIX.[53] On October 11, 1966, the House Ways and Means Committee reported favorably a bill to amend Title XIX.[54] The chief purpose of this bill was to restrict the eligibility provisions of Title XIX which the Committee felt had been interpreted by some States in a manner not consistent with Congressional intent to include families of moderate income.[55] The Committee bill, which was not acted upon prior to adjournment, would amend Sec. 1905 (a)(ii) by excluding from eligibility for Federal matching funds medical assistance payments to adult members of the family whose incomes are greater than the incomes set by States under the Aid to Families with Dependent Children program. Thus, inasmuch as an income of $6,000 for a family of four in New York exceeds the limits for cash payments under the State's Aid to Families with Dependent Children program, cash payments in behalf of medically indigent adults in such families would not share in the federal matching funds.

F. Recommendations

Title XIX explores fields which are new and uncharted in this country. The Federal government has taken a monumental step

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53. The Association of New York State Physicians and Dentists was formed to seek modification or repeal of the New York law (New York Times, November 16, 1966); see also, New York Times May 21, 1966; August 7, 1966.
54. H.R. 18225, 89th Cong., 2nd Sess.
55. H.R. Rep. No. 224, 89th Cong. 2nd Sess., 1966

to meet its responsibilities for the health of the American people. The unique character of the national-state relationship in the United States creates a partnership between the States and the Federal government in financing and administering this type of program. This is necessary and desirable to foster the widest diversity and allow for the greatest flexibility in meeting the varying and often greatly different needs of the 50 States.

However, the uproar over the New York program carries its own lesson which the proponents and defenders of government-supported health and medical care would do well to heed. The utmost vigilance will be required of supporters of this program to guard against its dilution and to assure that its broadly beneficial purpose is not weakened, let alone scuttled,[56] before the program has been tested in practice. Rather than dwell upon estimated ultimate cost, it would be better to emphasize the very real savings to a country and nation whose citizens are, to a considerable degree, relieved of the financial

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56. "It should be noted that, although the estimated reductions in Federal cost under the proposals to modify Title XIX are relatively small, nevertheless these proposals will well serve as a brake on undue expansion of the program in the future." id., p.8.

"The Association of New York State Physicians and Dentists, an organization formed to work for modification or repeal of the New York program, said it would continue to seek restrictive legislation. A spokesman expressed the hope that administrators of the program would 'go slow' in the meantime." New York Times, November 16, 1966.

burdens of illness. Whatever the ultimate cost, it cannot be greater than the cost of sick, disabled and medically deficient persons and their toll upon the Nation.

It appears that many persons in States with approved plans are not aware of their rights under Title XIX.[57] The Secretary should require that a plan provide for widespread and meaningful publicity in those areas and among those groups most likely to need the program. No changes should be made in Title XIX at least until a majority of the States, including the most populous ones, have submitted plans and Title XIX has been operative for a reasonable period of time. Only after such experience can the program be analyzed and an informed judgment be reached on its effectiveness. In the meantime, the Guild desires to record its opposition to any restrictive or limiting amendments to Title XIX and urges that it be implemented in a broad and liberal spirit.

PART IV

ADDITIONAL CHANGES RECOMMENDED

In Parts I, II and III, we have suggested certain improvements needed to rectify shortcomings in the statute and administrative procedures as they applied respectively to the hospital care provisions, the non-hospital medical care provisions, and the participation with the States in caring for the medically indigent. In this Part, we urge additional changes:

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57. New York Times, November 28, 1966, October 25, 1966.

A. Extension to All Persons Permanently Disabled

President Johnson, in a recent speech, stated that he would request the Congress in 1967 to extend Medicare coverage to persons under 65 who are permanently disabled. This concept is sound, and we urge the Congress to accept it. However, it will not be enough if the disabled persons eligible are only those who qualify for Social Security disability pensions.[58] Persons over 65 may qualify for Medicare even though they are not eligible for Social Security benefits, the general funds of the government providing for the cost.[59] The same idea should be applied to persons under 65 if they are permanently disabled; they should receive medical care benefits whether or not eligible for Social Security pensions.

B. Extension to Dependents and Survivors of Persons Over 65 or Permanently Disabled

The Social Security Act recognizes the needs of dependent and surviving spouses and children. It provides for pension benefits for them under certain specified conditions of age and dependency.[60] How much more important it is to provide for their health! The medical care provisions should apply to dependent and surviving spouses and children of all persons over 65, or permanently disabled, whether they are eligible for pension payments or not, the general funds of the government providing for the cost.

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58. Secs. 223 et seq.
59. See: Sec. 103 of Social Security Act Amendments of 1965 (Pub. L. 89-97) as to hospitalization coverage, and Sec. 1836 as to eligibility for supplementary medical benefits.
60. Sec. 202 (b) and (d)

C. Extension of Coverage to Include Dental Care, Prescription Drugs and Biologicals, Physical Examinations, Eye Examinations and Glasses, Hearing Aids, Orthopedic Shoes, Immunizations, Blood Transfusions in Full, and Custodial Care

These items are not included under Medicare, although they constitute a large portion of the expenses for health care of the elderly and the disabled. Frequently, the cost of dental care, hearing aids, eye care and glasses, custodial care, etc. far exceeds the cost of other health needs for such an individual. The exclusion of such items as these, plus the deductibles,[61] the co-insurance provisions,[62] and the time limitations on coverage,[63] result in overall failure to meet a substantial part of the medical care needs of the elderly and disabled. It has been estimated that less than one-half (1/2) of the total medical expense of persons over 65 will be met by Medicare. Moreover, under Title XIX of the Social Security Act, providing Federal grants to the States for the medically indigent, these expenses are expressly included as items for which reimbursement will be granted.[64] Why are they not included under Medicare? These items are all recognized and deductible as medical expenses for income tax purposes.[65] There is no basis

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61. See pages 4,5,9 , supra
62. See pages 4,5,9 , supra
63. See pages 4, 5 , supra
64. Sec. 1905 (a)
65. I.R.C. Sec. 213; U.S. Treasury Dept. I.R.S. Document No. 5020 (12-65)

for excluding them other than their cost. The costs of Medicare benefits have been actuarily estimated,[66] so that they ultimately will be covered by the additional payroll taxes, progressing from .70% to 1.60% over the next eleven years (with 1/2 paid by employer and 1/2 by employee, and specified rates for the self-employed), for the basic hospitalization coverage,[67] and by the $6 per month per person (1/2 paid by the person and 1/2 out of Federal general funds), for the voluntary supplementary medical care coverage.[68] The Congressional committees concerned with the program have expressed the belief that it is a matter for concern if any portion of the old-age, survivors and disability insurance system shows any significant actuarial insufficiency.[69] In our opinion, this concept of financing is unsound.[70] However, even if it is adhered to, these very significant health expenses should not be left to the elderly and the disabled any more than the ones paid by Medicare. If necessary, the tax rates or the earnings base of $6,600 should be increased to cover these costs. Medicare should be complete and comprehensive.

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66. See: Report of Advisory Council on Social Security, 1965, fn. , supra, p. 96 et seq.
67. Secs. 3101 and 3111
68. Sec. 1839
69. fn 66 , supra, at page 97
70. See "Financing", pages 31 to 33 , infra.

D. Elimination of Disqualification of Persons Who Are Members of Organizations Required to Register Under Internal Security (McCarran) Act of 1950

To mollify the witch-hunters in the Congress, sections were included in the Social Security Act Amendments of 1965 which denied Medicare benefits to persons who are members of organizations required to register under the Internal Security Act of 1950, and who are not entitled to Social Security pension benefits.[71] Thus, if they are members of such organizations, and are entitled to pension benefits, they are entitled to Medicare benefits; otherwise, they are not. Since persons not eligible for pension benefits must affirmatively apply for Medicare, a disclaimer oath has been requested of such persons.[72] Opposition to these provisions has been voiced in newspaper editorials and speeches throughout the country, including many in high governmental positions; the provisions also have been held by one Court to be unconstitutional.[73] Aside from any basic opposition to the Mc Carran Act itself, it should be clear that deprivation of medical care to the elderly and disabled is hardly appropriate as a penalty. Moreover, since such medical care is important to society as a whole, society is being penalized. It is to be

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71. Sec. 103 (b) (1) and 104 (a) (2), Social Security Act Amendments of 1965; P.L. 89-97
72. Question No. 15 on Application Form
73. Reed v. Gardner, 35 L.W. 2277 (U.S.D.C. Calif. Nov. 14, 1966); this three-judge Court held both the statutory provision and the disclaimer oath to be a violation of the First Amendment of the Constitution. The Attorney General has decided not to appeal this decision.

F. Financing

As indicated in "C" above,[77] the costs of Medicare have been actuarily estimated and the increasing payroll taxes plus the $6 per month per person, together with the interest earned on the accumulated funds, have been designed ultimately to meet a large part of these costs. The prescribed tax rates and the $6,600 earnings base are not expected to be adequate to cover the costs in perpetuity, and it is expected that increased hospital and medical costs, higher earnings, and a decrease in the value of the dollar will ultimately require higher rates, or a higher base or both. In May, 1966, United States Commissioner of Social Security, Robert M. Ball, urged "inflation-proofing" of Medicare - a plan gearing benefits to the Consumer Price Index.[78] If actuarial balance between increased benefits and increased income is to be maintained, it is likely that the tax rates, taxable earnings base, and the monthly premium for supplementary medical care will be increased, too. Politically, tying Medicare benefits to an increase in payroll taxes, specifically earmarked as a hospitalization tax, and deducting $3 per month out of increased Social Security pension benefits to provide supplementary medical care, were much easier for the Congress and the Administration. To have sought to cover these costs by increasing income, excise, estate, gift or other taxes

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77. Pages 27-28
78. New York Times, May 12, 1966

used to produce general funds for the Federal government, would have made passage of the 1965 Amendments much more difficult, if not impossible. Yet, we must recognize the situation for what it is. This is a payroll tax -- a tax on the first $6,600 of earnings - a regressive tax which falls most heavily upon those who can least afford it. A man earning $50,000 a year pays the same amount as the man earning $6,600 per year; and the amount is unaffected by the number of dependents or other factors which make the income tax more equitable. The situation is confused in the minds of many persons by statutory references to two "trust funds" to be known as the "Federal Hospital Insurance Trust Fund[79] and the "Federal Supplementary Medical Insurance Trust Fund.[80] These are basically bookkeeping devices pursuant to which the Federal government puts earmarked funds into one pocket instead of another. It sounds good! The National Lawyers Guild, as a matter of general policy, has repeatedly favored the principle that Social Security pensions and medical care benefits should be financed through general revenues, rather than through the present contributory system of taxes on payrolls and gross earnings.[81] It is to be noted that Federal general revenues already pay for:

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79. Sec. 1817
80. Sec. 1841
81. See Report of the National Lawyers Guild on Health Insurance Benefits for the Aged - July, 1960, page 6, "D-2"

hospitalization benefits for persons currently over 65, or who will turn 65 within the next few years, and who are not covered by the Social Security or Railroad Retirement systems;[82] also, one-half the cost of supplementary medical care benefits (matching the $3 monthly premium paid by enrollees over 65);[83] also, the money necessary to create an immediate operating fund and contingency reserve for the supplementary medical benefits equal to $18 per elderly person;[84] also, the entire cost of the grants to the States under Title XIX for medical care for the medically indigent.[85] Federal general revenues also for many years have been used for Veterans Hospitals, public health and for many other forms of public assistance both directly and through grants to the States.[86] Federal general revenues are also being made available for the construction of hospital and medical facilities, and the education and training of more doctors and other medical personnel. This is as it should be. However, the Medicare benefits also should be paid for out of Federal general funds rather than increased payroll taxes and monthly premiums which the elderly must pay.

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82. Sec. 103 (c) of the Social Security Act Amendments of 1965
83. Secs. 1839 (b) (2) and 1844 (a)
84. Sec. 1844 (b)
85. Sec. 1901
86. In an article in the New York Times for November 20, 1966, Section 1, page 59, Dr. Howard A. Rusk stated: "In the last two years Congress has appropriated more dollars for health than in the 168 preceding years since the Public Health Service was founded." The article named 14 laws passed during the past two years in which money was appropriated by the Congress for some phase of health and which were financed out of general funds.

CONCLUSION

It is almost universally recognized by Americans, including the "reluctant dragons" of the medical profession, that some kind of insurance coverage is necessary to provide adequate medical care for all but the very rich. The majority of our people also realize that the rising costs of medical care have made adequate and complete private insurance coverage too expensive for most people, particularly the aged, the disabled, the poor, and their dependents and their survivors. Many people, including many knowledgeable legislators, have also come to realize that even middle class citizens cannot afford the premiums for private insurance which will give them complete, or even substantial, coverage against the costs of serious disabilities, and cannot otherwise meet these costs. Moreover, many persons who can afford some kind of insurance protection fail voluntarily to purchase it; they are not willing to use part of their income for this "rainy day" protection. Still others are uninsurable, because of past or current health conditions. As a result, when serious illness occurs to such persons, or to their families, they defer needed medical or dental care, or become a problem to all around them, including society itself. For this reason, the National Lawyers Guild believes that the medical care coverage provided in the 1965 Social Security Act Amendments should be improved and expanded as suggested above. We believe that the ultimate

goal must be the application of the compulsory social insurance system to the medical and dental care of all our citizens, under as well as over 65, able-bodied as well as disabled. The proposed "National Health Act of 1945[87] was designed to cover substantially all of our people, not merely the aged or the disabled, so there is nothing revolutionary or startling in this proposal.[88] The Guild urged passage of the 1945 bill[89] and continues to support comprehensive Federal medical and dental care for the entire population.

Report prepared by:

Stanley J. Mayer, Chairman
Myron Holtzman
Marvin Marcus
Ralph Shapiro

December, 1966

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87. See note 1, supra
88. Theodore Roosevelt's Progressive Party had universal health insurance as a party plank in 1912, and the idea was first put forth in Bismark's Germany in 1883, and has been adopted in several European countries. "Annals of Legislators: Medicare", The New Yorker, July 2, 1966, p. 2
89. "The National Health Act", Lawyers Guild Review Vol. V, No. 6, Nov.-Dec. 1945, pp. 347 et seq.