THE KING-ANDERSON BILL: THE SOCIAL SECURITY APPROACH

By

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S.S. 499

Dr. J.R. Goutor

April 15, 1963
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Most of the materials compiled for the writing of this paper were obtained by the author as a result of correspondence with the Indiana Congressional delegation, the American Medical Association, the A.F.L.-C.I.O., and the Library of Congress Legislative Reference Service. The staff of Senator Vance Hartke were particularly helpful in allowing the author to borrow the House Ways and Means Committee Hearings on H.R. 4222 and materials from the Library of Congress. The other materials were obtained in the libraries of Ball State Teachers College and Anderson College.
Glossary of Terms

The King-Anderson bill, the Administration bill, and the Social Security Approach are other names for H.R. 4222 and S. 909, the proposals for medical care to the aged under social security.

The Kerr-Mills law is another name for H.R. 12580 and Public Law 86-778, the approach to medical care for the aged administered by the States.

OASI and OASDI refer to Old-Age Survivors and Disability Insurance under social security.

AMA refers to the American Medical Association.

A.F.L.-C.I.O. refers to the American Federation of Labor-Congress of Industrial Organizations.

The King-Anderson Bill: The Social Security Approach

Medical care for people over 65 years of age has been a subject of interest for legislators as well as for the medical profession since the early 1940's. These groups, and other, less vocal segments of the population, have become concerned because, as new drugs and medical techniques continue to extend the human life span, the problem of cost of the prolonged illnesses which frequently accompany old age becomes more acute. According to the Department of Health, Education, and Welfare figures:

nine out of ten of the people who live to be 65 go to the hospital at least once between age 65 and death. When an aged person goes to the hospital he is more likely to stay longer than a younger person because he is more likely to have serious and long-lasting disease. People over 65 are in hospitals, on the average, 2½ times as much as younger people. 1.

The costs of a hospital stay have tripled in the last 15 years. The average cost per day in 1946 was $9.39; by 1960 this average had risen to $32.28 a day. 2. According to the findings of the Bureau of Labor Statistics, in 1959 there were 15.3 million people over

2. Ibid.
65 years of age. 55% of these had annual incomes of less than $1,000. Only 13% of all people 65 years of age and over in this country had incomes of more than $3,000 a year. In a survey made in 1959 by the Federal Reserve Board, 67% of the families in which the head of the house was 65 or over had savings of $2,000 or less.

In view of the fact that the segment of the population 65 years and older have incomes and savings below that of the rest of the population, and are subject to more illnesses which require extended hospitalization, Congress and the President became convinced that some type of legislation is necessary to provide for these people. The purpose of this paper is to describe the types of legislation proposed up to the present time, with particular emphasis on the latest proposal--the King-Anderson Bills, H.R. 4222 and S. 909.

The first legislation to provide medical care for people 65 and older was introduced in Congress in 1942, 1943, and 1945. This legislation would have given hospitalization benefits to all people covered by the Old-Age and Survivors Insurance program (the Social Security Program) and their dependents. This legislation was

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4. Ibid.
defeated. In 1952 the first bill to extend hospitalization to those directly entitled to OASI benefits was introduced. Since then similar bills have been introduced in each session of the Congress. All have been defeated.

In 1954 President Eisenhower asked Congress to approve a program for limited Federal Government reinsurance of private health plans. Bills to carry out this program were reported to the House and Senate in 1954, but the bill failed in the House and was not called up in the Senate. 5.

The Forand Bill (H. R. 4700) was first introduced in 1957. This bill provided for:

hospital, surgical, and nursing home benefits for Old-Age and Survivors Insurance eligibles using the Social Security administrative mechanism and financed by an increase in the Social Security tax. 6.

The measure was not reported out by the House Committee on Ways and Means. The Forand Bill was introduced again in 1959 (86th Congress), and five days of hearings were held before the House Committee on Ways and Means in July of 1959.


On April 3, 1959 Secretary Fleming of the Department of Health, Education, and Welfare submitted a report to the committee advocating federal grants to the states to help finance benefits to the aged. Meanwhile, the Senate passed a resolution (S. Res. 65) authorizing a subcommittee of the Senate Committee on Labor and Public Welfare to study the problems of the aged and the aging. The subcommittee held hearings in various cities and submitted a report on January 29, 1960. The subcommittee recommended that:

Legislation be enacted to expand the system of Old-Age Survivors, and Disability Insurance to include health service benefits for all persons eligible for OASDI. 7.

The minority dissented from this recommendation and pointed out that the recommendation proposed even greater benefits than those offered under the Fordand Bill.

On May 4, 1960 Secretary Fleming presented the Eisenhower Administration proposal. This proposal would have "instituted a Federal-State program to provide low income individuals 65 and over with protection against the cost of long-term and expensive illness". 8.


8. E. Peel, p. 3.
Participation by the states would have been optional and the costs would have been financed by the Federal government from general revenues and by an enrollment fee of $24 per individual per year. The present Kerr-Mills Law (P.L. 86-778) was finally derived from this proposal. During the Senate debate on the proposal, several modifications were suggested and defeated. One of these was the Kennedy-Anderson amendment which would have authorized "hospital, nursing home, visiting nurses, and outpatient diagnostic services for OASI eligibles age 68 and over." 9 Another amendment by Senator Javits would have combined parts of the Administration proposal with earlier bills which had emphasized Federal assistance to voluntary prepayment health plans.

On June 13, 1960 the Committee reported out H. R. 12580 introduced by its Chairman, Representative Mills. The bill passed the House of Representatives on June 23, 1960, by a vote of 380 to 23. Following hearings before the Senate Finance Committee, the Senate Committee approved what was known as the Kerr-Frear version of the Mills Bill. Several motions for amendment to include the social security payroll tax financing mechanism were

9. Ibid.

defeated in the Committee. On August 23, 1960 the Senate amended and passed H.R. 12580. The vote was 91 to 2. Two days later conferees appointed by the Senate and the House resolved differences between House and Senate versions of the bill. The conference report was accepted by both Houses and the bill, now known as the "Kerr-Mills" Act was approved by the President on September 13, 1960 as Public Law 86-778.

Under this law, Federal grants are made to States to establish a medical care program

for aged persons not on public assistance but whose income and resources are insufficient to meet the costs of necessary medical service. States which participate under the new program have wide latitude to determine the standards of eligibility and the medical benefits they offer. The Federal assistance provided by both programs is derived from general revenue. 10.

As of June 4, 1962 the number of States and territories which were participating in the program under Public Law 86-778 was 26; plus Puerto Rico. 11.

The benefits which the individual state legislatures have approved vary greatly. Two of the highly regarded programs are those set up by Massachusetts and North Dakota. Both offer unlimited hospitalization, and Massachusetts requires reviews of the patient's condition

after 30 and 60 day periods. West Virginia also has offered unlimited hospitalization and other benefits. However, the financial resources of the state have proved insufficient to finance the medicare program as it exists in West Virginia.

At the present time Public Law 86-778 is the only federal law which makes provision for medical care to the aged. Under this law, the Federal government provides from 50 to 80% of funds for individual states to finance this program. The federal government will also pay 50% of the cost of administering state plans under Public Law 86-778.

The question which is now before Congress can be summarized as follows: is this law sufficient in providing for the medical and hospitalization needs of people 65 years and older? Opponents of additional legislation say that Public Law 86-778 give states the necessary funds to provide for their aged. Those in favor of additional legislation argue that Public Law 86-778 should be merely a supplementary measure to be used with other legislation.

President Kennedy is one of those who advocate more legislation for the health protection of the aged.

12. Ibid.
In his State of the Union Message to Congress, in 1961, he said: "no piece of unfinished business is more important or more urgent than the enactment under the Social Security System of health insurance for the aged". 13.

On February 9, 1961, President Kennedy sent his Special Message on "Health and Medical Care" to Congress.

In this message the President repeated the need for legislation under the Social Security System:

our social insurance system today guards against nearly every major financial setback: retirement, death, disability, and unemployment. But it does not protect our older citizens against the hardships of prolonged and expensive illness. 14.

As a result of the President's message to Congress, H.R. 4222 was introduced on February 13, 1961 by Representative Cecil R. King of California in the House; and S. 909 was introduced the same day in the Senate by Senator Clinton P. Anderson of New Mexico. 15. Representative King describes the bill as follows:

The purposes of this Act are to provide aged individuals entitled to benefits under the old-age, survivors and disability insurance system with basic protection against the costs of inpatient hospital services and skilled nursing home services, and to provide, in addition, as an alternative to inpatient care, protection against the costs of home health services and outpatient

hospital diagnostic services; to utilize
social insurance for financing the pro-
tection so provided; to assure adequate
and prompt payment on behalf of these
individuals to the providers of these
services; and to do these things in a
manner consistent with the dignity and
self-respect of each individual, with­
out interfering in any way with the free
choice of physicians or other health per­
sonnel or facilities by the individual,
without the exercise of any practice of
Federal supervision or control over the
practice of medicine by any doctor or
over the manner in which medical services
are provided by any hospital. 16.

Under this bill, payment would be made for a combina-
tion of services, including up to 90 days of inpatient
hospital care and up to 180 days of skilled nursing home
care after leaving the hospital, for each illness. There
would be a deductible provision—to be paid by the patient--
of $10 for each of the first nine days of inpatient hos­
pital care, with a minimum deductible amount of $20.
For each illness, payment would be made for a total of 150
units—a unit being one day of hospital inpatient care or
two days of skilled nursing home care. All costs in ex­
cess of $20 for hospital out-patient clinic diagnostic
services would be paid. Community visiting nurses services
and related home health services would be provided the
aged in their own homes for up to 240 visits a year. 17.

16. Ibid. p. 4.
17. Ibid. pp. 6-10.
We are now in April, 1963. The program was to go into effect in January, 1963. It was estimated that at that time there would be 17 3/4 million people 65 years and over in the United States. 13 3/4 million would be eligible under OASI, and 1/2 million would be eligible under the Railroad Retirement Act, for a total of 14 1/4 million people. 18.

The bill would have increased the social security tax one-half of one percent. One-half of this was to be paid by the employer and the other half by the employee. 3/8 of one percent would be added to the tax on self-employed persons. The maximum of yearly earnings to which the new tax would apply would be raised from $4,800 to $5,200. 19. After the taxes had been collected they would be placed in one of the three accounts of the Federal Social Insurance Trust Fund—Disability Insurance Account, Health Insurance Account, and Old-Age and Survivors Insurance Account.

The estimated first year costs of each of the types of benefits are as follows: 20.

<table>
<thead>
<tr>
<th>Amount (in millions)</th>
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<tbody>
<tr>
<td>Hospitalization</td>
</tr>
<tr>
<td>Skilled nursing home</td>
</tr>
<tr>
<td>Home Health</td>
</tr>
<tr>
<td>Outpatient hospital diagnostic service</td>
</tr>
</tbody>
</table>

Total $1,060

18. E. Peel, p. 4.
20. E. Peel, p. 5.
The Secretary of Health, Education, and Welfare would have the responsibility for administering the program and the Railroad Retirement Board would be responsible for those covered under railroad retirement benefits. Hospitals and nursing homes were to be subject to certain requirements to participate in the program.

The Secretary of Health, Education, and Welfare shall consult the State agencies, the Advisory Council (a 13-member council from private life, appointed by the Secretary, four of whose members shall be outstanding in the field of health) and other national accrediting bodies in the formulating of conditions for participation. The Secretary may, pursuant to agreement, utilize State agencies to determine which facilities are eligible to participate and to provide various consultative services to facilities which wish to qualify under the program. The Secretary may also find that accreditation by a national accrediting body provides reasonable assurance of the eligibility of a facility. 21.

The King-Anderson Bill did not reach the floor of the House in 1962. After hearings by the Senate Finance Committee, the bill was introduced on the floor of the Senate in July, 1962 and was defeated. At that time several alternative bills were proposed. They were H.R. 10981, introduced by Representative Bow of New York; H.R. 11253, introduced by Representative Lindsey of New York;

and S. 2664, introduced by Senator Javits of New York.

Representative Bow's bill provided for a tax credit of up to $125 to pay premiums on approved private health insurance. This would be offered to all people 65 or older, and the private health insurance would include the costs of doctor's services and surgery. 22. Representative Lindsey's bill supported the social security approach but added the "Rockefeller option". This provided that the person could receive cash in lieu of coverage as long as he was covered by a comparable private health plan. Senator Javits' proposal would have had the states administer the social security mechanism. 23. These three bills were defeated.

The 88th Congress (1st session) has been in session for two months at the time this paper is written. The King-Anderson proposal has not yet been introduced. However, it is expected to be submitted sometime during the first session. It has been argued by certain groups that the health needs of the aged should not be a political question; however, the fact remains that it has become a political issue and will continue to be so as long as pol-

Iticians are able to use the issue as a vote getting device.

The question facing the legislators is this: is the Kerr-Mills law sufficient to protect the aged; or is more legislation, administered by the social security mechanism, necessary?

Spokesman for both viewpoints are quite vocal. Those in favor of the Kerr-Mills approach argue that Public Law 86-778 is not being given an opportunity to work. This view is taken by Everett Dirksen, Minority Leader of the Senate. He says:

We feel that if the Kennedy administration had spent half as much effort stimulating the Kerr-Mills Act already on the Federal statute books to provide medical assistance for the aged, this law would today be operating successfully in 50 States instead of 21 States. 24.

In a letter to the author of this paper, Charles Halleck, Minority Leader of the House of Representatives, states that the above statement "is not merely an expression of my own views in this matter, but it represents the combined view of the Republican leaders in the House and Senate." 25.

Supporters of the Kerr-Mills approach add that despite lack of encouragement by the Administration, the


Kerr-Mills program is working well. The Social Security Administration reports that although the law did not go into effect until late in 1960, by December of 1961 payments under the new law were running around $1\frac{1}{4}$ million per month for aged not eligible for old-age assistance. These payments were made on behalf of nearly 72,000 persons in 18 states. 26.

In hearings before the Ways and Means Committee, Dr. Leonard Lawson, of the American Medical Association, stated:

"We believe the Kerr-Mills law deserves a chance to prove itself." 27. He went on to say:

we must point out that it has not been allowed to develop naturally so far. Statistical estimates concerning the number of aged who need help, the type of help they need and its cost have varied so widely that state legislatures, especially those with little experience with formal state-wide vendor payment medical care programs, wish to gain valid experience with the program before expanding. 28.

Another argument used by the Kerr-Mills advocates is that the law assists only those persons who actually need medical assistance. The National Association of Retail Druggists supports the Kerr-Mills law because:

28. Ibid., pp. 1392-93, Vol. 3.
the Kerr-Mills health plan is limited to the medically needy. It offers health care services to all medically needy aged, whether eligible for social security benefits or not. Benefits would not be needed by a fairly large proportion of those 8 million persons over 65 having adequate private health insurance plans. It would also be unnecessary for those eligible for the veterans health care program, or the plan for retired military personnel and dependents. 29.

Mr. Leslie Dikovics, representative of the Council of State Chambers of Commerce, offered the following statement in favor of the Kerr-Mills law:

We support the Kerr-Mills program as an adequate and appropriate solution to the problem of medical care to the aged. With its diversity as between states, it permits accommodation of regional differences. With its case-by-case administration, it permits consideration of individual needs and greater control over costs. Also it permits a greater control in respect to over-utilization of medical personnel and facilities. More adequate individual care can be provided at lower total cost because of the smaller number involved. Private insurance and prepayment programs will not be curtailed or supplanted. 30.

The American Medical Association has been the strongest booster of the Kerr-Mills law. In a statement in an issue of the Journal of the American Medical Association the official position is put forth: the American Medical Association favors this bill because

it preserves the quality of medical care; because it allows each state through federal grants-in-aid to provide as wide a variety of health services as it chooses; because it does not limit the length of time an eligible person may receive such services; because it supplements rather than supplants right to participate in voluntary health insurance programs; because it vests control at the state level where specific problems are known first hand; and because it avoids tax dollars waste. 31.

Opponents of the Kerr-Mills approach to medical care for the aged say that it is not sufficient to care for those 65 or over. They express concern over the ability of the individual states to provide the necessary money for the project. They point out that some states are in a much better financial position than others to provide for medical care. This view was expressed in hearings before the Ways and Means Committee by Mr. Charles Schottland of the American Public Welfare Association:

in talking with State welfare administrators, we find that limitations in the new program of medical assistance for the aged were not based on reluctance to help the aged, or on any deficiencies in the Federal law, but on the inability of many States to assume additional major financial burdens. We find, therefore, that although the Kerr-Mills bill was broadly conceived by its authors and by the Congress, it has not been possible for most of the States to implement this intent fully. 32.


Mr. Walter Ruther, of the A.F.L.-C.I.O., said:

...the Kerr-Mills bill will require action every year on the part of the Federal government to appropriate money for the coming year. It will require action on the part of 50 state bodies, where they will have to appropriate money. It will require all this complicated administrative machinery.

Half the cost of the Kerr-Mills Bill will be borne by the states and local communities. And the most regressive kind of taxation in America is the tax structure at the state and local community level, because it bears disproportionately heavy upon the small property owners. And they will have to pay for half of this cost. 33.

The Governor of Michigan, John Swainson, presented to the Committee a graph showing the financial impact of the Kerr-Mills law on the five Great Lakes States (Ohio, Indiana, Illinois, Wisconsin, and Michigan) if they were to provide the same medical benefits for the same numbers of individuals as proposed in the King-Anderson bill.

To provide the same amount of medical care for the same number of individuals who would receive aid through the social security approach using the Kerr-Mills law, the States would have to appropriate:

<table>
<thead>
<tr>
<th>State</th>
<th>Amount (Millions)</th>
</tr>
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<tbody>
<tr>
<td>Illinois</td>
<td>$33.4</td>
</tr>
<tr>
<td>Indiana</td>
<td>14.8</td>
</tr>
<tr>
<td>Michigan</td>
<td>25.75</td>
</tr>
<tr>
<td>Ohio</td>
<td>30.65</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>12.45</td>
</tr>
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</table>

33. Reprint from "Face the Nation" debate, February 23, 1961.
Under the Kerr-Mills program, about 50 percent of the aged are ostensibly eligible in the States now with a program or proposed programs. But few States are able to afford a comprehensive program. 34.

Proponents of the King-Anderson bill say that the Kerr-Mills law should be used to supplement the King-Anderson approach. This is the view taken by former Secretary of Health, Education, and Welfare, Abraham Ribicoff, before the Committee:

If the proposed program is enacted, Kerr-Mills would serve as a backstop—filling in for the smaller and smaller group of aged persons who cannot qualify for social insurance protection or whose benefits do not fit their needs. It is expected that enactment of the health insurance program would relieve the States of their present financial burden and enable them to provide more adequate programs of medical assistance for the aged. 35.

Proponents of the Kerr-Mills proposal offer the following reasons: Kerr-Mills is not being given an opportunity to work; the law is working well despite lack of encouragement by the Kennedy Administration; the law assists only those persons who actually need medical assistance; it provides for greater control over costs; and it allows each state to provide a wide variety of health services.

Opponents of the Kerr-Mills approach offer the following reasons for their opinion: some states do not have the necessary money to provide for the Kerr-Mills program; the program requires action every year on the part of Federal and State governments to appropriate money; and the Kerr-Mills law is not sufficient legislation—it should be used along with the King-Anderson approach.

The Administration does not feel that the arguments in favor of the Kerr-Mills law are strong enough to change its view that the social security approach is the best method of obtaining medical care for the aged. Despite the defeat of the King-Anderson bill last July, the Administration plans to move "ahead with vigor" with plans to reintroduce the bill.

Proponents of the King-Anderson, social security, approach present several arguments in favor of the program. The first argument is that medical care is a natural part of the social security of the older citizens. Former Secretary Ribicoff states it this way:

provisions for health insurance benefits for the aged are a necessary part of income protection in retirement. Without such benefits the social security program cannot adequately provide basic security for the aged. 36.

Another argument offered by those in favor of King-Anderson is that it does not require a "means" test as does Kerr-Mills. Governor Brown of California put it this way:

...enactment of H. R. 4222 would avoid the continued pauperization of many citizens who after lengthy periods as wage earners and contributors must virtually exhaust their personal and family resources in order to qualify for help in a medical crisis from either public or private sources. That this condition should exist in a country as rich and as enlightened as the United States borders on the indefensible. 37.

Walter Ruther is also opposed to the means test. According to him:

one of the most effective deterrents to the use of the medical assistance for the aged is the fact that not only must applicants undergo an exploration of income and resources, but their adult children will in most cases have to be subjected to an examination and evaluation of resources and that there will be an expectation that they contribute as an alternative to providing public aid. For many older people this procedure is completely unacceptable. 38.

The Governor of Pennsylvania, David Lawrence, asserts that the means test is repugnant because it sets up a charity financed by the public and is little more than

37. Ibid. p. 1616, Vol. 3.
38. Ibid. p. 1639, Vol. 3.
an extension of the relief system. 39.

In his book, James Dixon, an M.D., discussed the means test.

The means test is a devise, vestigial from an era in which poverty was regarded as a crime against the community. Another view of the means test is that it is a degrading hurdle between the individual and his state which prevents the use of government in meeting effectively health needs. Surely the matter of the health of the citizens is a matter of the general welfare. 40.

Another argument for King-Anderson is that its broad coverage will enable more people to avail themselves of medical care. This is the view of Mr. Ribicoff, who comments:

the social insurance approach, on a national basis, makes possible provision of basic protection for the aged regardless of where they may happen to live...About 95% of today's workers will have this protection when they reach age 65...Even among those already retired the majority will be protected immediately under this plan. 41.

Another argument in favor of the King-Anderson bill is that the social security system is already set up, and medical care could easily be administered under this sy-


stem because existing records could be used. Mr. Ribicoff, speaking for the Administration, said that it would be possible to administer the plan very cheaply because the administrative machinery is already "operating smoothly in the administration of the present program." 42.

Those who favor the King-Anderson approach say that the bill forbids any interference with the practice of medicine by the government. Even though the Secretary of Health, Education, and Welfare has the right to establish the standards for participation in the program, it is maintained that this would have no adverse effect on the way medicine is practiced in the hospitals. Mr. Schottland, speaking for the American Public Welfare Association, told the Ways and Means Committee:

...the Secretary already has similar authority with respect to hospitals, and nursing homes receiving grants under Hill-Burton legislation, but this has not resulted in government control. Similarly, the States, in their licensing of practitioners and institutions, establish standards as a protection to the public, and have administered such provisioners for many years without controlling the practice of medicine or the operation of medical institutions. 43.

The bill specifies that the costs of a doctor are not included in the costs covered by the bill. Former Sec-

42. Ibid., p. 37, Vol. 1.
43. Ibid., pp. 946-47, Vol. 2.
retary Ribicoff commented:

the bill specifically provides that every patient has the right to choose his own doctor. This has nothing to do with doctors. Every patient, no matter who he may be, chooses his own doctor, and there is nothing in this bill whatsoever that has to do with the private physician...The only doctors that are involved are the doctors who work with the hospitals, like the radiologist, or the anesthesiologist, or the pathologist...But there is absolutely nothing in this bill...that has anything to do with the doctor-patient relationship. 44.

Dr. Elkin Ravetz, Medical Director, Resthaven, Inc., spoke on the subject of doctors being affected adversely by the bill.

Any inference that quality of care will deteriorate is an unjust and unwarranted slur on the dedication and integrity of the American physician. I refuse to believe that any of my colleagues would allow their judgment and treatment to be influenced by the source of payment whether it be from the patient, an insurance company, or the Federal government. 45.

Another argument in favor of the King-Anderson bill is that the requirements of the bill, such as requirements of a doctor's certification for an admission into a hospital or nursing home, and the review of long-term stays by a patient in a hospital, will curb the abuses of those claiming benefits. Dr. Ravetz says that the bill provides

44. Ibid., p. 190, Vol.1.
several benefits: the bill provides preventive diagnostic services so that the patient can be treated at home before he reaches the point where hospitalization is necessary; it provides for payment of nursing home care, thus allowing the patient to leave the hospital sooner; the bill will pay for many of the expenses of a hospital stay, thus giving the family more resources to provide for the patient on discharge from the hospital. 46.

Opponents of the King-Anderson, social security, approach to medical care offer several arguments to counter those given by the proponents of the approach. Two groups who have vigorously maintained the program is unsound are the American Medical Association and the Chamber of Commerce of the United States. Both groups assert that medical care for the aged is not the concern of the Federal Government. In a statement before the Ways and Means Committee a spokesman for the American Medical Association said this:

We are opposed to H.R. 4222. We feel, first of all, that it is wrong in principle. We feel it is an assumption on the part of the Federal Government of responsibility which is essentially a local program. We feel that the responsibility for health rests, first of all, upon the individual; secondly, upon the members of his family. Thirdly, in our counties across the Nation, this type of responsibility has been assumed by churches, civic groups, by local organizations, community health organ-

47. Ibid., p. 1309, Vol. 3.
izations. Next it goes to the county level and then the State level...to reverse that process and make the responsibility first a Federal responsibility merely because a person reaches the age of 65--irrespective of need--is taking away from the individual, from his family, and his community the responsibility which has formed the background for the growth and development of our representative type of government. 47.

The Chamber of Commerce agreed with the American Medical Association that the King-Anderson bill is inappropriate:

H. R. 4222 would initiate completely new principles entirely contradictory to those basic to Social Security by providing health care service benefits to those who are still working full-time...

...Since the health care protection provided would be the same for all at 65, the fundamental principle in Social Security of wage relationship of benefits will be completely ignored.

Finally, the initiation of benefits in the form of services rather than in cash is a complete denial of individual freedom of choice... 48.

Opponents of the program say it will jeopardize the quality of medical care. They also claim that overstay­ing in nursing homes and hospitals would become a widespread practice. Lower quality, it is contended, results from overtaxing doctors and facilities. Critics of the Administration proposal point out that this has happened to Great Britain since that country adopted socialized medicine in 1947. An American newspaper man in London

writes about the British system—"The patients' complaints
fit mainly under the heading 'We wait, wait, wait'. If
fewer people went to a doctor with 'frivolous calls',
waiting time would be cut." 49.

The American Medical Association found this argument
useful against King-Anderson:

H.R. 4222 would introduce into our system
of freely practiced medicine the elements
of compulsion, regulation, and control.

A careful reading of H.R. 4222 will dis­
close the regulatory powers given the Sec­
retary of Health, Education, and Welfare
which constitute a blan'et authorization
for the Federal Government to control the
providers of medical services.

H.R. 4222 would further lower the quality
of medical care by causing overuse of hos­
pital and nursing home facilities. Such
over-utilization is implicit in all measures
of this sort. But H.R. 4222 blatantly en­
courages over-utilization by requiring
patients destined for a nursing home to
be admitted first to a hospital. 50.

Dr. Alvin Ingram of the American Academy of Ortho-
paedic Surgeons added these arguments: the bill would
interfere with the confidential doctor-patient relation-
ship because it would permit a government employee to
examine a patient's records to determine if he needed

49. Don Cook. "Socialized Medicine, Ten Years Old: What
"We Can Learn from England's Experiment", Harpers
Magazine, May 1959, p. 36.

50. Reprint from The Journal of the American Medical
the care prescribed; and the Secretary of Health, Education, and Welfare has the power to interfere with the facilities because he may determine the reasonable costs of the services that are rendered. 51.

Another argument against the King-Anderson proposal is that the administration of the program would become a burden. This is the view of Mr. Ralph Rooke, of the National Association of Retail Druggists.

The plan would produce an administrative nightmare, with Federal officials first working out contracts with 6,000 hospitals, 25,000 nursing homes, and 700 visiting nurse groups...The paperwork involved in processing claims for the 12 million beneficiaries of the plan staggered the imagination. An extremely large force of Government workers would undoubtedly be required to do the job. 52.

Dr. Frank Groner, President of the American Hospital Association added this:

Administration of the bill is further complicated by the fact that the beneficiaries of the railroad retirement system are to be included under the program...rather than the Social Security Administration.

Maintenance of a separate administrative system for the railroad retirement beneficiaries would be wasteful and cumbersome. Hospitals would have to negotiate with two separate agencies for the beneficiaries of a single program. Moreover,

52. Ibid., p. 679, Vol. 2.
differing policy interpretations are bound to arise either nationally or locally where there are two administrative agencies. 53.

Aside from the question of the need for a program of medical care for the aged under social security, there is the question of the effect of such a program on the private health insurance plans which are now offered throughout the United States. Health insurance programs are usually classified into three broad groups: service benefit plans as generally sold by Blue Cross and Blue Shield; cash indemnity plans sold by commercial carriers; and those plans sold by independent groups.

The Blue Cross and Blue Shield plans provide for hospital and surgical benefits. Health insurance plans of commercial carriers contract to pay a fixed amount for a particular medical service such as a day of hospital care or an operation. Thus the individual person who is covered by a Blue Cross-Blue Shield contract receives no cash but specified amounts of medical services regardless of their cost, while a person covered by a commercial carrier contract receives specified amounts of cash which may not cover the whole cost of the medical service. 54.

Few plans provide total medical expenses. Some of the independent plans come closest--covering hospital,
surgical, and physicians's non-surgical care; generally they cover neither dental care or all drugs. Health insurance may be purchased on an individual basis or as a member of a group, most often the employees of a particular company.

Those opposed to the King-Anderson bill say that private insurance together with the Kerr-Mills law make the King-Anderson legislation unnecessary. Dr. Larson of the AMA gives the following statistics:

At present, there are 51 plans in 41 states and the District of Columbia offering non-group coverage to persons over 65; and 11 additional plans under development in 4 states. This compares with 40 plans in 37 states last year...

Some 240 voluntary health-insuring organizations--including Blue Cross and Blue Shield--are now issuing hospital or surgical policies to the elderly...

Opponents of King-Anderson add that industry is playing a big role to help in insuring its employees. This was the substance of testimony given by Mahlon Eubank, Director, Social Insurance department, Commerce and Industry Association, New York, Inc.:

At present about 3/4 or more of our health insurance plans (group) are provided through employment. Five years ago, employers put up 1/4 of all the premiums paid for that type of group coverage. Now they are paying close to $2 billion of the $5.5 billion premium cost. More and more of these policies are being written to provide continuance of health insurance after retirement under the group plan or with provisions giving the employee the

right to convert to an individual insurance policy without evidence of health. 56.

Those in favor of the King-Anderson, social security, approach reply that the private insurance plans now offered are not adequate in regards to those 65 or older. The A.F.L.-C.I.O. concurs with this opinion and says through its spokesman, Walter Ruther:

In spite of efforts of recent years by private insurance companies and other health insurers to blanket the aged with some form of insurance, the performance thus far holds forth no hope that voluntary insurance can meet the basic needs of the aged. It is very late in the day for the voluntary movement to come up with, at most, an enrollment of less than \% of the population now 65 and over. 57.

The President of the A.F.L.-C.I.O., Mr. George Meany, went on to say that:

Blue Cross plans generally try to maintain community rates, identical for all subscribers.

Since the aged require about 2\% times as much hospitalization as the rest of the population, they push up costs out of proportion to their numbers. This has subjected Blue Cross to severe price competition from commercial plans that don't include older persons or set premiums on the basis of experience rating...No group plan that includes the aged can be sure of maintaining a broad enough membership to absorb the extra costs they entail. 58.

One of the major issues concerning medical care under the social security system is the possibility that the pro-

56. Ibid., pp. 1183-34, Vol. 2.
57. Ibid., p. 1641, Vol. 3
program will lead to socialism. This is a primary contention of opponents of the King-Anderson bill. They maintain that when the Federal Government undertakes to pay for a service, it must take some responsibility for the quality of that service. They point to a statement made by Walter Ruther during the July 1959 hearings for OASI Beneficiaries:

"obviously whenever Government has responsibility, it must have authority to discharge that responsibility. The two things are inseparable." 59.

Opponents argue that the bill gives the government the authority to fix a price ceiling on all government payments for drugs and supplies, and the wages of nurses and certain hospital physicians. They argue that the level of coverage would soon be lowered to those aged 60 and over, and then to age 50, and finally to people of all ages. Thus they feel that the Federal Government would fully control medical care and would be just one step from full socialization of medicine.

Former Secretary Ribicoff answers their charges.

What is socialization of medicine? If the Government owned the hospitals, if the Government paid the doctors and the doctors worked for the Government, that would be socialization. 60.

59. Statement of Walter Ruther before Ways and Means Committee Hearings on Hospital, Nursing Home, and Surgical Benefits for OASI Beneficiaries, July 1959, p. 422.

care. The administration of the King-Anderson approach would be simple because the existing records for the social security system can be used. The bill also does not require a "means" test, which is considered degrading by many older citizens. The authors of the bill point out that the provisions of the bill forbid any interference with the practice of medicine because doctors' costs are not included. Those in favor of the King-Anderson bill also assert that the many requirements of the bill will curb abuses of those claiming benefits.

Opponents of the King-Anderson bill give these arguments against the bill. First, they state that medical care is not the concern of the federal government. It is their contention that the Kerr-Mills law, in connection with private insurance, makes the social security approach unnecessary. The bill will jeopardize the quality of medical care. Overstaying in nursing homes and hospitals would become a widespread practice. The bill would cause regulation and control of medicine by the Federal government. Opponents also feel that the administration of such a program would be burdensome. Their final argument is that the bill will lead to socialization.

After compiling the materials for this paper, it is the conclusion of this author that some form of med-
ical care is needed to help our elderly citizens. In past years it was a custom in this country for children to provide for their parents in their old age. However, in recent years our population has become more mobile; children are now living hundreds of miles away from their parents, making it difficult to maintain close ties. Homes are much smaller now than in the past; often there is no room for an aged parent. In addition, many elderly parents now prefer to maintain their independence from their children. Because of this and the low incomes and high hospital costs of the aged that have already been mentioned, medical assistance is definitely needed for these people. The question then becomes: what type of assistance should be given, and who should have the responsibility to administer this assistance? It is the view of this author that the type of aid offered by H.R. 4222, the King-Anderson bill, and the means proposed to administer this bill are not the answer.

The author is opposed to this bill for several reasons. The first is that it would be administered by the social security system of taxation. The author is opposed to the social security system because one would be forced to contribute to the payment for the system even though he is opposed to it. The system
also forces payment regardless of one's financial position or one's need for medical assistance. Many people do not want or need assistance. The idea of accepting money from the Federal Government is repugnant to them, and yet under this system they would be forced to accept this assistance. The author is not convinced that the social security mechanism should be used to provide medical care for this one group. If the Federal Government is justified in alleviating the poverty of the aged through the social security system, would it then not also be justified in using the social security system to alleviate the poverty of all the other poor in the country—whether it be farmers, Negroes, urban slum dwellers, or others?

Another objection of the author to the bill is that as the bill is phrased it will interfere with the practice of medicine. The bill specifies that the costs will be paid for "only such drugs and biologicals, respectively, as are included in the United States Pharmacopoeia, National Formulary, or New and Non-Official Remedies." 63. As the American Medical Association has pointed out, it is often necessary to use drugs to preserve life that are so new that they are

63. H.R. 4222, p. 10.
not listed in the above. If the King-Anderson bill were in effect, doctors would not feel free to prescribe new drugs for the elderly which are not listed with one of these groups. Thus, they could be prevented from saving lives that could be preserved with the use of these new drugs. The King-Anderson proposal would also interfere with the practice of medicine because the bill specifies that the Secretary of Health, Education, and Welfare and his Advisory Council have the authority to approve the hospitals to participate in the program. Many communities have only one hospital; if the hospital in one of these communities is not approved, the elderly of the community may be forced to travel many miles to receive aid under the program, and may be forced to use the services of the doctors of that community rather than their own physician’s services, because he is not able to spare the time from his other patients to travel the distance to an approved hospital. The King-Anderson bill would also pay for the services of certain doctors—those in the fields of pathology, radiology, physiatry, and anesthesiology. The bill would also pay for the services that an intern performs in a hospital. This is the time during his education that a medical student works in a hospital under the guidance of doctors qualified to practice medicine. His first duty is to follow their instructions in order to become a competent
physician himself. However, if he is paid by the government there will be a conflict as to whom he owes his first allegiance—to the doctors from whom he must learn his craft or to the Advisory Council and Secretary of Health, Education, and Welfare from whom he receives his salary.

This author believes that before insisting upon a social security approach to medical care for the aged, the administration should give the present Kerr-Mills law an opportunity to prove itself. The bill became a law on September 13, 1960. Less than four months later on January 12, 1961, in his State of the Union message President Kennedy called for the social security approach as embodied in the King-Anderson bill. His reason for this action was that the Kerr-Mills law is inadequate. It is this author's contention that four months is not sufficient time to determine the adequacy of a law. When the bill was made law, the vote was 380 to 23 in favor of the Kerr-Mills proposal in the House; the vote in the Senate was 91 to 2 in favor. In view of this overwhelming support of the law, it should be given a chance to become effective before other legislation is proposed.

Finally, the author feels that the growth of private group health insurance plans sold to company employees will be great enough, along with the Kerr-Mills law, to provide the necessary protection for those elderly people who need and desire medical care.
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5. Curtis, Representative Thomas, Speech Reprinted from Congressional Record, March 6, 1962.


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TO: Honors Committee
FROM: Dr. Jacques R. Goutor

I recommend that the Senior Honors Thesis entitled "THE KING-ANDERSON BILL: THE SOCIAL SECURITY APPROACH," Submitted by Miss Judith Dilts, be accepted as fulfilling the requirements for graduation with Honors.

I further recommend that this Thesis be given a grade of "A".

Respectfully submitted

Dr. Jacques R. Goutor
Asst. Prof. Social Science