CONGRESSMAN'S REPORT
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Medicare v. Eldercare -A Big Issue Finally Resolved

As I write this report the House of Representatives is about to resolve an issue that has been stirring passions -- and congressional mail -- for years on end. By the time you read this the vote should have occurred. I am writing you today in order that you may share my thoughts on the eve of a great vote affecting the lives and needs of all of us.

The bill we are about to vote on is "Medicare" -- not a new subject to you or me. In fact, for four years and three campaigns we have been doing a lot of talking about it in Arizona. Many of you will recall that one of my 1962 newsletters discussed the subject in the mistaken belief that I would have a chance to vote on it that year; I didn't.

By the time you read this I predict the bill will have passed the House by a substantial margin and will have gone to the Senate, where a similar measure was approved last year. There seems little doubt that the President will sign the bill before many weeks have passed. What will the bill do? Why have I decided to vote for it? What were the alternatives? These are questions I want to discuss in this report.

If a system of representative democracy works properly (and ours does), no major legislation passes the Congress unless congressmen and senators are convinced that (a) there is a serious problem to be solved, (b) the Federal government is the proper one to solve it, and (c) a majority of the American people want it solved by the particular bill in question. All three of these tests were met in this case.

A REAL PROBLEM EXISTS

Older people -- those over 65 -- are a growing segment of our population. Nearly one American out of every 10 is in this age group, and the segment is increasing every year. While medical care is a serious matter for all Americans, this group has special problems:

Less Income. Of the 18 million people over 65 more than half have incomes of less than $1,000 a year. The average for two-person families is just $2,530. Incomes like these will buy very little hospital care.

Fewer Assets. A third of the people over 65 (6 million Americans!) have no assets at all. Half have less than $1,000. Yet, when a husband or wife is hospitalized, half the aged couples today have total medical bills exceeding $800 a year.

More Illness. People over 65 use three times as much hospital care as younger people. When they go to the hospital, they stay twice as long on the average.

Medical Cost Increases Hit Them Hardest. Since their productive years many of these people have seen tremendous increases in medical costs, 63 per cent since 1950. In the same period hospital rooms have gone up 154 per cent. Few have savings to meet these mounting costs.

In my 1962 newsletter I printed samples of the thousands of cases in which retirement years have been turned into nightmares of debt and disillusionment for people who have led useful lives, only to see major illnesses wipe out their life savings. Others wrote of their shock at having health insurance policies cancelled without warning. Hundreds of such cases have come across my desk. Every reader will know of others.

WHAT SHOULD BE DONE?

No amount of oratory about self-reliance is going to keep our older citizens from getting sick, nor will it put money in savings accounts of retired persons who have exhausted their savings and can't get a job. This great wealthy society has never totally ignored such facts; we have always had some recourse, however painful, for those who needed care. We have provided this care, and we will continue to provide such care, somehow, at some level of government. No matter how we do it, it will cost money.

In all this debate there have been essentially three different approaches and three different philosophies. Let's see what they are:

1. Do Nothing. Keep the Present System. In Arizona, where we have no Federal program and no state program, indigent older people are taken to the local charity hospital -- usually operated by the county. Those who urge "do nothing" about this problem think they are for saving public funds. But, we are paying these costs right now in our local property tax bills. Those who live in Pima County ought to take a hard look at their county tax bill the next time it comes in -- nearly one-third of it will go to cover the $2 million-a-year deficit at Pima County Hospital.

2. The Kerr-Mills Approach. In 1960 Congress passed the Kerr-Mills Act as an attempt to meet this problem. Under Kerr-Mills a state may, but need not, set up a system of medical care for older citizens. Under this plan: (a) care is available only to those persons who can pass a means test (i.e., assets of less then $800, income below $1,500, to cite one example); (b) the state decides what benefits it will pay, puts up 20

to 50 per cent of the money and runs the program; and (c) the Federal government puts up 50 to 80 per cent of the money, a substantial sum coming directly from Federal income taxes.

A few weeks ago the American Medical Association proposed an expansion of the Kerr-Mills program, labeling the proposal "Eldercare." The Kerr-Mills-Eldercare philosophy might be summed up like this: "The Federal government should help with this problem, but let the individual states which want a program pay half the costs and administer it themselves. And let each state decide whom to help, if anyone, and how much."

3. The Social Security, or "Medicare," Approach. While the first two plans cover only the very poor, Medicare (proposed originally in the King-Anderson Bill) provides universal coverage for all older citizens, both rich and poor. A separate payroll tax is paid by everyone during their working years, and on retirement benefits are paid. These benefits are not charity or welfare; they are paid because the person has earned them. The Medicare philosophy: "This is a major social problem which can be solved by spreading the risk over the broadest possible base. Everyone who works should pay, and everyone should benefit."

It seems certain a big majority of the House and Senate will choose the solution and philosophy of the Medicare proposal as the best of these alternatives.

SHOULDN'T LOCAL GOVERNMENTS DO THIS JOB?

I believe the Federal government should undertake to solve problems only when private enterprise and local governments cannot do the job. It is clear to me that this is a case for Federal action. Let's look at the state governments first. Kerr-Mills is essentially astate solution to this problem. We've had five years experience with it, and in my judgment it is a miserable failure:

** Arizona and eight other states haven't even bothered to pass Kerr-Mills legislation. Arizonans' Federal income taxes go to pay one-half of the cost of such programs in the other 41 states; we get no benefits at all.

** Even the states operating such programs have been unable to agree on any uniform treatment of older people. In Oklahoma an aged couple is eligible if their income is below $3,000 and assets are less than $1,000; in neighboring Arkansas they would be ineligible if their income exceeded $1,500, but they could have as much as $3,100 in assets. In Utah they could have $2,400 in income and $10,000 in assets.

** Benefits vary even more widely. New York has a reasonably comprehensive program covering hospital care, physicians' fees, nursing homes and drugs. Maine pays only for hospital care, and that on a limited basis. Benefit payments per recipient range from an average of $14 in Kentucky to $410 in Illinois.

** The truth is that only seven of the 41 states with Kerr-Mills laws have anything like an adequate program.

** Kerr-Mills fails to take into account our highly mobile population. A Massachusetts couple, having paid taxes to maintain a fairly good medical program in that state, will receive extremely limited care, should the need arise, if they later move to Vermont and no care at all if they move to Texas or Arizona.

HOW ABOUT PRIVATE INSURANCE?

Three years ago we heard a great deal about the capacity of the private insurance industry to meet this need. However, these arguments only prompted thousands of aged ex-policy-holders to recite their experiences of cancellations when illness struck. In an attempt to bolster their position various private companies combined their resources to offer special plans for older citizens. How have they done? They have not done well.

Many of these plans, such as "New York 65" and "Connecticut 65", have had to raise their rates substantially after initial periods of operation. The plans vary enormously; the lower the premium, the less you get. The "Golden 65" plan of Continental Casualty Co. is fairly complete but costs a couple over $600 a year -- obviously more than millions of retired persons can afford.

THE AMERICAN MEDICAL ASSOCIATION

In my public career, and in my career as a lawyer, I have had the privilege of meeting and working with a large number of Southern Arizona physicians. With few exceptions I have found them to be sincere, humanitarian, progressive citizens who work hard at an arduous and increasingly complex profession. The vast majority of them give time and service to charity and non-paying cases. I have rarely met a doctor I did not like and respect.

In the judgment of this congressman the medical profession has been badly advised and poorly led by its national organization, the American Medical Association. Too often the AMA has taken the path of obstruction when a progressive and humanitarian course would have been better for the profession and the country. Dominated by an obsessive fear of "socialized medicine" (which I oppose, and which nearly all Members of Congress oppose), the AMA has played a largely negative role through the years.

In the 1930s the AMA denounced Social Security itself as a "compulsory socialistic tax" which would lead to totalitarianism. Later the AMA opposed extension of Social Security benefits to the permanently and totally disabled at age 50, calling it "a serious threat to American medicine." It tried to stop Federal grants for maternal and child welfare programs, charging that this program to reduce the death rate among mothers and children tended "to promote communism." And, finally, the AMA fought long and hard against adoption of Blue Cross-type voluntary health insurance programs, the very thing they now praise most highly.

"It is a sad fact," the Journal of the American Hospital Association wrote in 1949, "that through the 1930s and early 1940s the AMA did not believe in voluntary sickness insurance, did almost everything possible to prevent its development."

The AMA's zig-zag course reached a climax of some kind in late 1964 when the election results made it clear that Medicare would probably pass. The association hastily constructed a proposal called Eldercare and embarked upon a multi-million-dollar advertising program to sell it to the Congress and the country as a substitute for Medicare. The Eldercare ads, many of which appeared in Arizona, took two strange tacks:

1. Medicare is socialized medicine. It goes too far.
2. Medicare should be defeated because it doesn't go far enough.

In the words of one Eldercare ad in an Arizona newspaper: "Eldercare would offer better care than Medicare. . . Eldercare would provide for physicians' services -- Medicare would not. Eldercare would provide for surgical costs -- Medicare would not."

It seemed to me that the AMA proposal was both inconsistent and illogical. In effect, the AMA officials were saying:

> "Friends, you know that problem we said didn't exist? Well, it does exist and it is very, very serious. While we told you that Medicare was socialized medicine and should be defeated, we now recognize that it should be defeated only because it doesn't go far enough. The Congress should do more for our older citizens and pass our Eldercare bill instead."

WOULD ELDERCARE REALLY DO MORE?

In a sense, Eldercare would do more than the King-Anderson Medicare program. But here are some "ifs":

> IF your state has a Kerr-Mills program, and IF it provides for all the benefits authorized by the Congress, and IF your state legislature puts up about half the money required for a comprehensive program, and IF you are willing to apply for aid as an indigent, and IF you can qualify as an indigent (that is, if you had income of, say, less than $1,500, and if your car and savings and life insurance, and maybe even your home, add up to less than perhaps $2,500), and IF, in some cases, your sons and daughters are willing to pass a similar test of indigency -- IF all these requirements are met, then perhaps you would receive more care under Eldercare than under the original Medicare proposal (since revised and expanded). If not, you wouldn't.

On the basis of official government reports on the Kerr-Mills program I estimate that Eldercare legislation in all 50 states would enable a maximum of 3 million people to qualify for benefits, about 1/2 million actually receiving care in any given year. The remaining 15 million older people would get nothing.

OTHER SHORTCOMINGS OF ELDERCARE

Eldercare had other shortcomings. Here are two:

** I think most Americans would prefer to pay for their own future medical care during their working years rather than face the prospect of going to the state for charity care if their savings are exhausted.

** Medicare provided known benefits; Eldercare did not. In fact, Rep. A.S. Herlong, Jr., co-sponsor of the Eldercare bill, condemned the AMA for its glowing ads. "For them to give the impression it provides complete coverage is not so," Mr. Herlong said. "It just makes it available for the states to provide it if they want to."

NOT ALL DOCTORS WENT ALONG

While I am critical of the AMA, I don't want to leave the impression that all Arizona physicians concurred in the AMA position. On the contrary, I have had letters from a surprising number of leading physicians supporting Medicare and opposing the AMA program. Here is what one outstanding Arizona physician wrote me: "We have been watching with marked interest the progress the Medicare bill has been making in Congress, and contrary to the beliefs of many doctors in this area, I am firmly behind the principle of this bill." Wrote another: "...the recent reactionary practices are not part of the foundation and original structure of the AMA."

THE NEW LAW -- WHAT BENEFITS WILL IT PROVIDE?

Since it is likely that the House bill will soon become law, perhaps with minor Senate changes, let's see what benefits it will provide and how it will work:

BASIC PLAN -- Coverage for all persons over 65, benefits commencing July 1, 1966 with one exception. Up to 60 days of full hospital care per illness, with patient paying only the first $40. From 20 to 100 days of post-hospital care in an affiliated facility for each spell of illness (this coverage to begin January 1, 1967). Outpatient diagnostic services following payment of $20 deductible. Post-hospital home health services up to 100 visits per spell of illness. Payments made directly to hospitals, etc.

VOLUNTARY SUPPLEMENTARY PLAN - - Coverage for all persons over 65 enrolling before March 30, 1966 or as they reach 65. In exchange for $3 monthly premium ($6 for a couple) enrollees will be covered for 80% of these additional services following payment of $50 annual deductible: physicians' and surgical

services, up to 60 days per illness in a mental hospital (180-day lifetime maximum), up to 100 visits per year for home health services without prior hospitalization, diagnostic tests, X-ray, radium and radioactive isotope therapy, ambulance services under limited conditions, surgical dressings, rental of durable medical equipment, etc. Plan to be administered by private carriers like Blue Cross. Benefits effective July 1, 1966.

Financing of the Basic Plan will be through an additional Social Security tax applying equally to employees, employers and self-employed persons. Initially the increase will amount to 35/100 of 1 per cent of a worker's wages, up to a new base of $5,600 (compared with present base of $4,800). By 1987 the Medicare tax will be 80/100 of 1 per cent; the earnings base will be $6,600 after 1971.

WHAT THE PUBLIC WANTS

In a democracy the public eventually gets what it wants by way of legislation. I have received many letters demanding to know why I favor Medicare "when the people of my state and the country are opposed." The answer is that all the information I can obtain indicates that a majority of my constituents and of the American people favor passage of this legislation:

** The nationwide Harris Poll recently reported that, if they had to choose between Medicare and lower taxes, or Medicare and a balanced budget, Americans would choose Medicare by a margin of 2 to 1.

** Last year I sent a questionnaire to every resident of my district, and the responses ran 3 to 2 in favor of Medicare.

** An expensive private poll in Arizona last year revealed that a big majority of Democrats and a narrow majority of Republicans favored Medicare.

DEMOCRACY AT WORK

Thus I believe that in a very real sense the final decision was made, not by those of us in Congress, but by the people of this country who have in various ways made their wishes known. This is an example of the workings of a representative democracy. While there may be delays and protracted debate, in the long run legislation is based on popular support. I have read all your letters and studied each of these proposals, and it is my conviction that we are doing the right thing. Within a few years, in my judgment, many of those who bitterly and sincerely opposed this law will wonder why we waited until 1965 to meet this serious need.